Report to Oxfordshire Health Overview Scrutiny Committee

Date of Meeting: 11 December 2015	**Paper No:**

Title of Presentation: Better Care Initiative - action plan to address Delayed Transfer of Care

Is this paper for (delete as appropriate)	**Discussion**	✓	**Decision**	✓	**Information**	

Purpose and Executive Summary (if paper longer than 3 pages):

The Oxfordshire health and social care system has the highest number of delayed transfers of care (DToC) in the country. This is bad for patients and bad for our budgets. At any one time we have around 150 patients whose medical care has finished, but they remain in hospital waiting to be discharged. A large number need some form of ongoing health and social care or rehabilitation in their own homes or nursing home care.

Over the past few years we have developed a number of plans to reduce the number of DToCs; however, these have not had the impact of significantly reducing the numbers. There have been improvements to many of the processes which cause delays to occur, which we should acknowledge; however, merely doing more of the same is unlikely to give us the breakthrough we need.

The plan presented in this paper is intended radically to change how patients are discharged in order that they are not inappropriately delayed in hospital.

The CCG has offered to provide up to £2.0m in this financial year to enable patients to be discharged. We see this funding as a double – running cost and a one-off injection of funding. Any ongoing financial implications of this plan will need to be addressed in the negotiation of contracts for 2016/17.

We have set out in the paper the risks inherent in the plan and how these are being mitigated.

Financial Implications of Paper:

CCG resources of up to £2million have been identified to support the plan in 2015/6. Dependent on outcomes the future shape of services will be informed and funding flows would be required to be adjusted accordingly. No long term commitment is being entered into at this stage.

OCC have flagged concern on additional risks to the long term management of patients if we do not retain the current flow of patients into their own home with or without support.

Action Required:

The HOSC is asked:

- To note the plan being developed and the need to take radical action to reduce DToCs
- To note the need for potential public consultation if the transferred bed arrangements become permanent
- To note the outcome of the equality analysis identified the need to ensure those with protected characteristics.

NHS Outcomes Framework Domains Supported (please delete tick as appropriate)	
✓	Preventing People from Dying Prematurely
✓	Enhancing Quality of Life for People with Long Term Conditions
✓	Helping People to Recover from Episodes of Ill Health or Following Injury
✓	Ensuring that People have a Positive Experience of Care
✓	Treating and Caring for People in a Safe Environment and Protecting them from Avoidable harm

Equality Analysis completed (please delete tick and attach as appropriate)	Yes ✓	No	Not applicable
Outcome of Equality Analysis	**Statement** for all nine protected characteristic groups and including carers: OCCG should be assured that commissioned nursing home services, even if jointly commissioned, include a robust assurance framework for monitoring equality and diversity through the contract monitoring process. This needs to encompass patients placed in the nursing homes, their carer's and staff working in the nursing homes. OCCG should ensure that all nursing home staff have received up to date equality and diversity training and that equality policies are in place. The providers should not discriminate between or against service users or carers on the grounds of age, disability, marriage or civil partnership, pregnancy or maternity, race, religion or belief, sex, sexual orientation, gender reassignment, or any other non-medical characteristics, except as permitted by the Law. This has been addressed via contract.		

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Delayed Transfers of Care –'Better Care' Action Plan

1. Introduction

Oxfordshire Clinical Commissioning Group (OCCG), Oxford University Hospitals NHS Foundation Trust (OUHFT), Oxford Health NHS Foundation Trust (OHFT) and Oxfordshire County Council (OCC) have developed a joint plan to enable patients to leave hospital sooner and be cared for in the best place for them. This may be either in their own home with a care support package or a place in a nursing home. This approach will build on last year's winter plan, will have time limited interventions and will provide the means to inform the design any future permanent model of care.

The focus of the plan is:

- Patients being cared for in the right environment
- Further increased capacity for ambulatory based care
- Reduce avoidable deterioration in patient health and wellbeing caused by delays in bed-based care
- Increased capacity for acutely ill patients in A&E and additional capacity in the emergency assessment unit
- Reduced dependency on bed based care for patients who can be supported in their own home.

This paper describes the plan, the benefits, risks and mitigations within it.

HOSC is asked:

- To note the plan being developed and the need to take radical action to reduce DToC in Oxfordshire
- To note the financial implications of the plan
- To note the need for potential future public consultation if the transferred bed arrangements become permanent
- To note the outcomes of the equality analysis

2. Background

The Oxfordshire Health and Social care system has long standing problems in being able to discharge patients to the next stage of their care from OUHFT – whether home with domiciliary support, or to a nursing home. Likewise, OHFT experiences delays in being able to discharge patients from community hospitals. Oxfordshire is the worst performing system in the country and has been for a number of years. More detail on the causes and trends of delays is attached in Appendix 1.

For an individual who is delayed, the key risk , particularly within acute hospitals, is that s/he might remain in a setting that is not an appropriate place to rehabilitate them and where they risk both catching hospital related infections and becoming institutionalised and increasingly dependent. Delayed Transfers of Care (DToC) are also costly for the system as a whole and can create dependence rather than promoting independence as an outcome for individuals.

Oxfordshire health and social care organisations are committed to getting patients out of hospital promptly, so that they are cared for in the best place for them. Patients who are ready to leave hospital but are delayed can, over a sustained period of time, become dependent on inpatient care, with the loss of skills for independent living leading to a requirement for a higher level of ongoing domiciliary care or residential nursing care.

Despite the development of successive plans and support from external bodies, we have not made the breakthrough to resolve this issue. On 5 November there remained 173 patients in our hospitals who are experiencing delays. This number has deteriorated week on week since July. Many approaches have been taken to address this issue; they have not made the difference needed but have produced some small benefits.

Delayed transfers of care have a considerable impact on hospital services, as the inability to discharge patients in a timely manner makes it more difficult to admit those patients who need both emergency and planned treatment. This plan will create capacity to improve the flow through the hospitals and the quality of care for patients admitted, by freeing up beds on hospital wards for acutely ill patients.

The Emergency Care Intensive Support Team (ECIST) visited in 2014 and concluded:

- '*there is significant risk….associated with episodes of Emergency Department crowding'*
- *'our view is that whole system working in Oxfordshire is less effective than many other systems'*
- *'[no] clearly defined whole system development agenda'*
- *'lack of local consensus on [future priorities for emergency pathways] is a major hindrance to improving patient flow'*
- *'too many patients are staying too long in hospital …increasing their risk of decompensation'*

They further shared conclusions of research stating:

48% of people over 85 die within one year of hospital admission

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10 days in hospital (acute or community) leads to the equivalent of 10 years' ageing in the muscles of people over 80

The following whole system proposal involves a significant investment in care in the community which is consistent with Oxfordshire's strategy for health and social care going forward. The scale of the proposal will challenge entrenched views amongst many professionals, require the system to develop best practices and encourage a less risk adverse attitude which will benefit patients. The early stages of implementation have been supported by a very positive level of engagement across staff groups.

3. The Plan

The system will redeploy resources outside of hospital to deliver care where it is most needed. Community and emergency assessment capacity will increase. The best practice processes will be applied to optimise patient flow.

In discussion with families, up to 150 patients currently delayed in Oxfordshire's hospitals will be transferred to a number of the county's nursing homes into temporary intermediate care beds. The beds have been secured by OUH from homes that have been quality assured by CQC and OCC. They are distributed across the county. Patients will remain in the temporary intermediate care beds for a period of up to 8 weeks to ensure their on-going care arrangements are in place. Where patients are moved on within this period the beds may be utilised for more patients who need to move on. The initial transfers commenced on 2nd December and will be concluded before Xmas.

The 150 patients are made up of 120 patients currently in Oxford's John Radcliffe Hospital, the Nuffield Orthopaedic Centre, and in the Horton General Hospital in Banbury and a further 30 patients across Oxfordshire's community hospitals. These patients are all waiting to move on to the next stage of their care in a nursing home or their own home supported by a domiciliary care package but this movement has already been delayed for non-medical reasons.

This additional capacity is being purchased in care homes as *intermediate care beds*. Staff from OUHFT are being aligned into the Liaison Hub to ensure expertise in discharge and good support for discharge for transferred p[patients. To support this initiative Oxfordshire will strengthen the Care Home Support Service provided by OHFT. This will be supplemented with a multi-disciplinary team (social workers, therapists, occupational therapists, placement officers) whose sole task is to safely discharge the transferred patients from the intermediate care beds on to their final destination.

Additionally we are seeking increased capacity to support people in their own home. Wherever possible the preference is to take people home, but current workforce constraints in domiciliary care are a limiting factor. This initiative is seeking to secure alternate solutions in the absence of sufficient domiciliary care.

As people are discharged from the care home setting it is intended that we retain 75 intermediate care beds (in addition to the 49 intermediate care beds currently commissioned by Oxfordshire County Council). This additional capacity will remain until the system has stabilised so that we have reduced the overall level of delays. These additional beds will be commissioned for a further 8 weeks.

The staffing resource in the acute hospitals that currently supports the 150 beds will be redirected to

- support the increase in Emergency Assessment beds at the front door of the acute hospital, together with a supporting ward

- increase capacity within the community therapy service and within the Care Home Support Service.
- providing additional capacity to the Supported Hospital Discharge Service and the Oxfordshire Reablement Service.

The Care Home Support Service will provide an enhanced level of support to the temporary intermediate care beds purchased through this period. In addition extra medical cover is being contracted to support the temporary intermediate care beds. This will either be contracted from GPs in addition to their other contracted services or provided by OUHFT. To mitigate risks, OUHFT will have an overarching role in providing support to GPs delivering the service through a liaison hub. Also more frail complicated patients may be transferred to homes where OUHFT is in sole charge of the medical cover. No patient will be moved without the medical cover being in place.

Contracted GPs will provide a regular pro-active weekly review of patients and respond to any emerging concerns. The Nursing Homes providing these beds will be supported by OUHFT staff who will call each home daily from the liaison hub and where necessary arrange urgent clinical review tailored to the needs of the patients. Where no GP is contracted to provide the cover it will be provided directly by OUHFT.

For those patients who are transferred into the temporary intermediate care beds and who would otherwise be discharged to residential or nursing care but where the intermediate care beds do not sit within their planned permanent destination, discussions between the patient, family and healthcare team will reinforce that the move is in the best interests of the patient from both a safety and quality of care point of view. Every effort will be made to ensure that they are transferred to an intermediate care bed near to their home. The transfer plan includes mapping nursing home and patient home post codes to ensure patients are moved to a home near where they live as far as is possible. When the patient moves on from the temporary intermediate care beds and on into a permanent nursing or residential home this move will be supported in line with the Oxfordshire choice policy.

Oxfordshire health and social care organisations will be working to rebalance the flow of patients through our hospital system and to ensure patients are cared for in the right environment. A key part of our strategy is to reduce dependency on bed-based care for patients who can be supported in their own home. This means that wherever possible patients will only remain in nursing homes for a short period of up to 8 weeks

Plan in summary

- Contract 128 intermediate care beds in independent sector for 6-8 week period from known market capacity of approximately 220
- Transfer upto 120 patients from OUHFT and upto 30 from OHFT who are delayed to intermediate care with multidisciplinary support in the first cohort
    - Ensure we maintain or improve the proportion of patients on a home based final pathway
- Continue to contract 75 intermediate beds until equilibrium is attained

- Use transferred staff resource and increased community capacity to ensure sufficient flow to support a reduced level of DTOCs aiming to achieve no more than 30 DTOCs at any one time.
- OUHFT will release 120 beds. These beds were opened in response to the delays in being able to transfer patients ready to leave hospital. Around 50 beds will be retained to support the through flow of patients being admitted from the Emergency Department and into the Emergency Assessment Unit. Others will remain available as a contingency.
- The transfer element of the initiative will exclude out of county delays (predominantly at the Horton)
- Best practice approaches to flow and assessment will be applied

4. Achieving a balance in capacity and demand to prevent DToCs

Acute Care is provided by OUHFT across four sites. Where further inpatient rehabilitation is required the system is supported by Community Hospitals, managed by OHFT across eight sites. In addition there are 49 intermediate care beds, and 70 discharge to assess home care placements.

Delays in hospital beds have been compounded by workforce capacity which affects the ability to recruit staff right across the health and social care system. In particular this challenges home care agencies and the Oxfordshire Reablement Service. There is a workforce strategy group exploring development of short and intermediate term workforce actions to deliver required capacity with appropriate capability. The actions from this will not mitigate the anticipated pressures in this winter period. In addition ECIST has previously identified we would benefit from additional emergency assessment capacity given the acute Trust's current patient demand.

The initiative proposes a whole system approach to support a transformation agenda which focuses on an 'out of hospital' strategy. The aim is to ensure that patients who are medically fit are transferred appropriately and in a timely way to the right environment to meet their on-going needs.

Improvements include:

- Secure capacity for all acute patients requiring assessment or admission within 4 hours and achieve the national 4 hour standard
- Greater focus on ambulatory pathways to care for the patient in their normal place of living
- A quantifiable and sustained productivity achieved through streamlined care pathways and service integration
- Further enhance Discharge to Assess secure up to 20 placements for the assessment of patients potentially eligible for continuing healthcare
- Ability to undertake demand and capacity assessment covering domiciliary care hours, reablement hours, acute beds, community beds and assessment capacity (Emergency Multi-disciplinary Units – EMU's/EAUs)
- Initial increase in intermediate care capacity from 49 to 199 (the 150) and phased reduction of additional intermediate care bed capacity (prevents bottle-neck into longer term care where required) from 199 to 124 beds after 8 weeks and assessment of long term need. The Board

should note that, in its current budget options Oxfordshire County Council has proposed that amount of bed-based intermediate care is reviewed in light of evidence that non-bed based care delivers better outcomes for patients.
- Implementation, particularly in the acute sector of a number of recommendations from the “Breaking the Cycle” reviews which identify process improvements which can benefit patient flow, see Appendix 2.
- Assessment of use of intensive home care packages
- Increased decision support and rapid response capacity to enable South Central Ambulance Service NHS Foundation Trust (SCAS) to avoid conveyance
- For those patients transferred the objective is for all (excluding identified nursing home placements) patients to be in their normal place of living with 8 weeks from the date of transfer
- Enhance independent living in reaching ‘equilibrium’ with resource shift to support community and home based care
- Integrate bed management and medical oversight of acute medical, community hospitals and EMUs to optimise equilibrium of risk and patient flow – OUHFT as lead
- Implement smart technology to support care of patients in domiciliary settings
- Explore with GP Federations rapid actions to accelerate joint working (including Prime Minister’s Challenge Fund and Care Homes Initiative)
- Uptake of additional voluntary sector capacity to provide “home and settle” function where deliverable and sustainable.

This plan has the highest possible priority within the Oxfordshire system and will be overseen as follows: :

- Chief Executive (CEO) oversight with weekly reporting from Chief Operating Officers (COOs)
- Daily COOs DTOC Control Grou to assure progress and deal with issues escalated from operational teamsform oversight and performance management group reporting to CEOs
- Establishment of a liaison hub to oversee all actions necessary to ensure a safe transfer of patients to the temporary beds and onward to their final destination
- Clearly established clinical oversight and escalation processes to provide support to staff
- Triggers and performance indicators agreed by whole system, together with rapid mitigating actions
- Project Work Streams reporting to COO oversight group

5. Costs

OCCG is making a maximum contribution of £2m from its investment reserve to support the plan in 2015/16. At the point of writing the short term costs exceed £2 million however the NHS CEOs and Director of Adult Services have reached clear system wide agreement to work within the £2.0m CCG funding. This is being addressed in the implementation planning with

expectation that reduction in costs or additional partner contributions (e.g. from savings) will mitigate any excess.

In next financial year no long term commitments have been made. However it is a known risk that the equilibrium levels may not have been reached at 1 April 2016. It may be necessary to identify additional funding and this represents a system-wide risk at this point. Against this risk there is a potential benefit of an estimated £1.5m of current £2.2m of excess bed days related to DTOC. We also anticipate a reduction of admissions due to the increased EAU capacity. There is also an opportunity cost from current decompensation of patients experiencing a delay in our system today. This substantial cost to a patient's quality of life will also be contributing to increased care costs from health and social care.

6. Stakeholder views

The Locality Form Chairs of the CCG have all been briefed. CCG Locality meetings mostly have patient representatives in the room and will have been hearing this plan evolving. The GP Federations have been involved and at certain points the Local Medical Committee. There has been considerable media coverage with interviews and a video produced with the CEOs describing the initiative. There has been some discussion with Healthwatch. The Voluntary sector has been invited to assist and have made some proposals. The CPN is being briefed 7/12/2015.

NHS England and Monitor reviewed the emerging plan on 6 November. The feedback was generally supportive. OCCG was encouraged to ensure the system worked assertively to deliver best practice. There was keenness to demonstrate improvement through system agreed key performance indicators (KPIs) allowing rapid response and mitigation where things may not be working.

There has been strong engagement from all the partners to this initiative both from clinical leads and from management and staff. This was confirmed in an event to review and align the project work streams on 3rd December which was well attended by staff from all organisations, over 50 participants. There is a sense of common purpose to achieve a major and lasting breakthrough in the achieving better outcomes for our patients, their families and the system.

Oxfordshire County Council has been engaged as a system partner but also as a stakeholder. They have described main areas of concern related to them:

a. Patient Deterioration: Oxfordshire County Council estimates that two thirds of the 150 cohort are at high or moderate risk of a deterioration of functioning and a loss of independence if they go into a care home rather than return home. Thus maximising the number of people going home will be critical. Concern has been raised that in last year's winter initiative only 44% of discharges went home with or without a package. If the level of dependency of patients is increased as a consequence of this initiative, the County Council estimates that the costs in social care over the period through until 2018/19 would be in

the order of £8,473,218 should the project operate for six months. To mitigate this significant risk, it is crucial that those 2/3 of patients who can go home do go home. When they are placed in these intermediate care beds these patients will be supported by social workers, therapists and other community health workers to assure their rehabilitation and ensure that they return home rather than end up living permanently in a care home.

b. Market Stability: the purchase of additional beds is likely to adversely affect the care home market. 75 beds is nearly 40% of the available free capacity and 150 beds 75% of the available free capacity. This could lead to risks to market stability, increases in sourcing delays, with a potential consequence that people will wait longer for placements from the community; their situation may break down resulting in a potential hospital admission. A significant reduction in care home capacity may make the default route to a placement being via an acute admission.
c. Price: the purchase of between 75 and 150 beds on a temporary basis by OUHFT, and 75 on a longer term basis may increase the price of care homes beds, leading to a financial risk to the county council and within Continuing Healthcare to the CCG.
d. At times of a major incident (e.g. flooding) the Council has been able to move service users to safe locations. The availability of fewer beds may lead us to look to alternative less suitable accommodation if required. This is a potentially significant business continuity risk, especially over the winter period.

Oxfordshire County Council in supporting this initiative has stated:

“The additional costs will need to be met from within the total resources for health and social care within the Oxfordshire system. There will be costs this year which will be met from resources held by the Clinical Commissioning Group for system transformation. Costs next year (and potentially the following year) will need to be met from savings arising from reduced activity in the acute sector (notably reduced excess bed days).”

The terms of support therefore revolve around assuring we maximise people’s potential for rehabilitation which we all support. For Adult Social Care, the main impact of delays is in the number of people who should return home supported with a home care package, but who may have to be referred to a more expensive long-term residential care bed instead as an interim option. This is driven by market availability of home care provision.

There is a requirement for Oxfordshire Clinical Commissioning Group to commit to fund this project from outside of any pooled budgets with Oxfordshire County Council. This is because the majority of the saving delivered will be to the acute bed based system and this is not currently pooled.

There have been a number of risks highlighted from this process and these are detailed below.

7. Risks

As with any initiative there are concerns or risks which will need to be addressed as part of the planning of this initiative. This table seeks to layout the risks and their potential mitigation.

Risk	Level	Mitigation
Decompensation from being a DToC Research findings 48% of people over 85 die within one year of hospital admission 10 days in hospital (acute or community) leads to the equivalent of 10 years ageing in the muscles of people over 80	Very High – Highest DTOC in NHSE	Undertake 'Better care' initiative short term waiting lists style activity underpinned by right sizing services to reach equilibrium.
Risk of overcrowding in ED Research finding Outcomes less good	M – V High (if poor winter) – ECIST 2014	Open 20 EAU beds and look to achieve 40 % of patients non admitted – equivalent to around 8,000 (Trust wide).admissions if achieve same level as current EAU
Safety of patients moving	M/L	Full MDT for each patient moving Audit of outcome of DTOC moves for comparison
Reduction in bed capacity at OUHFT	M	Continue to commission IC beds in the community – 75 post first 8 weeks to support until reach equilibrium Hospital process to improve – deliver breaking the cycle process improvements, EAU turnaround

Don't deliver equilibrium	M	KPIs agreed prior to initiative and responsibility for delivery
		
		Services being developed/expanded
		- Additional Discharge to assess capacity
		  - 70 D2A in DANA increased to 80 (own home)
		  - Upto 20 D2A CHC bed assessment places
		- SHDs and ORS service being merged
		- Transfer of staff from OUHFT to ORS/Care home support service (number unclear and a risk) to support up to 150 nursing home beds
		- Up to 150 nursing home beds dropping to 75 at 8 weeks
		- Over time of initiative additional SW, therapist and OTs
		- Single bed management across OUHFT/OHFT
		- Additional EAU
		- Purchasing additional voluntary sector, Response (home care), EOL care
		- 30 beds are freed in the community hospitals to open up flow in the system

Medical cover for the patients moving to an additional Intermediate care bed	L	No patient moving without the medical cover being established. Contracts are being let in a range of homes (around

		15) - the number of beds contracted varies from 2 - 15. 2 is the exception with most ranging from 5-10. The arrangements are being negotiated with lead Practices on a home by home basis. There is a fee per patient. Where agreements cannot be reached then the default will be that OUHFT holds the medical cover for those patients.
Additional pressure on GPs or other areas of the system	M	The PMCF schemes will be evaluated to see how they can support GPs in having additional time to spend on the patients with greatest need During the initiative we will be able to further judge where pressures in the system are exerting - so does greater ambulatory care require more response from GPs for example
Patients do not leave the 150 transferred beds	L	Multi disciplinary team being set up additionally to core team whose sole task is to discharge these patients. KPI of retaining > 2/3rds home reviewed up to three months
Funding exceeded from OCCG budget Short term – ie to March 2015	L	Initiative has a maximum of £2m. Recent proposals from Trust have tipped this over and whole system discussion know it must bring it back within. Bed costs less than current budget so offers some mitigation.
Funding exceeded from OCCG budget Long term from March 2015	M	Known spend on excess bed days for DToC is around £2.2m. There is potential to dramatically reduce this. In addition best case new EAU delivers 40% turnaround of patients assessed but not admitted then admissions reduce up to 8,000 (Trust wide). If say 6,000 episodes were for OCCG we could save in excess of several million but there are complex assumptions on assumed tariff and MRET which will need negotiation with OUHFT. For next year risk whole system agreement made that the new contract funds availability will need to account for this initiative
Ongoing financial risks to Social care	M	OCC has sought and gained. Objective is 2/3rd of all DToCs on pathway to home must be retained/minimum - will be a KPI OCC full participants and confirmation funds are outside the older person joint pool Capacity modelling of services required for equilibrium We have known shortfalls in capacity – eg home care this initiative offers proactive review of how to mitigate – alternate solutions – e.g > reablement, challenge to large packages (4 per day 2 hander) uses high number of care workers If the capacity of SHDS increases, and ORS delivers to its current contracted capacity then significant number of people could be appropriately supported home and the therapeutic and financial risks inherent in the plan substantially mitigated. An increase in the capacity of these services benefits patients, as only 30% leave this service requiring on going care and this also benefits the wider system, as it reduces demand for home care capacity.
Risks of saturating the social care	M	No placement is to be agreed above agreed a

market and price rises		maximum per week. Most achieved expected level. Joint agreement on nature of contract.
Risk of using poor providers	L	Shared intelligence and information on providers used before contract
Business continuity risk (e.g flooding) less flexibility for Council to move service users to safe locations.	L	During this initiative the NHS will have ward space in the Acute and also Community locations that in extremis could be considered for business continuity

8. Conclusion

This is a transformational plan with the potential to significantly shift resources from the bed based sector into the community. The whole system ambition to reduce reliance on expensive and inappropriate bed based care and shifting this into the community is one that has the potential to substantially benefit patients.

It is acknowledged that there are risks to the system if we do not secure the right discharge destinations for patients; however, we know we have a risk today in the sub optimal flow of patients evidenced by the current high levels of DToC. If we implement with sufficient staffing resource transfer to community support these proposals have the potential to significantly reduce the number of delayed transfers of care which is the most significant problem facing the Oxfordshire health and social care system.

The proposals involve a significant investment in care in the community which is consistent with the strategy for health and social care going forward. The scale of the proposal will challenge entrenched views amongst many professionals and encourage a less risk adverse attitude which will benefit patients.

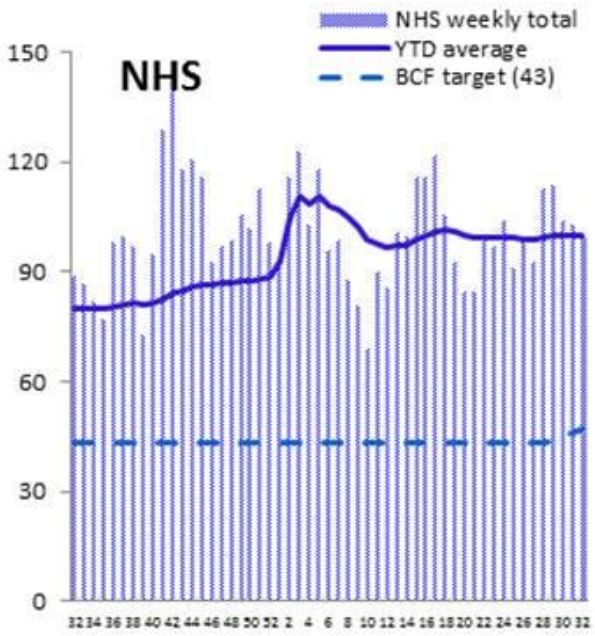
The early implementation signs are good: patients are being safely discharged with the agreement of their families; staff are pulling together within new configurations to make this happen; we have strong system support and the commitment of independent providers to deliver the intermediate care beds.

Appendix 1 - Delayed Transfers in Oxfordshire

Data is published nationally once a month by the department of health on delayed transfers of care. It breaks down all delays by hospital trust, local authority of the resident, reason for the delay and who was responsible for the delay (health, social care, both).

Definitions of what fits in each category need a little explanation

NHS	**Social Care**	**Both**
Community hospital beds	Domiciliary care packages	Awaiting package with therapy support OCC purchased
Intermediate care bed purchased by OCC	Care home placements OCC	Awaiting shared care package
Care Home placements (Self funders)		Assessment - multi disciplinary
Assessment - Continuing Healthcare or multi disciplinary		
Choice of care home		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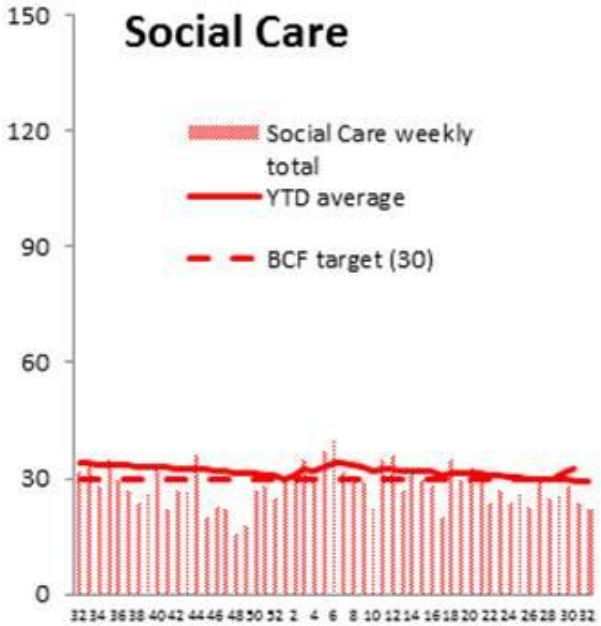
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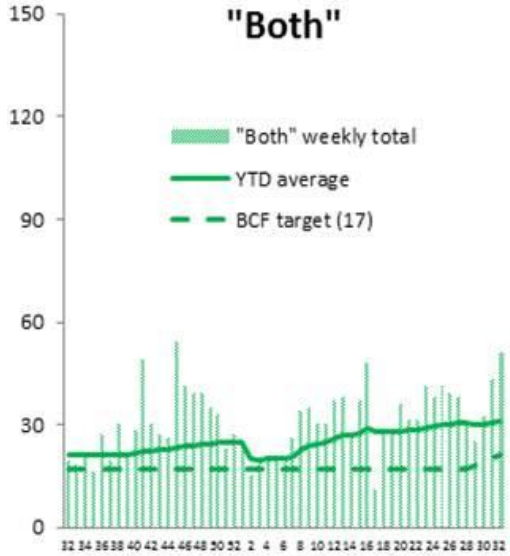
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"Both" weekly total
YTD average
BCF target (17)
150
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Appendix 2 - Breaking the Cycle high level recommendations

Recommendations	Actions
To undertake a review of pathways and referral processes	• Reduce numbers of CODs and repeated assessment. • Streamline the assessment process and reduce the number of pathways to reduce delays and ensure patients were transferred in time order. • Explore standard assessment tool with specific care triggers defining most appropriate pathway. • Trigger scores change so would their defined pathway without the need for changes of direction and reassessment.
Introduce system wide processes for sharing information on demand and capacity across all pathways.	• Improve communications on resolving DTOC. • Reshape conference calls and rapid escalations through command and control structures. • Decisions impacting on patient flow made at the most appropriate managerial level. • Develop a viewable single system wide “live” patient tracking list (PTL) incorporating all patients across all pathways from the acute Trust through to reablement pathways. • PTL system also track repatriations, ensuring adherence with system wide policy timelines and informed escalation.

Recommendations	Actions
The development of an electronic PTL	• Process for monitoring accurately demand and capacity for both bed based and home based services is required. • Going forward, refused activity should be measured to understand capacity gaps.
Wherever possible assessment for CHC funding or decisions on long term care should be undertaken out of hospital.	• Increase the number of discharge to assess packages so that no patient waits in hospital whilst full assessment and package of care is being commissioned.
Review commissioning arrangements for post-acute care	• Review post-acute pathways to ensure capacity meets demand. Consider best practice and innovations from other organisations, health economies. • Therapy led services to provide more home based and intermediate care. • For patients requiring large domiciliary care packages or long term care, interim beds should be made available for patients to wait out of the acute trust whilst packages or placements are sought. • Bariatric patients- post-acute pathway to ensure sufficient capacity and infrastructure to safely manage these. patients from admission through to discharge home.
Provide a Trust wide discharge liaison nursing team with senior leadership and management support	• Standard approach to planning more complex discharges. • Clear escalation process with defined authority levels. • Patient choice - standard approach with daily senior oversight. • Involvement of voluntary sectors in discharge planning and choice processes with self-funders.
Increase focus on out of county arrangements	• Management focus on progress chasing and escalation. • Agree process improvements with Northamptonshire and Warwickshire.
Transport	• Daily communications, escalations and KPI's