

To: Members of the Shadow Adult Health & Social Care Board

Notice of a Meeting of the Shadow Adult Health & Social Care Board

Thursday, 23 May 2013 at 3.30 pm

County hall



Peter G. Clark
County Solicitor

May 2013

Contact Officer: **Lynda Chalcraft, Policy & Partnership Officer**
Tel: (01865) 328560; Email: lynda.chalcraft@oxfordshire.gov.uk

Membership

Chairman – Councillor Mrs Judith Heathcoat
Vice Chairman - Dr Joe McManners

Board Members:

John Jackson	Director for Social & Community Services
Cllr Anna Badcock	District Council representative
Vacancy	Clinical Commissioning Group
Glenda Daniels	Public Involvement Network
Lorraine Foley	Clinical Commissioning Group

Notes:

- ***Date of next meeting: Date Not Specified***

Declarations of Interest

The duty to declare.....

Under the Localism Act 2011 it is a criminal offence to

- (a) fail to register a disclosable pecuniary interest within 28 days of election or co-option (or re-election or re-appointment), or
- (b) provide false or misleading information on registration, or
- (c) participate in discussion or voting in a meeting on a matter in which the member or co-opted member has a disclosable pecuniary interest.

Whose Interests must be included?

The Act provides that the interests which must be notified are those of a member or co-opted member of the authority, **or**

- those of a spouse or civil partner of the member or co-opted member;
- those of a person with whom the member or co-opted member is living as husband/wife
- those of a person with whom the member or co-opted member is living as if they were civil partners.

(in each case where the member or co-opted member is aware that the other person has the interest).

What if I remember that I have a Disclosable Pecuniary Interest during the Meeting?.

The Code requires that, at a meeting, where a member or co-opted member has a disclosable interest (of which they are aware) in any matter being considered, they disclose that interest to the meeting. The Council will continue to include an appropriate item on agendas for all meetings, to facilitate this.

Although not explicitly required by the legislation or by the code, it is recommended that in the interests of transparency and for the benefit of all in attendance at the meeting (including members of the public) the nature as well as the existence of the interest is disclosed.

A member or co-opted member who has disclosed a pecuniary interest at a meeting must not participate (or participate further) in any discussion of the matter; and must not participate in any vote or further vote taken; and must withdraw from the room.

Members are asked to continue to pay regard to the following provisions in the code that *“You must serve only the public interest and must never improperly confer an advantage or disadvantage on any person including yourself”* or *“You must not place yourself in situations where your honesty and integrity may be questioned.....”*.

Please seek advice from the Monitoring Officer prior to the meeting should you have any doubt about your approach.

List of Disclosable Pecuniary Interests:

Employment (includes *“any employment, office, trade, profession or vocation carried on for profit or gain”*.), **Sponsorship, Contracts, Land, Licences, Corporate Tenancies, Securities.**

For a full list of Disclosable Pecuniary Interests and further Guidance on this matter please see the Guide to the New Code of Conduct and Register of Interests at Members’ conduct guidelines. <http://intranet.oxfordshire.gov.uk/wps/wcm/connect/occ/Insite/Elected+members/> or contact Rachel Dunn on (01865) 815279 or Rachel.dunn@oxfordshire.gov.uk for a hard copy of the document.

If you have any special requirements (such as a large print version of these papers or special access facilities) please contact the officer named on the front page, but please give as much notice as possible before the meeting.

AGENDA

9. Performance Monitoring (Pages 1 - 8)

4:40

25 minutes

People responsible: Members of the Adult Health and Social Care Partnership Board

Report presented by: Robyn Noonan, Strategy and Performance Service Manager, Oxfordshire County Council

Reports attached.

Action: to consider progress on the Health and Wellbeing Board indicators.

This page is intentionally left blank

Agenda Item 9

Oxfordshire Adult Health and Social Care Board Detailed performance report

1. Details

Strategic Priority 6: Support older people to live independently with dignity whilst reducing the need for care and support

Strategic Lead: Alan Sinclair, Lead Commissioner Older People, County Council

Last updated: 17 May 2013

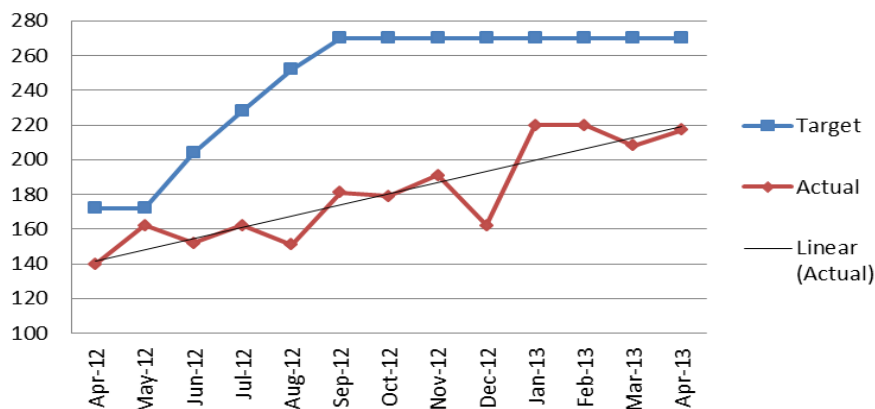
PROGRESS MEASURE: Target of 3,140 people to receive a reablement service in 2012/13. 2,128 people actually received the service in that period.

Current indicator RAG Rating RED

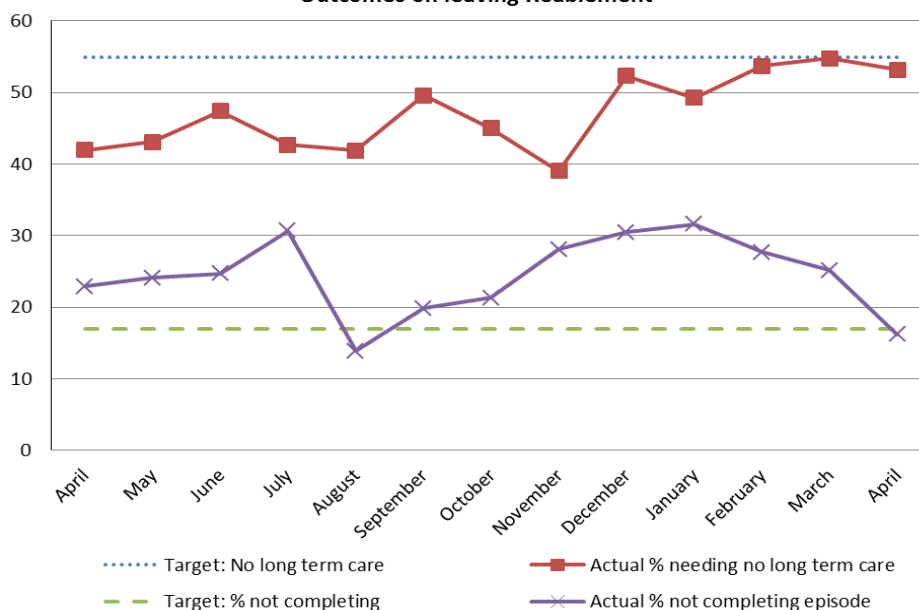
2. Trend Data

The Reablement Service reports to an activity and performance framework of 26 indicators. The three key performance indicators are intake (target 279 per month), the percentage of people leaving the service with no long term care needs (target 55% or higher) and the percentage of people who do not complete their episode of reablement (e.g. due to hospital admission; target 17% or lower).

Number of people who started receiving Reablement



Outcomes on leaving Reablement



3. What is the story behind this trend? - Analysis of Performance

- Intake has improved slightly. Since January the service has consistently seen over 200 people per month. This is still some way off its target of 270 per month. (Financial modelling on the whole system effect of reablement on the amount of home care purchased show that the major factor is the number of people receiving the service, rather than the % leaving with no long term care needs so performance improvement has focussed on improving intake figures.)
- Performance against the outcome performance indicators does seem to have improved though there are some concerns about the reporting of this which are still to be validated.
- Transfers out of the Service continue to work well. There are currently 9 people waiting to transfer out of the Service and only 2 with no planned agency.
- Three reasons were given by the Service for the failure to hit the target on new episodes:
 1. Interface with Oxford University Hospitals Foundation Trust (OUHFT). Although 217 episodes started in the month there were 316 referrals. 127 of these came from the OUHFT. The service reports that only 25% of these referrals end up as being new packages. The reason people do not translate to starts include
 - a. The person is not well when the service arrives to pick them up
 - b. The person has been discharged by a separate service normally Supported Hospital Discharge Service.
 2. Capacity. Although the service believes they have sufficient overall capacity, there is an issue about whether it is the right capacity i.e. in the right place and at the right time to deliver the right care. Although the issues in 1 above explain problems in relation to discharges from the OUHFT it does not explain delays from their own hospitals. This week there are 17 reablement delays and 8 are from community hospitals not the acute.
 3. Lack of community based referrals. There were only 84 community based referrals in the month (against an assumption of half coming from the community so 135 expected). Of the 209 reported new packages in April 109 are recorded as from people in the community who did not go to reablement (as opposed to 69 via reablement; 30 directly from hospitals and 1 from an intermediate care bed).

4. What is being done? - Current initiatives and actions

Actions

Improve interface with OUHFT

Commentary

Actions here have included:

- Working to ensure appropriate paperwork is sent through
- Challenging referrals for people who are not fit
- Ensuring all other parts of the discharge are in place (transport, meds etc.)
- Questioning the role of Supported Hospital Discharge Service
- Attempting to take cases from Supported Hospital Discharge

Actions

Commentary

Service (but the service is apparently unhappy to do this as it will mean they have idle staff)

- Introducing a cut off time (10am) whereby if the patient is not ready they will move their capacity to community services and pick up these cases.

There appear to be significant practical issues in the way teams work together on the interface of hospital discharge, which is affecting performance, wasting resources and providing a poor patient experience.

Capacity

Recruitment figures for the service show no significant increase - in the last two months the number of people employed increased by 0.33 people. The service say this is a misleading indicator as they flex capacity based on people on zero based hours contracts taking more hours.

Increase community referrals

The City Area Service Manager, Melanie Pearce, has promoted the service to County Council locality teams and continues to send weekly emails highlighting capacity in each area.

5. What needs to be done now? - New initiatives and actions

Action	By Whom & By When
Increase community referrals from health professionals by emailing OUHFT teams and GPs	Reablement Service, May & June 2013
Increase community referrals from County Council Social Care teams by promoting specific capacity in each area and looking with teams at why new packages started without clients first receiving reablement	Melanie Pearce, Ele Crichton & Steve Thomas, May & June 2013
Look to identify whether there is a capacity issue by analysing data on all the referrals the service picked up late or did not pick up.	Reablement Service, May 2013
Audit sample of clients who received the service to attempt to identify who does benefit and who does not	Reablement Service and Council, June 2013.

This page is intentionally left blank

Oxfordshire Adult Health and Social Care Board Detailed performance report

1. Details

Strategic Priority 6: Support older people to live independently with dignity whilst reducing the need for care and support

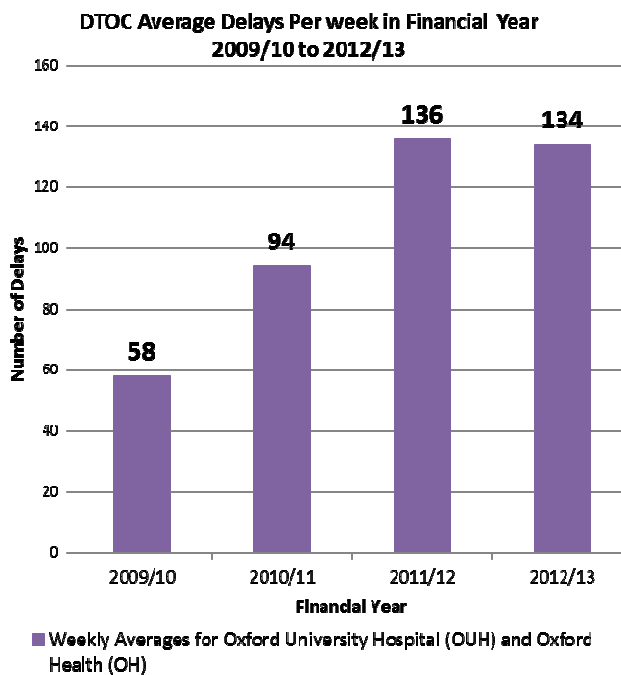
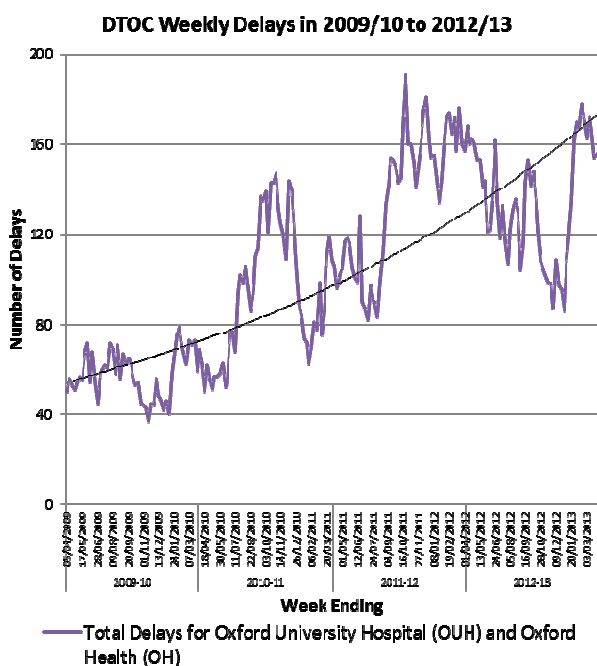
Last updated: 13 May 2013

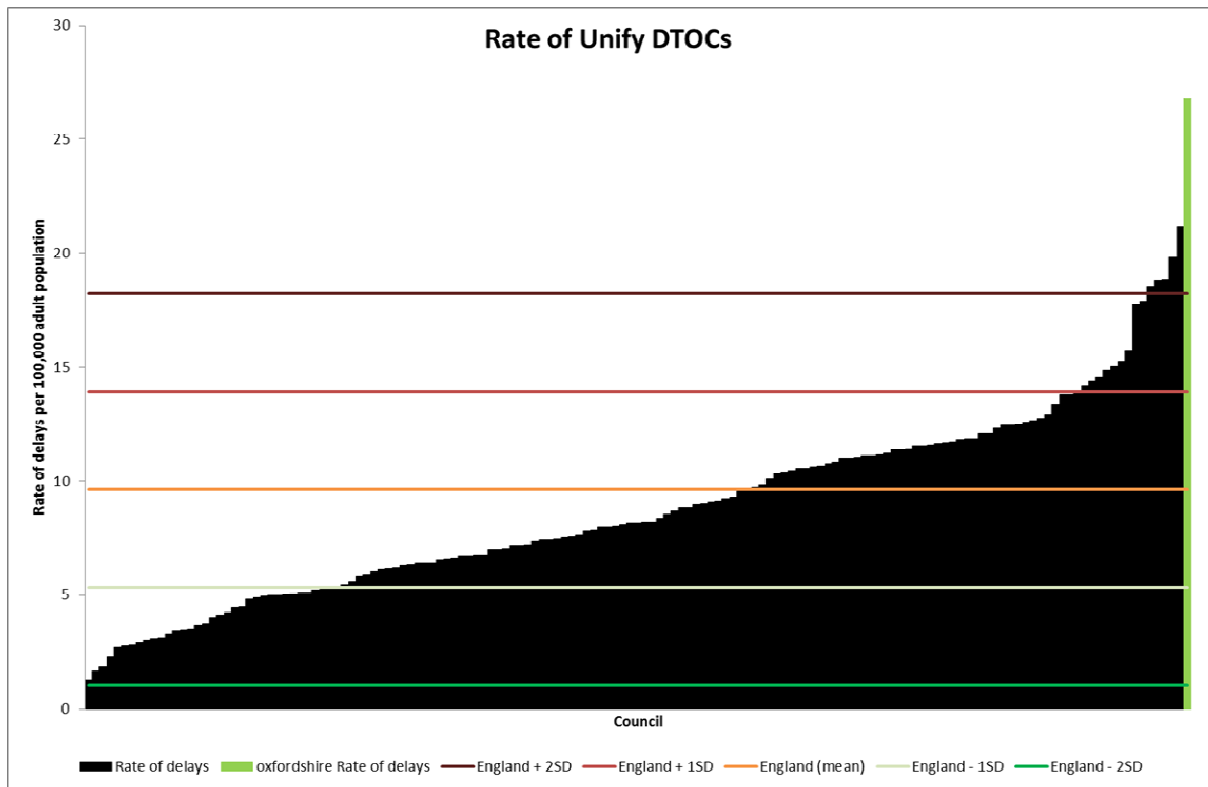
PROGRESS MEASURE: A reduction in delayed transfers of care so that Oxfordshire's performance is out of the bottom quarter. (It was estimated that 72 delays or fewer would mean that Oxfordshire would be out of the bottom quartile. At the end of the year there were 182 delays, and comparative performance was the worst in the country)

Current indicator RAG Rating RED

2. Trend Data

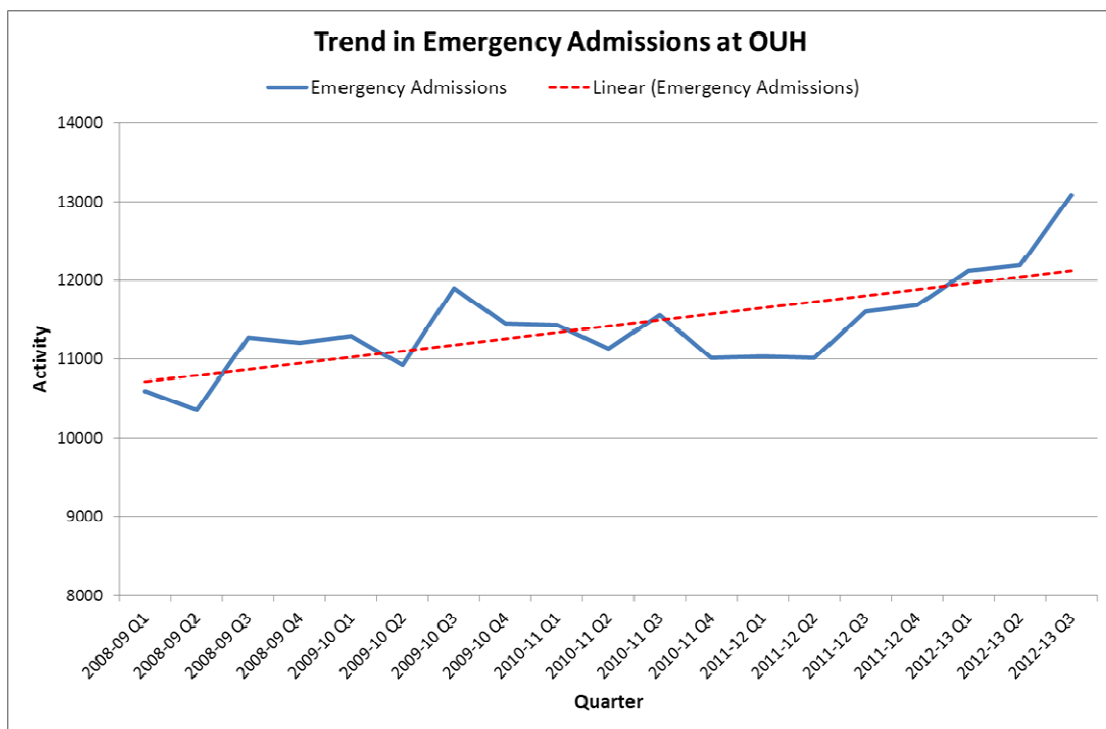
Oxfordshire has the highest rate of recorded delayed transfers of care in the country. This reduced in 2012/13, but not significantly. Within this, delays from acute hospitals increased while delays from community hospitals fell.





3. What is the story behind this trend? - Analysis of Performance

- There has been an increased number of non-elective admissions to hospital. These are the people that are most likely to need onward care. There has been a 10% rise in 2012/13.



- Delays dropped through 2012/13 until December and were close to hitting the target within the year. The subsequent rise over the winter was against a backdrop of an increase in demand of around 30 per cent.

- The subsequent rise also coincided with the change in discharge arrangements, whereby people were moved out of hospital to be assessed rather than being assessed in hospital. The system is still being piloted, with staff learning the new system, and this will cause some short term delays.
- However it is not clear that the rise was caused by the change in arrangements, as delays normally increase in winter and additional funding is used to support people leaving hospital. This did not happen in the last year.
- In April 2013 the number of delays dropped from 182 to 127 (30%).
- The average delay is 15 days from an acute hospital and 22 days from a community hospital. This means that around 50% of a delayed person's time in hospital is due to the unnecessary delay.
- Despite the high level of delays, the average length of stay in Oxfordshire hospitals (for all episodes) remains below those nationally and for the health authority (4.6 days compared to 4.9 nationally).
- There are also differing interpretations of delays across the country which will impact on comparative figures.
- There appears to be sufficient capacity to facilitate discharge but
 - There can be delays in accessing it
 - People are often sent down the wrong pathway.
 - It cannot always be appropriately flexed for spikes in demand (eg winter pressures) or geographical differences

4. What is being done?

Actions

Oxford University Hospital are reviewing why admissions have increased and what can be done to change this trend

Revised discharge arrangements were piloted in November 2012. The pilot is still continuing.

Commentary

We are working hard across the system to ensure we continue to focus on timely discharge even as pressure eases at the front door. The Council and Oxford Health are agreeing a joint data set with Oxford University Hospital for people presenting at emergency departments. The aim is to establish client profile and identify types and capacity of services which may reduce admission. A report and recommendations will be produced by August 2013.

We continue to develop and improve the Oxfordshire discharge pathway and single point of access for community services

Hospitals are not the best places to make decisions about the long term future of patients. In Oxfordshire more people than elsewhere were leaving hospitals and moving permanently to a care home. The pilot discharges people as soon as they are fit, with a care package and ideally to their own home, where they will then be assessed for long term care.

5. What needs to be done now?

Action	By Whom & By When
Profile demand at the acute hospitals and so be able to better match that demand by flexing capacity within community health and social care services	OCC, OCCG, OUH, OHFT by September 2013
Review the current admissions avoidance pilot at Sonning - see what lessons can be applied elsewhere	OCC, OCCG, OUH, OHFT by September 2013
Re-design the referral process out of acute hospitals (including reviewing the effectiveness of the Discharge Pathway Team)	OCC, OCCG, OUH, OHFT by end of June 2013
Review and identify ways to better deal with the most complex cases and speeding up the re-start pathway and ensuring people get the chance of reablement where it might help.	OCC, OCCG, OUH, OHFT by end of July 2013
Clarify capability and eligibility criteria for Community Hospitals & Therapy-led Intermediate Care Beds	OCC with OCCG & OHFT by June 2013
Re-shape the existing supply of Therapy-led Intermediate Care	OCC by March 2013
Establish direct route to permanent care home placement from acute for some, subject to controls	OCC by June 2013
Review and boost community services – address gaps and weaknesses including rapid response and intensive care packages	OCC & OCCG by September 2013