DTOC Provider Programme

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Project Initiation Document

Project Name:	DTOC Providers Programme		
Date:	16 August 2012	**Release:**	Draft
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Owner:	Paul Brennan – Director of Clinical Services, OUH		
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Note: This document is only valid on the day it was printed

The source of this document will be found in the Project file

Revision History

Date of next revision: 25 June 2012

Revision Date	Previous Revision Date	Summary of Changes	Changes Marked
19 June 2012		Updated workstreams detail and dates, project structure	tracked
22 June 2002	19 June 2012	Updated Project Board leads and workstream leads, incorporated comments from John Dixon and Marie Pritchard as to content	tracked
25 June 2012	22 June 2012	Incorporated comments from Paul Brennan	
4 July 2012	25 June 2012	Updated Project Board: John Jackson (OCC and Lucy Butler (OCC) Project Structure re-drawn	
16 August 2012	4 July 2012	Updated Project Board composition, updated workstream progress as per 26th July update	
17 August 2012	16 August 2012	Included SPA referrals received from OUH from 20 August	

Approvals

This document requires the following approvals. A signed copy should be placed in the project files.

Name	Signature	Title	Date of Issue	Version
Yvonne Taylor		Chief Operating Officer (OHFT)		V2.5
Lucy Butler		Deputy Director for Social Care for Adults (OCC)		
Paul Brennan		Director of Clinical Services (OUH)		

Distribution

This document has been distributed to:

Name	Title	Date of Issue	Version
Yvonne Taylor	Chief Operating Officer (OHFT)	16 August 2012	V2.5
Lucy Butler	Deputy Director for Social Care for Adults (OCC)	16 August 2012	V2.5
Paul Brennan	Director of Clinical Services (OUH)	16 August 2012	V2.5

Overview

Purpose

This Project Initiation Document's purpose is to define the project, to form the basis of its management and the assessment of overall success.

The Project Initiation Document gives the direction and scope of the project and forms the 'contract' between the project management team and corporate or programme management.

The two primary uses of the document are to:

- Ensure that the project has a sound basis before asking the Project Board to make any major commitment to the project
- Act as a base document against which the Project Board and PM can assess progress, Project Issues and on-going viability questions.

Background

In 2011, the main commissioners for Oxfordshire of health and social care - NHS Oxfordshire and Oxfordshire County Council – and the main providers of health and social are in Oxfordshire – Oxford Health NHS Foundation Trust (OHFT), Oxford University Hospitals NHS Trust (OUH) and Oxfordshire County Council Adult Social Services agreed to deliver a joint approach to resolve persistent issues affecting care delivery in the county. This union of providers and commissioners supported the Oxfordshire Appropriate Care for Everyone Partnership Programme (ACE).

A key issue affecting performance in the county is Delayed Transfers of Care (DTOC). This programme addresses this issue with a joint approach from the three main statutory public sector care providers of Oxfordshire.

The Department of Health defines a DTOC[1] as below:

> A delayed transfer of care from acute or non-acute (including PCT and mental health) care occurs when a patient is ready to depart from such care and is still occupying a bed. A patient is ready for transfer when:
>
> a. A clinical decision has been made that patient is ready for transfer AND
> b. A multi-disciplinary team decision has been made that patient is ready for transfer AND
> c. The patient is safe to discharge/transfer.
>
> A multi-disciplinary team in this context includes nursing and other health and social care professionals, caring for that patient in an acute setting.
>
> For patients of no fixed abode, the council responsible for the patient is the council whose area they reside. This is irrespective of whether the patient lives on the street or in a hostel.
>
> Asylum seekers and others from overseas should be listed under the council in which they currently reside. It is the responsibility of this council to decide whether they are eligible for social services.

The programme commenced in March 2012 with a primary objective to reduce the number of DTOCs in Oxfordshire. Such a reduction would have benefits inherently to the patients and service users affected but also performance and financial benefits to commissioners and providers. NHS Oxfordshire identified a Commissioning for Quality and Innovation (CQUIN) incentive payment for both NHS providers to achieve the required reductions in 2012/13. Based on the current workplan the programme should have delivered its key objectives by end of Q3 (December 2012).

The DTOC Provider's Programme can be broken down into four key stages:

[1] Monthly SitReps definitions v1.06 DTOC Final, http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/@ps/@sta/@perf/documents/digitalasset/dh_128687.doc

1. **Initiation and Setup**: commencement of the programme with the establishment of a governance structure and key organisational agreement
2. **Specification**: circulation and ratification of specifications and quality indicators for various deliverables throughout the project. This stage includes the eight (8) workstreams outlined later in this document.
3. **Implementation**: putting the measures in place and monitoring progress towards outcomes. This is the delivery stage of the various workstreams in a coordinated manner to achieve the programme's aims and objectives.
4. **Close**: upon completion of the programme objectives, the programme is brought to a controlled finish with a review of achievement against the initial business case. If continued work is required this should be identified and agreed in this stage.

Project Definition

The programme will be delivered via a range of eight workstreams. Each workstream reports to an operational director and is led by a senior clinical lead. Initial analysis and workshops identified the need to resolve major problems in the current systems. The coordinated actions of the eight workstreams should deliver the required improvements.

The Oxfordshire Health and Wellbeing Board published its draft strategy in May 2012 with specific targets for 2012/13 as below:

- a reduction in delayed transfers of care so that Oxfordshire's performance is out of the bottom quarter (current ranking is 151/151)
- 3,250 people will receive a reablement service (currently 1,812)
- 55% of the people completing the reablement service will be successfully supported so that they need no on-going care (currently 47%)
- No more than 400 older people permanently admitted to a care home (currently 546)
- 50% of the expected population with dementia will have a recorded diagnosis (currently 37.8%)

Achievement of the DTOC and reablement goals sits squarely with the main providers in Oxfordshire who, through this programme, will work in partnership to deliver the necessary changes. The aspirations for dementia recording and reducing care home admissions are supported by the providers though they are not part of the joint provider plan at this stage.

Project Objectives

The programme's aims were identified through workshops and analysis as below:

- Improving patient pathways through the various services
- improving joint working and cooperation between providers to improve consistency and reduce duplication of effort
- increasing the trust and understanding of services across organisations
- making referral processes simpler and more targeted in the required documentation
- increasing capacity in the appropriate areas to remove blockages in the system
- Agreeing standardised metrics and data capture tools
- Standardising assessments between clinical and social care teams

Project Workstreams

The aims will be achieved through eight workstreams delivered in 2012 as outlined below:

Workstream 1: Change Management and Clinical Leadership	
Project Board lead	Paul Brennan
Project Lead:	Medicology
Summary	Professional and Clinical Development work should be undertaken to address the issue of lack of trust across organisations and staff groups and a common purpose in reaching decisions that facilitate effective patient discharge and join working. Given the long standing nature of this and deep rooted behaviour patterns it is felt that we need some external facilitation and development work to help change the current culture. 30 OCC staff, 40 from OH and 50 from OUH. OUH participants to include consultants, matrons, operational managers, ward sisters and therapists. Proposed workshop dates: • 31st July • 1st August, • 9th August, • 10th August • 3rd September • 4th September 2012 • 17th September 2012 • 24th September 2012 Programme has been confirmed: with the initial 'INSIGHT' workshops will be followed by a series of one day training events on 'RESOLVING COMPLEX CHALLLENGES' and the sessions will cover clinical pathways and delivering sustainable system improvements. The training sessions will be followed by a 'CHAMPIONS' day which will aim to distil all of the learning for the leaders and champions to be able to identify and resolve future issues when these arise. In addition to the face to face sessions staff will have access to various on line tools including the Medicademy learning web point, an online forum hosting and a shared working area covering the three provider organisations. The contract for the Medicology work is directly between OUH and Medicology on behalf of the three providers. The cost will be shared equally by the three provider organisations
Event	**Timescale**
Invite proposals for change management	20th April 2012 (complete)
Shortlist	30th April 2012 (complete)
Interview and Appoint	23rd May 2012 (complete)
Finalise work programme with selected organisation and confirmation of participants	8th June 2012 (complete)
Work programme starts	3rd July 2012 (complete)
Review point on effectiveness, delivery and impact	Week of 24th September 2012
Programme concludes subject to review point	21st December 2012

Workstream 2: Streamlined pathways and integrated services	
Project Board lead	Lucy Butler and Yvonne Taylor
Project Lead:	Anne Brierley
Project Delivery Lead:	James Venables, Nick Horn
Summary	Phase 1: Single point of access is a patient bureau, with the key objective being to ensure the seamless and safe management and referral of patients that would benefit from community service intervention, either to prevent an admission or to support early discharge. Move to include integrated locality teams. Next stage: Review of pilot outcomes and align organisations agreement with regards the focus of SPA – particularly the role of SPA in discharge planning from OUH
Event	**Timescale**
Implement single point of access for GP referrals to community health based services	30th April 2012 (complete)
Finalise and sign off response times from time of referral to the combined health and social care single point of contact	10th September 2012 (revised)
Review of pilot outcomes	October 2012
Open single point of access for Community Hospital referrals to community health based services	Commences 18th June 2012 and operational across all community hospitals by 31st August 2012.
Pilot SPA to accept referrals from OUH (initially 7 referrals per week)	20th August 2012
Single point of access extended to incorporate social care services	December 2012

Workstream 3: Health & Social Care for Elderly Frail Contractor or Joint Venture	
Project Board lead	Paul Brennan, Yvonne Taylor
Project Lead:	DAC Beachcroft
Project Delivery Lead:	Paul Brennan
Summary	Exploring opportunities to work together in a more formalised basis. Setup an integrated partnership – corporate structure to be decided. The partnership aims to introduce a single management structure focusing on acute medical and frail elderly beds, Supported Hospital Discharge Scheme, Reablement and the deployment of intermediate care beds. The partnership would operate as a single entity and manage the patients' total acute and community bed based care alongside reablement and short term social care. This workstream is a possible pre-requisite for the work to be undertaken in workstream 4: Domiciliary Care. Where the partnership will seek to provide a responsive and competitive service that will offer an alternative to the independent sector providers. A planned teleconference with lawyers over possible JV structures did not occur due to conflicting commitments from participant providers.
Event	**Timescale**
Appoint legal advisors	23rd April 2012

Set out options for JV structure	14th May 2012
Draft Outline structure for Joint Executive and Board Report	14th May 2012
Establish Project Team to prepare business case	28th May 2012
Draft business case for review	October 2012
Completion of Full Business Case	November 2012
OUH and OHFT Board Decision	December 2012 Board Meetings
Commence Implementation	January 2013

Workstream 4: Domiciliary Care	
Project Board lead	Lucy Butler
Project Lead:	Anne Brierley
Project Delivery Lead:	James Venables
Summary Revise the description	Domiciliary care is currently provided by 49 private providers commissioned by OCC. It is also provided for a 2 week period following discharge from OUH by the Supported Hospital Discharge Service. There are however waiting times for some patients to get a service from the private providers. This can vary significantly dependent on type of care and/or geographic location. This has an impact in delaying patients being discharged from acute and community beds and also the reablement service provided by OHFT. Total commissioned cost of this service to Oxfordshire County Council is £24 million In the short term it is essential to improve the access and flow of patients from beds and reablement into the private providers. This workstream is related to workstream 3 on agreeing a partnership corporate structure.
Event	**Timescale**
OHFT and OUH to explore provision of domiciliary social care with particular emphasis on double-handed/QDS complex premium packages of care – those that would be joint funded.	September 2012; note link to workstream 3
Implement a RAG rating of patient need and complexity in acute or community setting.	October 2012
Record assessment delays as to whether the delay is waiting for assessment or assessment in progress	August 2012
Review of care workforce characteristics and reward packages	October 2012

Workstream 5: Reablement and supported hospital discharge service (SHDS)	
Operational Director lead	Paul Brennan, Yvonne Taylor
Project Lead:	Anne Brierley/Siobhan Hurley
Project Delivery Lead:	Suzanne Jones/Liz Hobbs

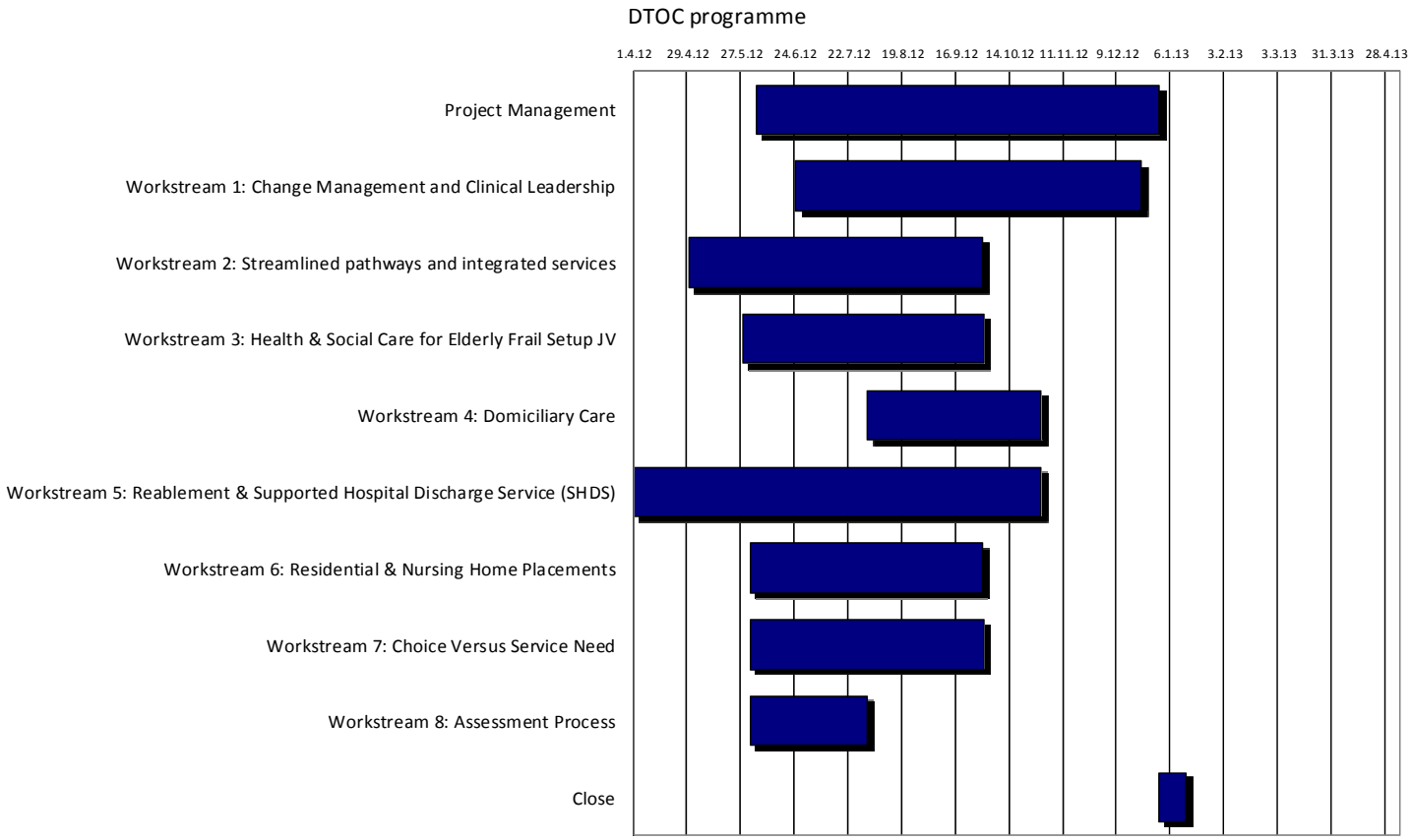
Summary (reablement)	The Reablement Service currently provided by OHFT can have a significant reduction on the numbers of older people requiring either on going domiciliary care or placements in a nursing/residential home. National evidence has shown that a well-functioning Reablement Service can have a positive impact within a range of 50-60%. Oxford Health has appointed 20 staff, further interviews are scheduled next week with 6 candidates and a second round of recruitment is underway with a closing date of the 29th July; currently 33 applications. The key targets for the service relate to new admissions per week, the proportion of people who leave the service having completed their reablement episode and the proportion of people who complete their reablement package and have no ongoing care needs. Current respective performance is 502 against a target of 655, 75.3% against a target of 83% and 44% against a target of 53%.
Event	**Timescale**
Increase pick up rate from 38 to 55 EOC per week giving annual rate of 2,750 new episodes	April 2012 to 43 then sliding trajectory to 55 from July 2012
Increase pick up rate from 55 EOC to 63 EOC per week giving annual rate of 3,250 new episodes	From October 2012 63 EOC per week;
Reduce delays for long term care for patients discharged from Reablement Service to 12 (delivered via two specific actions)	No more than 12 people remaining with the service beyond the completion of the reablement episode at any one time
Percentage of patients requiring no on-going care post reablement increasing from 47%% to 55%	from October 2012 55%
Summary (SHDS)	The Supported Hospital Discharge Service has been operational since December 2011 and has managed 92 patients delivering a reduction of 1100 excess bed days during the period December 2011 to March 2012. The service is currently managing a daily case load of 21 patients which falls short of the 80 caseload capacity. The primary reason for the underperformance against caseload capacity is staffing however it is of note that the excess bed day reduction target is being achieved.
Event	**Timescale**
Review and revise pay and reward package for home care workers	April 2012
Commence Stage 1 recruitment process	April 2012
Interviews and appointments – target is to recruit an additional 20 care workers	w/c 14th and 21st May 2012
Stage 2 recruitment process – target is to recruit an additional 10 care workers.	Commence 4th June 2012 and complete, including induction/academy, by 17th September 2012
Induction and care worker academy complete	2nd to 13th July 2012 for stage 1 and 3th to 14th September for stage 2.
New staff operational	16th July 2012 for stage 1 and 17th September 2012 for stage 2
Extend geographic coverage of service in agreement with OCC and OCG	10th September

Workstream 6: Residential and nursing home placements	
Project Board lead	Lucy Butler
Project Lead:	Joan Norris
Project Delivery Lead:	Joan Norris
Summary	There are 10 patients currently assessed as requiring residential/nursing home placements delayed in community and acute hospital beds. The current rate of placement is approximately 10.4 per week. OCC are assessing the feasibility of implementing temporary placements within a concentrated 2 week period.
Event	**Timescale**
OCC to confirm arrangements for short term temporary placement of 30 patients to be achieved within a time limited period of two weeks	Confirmation by 1st June 2012 with patient transfers to occur between the 11th and 23rd June 2012. Patients have been placed in long term care as of 19 June
Continue 10 placements a week until September 2012	
Residential placements confirmed at average of 11.1 placements per week for the 2012/13 year to date against a target of 10.	

Workstream 7: Choice versus service need	
Project Board lead	Paul Brennan, Yvonne Taylor
Project Lead:	Caroline Landon, Karen Campbell
Project Delivery Lead:	Caroline Landon, Karen Campbell
Summary	Choice is resulting in patients remaining in both acute and community hospital beds when clinically their requirements indicate residential or care home support. This could be for example the choice of a particular nursing home or community hospital or relatives refusing to take home relatives after a spell in hospital. The existing choice policy has been amended and proposes charging patients who remain in an acute or community hospital bed as a consequence of choice.
Event	**Timescale**
Finalise policy to reflect system wide agreement	1st June 2012
Obtain legal advice on charging options (both FT and NHS Trust as aim is for consistent policy)	8th June 2012
Sign off by ACE Programme Board	June ACE Programme Board
	Commissioners asked for the workstream to proceed without charges. PB/YT to seek confirmation at Project Board meeting on 29/7. Still look for full policy to go to respective Trust Boards in September 2012 for decision on charging.
Draft communication protocol and media handling strategy.	29th June 2012
Agreement by Boards – OUH, OHFT, OCG, PCT and OCG.	September2012 Board Meetings
Implement, subject to Board sign off.	1st October 2012

Workstream 8: Assessment processes	
Project Board lead	Paul Brennan, Yvonne Taylor, Lucy Butler
Project Lead:	Pete McGrane, Melanie Pearce, Joan Norris
Project Delivery Lead:	TBD
Summary	Cross reference to domiciliary care assessment delays. Cultural change link in workstream 1 with Medicology to encourage joint decision-making A system wide agreement needs to be made to limit the multiple assessment processes currently undertaken and a working protocol is to be prepared to introduce an integrated assessment tool and dramatically reduce the scale of the bureaucracy associated with assessment. Actions are to be agreed with the aim of implementing a shared assessment process from the 1st August 2012. • This work stream corresponds closely to the new Discharge to Assess proposal. • Social services have achieved their target of achieving fewer than 10 delays due to assessments not being undertaken. This is 1/3 the previous figures from earlier in the year. Assessment delays for July are w/e 1/7 = 2, w/e 8/7 = 4, w/e 15/7 = 4, w/e 22/7 = 3. Previous average was 16.
Event	**Timescale**
Standard Operating Procedures for each stage of a patient pathway	
Shared assessment process	1st August 2012
Single case management lead and risk profiling	

Initial Project Plan



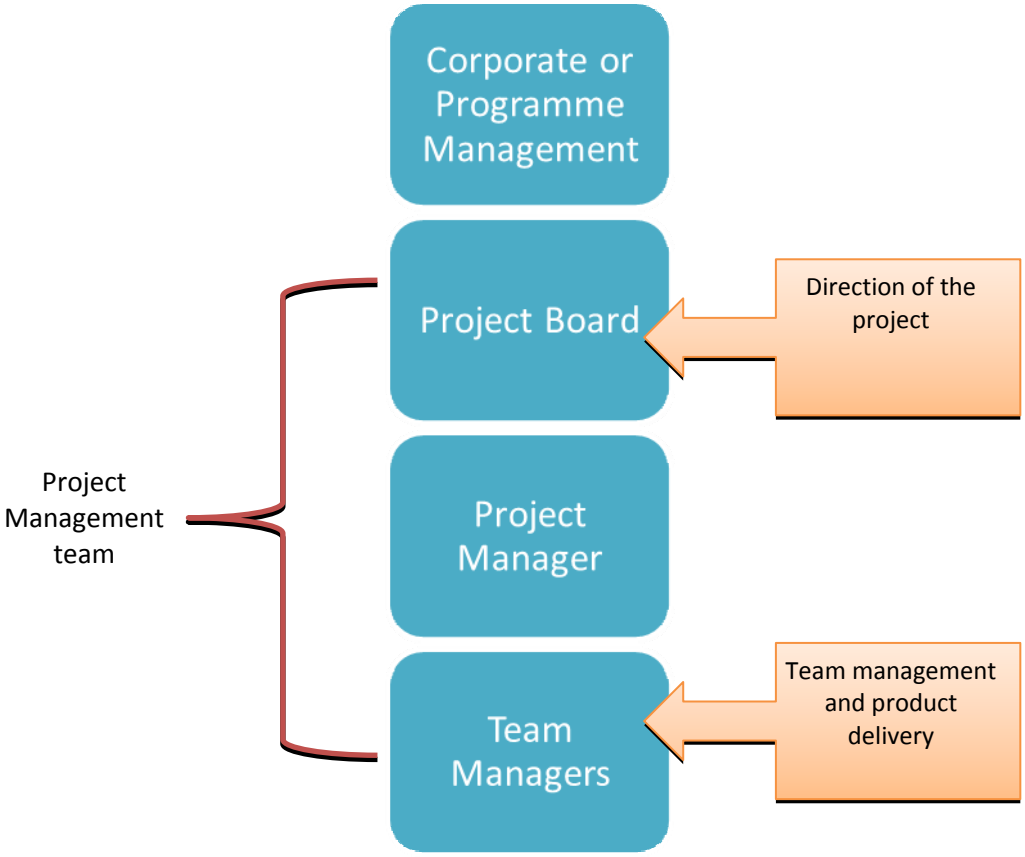
Risk and Issue Management

A shared risk and issue register for the project will be maintained. The risk register will be reviewed as part of the board review process. Risks can be added at any time by any member of the project team. A list of risk mitigating actions will also be maintained. In the event that a risk occurs, the project board will make a decision on the necessary actions.

The risk register will be reviewed as part of the weekly/monthly review process. An action list of risk mitigating actions will also be maintained. In the event that a risk occurs the project board will make a decision on the necessary action and the implications on project.

Project Organisation Structure

Project Management team structure



Corporate or Programme Management

- Julie Waldron — Oxford Health NHS FT
- Sir Jonathan Michael — Oxford University Hospitals NHS Trust
- Joanna Simons — Oxfordshire County Council
- John Jackson — Oxfordshire County Council
- Stephen Richards — Oxfordshire Clinical Commissioning Group
- Yvonne Taylor — Oxford Health NHS FT
- Lucy Butler — Oxfordshire County Council
- Paul Brennan — Oxford University Hospitals NHS Trust

Project Board

- Yvonne Taylor — Oxford Health NHS FT
- Pete McGrane — Oxford Health NHS FT
- Karen Campbell — Oxford Health NHS FT
- Paul Brennan — Oxford University Hospitals NHS Trust
- Lucy Butler — Oxfordshire County Council
- *GP for nomination* — Oxfordshire Clinical Commissioning Group
- James Price — Oxford University Hospitals NHS Trust
- Chandi Ratnatunga — Oxford University Hospitals NHS Trust

Project Manager to co-ordinate all three organisations

- Matthew Lawrence — Oxford University Hospitals NHS Trust

Team Managers lead delivery of workstreams

Team managers drawn from all three organisations relevant to workstream focus

• Anne Brierley	Divisional Director Community Services	Oxford Health
• Pete McGrane	Clinical Director Community Services Urgent Care	Oxford Health
• Karen Campbell	Service Manager Community Hospitals	Oxford Health
• Melanie Pearce	Locality manager	Oxfordshire County Council
• Dan Leveson	Programme Management Office	Oxford Health
• John Ray	Programme Manager	OCCG
• James Venables	Head of Integrated Care - Programme Manager	Oxford Health
• Suzanne Jones		Oxford Health
• Joan Norris	Social work (base JR)	Oxfordshire County Council
• Nick Horn	Adult Social Care	Oxfordshire County Council
• Caroline Landon	Deputy Director Service improvement	Oxford University Hospitals NHS Trust
• Siobhan Hurley	Operational Service Manager	Oxford University Hospitals NHS Trust
• Liz Hobbs	SHDS Manager	Oxford University Hospitals NHS Trust
• Steve Thomas	Monitoring	Oxfordshire County Council
• David Rugman	Monitoring	NHS Oxfordshire

Communication Plan

Fortnightly meetings
Project Team meetings: project management team and project board will meet to report on progress against agreed milestones, any revisions to objectives or specifications

Four Weekly
CEO Programme Board meetings

Ad-Hoc meetings
The Project Board or Corporate Management will meet to discuss any ad-hoc urgent business that cannot be attended to in the regular fortnightly or monthly meetings.

Interactions

The DTOC Provider Programme reports to the Chief Executive Group. The Provider Action Plan reports for information only to the ACE Programme Board.