

## **Briefing to Oxfordshire Health Overview & Scrutiny Committee 5 December 2013**

### **Older People's Care, Long Term Conditions and Urgent Care Service Remodelling and Current Delivery**

#### **1. Introduction**

This paper sets out a briefing on the actions being undertaken by Oxford Health NHS Foundation Trust to develop and implement a model of care for older people, long term conditions and urgent care in a community setting that is right for the 21<sup>st</sup> century. This focuses on integration of physical health, mental health and social care for older people, and adults with complex and multiple needs. This is being undertaken in conjunction with partners from across the County (primary care, adult social care, acute services and the voluntary sector).

This paper also provides a summary briefing on progress to date in delivery of this, and how service remodelling and winter planning has been combined to drive the change needed and meet the significant increase in patient need and demand predicted for this winter.

#### **2. Context**

The step increase in demand in urgent care, especially for older people has been well documented both locally and nationally. This increase in demand reflects not only the increase in volume of care interventions required: it also reflects the increasing acuity and complexity of patients' needs. Community health and social care services (including GP practices) have a significant role to play in extending services closer to home to enable more patients with higher complexity of need to be treated closer to home wherever this is clinically appropriate. This approach aligns to health policy of the last ten years, and has significant benefits for patients (independence and well-being) as well as reducing avoidable spend in acute hospital settings and long term care (domiciliary and residential).

The evidence base for how best to deliver integrated community-based provision to drive care closer to home is still emerging. However, there are two principles that are always present in effective care closer to home: rapidity of response by community services, and multi-disciplinary clinical co-ordination of care. The need for integrated care delivery is reiterated by national patient and carer feedback, in which multiple handovers and slowness or disjointed health / social care response are frequently cited as the primary source of stress and anxiety to patients and carers.

The need for a 21<sup>st</sup> century integrated model of care is clear: and this need is even more compelling given the fiscal constraints facing both health and social care. Increased demand and complexity of need is occurring at a time when funding resources are at best stagnant, or subject to significant cost efficiencies.

For Oxford Health NHS Foundation Trust this challenge is evidenced by the current average 20% over-activity against funding (via block contract) for community services. This reflects the additional care closer to home already being provided by community health services; and is a demand / capacity pressure particularly felt in community therapy and community nursing services.

Oxford Health NHS Foundation Trust is currently undertaking significant remodelling of its services to address these challenges so far as is possible within our resources. Broadly badged as “integration”, these changes are based on core principles:

- A multi-disciplinary clinical model that comprises four elements: promoting independence and self-care, care at home, crisis management and recovery /reablement or end of life care.
- Integrated, multi-disciplinary team working for those patients with complex or escalating need, based on a local model of care
- Increased clinical skills to support a patient population with increasing complexity and instability of need in a community setting (home and bed-based care)
- Improved community response times for all aspects of urgent care need (0-2 hours where clinically needed)
- Service provision aligned to patient demand: core services provided 7 days a week, over extended hours (8am to 8pm)
- Model of care based on evidence-based research: and where this is not available, developing this in conjunction with provider partners and academic institutions
- Modernisation of service infrastructure; re-procurement of the electronic patient record (to enable mobile working, patient access to their own records etc.) and development of holistic and patient centred performance framework (replaces multiple performance indicators for individual service lines, as currently commissioned)

### **3. Service Remodelling**

There are a number of work programmes in place to ensure consistent implementation of the above principles across the services provided by Oxford Health Foundation Trust. The breadth of these changes presents challenges in co-ordinating the delivery of these interventions, which will only deliver the intended benefits if achieved across the entire patient pathway (including partner providers).

Given that Oxford Health NHS Foundation Trust community health and older adult mental health services in Oxfordshire delivered around 920,000 face to face patient contacts last year, there is

an equivalent challenge to focus service remodelling on the patient cohort who will benefit from integrated care.

This has been defined as those who have:

- Complex co-morbidities (physical and mental health and social care)
- Escalating need or instability
- Multiple patient and / or carer needs

The summary overview of these is as below:

### *3.1 Emergency Multi-disciplinary Assessment Units (EMUs) and Interface Medicine*

Building on the success of Abingdon EMU, implementation of an additional 3 EMU functions (John Radcliffe, Horton and Witney Community Hospital). These will provide county-wide same day multi-disciplinary assessment and treatment for adults at immediate risk of acute medical admission.

These will be supported by the recruitment and development of a new genre of medical care (interface medicine), in which the clinical skills of acute geratology and medicine and enhanced primary care are integrated to enable increased community-based care of people with sub-acute and complex medical needs.

Delivery of this is progressing well, with the additional EMU functions planned to commence gradually at the remaining three sites from late November.

### *3.2 Integrated Localities*

This centres on developing new ways of working together (community health, adult social care and older adult mental health) to provide improved co-ordination of care and a very rapid response for people with complex or escalating needs.

This has commenced with the development of a rapid multi-disciplinary assessment and treatment team response team in each locality, which began implementation in October. During the next five months this will develop as changes in specific services come together to provide the sustainable operational model for delivery by March 2014. This will function 7 days a week, 8am to 8pm.

### *3.3 Rehabilitation Pathway*

This is focused on the development and implementation of an integrated pathway across community settings (community beds, adult social care and community health care at home). This includes extended hours provision for therapy services (specialist and rehabilitation) aligned to patient need, for example 7 day rehabilitation and increased access to specialist provision such as podiatry (for example, evenings and Saturday morning).

Within Oxford Health FT, some of these developments are currently being implemented and others trialled, with incremental changes taking place in line with the wider integration

plans. These changes will be a significant contribution to the implementation of integrated locality working.

### *3.4 Memory Clinic Pathway*

Oxfordshire has set itself the challenge of increasing the prevalence of dementia diagnosis by 30% by 2017. This requires a significant reworking of the service model to deliver this increased volume within existing resources.

Work is underway to refine the diagnosis pathway within Oxford Health NHS FT to achieve all aspects of dementia diagnosis within a single clinic attendance for the majority of patients. This will reduce duration of the pathway for patients and enable more patients to be seen within the existing resources.

### *3.5 Older Adult Mental Health*

As with physical health services, there is a challenge to move more care closer to home to improve outcomes for patients and reduce acute admissions where this is clinically appropriate.

Currently older adult mental health community teams work Monday-Friday, 9am-5pm, with dedicated crisis teams responding to urgent need during the out of hours period.

The new model of care for older adult mental health will increase the number of staff working in a community setting, as well as extending the hours of service delivery to seven days a week, and to 8pm weekdays.

This will provide greater capacity for community older adult mental health practitioners to respond proactively to escalating mental health need in older people (dementia and functional illness such as schizophrenia) and provide more treatment and support in the home. For people with dementia this will be augmented by better joint working across physical health, mental health care and social care (for example, Hospital@Home, community therapy, district nursing, reablement and crisis response) to assess, treat and stabilise both physical and mental health crises at home wherever clinically appropriate.

This additional resourcing will be achieved by improving MDT discharge planning on Older Adult Mental Health wards to reduce the average length of stay closer to the national average (currently Oxfordshire is an outlier, with an average length of stay of 100 days). Together with increasing the ratio of inpatient staff to patients, this will enable improved bed use allowing overall bed numbers to reduce (and the staffing resource to be deployed in community settings) without reducing capacity for number of inpatient episodes.

This is a significant development of the older adult model of care, which has been extensively clinically developed and reviewed. Formal consultation on these proposals is due to commence in Oxfordshire in January 2014, with the intention of implementing this model of care during 2014.

These changes will be a significant contribution to the implementation of integrated locality working.

### *3.6 Community Hospitals*

Last year improved multi-disciplinary discharge planning in community hospitals significantly reduced average length of stay, and enabled an extra 700 admissions to take place within the same bed resources. Locally-led clinical improvement actions also reduced falls by for inpatients.

Community hospitals are continuing to build on this achievement, with a specific focus on:

- Clinical skills and processes to provide care for more sub-acute patients as part of the EMU pathway (removing need for acute admission)
- Improvement of the physical environment for people with dementia through the Dignity Plus Programme (refurbishment of day rooms, signage, crockery and cutlery and increased garden spaces)

The aim is to increase the proportion of “step-up” admissions to community hospitals (via the EMU pathway). This improves outcomes for older people (reduced length of stay and increased rehabilitation increases independence on discharge) especially for people with dementia, for whom the multiple changes in inpatient settings of the existing urgent care pathway increases confusion and distress.

### *3.7 Reablement*

The Reablement Service (ORS) has made significant progress in the number of new episodes of care it is providing each month, despite an increase over recent months in the number of patients delayed at its back door (20-33 delays each week since June 2013). For example, in August 2012 started 170 new episodes of care; by August 2013 this had increased to 236.

Much work has been done within the service to improve scheduling and timely review and discharge of patients to achieve this; as well as significant work with acute and adult social care partners to smooth the referral pathway into the service.

Outcomes for the service have consistently improved with over 50% of patients discharged with no ongoing care needs, and 27% with reduced care needs. Feedback from clients is very good, with the service rated very highly for the quality of care provided, including kindness and understanding, respect and dignity and listening to what you had to say.

The service is working very hard to achieve the final 15% increase in patient episodes contracted, especially given the predicted demand over the winter period. This includes maximising use of flexible staffing contracts to increase capacity, continuing to refine scheduling processes (to make effective use of capacity, given the high throughput of the service and rapid change in patient dependency, the whole service needs to be rescheduled

around every two hours), and reducing time spent on travel through operational integration with crisis response staff.

The Reablement service will have a critical role to play in the implementation of the EMU functions at the John Radcliffe, Horton and Witney Community Hospital. This pathway will increase the number of people who have a same day comprehensive geratology multi-disciplinary assessment and are brought home same day with health and social care at home (avoiding the need for acute admission).

### *3.8 Community Nursing*

Community nursing (District Nursing as well as specialist community nursing functions such as heart failure, respiratory, tissue viability) is a critical component to supporting people at home who have complex long term conditions, frailty or palliative care needs. This service has seen a significant increase in the demand (number of patients) as well as the level of need (complexity, acuity and instability of clinical presentations). This is now running at a monthly average of 19% over the contracted activity, which is funded under a block arrangement.

In context this is an increase from the contract levels of 19,500 home visits a month to as high as 24,663 (July 2013). This reflects the step change in patient need and demand seen across the urgent care pathway for the frail elderly (locally and nationally).

The Trust is working with OCCG to ensure that the service sustainably has the clinical capacity to meet local patient need as part of the drive to provide more care closer to home.

### *3.9 Personal Health Budgets*

In Oxfordshire personal health budgets have been successfully implemented in Continuing Healthcare, and the Oxford Health leads are now supporting other health teams across south-east England in the national programme of implementation for April 2014. There has been a successful pilot of use of personal health budgets in Neuro Rehabilitation, which found that it had a positive impact on the participant's health and wellbeing.

The current work is focusing on 'integrated budgets' for those people who receive care from both health and social care, so the recipients, or their carer have just a single integrated personal budget. This supports the integrated delivery of hands on care by financial integration at an individual level. The team are also working with the older peoples mental health on the dementia care pathway, to see how personal health budgets could support people maintain their independence at home for longer.

## **4. Expected Benefits**

The expected outcomes are:

*For patients and carers*

- More urgent care provided locally
- Improved proactive community response to escalating need
- Better access to services over 7 day period
- Improved co-ordination of care (fewer hand-offs and duplication of assessment)

*For staff*

- Pathways of care support integrated and holistic care for people with complex and escalating needs
- Reduced duplication of effort
- Greater proportion of time spent of clinical care
- Team working replaces multiple service approach to locality-based care

*For Providers and Commissioners*

- Better outcomes and experience of care for patients and carers
- More effective use of existing resources to help address increasing need and demand

## **5. Conclusions**

This is an extensive programme of remodelling, which is centred on ensuring MDT rapid and local care for older people and those with complex needs in Oxfordshire. It aims to deliver a positive impact which is greater than the sum of its many parts through modernising all aspects of community health care, and improving integrated working across physical health, mental health and adult social care.

However, the change required extends beyond community services, with changes in the interface between primary and community services and acute / emergency services and community services necessary to enable integrated care closer to home.

These changes are expected to be completed within 18 months, with the significant level of change implemented by March 2014.