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Adult Services Scrutiny Committee
Tuesday, 25 October 2011

ADDENDA

6. Delayed Transfers of Care (Pages 1 - 6)

11:00

Steven Richards, Chairman of the Oxfordshire Clinical Commissioning Consortium will deliver an update on current performance and progress within the Acceptable Care for Everyone programme.

A briefing note on current performance is attached (**AS6**).

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Report to Adult Services Scrutiny Committee
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Introduction

1. This paper provides an update on delayed transfers of care in Oxfordshire. This follows the presentation given to the joint meeting of the Adult Services and the Health Overview Scrutiny Committee on September 6th by Dr Stephen Richards from the Oxfordshire Clinical Commissioning Consortium and officers from Oxfordshire PCT, Oxford Health, the Oxford Radcliffe Hospitals and the county council.

2. This paper provides an update on the numbers of delayed transfers of care, levels of activity to support the timely discharge of people from hospitals and the progress of the Acceptable Care for Everyone (ACE) programme which is addressing the system-wide issues that lead to delayed transfers of care.

Numbers of Delayed Transfers of Care

3. The department of health publishes monthly figures on delayed transfers of care. The most recent figures at the time of writing this report are for August 2011, where Oxfordshire had 152 reported delays, an increase of 7 on the previous month. The department of health are expected to publish the next set of figures on October 21, where the Oxfordshire figure is expected to rise slightly to 164.

4. The average number of referrals from acute hospitals in Oxfordshire (the Oxford Radcliffe Hospitals and the Nuffield Orthopaedic Clinic) has risen in August and September from a 319 per month to 388 per month, with August and then September having the highest number of referrals so far this year. Last year August and September had the lowest number of referrals for on-going care.

Table 1: Referrals for on-going care from Acute Hospitals in Oxfordshire

	Health care [1]	Social Care [2]	Both	Total
Apr	113	210	11	334
May	147	175	15	337
June	126	213	15	354
Jul	147	162	10	319
Aug	159	197	13	369
Sept	135	235	18	388
Average	138	199	14	350
Total	827	1192	82	2101

[1] Referrals will primarily be for Community Hospital beds
[2] Referrals will be for reablement at home ; rehabilitation at home; care homes and long term care packages

5. Table 2 below identifies the delays at the end of August by reason and responsibility

Table 1: Oxfordshire delays at the end of August 20111 by reason

	NHS	SCS	Both	Total
Completion of Assessment	4	18	0	22
Awaiting Public Funding	0	0	0	0
Further non acute NHS care	55	0	0	55
Residential Home	2	4	0	6
Nursing Home	0	21	0	21
Care Package at Home [3]	0	10	15	25
Community equipment or adaptation	1	3	0	4
Patient or Family Choice	14	0	0	14
Disputes	0	0	0	0
Housing	5	0	0	5
Total	81	56	15	152

6. Over a third of all delays are people in an acute hospital who are awaiting a community hospital bed. There are currently 221 community hospital beds in 8 community hospitals, with another 14 beds managed at Chipping Norton by the Orders of St. John. The community hospitals have admitted 41 people per week this year, as last year and 23 of these people on average have moved into community hospitals from an acute hospital. The actual number of delays for community hospitals have varied month on month, but been at these levels since December. Before this delays were much lower, but at the time Community Hospitals applied access criteria before people could be admitted. These criteria were removed to ensure all people were given a chance at reablement and to ensure people did not queue in the more expensive and less appropriate acute hospitals. However the result appears to be that people have remained delayed in acute hospitals and the effectiveness of community hospitals has been severely weakened. The proportion of clients leaving community hospitals needing no ongoing care has dropped from 11.3 per week in the last 6 months to 8.3 per week in the first 6 months of 2011/12.

7. Within the ACE programme we are therefore looking at the whether to reinstate the access criteria for community hospital beds, whilst ensuring that there is sufficient alternative services, such as short term placements in nursing homes, for people who would have gone to a community hospital bed if the access criteria were still removed. The advantages of this approach are that the number of short term beds purchased in nursing homes can more

[3] A person waiting for c are package at home that is a responsibility of both agencies will be waiting specifically for reablement. A person waiting just for social care will be waiting for a long term care package

easily be changed in the short term to reflect changing levels of demand than the number of beds in community hospitals, which are relatively more fixed.

8. At the end of August, 27 people were delayed awaiting a care home (most of them for a nursing home). In September it was agreed to immediately place the people waiting in the community hospitals or the ORH. This accounted for 22 people, and meant the only queue was in mental health beds. We are currently reviewing the costs of placing the people in mental health care beds and looking to agree the funding of these as a matter of urgency. However the current rate of referrals for care home placements from hospitals has meant that delays for care home beds has risen to 31 at the end of September. Between April and September 2010 81 people in hospitals were placed in a permanent care home placement; between April and September 2011 this rose to 133 people – an increase of 64%. This is significantly more than would be expected through increased demography, and is against the joint health and social care policy of moving people away from bed based care. This growth in demand is a key issue that needs to be addressed within the ACE programme. The model of care workstream in the programme includes work on demand avoidance, which is looking at how we move away from reliance on bed based services. This requires us to set up community based services, which can be accessed 7 days a week and cover core hours of up to 14 hours a day.

9. There are currently 25 people awaiting care at home, 15 of these are waiting services from the reablement service and 10 are waiting for long term packages. In the last two months the reablement service has increased the number of new people it takes on each week to 41 people compared to a year to date average of 34 admissions. A number of people in the reablement need service need onward care long term care. Virtually all of these people have funding for onwards care, but there remains an issue of actual capacity in care providers to provide this care. The contracts team in the council is working closely with providers and the number of people waiting to leave the reablement service for long term care is dropping. As with care placements discussed in paragraph 8, demand for care at home is rising significantly. In the last 6 months of 2010/11 there were 20 referrals for new long term care packages per week, but this has risen to 35 per week this year – an increase of x per cent.

10. The other major areas for delays remain delays in assessment (22) and delays in choice (14). Choice delays have continued to rise in September and are expected to be 21 (or 13%) of all delays when figures are published. Both of these areas will be addressed through a higher focus on pursuing individual delays.

11. Although delays have not dropped since the last meeting of the scrutiny committee, it is important to note that this is because of an increased demand

for on-going services rather than services working below capacity. Although injections of funds can have a short term impact on delays they cannot consistently reduce the numbers, as evidenced by the continued level of care home delays. This is why the current programme of work needs to be system-wide review of how people move through the health and social care system.

12. Although demand for services to support discharge from hospitals is clearly increasing, there is no corresponding increase in demand from people entering hospitals. We therefore need a better understanding of what is happening to people in hospitals that leads to this increased demand. It is imperative that we ensure that the pathway through hospitals works to support people to independence, where ever that is possible for the individual, rather than increased dependency. This re-enforces the importance of understanding the pathway and ensuring that people spend as little time as possible within an acute setting and that settings that are meant to provide rehabilitation services genuinely do provide them.

Update on the ACE programme

13. The ACE programme has 5 key work streams covering
    - The model of care
    - Governance and Finance
    - Communication and Cultural change
    - Tariff change
    - Informatics and Evaluation

14. In the last month the main focus has been on the model of care. This is being designed to cover:
    - Admission Avoidance (“help to keep me out of hospital”)
    - Integrated Community Teams (“I know where to go to get the help I need”)
    - Short Term Community Bed Based Care (“When I can’t be treated or cared for at home, I go to the right place”)
    - Maintaining Independence / Long Term Care (“I get all the help I need with everyday living”)
    - Acute Services (“If I need to go to hospital, I get the right care while I’m there and only stay as long as I need to”.)

15. Meetings were held in September with clinical leads and directors of all the key services to ensure appropriate sign up to the principles across the system. There was agreement that the first change in the model of care is the flow through acute hospitals to community hospital beds described in paragraph 6 above.

16. Key clinicians have attended regional learning sets to see what is working elsewhere in the county and bring this back to Oxfordshire. For example, an Integrated Single Point of Access pilot in Worcestershire which has integrated health and social care which in-reach into hospitals to support both admission avoidance and facilitate timely discharge. This has led to a 15% reduction in admissions in over 75 year olds for specific conditions, allowed the system to close 48 acute beds and reduce the number of acute hospital delays to 10.

Conclusions

17. Delays remain high and are not yet consistently dropping. This has been driven by an increase in demand for services. Services that support discharge from hospital are all working to agreed capacity.

18. Where short term injections of funding have been agreed e.g. to place people in care homes, this has had limited effects on the numbers of delays because the underlying issue of increased demand for services has not been addressed. This situation is providing a financially unsustainable position for the local health and social care economy and produces worse outcomes for people using services.

19. The key step to reduce delays is to map the flow of patients and finance through the system to ensure that people are receiving the right care for their level of need. This work is being progressed by the ACE programme. Since the last meeting of Scrutiny committee the three major developments have been to increase the input of senior clinical staff, who remain crucial in understanding where changes in the process can and should be made, and the review of the flow from acute to community hospital beds and to agree to the setting up of a Social care Crisis Response service. This service is a short term service for up to 72 hours, which will be offered to people at risk of hospital admission, care home admission or significant health risk if a service is not provided. Responses will be provided within 4 hours of referral.

20. There will be a further DTOC lock in on 8th November to specifically look at the increased demand issue and the model of care

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