Oxfordshire Clinical Commissioning Group

NHS

Report on the Appropriate Care for everyone (ACE) Programme

1. Background

The ACE programme is a partnership programme focused on determining and delivering fundamental and permanent changes to the ways in which local health and social care organisations work together, in order to reduce the number of delayed transfers of care in Oxfordshire.

Partners to the programme are Oxfordshire Clinical Commissioning Group (OCCG) , Oxfordshire County Council (OCC), Oxford University Hospitals Trust (OUHT) and Oxford Health Foundation Trust (OHFT). The Programme Board is chaired by Dr Stephen Richards.

HOSC received an update on the work of the ACE in November 2011, and asked that an update report be brought in 6 months time. This report forms that update.

2. Delays

Delays in the system were steadily reducing in late April and May, but the trend in June has been upward again, and at June 17th stood at 152. The principal reasons for delay at the beginning of June were:

- 39 people awaiting community hospital beds
- 32 people waiting for a care home placement
- 24 people awaiting the completion of assessments
- 22 people awaiting re-ablement
- 19 people were choice delays
- 10 people awaiting long term home care packages
- 3 people delayed by housing related issues
- 2 people waiting for equipment
- 0 people waiting for intermediate care bed

3. Improvement trajectory

All parties have signed up to a contractual arrangement (a CQUIN) which will reward OUHT and OHFT if they deliver a reduction in delays to:

- 146 by July 1st
- 103 by September 30th
- 72 by January 10th

- Maintained at monthly average of 72 by March 31st

Ultimately we want delays sustained at around no more than 40 per week.

4. Key issues

Key issues that need to be resolved to achieve a sustainable solution are that:

4.1 The number of people referred to community hospital from OUHT continues to exceed capacity to receive those referrals, with associated bottlenecks in the system – so we need to get demand for community hospital beds down.

4.2 More people go to a care home from hospital in Oxfordshire than in most other parts of England, and we need to reduce this percentage so that more people go straight home from both acute and community beds.

4.3 The time taken to place people in hospital into care homes, reablement or home with care remains too high and this needs to be significantly reduced.

5. Current ACE programme content

The programme currently comprises the following projects – all of which are county wide in their remit, and all of which are designed to reduce the primary causes of delay identified above and to improve flow through the system :

5.1 *Improving the reablement service*: This project requires OHFT to focus on minimising delays caused by waits for reablement or waits at the end of a period of reablement. It should double the number of new episodes of reablement care available each week by September. It is not currently on track to achieve this, although delays at the end of a period of reablement have substantially reduced and steps are being taken to ensure overall performance improves. These include a new contract based on payment by results, regular monitoring of performance and development of an OHFT improvement action plan. Partnership work is also being undertaken by OUHT and OHFT to co-ordinate rehabilitation and reablement services.

5.2 *Supported Hospital Discharge:* This project enables OUHT to provide 2 weeks of domiciliary care to patients, while a permanent home care package is being put in place. It is designed to reduce delays caused by waits for simple, single hander home care packages. It is not currently meeting its targets because it has not yet got its

staffing levels up to contracted levels, but does appear to be impacting positively on excess bed day numbers.

5.3 *Social services crisis response team*: This new team has been commissioned by OCC to provide social care within four hours and for up to three days , to avoid a hospital admission that may be triggered by the need for social services support, whilst permanent care arrangements are put in place. GPs can refer to this service directly, but referral rates have been considerably lower than expected and work is ongoing to re-promote the service and also to redirect this social care capacity.

5.4 *Domiciliary care delays*: This OCC led project is designed to build the capacity of the domiciliary care market and to improve the response time of providers once assessment has been completed. Some of the changes required by this project will take time to impact because they depend on the ability of the market to recruit and retain additional carers. It is having a positive impact and waits for domiciliary care are no longer a major contributory factor.

5.5 *Care Home Placement delays:* This OCC led project is designed to reduce delays caused by waits for permanent care home placements. The focus of the project has been on understanding the demand for care home placements and trying to find solutions to reduce that. To ease the issue extra care home capacity has been commissioned as a temporary measure, and 10 new placements per week are now being purchased, which should be sufficient to meet current demand. This increase is funded until September, but is not sustainable in the long term. Further work is being undertaken to try and identify how to get the rate of referrals to a care home from hospital closer to the national average, and to provide viable care alternatives, so that the number of new placements purchased per week can be safely reduced again without risking a resulting increase in delays. There will be an additional one off purchase of 26 placements per week, to clear the backlog of patients waiting. It can take some time to finalise a permanent placement because the individual and their family will want to be happy with what is likely to be their final home. However, it is not appropriate for them to stay in a hospital bed. We will continue working to move people on a temporary basis to a suitable home whilst their permanent move is finalised – where that is necessary.

5.6 *Move on team*: This joint OHFT, OUHT, OCC project seeks to streamline clinical decision making about fitness for discharge from hospital, so that delays are not caused by the wait for multiple assessments by different clinical disciplines. In addition provider partners are working together to improve team working, trust and joint decision making across organisational boundaries, in recognition that this team has not been as effective in making final decisions on discharge as had been anticipated. Providers are undertaking an organisational development project, with external support, to improve risk management, clinical decision making and clinical leadership. It is anticipated that, as a result, the Move on Team can be stood down in the autumn.

5.7 *Assessment and discharge planning improvements*: OCC have recruited an additional hospital based social work team which should significantly enhance the rate of hospital based assessments that it can complete, so reducing delays caused by waits for social care assessment. A contractual incentive is in place for OUHT to deliver a ward management improvement programme, and it is hoped that this will lead to improved discharge processes. Further work is also being developed to streamline assessment processes and to identify further improvements that can be made to discharge planning. A key recommendation of the recent peer review comparing processes in Buckinghamshire and Oxfordshire , is that Oxfordshire should put in place a system wide discharge policy, but agreement has not yet been reached on how to take this forward. This is a priority for further debate at the ACE Programme Board.

5.8 *Integration of health and social care community services on a locality basis:* This project will provide a single point of access for referring GPs or discharging hospital clinicians to community based health and social care services. It will provide an integrated physical health, mental health and social care assessment for patients leading to an integrated care plan and the appointment of a named lead professional responsible for ensuring that the care plan is delivered by a locality based team (as far as is practically possible). This OHFT/OCC project will significantly speed up the process of discharge and contribute to admission avoidance, simplify the pathway and deliver improvements to patients' experience of care. We expect that, over time, this will lead to rationalisation of the multiple services currently available within the community, but as an important first step it provides a simple one stop shop for referees, rather than requiring them to navigate the maze of existing services. In May 109 referrals were made through the service from 17 different referral routes. Approximately two thirds were from GPs and inpatient care teams.

5.9 *Development of shared information systems*: This OCC led project is developing a close to "real time" tracker that shows where patients are in the system and what their anticipated needs are. It will allow all organisations who will be involved in providing care for a patient to see that information so that they can be planning in advance and therefore be ready to meet a patient's needs, when that patient reaches their part of the system. A specification is currently being defined.

6. Additional development plans

In addition to the projects outlined above further work is being undertaken by NHS and local authority commissioners and providers.

6.1 The function and purpose of community beds will be looked at, as well as the skills and workforce of clinicians providing medical support (both within Community Hospitals, Intermediate care and for unstable frail older people living at home).

6.2 Commissioners will jointly evaluate the effectiveness and efficiency of the Reablement Services (provided by OHFT), the Supported Discharge Service (OUHT), and the Crisis Response Service (commissioned by OCC from a private sector provider) alongside the home care services available in Oxfordshire. This review will ask: How can we improve performance of these services, in particular the reablement service? Should these services be used in a different way for the benefit of patients and to use public resources better? A key element of this will be to ensure that there are sufficient care workers with appropriate expertise available in the right services.

6.3 Commissioners are working to develop a joint health and social care older people's commissioning strategy. This will identify any further changes required in the system to reduce delays.

6.4 Providers have very recently proposed a suite of additional collaborative projects, which were discussed at the ACE Programme Board on June 11th, and which will go to Provider boards for ratification in July – these will include looking at how we can ensure patients do not remain in NHS beds whilst waiting for their preferred home or community location to become available.