OLDHAM URGENT CARE ALLIANCE

New Programme Management Office set up to improve health and social care integration results in 5.8% reduction in unplanned hospital admissions

In 2012 Oldham established a voluntary, informal partnership between several partners (Oldham Council; Pennine Acute Hospitals NHS Trust; Pennine Care NHS Foundation Trust; GotoDoc, a social enterprise providing an out of hours GP service; Oldham Care and Support, a limited company owned by the council to provide homecare and re-ablement services) in the local health economy called the 'Oldham Urgent Care Alliance' with attendance by Oldham CCG. Additional partners have joined since, including: Voluntary Action Oldham, First Choice Homes and a GP representing GPs in the area.

The Alliance's initial aims were to improve the urgent care system across all partners in the Oldham locality. However, after a year, and despite good intentions, frustration had set in due to the lack of coordination and structure around the workings of the partnership to deliver any real and meaningful change.

The partners had lots of great ideas to improve performance but the effort needed to coordinate and energise multi-organisation programmes and projects meant that there was little progress in setting and achieving targets.

In December 2014 the CCG agreed to fund an Urgent Care Alliance Programme Management Office (PMO). V4 Services were appointed as the delivery partner to develop project plans, establish performance monitoring and implement effective communications between the key stakeholders in order to provide greater clarity across all partners on what was required to improve the urgent care system.

Oldham Council · Oldham Care & Support · gtd urgent care · NHS Oldham Clinical Commissioning Group · Pennine Care NHS Foundation Trust · firstchoice HOMES OLDHAM · IGPC INNOVATIVE GP CARE Oldham GP Federation · V4 · The Pennine Acute Hospitals NHS Trust · VOLUNTARY ACTION Oldham

THE CHALLENGE

The main objective of setting up the PMO was to coordinate all projects within the overall programme to ensure the Better Care Fund (BCF) guideline reduction of at least 3.5% in non-elective admissions to hospital was met compared to the previous year.

Although data existed for the previous year, it was not coordinated or in a form to be able to use as a starting point.

Nine different initiatives had already been identified by the partners, along with a list of projects but there were no clear objectives, targets or project plans set out to deliver against.

The multi-faceted programme needed a clear governance structure to be designed and implemented.

8 Alliance partners

A&E
5.8% reduction in non-elective admissions

2.6% increase in A&E attendances

Paediatrics
600 fewer admissions

2% reduction in deaths in hospital per 1,000 population

Minor injuries
>250 deflections

Long term conditions
c500 deflections

Stroke rehabilitation
15 deflections

Intermediate care
>250 deflections

Programme governance structure

ALLIANCE BOARD
Monthly meetings

→

OPERATIONS BOARD
Fortnightly meetings

→

TACTICAL ALLIANCE GROUP
Weekly meetings

THE SOLUTION

- A central PMO was set up to be independent of the partners. Its role was to provide challenge to the partners and ensure the best interests of the Alliance were promoted.
- Its core responsibilities included: relationship management, acting as a honest broker, negotiation to get the projects delivered, building bridges between partners and driving forward solutions.
- All historic data for hospital admissions was captured for the previous year to provide a baseline.
- A governance structure was established for day-to-day management, as well as oversight of the whole programme.
- All nine deflection schemes identified in the BCF bid were reviewed. They varied substantially in development; some were thoughts, some had been running for a while and some had just started. At this stage no data was being captured and no project plans were in place.
- A lead person within each organisation was nominated for each of the nine schemes.
- A project plan was produced for each of the schemes with clear actions and responsibilities.
- A method for capturing data for the current year was designed, along with reporting mechanisms to assess the success of the projects on a month by month basis.
- A weekly Performance Report was established showing weekly deflections by age group and by week.

The nine different schemes within the programme were:

	BCF Scheme	Project objective	Results (2015 compared to 2014)
1	Paediatric admissions	To divert patients who would typically stay less than four hours to a triage system (following statistics that in 2014 1,000 patients were admitted and stayed less than 4 hours)	→ Triage system introduced to assess conditions prior to admission. → Admissions decreased by 600
2	Alcohol Liaison Service	To divert acute alcoholics frequently admitted to A&E to signposted community services and home visits, assisting them with preventative measures.	
3	Alternative to transfer	To set up assessments of minor injuries within A&E.	→ A physiotherapy and occupational therapy service established enabling initial assessment of patients. → >250 deflections
4	Long term conditions	To pro-actively manage patients with long term conditions such as diabetes, asthma, breathing issues and chronic illnesses to be cared for within community clinics and enable self-management of their conditions and required support.	→ c. 500 deflections
5	Early supported discharge for stroke rehabilitation	To identify patients who can be discharged quicker and supported in the community.	→ 15 deflections
6	Nursing home outreach	To introduce an outreach scheme to enable a specialist doctor on call to respond to people with medical issues in care homes rather than the person coming into hospital. This includes administering intravenous antibiotics in the home/residential care home.	
7	End of life	To improve and provide consistent management of End of Life Plans and provide greater choice for people to die in their preferred place.	→ 2% reduction in deaths in hospital per 1,000 population, including a small reduction in deaths in hospital amongst the over 65 age group.
8	Intermediate care, A&E – therapy inreach	To divert patients that do not need to be admitted to A&E for intravenous medications to intermediate care facilities in the community as day visitors.	→ >250 deflections
9	Intermediate care – Rapid response	Rapid response alternative to 999.	

Frail/Elderly Unit
The PMO also supported the creation of a Frail Elderly Unit (SPRINT) occupying two bays of the Acute Medical Unit. A set of criteria was developed for patients who were frail, but not seriously ill, and a multi-disciplinary team was made available to review each patient as soon as possible after admission to immediately start preparing for discharge. The PMO ran a series of Plan, Do, Study, Act (PDSA) cycles to test the processes and assist with embedding them. The average length of stay on the unit for patients over 65 years has been reduced from 7.4 days to 2.7 days (64%) compared to the average before this unit was created.

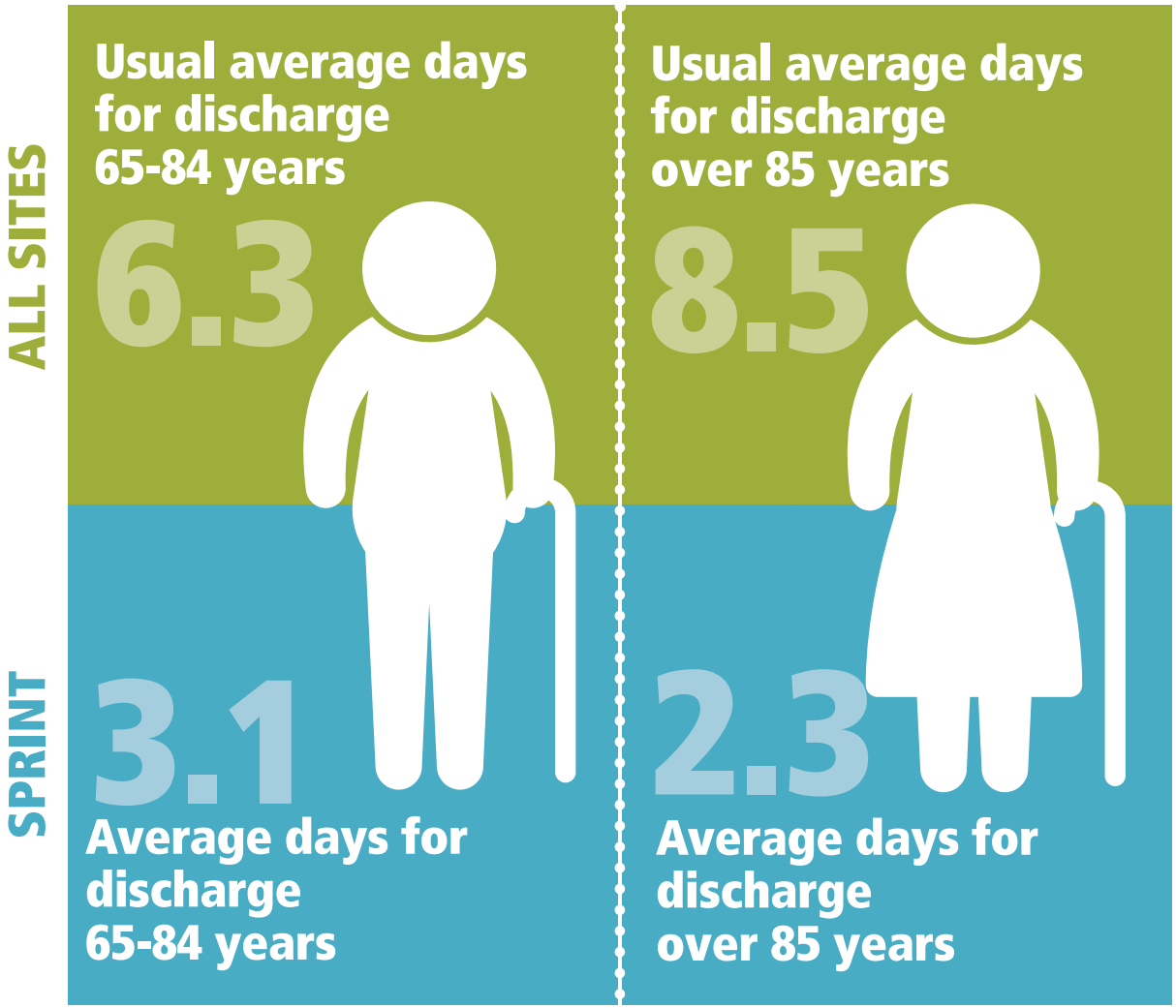
Despite a 2.6% increase in A&E attendances in 2015, compared with the previous year, non-elective admissions fell by over 5.8%, reducing the conversion rate from attendance to admission by 2.7% in 2015.

"As a partnership of different organisations we are passionate about improving services for our patients and our local community.

We have plenty of ideas but V4 Services has acted as the glue to hold the Alliance together, provide structure to the programme and practical support to each of the projects within it as well as the independence to be able to broker difficult conversations and decisions with the patient at heart."

Dan Cassell, Oldham CCG

Average length of stay by age group



About V4 Services Limited

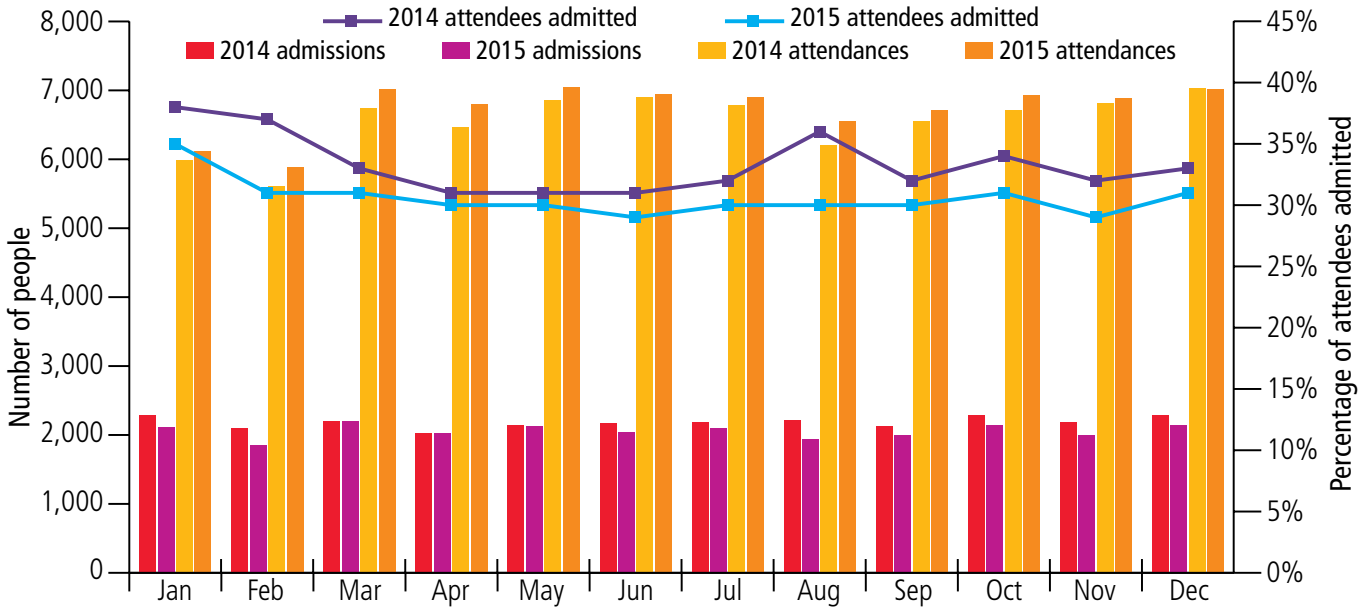
We have worked in partnership with over 120 UK public sector organisations including: councils, NHS, social enterprises and trading bodies providing hands-on delivery support to set up new business structures, improve the efficiency of in-house services, encourage a commercial approach and generate savings and service improvements.

Resilience funding

Following the success of the PMO and the integrated approach to managing non-elective admissions through the concerted effort of multiple parties, the PMO was asked to improve the process for allocating winter resilience funds across the Alliance partners. This would involve developing KPIs and a performance monitoring framework to assess which schemes were delivering the estimated improvements and which ones were falling short so that funding could be re-allocated.

The Winter Resilience annual budget of £1.6m included 15 individual schemes. Each Alliance Partner was asked to submit a business case with KPI measures for each resilience scheme and justify what impact it would have in maintaining performance over the peak periods. These business cases were then reviewed and prioritised by Alliance Partners. A Performance Report has been set up on each resilience scheme and is reviewed by the monthly Alliance Management Board.

Attendances, admissions and attendees admitted at the Royal Oldham Hospital 2014-2015



THE BENEFITS

- 5.8% reduction in non-elective admissions against a 2.6% increase in attendances compared to previous year.
- BCF Performance Report circulated weekly to all partners and project leads. The report includes:
  - Key findings
  - Total emergency admissions by age
  - Comparison with the previous year
  - Running totals and percentage change
  - Attendances versus admissions
- Performance dashboard set up for all deflection schemes and reported in detail on a monthly basis.

> The key strengths of Oldham's BCF programme are built on very strong relationships between the council and CCG, and also with providers. The Urgent Care Alliance brings together all of the major players on the patch and is the vehicle for their BCF plan.
>
> They have resourced a PMO to support the alliance and see this as a key factor in their success, with a strong focus on data and key metrics.
>
> **Anthony Kealy, Head of Delivery Support (Better Care Fund, Out-of-Hospital and Elective Care Programmes)**