Oxfordshire
Clinical Commissioning Group

Oxfordshire Clinical Commissioning Group
Board Meeting

Date of Meeting: 28 January 2016	**Paper No: 16/06a**

Title of Presentation: Delayed Transfers of Care: update on *Rebalancing the Health & Social System* initiative

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

Purpose and Executive Summary (if paper longer than 3 pages):
This paper updates the Board on the implementation of the DTOC initiative approved at the meeting on 26 November, sets out the initial impact of the initiative to 13 January and reviews the risks considered at the last Board meeting.

Financial Implications of Paper:
OCCG Board has previously (26/11/2015) approved one-off investment of up to £2million to support this initiative

Action Required:
The Board is asked:

- To note progress against implementation of the plan
- To note the mitigation of the risks identified in the earlier paper
- To note and approve the next steps in the implementation of the plan

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	To provide verbal update at Board		

Author: Diane Hedges, Director of Delivery and Localities	**Clinical Lead:** Dr Barbara Batty, Urgent Care Lead

Delayed Transfers of Care –'Better Care' Action Plan

1. Introduction

At its meeting on 26 November 2015 Oxfordshire Clinical Commissioning Group (OCCG) approved allocation of resources of £2million to support an initiative to reduce Delayed Transfers of Care (DTOC) in the Oxfordshire system.

This paper updates the Board on progress with the implementation of the DTOC plan and gives an assessment of its impact at 13 January 2016.

The Board is asked:

- To note progress against implementation of the plan;
- To note the mitigation of the risks identified in the earlier paper;
- To note and approve the next steps in the implementation of the plan.

2. Implementation

The initiative went live on 7 December 2015 with the establishment of a central liaison hub co-ordinated from the John Radcliffe Hospital and the first patients were transferred to intermediate care beds on 8 December.

Key aspects of implementation:

- Oxford University Hospitals NHS FT (OUH) has contracted 126 intermediate care beds (ICB) in 17 nursing homes.
- Not all of these ICB have yet been deployed; the contract is 8 weeks from the first day of use.
- A DTOC Control Group was established consisting of Chief Operating Officers from OCCG, OCC, OUH and Oxford Health NHSFT (OH) and met daily (Monday-Friday) to 23 December. It has now scaled back to 2 meetings a week
- The liaison hub
    - Manages the logistics of communication with patients and families and escalate any concerns and issues;
    - Administers arrangements with Nursing Homes and GPs and OUH clinicians;
    - Maintains a tracking system on all patients who have moved and their onward destination;
    - Makes a daily check with the Nursing Home to proactively support patient management;
- Medical cover to the homes is mostly being provided by OUH with 6 homes supported by primary care.
- 83 people had been discharged to the ICB by 23 December and this led to a number of temporary vacations of wards across the OUH estate. This freed up capacity supported the establishment of the

Liaison hub and also on 21 December Ward 5A was re-configured as an extension to the Emergency Assessment Unit, adding additional ambulatory assessment and treatment and short-stay accommodation.

- OUH members of staff have been redeployed into the extended Emergency Assessment Unit and the Supported Hospital Discharge Service. Additional temporary staff have been recruited by OH and OCC.
- As part of the key performance indicators to evaluate the project, Oxfordshire Health Overview and Scrutiny Committee (HOSC) received the following metrics based on the previous performance of the Oxfordshire system in relation to patients discharged from hospital. These indicators will be used to offer assurance against some of the risks as outlined in Board paper 15/100. Our intention is to maximise independence and create no increase in the rates of placement.

Table 1

Outcome-final discharge destination	**Range**	**Indicative range for the 150 patients moved through ICB**
Care home	**32-38%**	**48-57**
Long-term home care	**27-33%**	**40-59**
Readmission to hospital	**7%***	**10**
RIP	**13-20%**	**19-30**
Discharged home with no ongoing support	**16-20%**	**24-30**

*HOSC agreed that this would be measured across a range.

3. Impact of the Plan at 13 January 2016

Number of patients delayed in hospital
At 13 January, 134 patients had been transferred to the intermediate care beds (113 from OUH and 19 from OH). The numbers of DTOC in OUHFT and OHFT (excluding mental health) for the Oxfordshire system has reduced as follows:

Table 2

Date	No of DTOC
3 December	159
10 December	139
17 December	93
24 December	83
31 December	102
7 January	114
14 January	133

The increase in the most recent counts can be attributed to the impact of the Christmas and New Year Bank Holidays. This seasonal variation can be identified each year and reflects the challenges in maintaining throughput across the holidays as well as the specific challenges in implementing this initiative at pace at this time of year. The throughput at the front door of the hospital held up well over this notoriously difficult period: we attribute that in part due to the redeployment of resources as part of this initiative.

Onward movement from Intermediate Care Bed

43 patients have been moved on from the intermediate care beds. The destination of this cohort is as follows:

Table 3

Outcome- destination	Actual at (date) 43 at 13/1/16
Care home	10
Long-term home care	3
Readmission to hospital	10
RIP	7
Discharged home with no ongoing support	3
Currently receiving reablement	10
[redacted]	43

A further 8 patients have been readmitted to hospital but returned to their intermediate care beds - they are not in these figures as they remain within the cohort still waiting to move to their outcome destination.

Given the focus on people expected to move on to care homes in the first cohort of patients placed in the ICB, it is not possible to compare the performance to date with the projected profile agreed with HOSC. This cannot be done until the whole cohort has been worked through. The 10 patients currently receiving reablement will not reach their outcome destination until that intervention is complete.

Readmitted patients return to the hospital cohort. Their outcome destination will only be counted should they be moved on again through the ICB. The rates of readmission in the first weeks of the initiative were high owing to a more cautious approach to managing patient care in the ICB. The liaison hub has now worked with the homes to improve processes and confidence and this rate has reduced.

Broader system impact
The liaison hub has proved effective in both the management of the patients in the intermediate care beds within a virtual ward, and in developing and promoting responsive approaches to the needs of those patients. There has been a positive impact on the wider system at an operational level. After the first few weeks the hub has learned more about the individual homes' approach to risk and has been able to respond more effectively to issues

raised in relation to patient care in the light of this. There has been particular learning around the management of system pressures at the weekend.

4. Next steps with implementation

There are a number of next steps with implementation.

Patients in intermediate care beds
At 13 January there were 91 patients in the intermediate care beds. Their planned onward destination at that point was:

Table 4

Outcome- destination	Patients in ICB
Care home	38
Long-term home care	21
Readmission to hospital	0
RIP	0
Discharged home with no ongoing support	
Needing reablement	11
Needing further assessment or therapy or equipment	21
	91

The immediate challenge for the initiative is that a number of patients have been in the intermediate care beds for several weeks and so OCCG is currently assuring provider and social care plans to move the patients on to their outcome destination.

In terms of length of stay in the intermediate care beds the breakdown is as follows

Table 5

Length of stay	No. of patients
0-7 days	19
8-14 days	8
15-21 days	21
22-28 days	21
29-42 days	22
43-56 days	0

Planning for equilibrium
The key next step for the initiative is to model future capacity needed to maintain better throughput and a continuing lower level of delays. There are a number of aspects to this:

- Understanding the impact of the extended Emergency Assessment Unit in reducing flow into hospital. This work is being led by Dr Dan Lasserson at OUH;
- Integrating reablement services into one streamlined pathway that reduces the risk of delays created by multiple routes out of hospital that function to

slightly different criteria. A paper is going to OCC Cabinet in January 2016 seeking approval to negotiate this new contract with OUH and OH subject to delivery of performance and price evidenced through a number of gateways;

- Planning for discharge to assess beds for people who are eligible for interim continuing healthcare funding. This work is under review: only 2 patients who meet this criterion have transferred into the intermediate care beds whilst a number more with possibly more acute needs have been assessed and managed on the wards. This will determine the scope and extent of the discharge to assess capacity that OCCG commissions;
- OCC will let their new home care contracts commissioned under the Help at Home programme from May 2016.

5. Risks

At its meeting in November OCCG Board considered a number of risks relating to this initiative. These are updated below. .

Risk	Level	Mitigation	Update at 20 Jan
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.	The initiative has moved patients who would be in a hospital bed into a setting where there is reablement and therapy support to help avoid decompensation.
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	Extra EAU beds opened. Christmas period managed without significant incident.
Safety of patients moving	M/L	Full MDT for each patient moving Audit of outcome of DTOC moves for comparison	Patient transfers successfully managed. No significant issues identified to date. Each patient death is reviewed.
Reduction in bed capacity at OUH	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	We are reviewing plans to continue to contract at lower levels once we have agreed the appropriate level of provision.
Don't deliver equilibrium	M	KPIs agreed prior to initiative and responsibility for delivery	Suite of KPI developed that are being monitored in the DTOC Control Group.

		-	The recent DTOC increase needs to return to trajectory to ensure that the risk is not rising in this area
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 OUH holds the medical cover for those patients. Progress is good. Banbury only particular issue so far – OUH will cover if no GP. Meanwhile OUH to talk to PML.	6 homes are covered by primary care with the remaining 11 covered directly by OUH. Work is ongoing with Practices and Federations to see how GP led medical cover can be extended
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	PMCF progressing well. Those few GP issues raised are being followed up.
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	134 patients transferred at 13 Jan. The logistics have been very effectively handled and overseen by the Liaison Hub
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.	No anticipated overspend at this stage.
Funding exceeded from OCCG budget	M	Known spend on excess bed days for DToC is around £2.2m. There is potential to	At this stage this remains hard to judge. The current DTOC level has reduced but

Long term from March 2015		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 OUH. For next year risk whole system agreement made that the new contract funds availability will need to account for this initiative	the impact on XBD is not yet quantifiable.
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.	To be determined as data emerges: any risk cannot as yet be quantified.
Risks of	M	No placement is to be agreed	OCC is currently reporting

saturating the social care market and price rises		above agreed a maximum per week. Most achieved expected level. Joint agreement on nature of contract.	difficulties in meeting costs of care homes outside of the initiative but made 19 placements in w/e 15 January. This will be kept under review.
Risk of using poor providers	L	Shared intelligence and information on providers used before contract	No concerns raised around the homes to date. Risks assessed and management protocol agreed prior to patients being placed
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	Not an issue to date

6. Conclusion

This initiative has demonstrated the ability of the wider health and social care system to mobilise and work together to achieve a large scale, safe and orderly transfer of patients. We have successfully commissioned significant amounts of extra capacity and redeployed resources within budget and at pace which has led to people who do not need to be in hospital being moved to more appropriate accommodation. The long-term impact of the initiative is still being assessed.