Older People’s Joint Management Group

Date of Meeting: 19th September, 2013

Title of Report:
Urgent Care assurance framework and Winter monies bid 13/14

Is this paper for:Discussion Decision Information
Y N Y

Purpose of Report:
Inform the Older Person’s Joint Management Group of the assurance framework around the urgent care system for Winter 13/14, the engagement of all provides in the development of plans, and details of the winter monies bid.

Action Required:
To note the assurance framework and the plans for the Winter monies bid, to be agreed at the Oxfordshire Clinical Commissioning Group Governing Body on 26th September, 2013.

Impact on users/carers:
This will significantly improve the responsiveness time for service users and improve the experience for both service users and carers during the winter months.

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Urgent Care assurance framework and Winter monies bid 13/14

Executive Summary

This paper is the same as the paper on Urgent Care and Winter monies that is going to the Oxfordshire Clinical Commissioning Group Governing Body on 26th September, 2013. It has been brought to the Older People’s Joint Management Group as a large proportion of the Winter monies bid will support the implementation of the Older People’s Joint Commissioning Strategy and the population of people who will receive services funded through it are Older People.

It provides the Oxfordshire Clinical Commissioning Group Governing Body with assurance regarding system wide preparation for Winter pressures, lessons learned from last year and sets out details of the winter monies funding that Oxfordshire applied for and was successful in gaining to provide additional resilience in case of a repeat of the unprecedented demand experienced last year.

Background

- Demand for urgent care services, such as Accident and Emergency (A&E), 999 ambulance response and emergency admissions, is seasonally highest during Winter. This pattern of demand is predictable and well known across health and social care nationally.
- Oxfordshire Clinical Commissioning Group (OCCG) as the leader of the local health and social care system, co-ordinates planning for Winter each year, so that organisations are resilient and able to maintain performance in the face of peaks in demand or reduced capacity in staffing or services due to poor weather or seasonal illnesses such as influenza.
- This planning begins in April, with a review of the preceding Winter and continues until October, when the system produces a resilience and escalation plan to be approved by National Health Service (NHS) England. This sets out the actions that organisations will take internally and mutually to manage pressures.
- Oxfordshire experienced the highest demand for urgent care services for nearly a decade last Winter. The system was under strain for a more prolonged period than usual, with significant numbers of Delayed Transfers of Care (DTOCs) and high acuity of patients requiring admission. Patients were sicker, for longer and required more care, than in recent years.

Actions to date 2013-14

- Significant lessons were learned from last Winter. The system has worked hard to review each provider to understand internal and external issues experienced last year and how these might be mitigated in the future. These provider reviews have formed the basis of plans for this year.
- Delayed Transfers of Care have reduced since Winter, but this is in line with previous years. Delays at the end of July are higher than the corresponding month last year.
- The Urgent Care Board (UCB), a director-level group across health and social care, has been established to co-ordinate actions and offer rapid, senior leadership. UCB are leading the implementation and monitoring of the urgent care recovery and improvement plan.
• The UCB is supported by a fortnightly Urgent Care Taskforce, where operational leaders across organisations review performance, key issues and agree co-ordinated responses.
• Clinical leadership has significantly informed and shaped urgent care plans since April. Dr. Andrew Burnett as Urgent Care Lead and Dr. Joe McManners as Older Peoples Lead have led the development of Winter planning for the CCG and have been supported by a number of other General Practitioners (GPs) in the development of urgent care pathways, including Winter monies plans and prioritisation.
• Oxford University Hospitals NHS Trust (OUH) invited the NHS England Emergency Care Intensive Support Team (ECIST) to review the Horton and John Radcliffe Hospitals and offer their expertise in improving services.
• An Older Peoples Joint Commissioning programme has been established, working across teams within the CCG and with partner organisations, to specifically plan for this growing population of patients.
• A number of director and chief executive level workshops have been held to identify and address key issues within the system. The output from these has informed planning for Winter.

Winter monies 2013-14
• NHS England invited CCGs, on behalf of their local systems, to bid for additional funding to manage Winter pressures this year. A total fund of £250m was made available.
• OCCG consulted extensively with its partners across health and social care to identify a range of services that would benefit from short-term funding to support patients being cared for in the community or enabling admitted patients to be returned home as soon as possible. GP localities were consulted and a number of GPs, including the Urgent Care Lead and Chief Executive led workshops to develop prioritisation of plans to ensure their local populations would be supported this Winter.
• Oxfordshire requested funding of £10.2m and were one of 53 successful bids, receiving the full amount sought. This amount is the second highest nationally, with CCGs receiving on average £4.17m and recognises both the pressures that Oxfordshire experienced last year and the range of actions that will be undertaken locally to ensure high quality, safe services this Winter.
• Winter monies will be used to provide more consultants at the front door and in the community, to enable rapid triage and treatment of patients, equipment in patient’s homes to enable them to stay out of hospital longer, additional ambulances and patient transport to enable rapid assessment or discharge from care and a range of other services.

1. Background

Oxfordshire experienced significant and prolonged demand for urgent care services last Winter. This pressure was experienced across the country, with some areas reporting the most significant strain for a decade.

Patients, particularly the young and the frail elderly, were of higher acuity than in recent years, requiring more intensive input from clinical staff to maintain them in the community or if attending A&E, presented a challenge to hospital staff to review and
identify the most appropriate onward step for them within nationally mandated timeframes.

The levels of demand locally were profound:

- A&E attendances over Winter (October to March) were 9% higher in 2012/13 compared to 2011/12
-ambulances responding to life-threatening (Category A calls) incidents were 12% higher than the previous year
- The percentage of A&E attendees requiring emergency admission was 15% higher over 12/13 compared to 11/12

The table below shows the pressure that A&E faced last Winter, where achievement of the 4-hour standard (national target 95%) was below 90% for Quarter 4.

<table>
<thead>
<tr>
<th></th>
<th>2012-13</th>
<th>2013-14</th>
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<tbody>
<tr>
<td></td>
<td>Q1</td>
<td>Q2</td>
</tr>
<tr>
<td>No. of A&amp;E patients seen within 4 hours of arrival</td>
<td>28,697</td>
<td>30,483</td>
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<tr>
<td>Total number of patients attending A&amp;E</td>
<td>31,905</td>
<td>31,789</td>
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<tr>
<td>Percentage</td>
<td>89.95%</td>
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Activity by month shows the extended effect of Winter pressures last year, with achievement of the four-hour standard significantly below the national target in March and April 2013.

<table>
<thead>
<tr>
<th>% pats seen in 4 hrs</th>
<th>Nov-12</th>
<th>Dec-12</th>
<th>Jan-13</th>
<th>Feb-13</th>
<th>Mar-13</th>
<th>Apr-13</th>
<th>May-13</th>
<th>Jun-13</th>
<th>Jul-13</th>
<th>Aug-13</th>
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<tr>
<td></td>
<td>94.7%</td>
<td>94.5%</td>
<td>92.2%</td>
<td>91.5%</td>
<td>84.7%</td>
<td>85.1%</td>
<td>95.2%</td>
<td>96.4%</td>
<td>97.4%</td>
<td>94.30%</td>
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Colleagues across health and social care in Oxfordshire worked highly effectively over Winter and in many cases, were supporting patients to stay in their homes whose needs would ordinarily have required admission. However, the system experienced significant strain and it is unlikely that without change to channel demand away from A&E, or managing demand at the earliest point of decision making by senior clinical staff, that Oxfordshire will be able to manage a second winter at similar levels of demand.

Mike Farrar, Chief Executive of the NHS Confederation, recently identified that in order to manage Winter pressures, funding must be directed toward actions that reduce the demand for urgent or emergency care, such as managing patients with long term conditions in the community. Many of the plans within the Winter monies bid are designed to support patients in their homes or to enable rapid access to care within the community rather than a default attendance and potential admission at A&E.
2. ECIST & Kings Fund reviews

Oxfordshire invited the Emergency Care Intensive Support Team (ECIST), an NHS England funded group of experts in urgent and emergency care, to review protocols and processes within OUH and the transfer of patients to and from other providers.

ECIST made a number of recommendations, based on best national practice and evidence, to improve patient experience, improve flow from the point of entry through the acute setting and reduce inappropriate admissions.

The team recommended that a number of additional senior clinicians were recruited, to support senior decision making at the earliest point of patient contact; the Winter plan for this year includes recruitment of a significant number of consultants, senior nursing staff and clinical navigators to support assessing and directing patients to the most appropriate stream of care as early as possible.

ECIST recommended that patient pathways were strengthened and that greater capacity was created in assessment units, such that there were specific routes for frail elderly patients or those with long term conditions to be managed as quickly as possible. In response, the system will invest in consultant geriatricians to specifically manage the elderly population, will recruit additional consultants and specialist paediatric nurses and has substantially increased the availability of senior staff and capacity within rapid assessment services such as the Medical Assessment Unit (MAU) and Surgical Emergency Unit (SEU) to ensure that patients are assessed, treated and returned home if admission is not required.

In addition, additional patient transport has been commissioned, to support patients being safely discharged to their homes, rather than remaining in hospital unnecessarily because their families or neighbours could not pick them up. Patient transport has also been arranged to transfer patients from their homes to their registered GP practice where rapid primary care assessment may avoid admission or attendance at A&E, supporting patients to remain in the community and in their homes safely for longer.

The King’s Fund, a nationally renowned academic healthcare organisation, was invited by NHSE to review urgent care across the South of England in March 2013.


This report found that Oxfordshire had the second highest rate (28%) of patients attending A&E admitted between three and a half to four hours, compared to a regional average of 19%. The report suggested that this was indicative of pressure to meet the four hour standard resulting in the patient being admitted to the next available bed, rather than being initially assessed by the most appropriate specialty team. This issue has been specifically addressed in preparation for this Winter and within the bid for Winter monies, with increased consultant capacity across seven day working, which will allow early senior decision making and streaming of patients to the right care, first time.
The report recognised the low number of A&E admissions per 1,000 population in Oxfordshire (159 per 1,000 compared to a regional average of 256 per 1,000), which reflects the strong commitment to maintaining patients in the community and the range of alternatives to A&E, such as Minor Injury Units, which patients are able to access locally. It did note however a 28% increase in emergency admissions in Oxfordshire between 2007 and 2012 against a regional average of 21%, perhaps reflecting the elderly population resident locally. The Winter plan has identified a range of support to maintain patients in the community, such as social care equipment, increased community nursing and step-up beds within community hospitals, which are intended to reduce the numbers of patients being admitted as unplanned cases.

3. Urgent Care Board

NHS England required each CCG to form an Urgent Care Board (UCB), with director level leadership to strengthen existing relationships between providers and offer senior strategic planning and allocation of resources.

Locally, the UCB was introduced in June 2013 and features representation from Oxford University Hospitals NHS Foundation Trust (OUH), Oxford Health NHS Foundation Trust (OH), Oxfordshire County Council (OCC), South Central Ambulance Service (SCAS), OCCC and primary care, with a number of GPs attending, representative of both OCCC and their locality colleagues. Thames Valley Area Team, representing NHS England, also attend. The UCB is responsible for the delivery of the system-wide Urgent Care Improvement plan, which includes actions being taken by all providers to ensure the flow of patients, reduce inappropriate attendances and admissions within the acute setting. The improvement plan incorporates relevant commissioning programmes, such as Healthier at Home for the frail elderly, OUH’s emergency department plan, based on the ECIST recommendations noted above and the Delayed Transfers of Care plan.

This group has quickly strengthened dynamic leadership across providers and has agreed, in preparation for this Winter, a daily rota of directors who have been empowered to commit resources from any organisation to quickly resolve issues, without seeking authority from that organisation to do so. This commitment is demonstrative of the level of trust that exists between providers locally and the cohesive approach that the system is taking to manage Winter pressures this year.

OCCC has led a series of system wide workshops, attended by directors and senior managers from all relevant health and social care providers, locality GPs and clinical leads for the CCG over this Summer. These workshops have been designed to ensure that commissioners and providers are united in working together towards common goals in preparation for Winter, that key problems within organisations or across the system were identified and the priorities for each organisation communicated. The output of these workshops has informed priorities for the Winter resilience plans and have informed the bid for Winter monies funding.

4. Urgent Care Taskforce
The Urgent Care Taskforce (UCT) has been established for over five years. This fortnightly meeting, with representation from operational managers across health and social care providers enables rapid escalation and resolution of issues and acts as the engine room for driving forward improvements throughout the patient pathway.

In April, the UCT reviewed system wide management of pressures during Winter and undertook in-depth reviews of each provider. These reviews explored:

- Organisational priorities for 13/14
- Patient pathways in and out of services, where these work well and where they could be improved
- Bottlenecks, internal and external factors affecting service delivery
- Quick wins for the organisation, the system and where the system should focus its efforts

These reviews provided the system with a comprehensive strategy for managing demand during the current year and informed the local escalation and Winter plans.

The escalation plan is a comprehensive system for organisations to respond to increased demand or reduced capacity by implementing pre-determined actions or allocating resources. These actions are clearly defined in terms of their impact within organisations but also establish the corresponding actions that will occur in other providers in response. This allows Oxfordshire to react cohesively and flex in response to strain on any part of the system.

5. System Resilience calls

Oxfordshire has developed a daily system resilience teleconference between providers, which identifies key pressures within the system that day, allows providers to co-ordinate resources or patient movement to alleviate demand and escalation to directors where necessary, to provide strategic leadership. This teleconference provides a fundamental role in allowing the system to react positively to changes in demand or capacity.

It is supported by an online dashboard, which provides an at-a-glance summary of pressures- each organisation provides a Red Amber Green (RAG) rating of key indicators which allow staff to see the system and where focus is required to maintain patient flow. A summary of both the teleconference and the dashboard is sent to directors and Chief Executives daily across health and social care.

6. Healthier at Home

OCCG and Oxfordshire County Council’s Joint Commissioning Strategy have jointly commenced an implementation plan for priority 2, of the Strategy ‘I get the care and support I need in the most appropriate way and at the right time’ described in the blueprint ‘Healthier at Home’. This is an ambitious programme being implemented this year. The overarching strategy will support older patients with long term conditions and the frail elderly to remain healthier in the community for longer, avoid unplanned admissions, increase timely discharge home and ensure an integrated approach to care that delivers multi-disciplinary assessment and care at each point of the patient pathway.
Patients are supported with personalised care plans that address both their health and social needs, with rapid assessment and escalation for patients in need of urgent care within a two-hour response. This ensures that patients that are most in need of management receive this in a timely way and are supported to remain in their homes where possible. A co-ordinated single point of access to care and integrated teams ensure that the patient pathway is as smooth as possible.

The Healthier at Home programme has informed work by the Urgent Care Board and Taskforce throughout the year and has been further supported within bids for Winter funding by such measures as increased community nursing, transportation to enable rapid assessment at GP practices and increased domiciliary care and equipment. Co-ordination of Healthier at Home with other CCG and County Council workstreams is managed via the Older People’s Joint Management Group, a cross-organisational director level group and the Urgent Care Board.

7. Delayed Transfers of Care

Patients that are medically fit for discharge, but who are unable to move on to the next stage of their care due to non-medical reasons, such as awaiting for a care home placement or lack of capacity in the onward provider, are recorded as Delayed Transfers of Care (DTOC).

Over recent years, Oxfordshire has experienced the highest rates of DTOC in the country. Last Winter the number of delayed patients being managed in a hospital bed (both in the acute and in community hospitals) reaching a peak of 184 in February. The table below shows the peak in demand across the system that occurred after the Christmas holiday.

<table>
<thead>
<tr>
<th></th>
<th>06-Jan</th>
<th>13-Jan</th>
<th>20-Jan</th>
<th>27-Jan</th>
<th>03-Feb</th>
<th>10-Feb</th>
<th>17-Feb</th>
<th>24-Feb</th>
<th>03-Mar</th>
<th>10-Mar</th>
<th>17-Mar</th>
<th>24-Mar</th>
<th>31-Mar</th>
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<tbody>
<tr>
<td>Delays</td>
<td>110</td>
<td>123</td>
<td>144</td>
<td>169</td>
<td>177</td>
<td>176</td>
<td><strong>184</strong></td>
<td>174</td>
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<td>183</td>
<td>175</td>
<td>165</td>
<td>164</td>
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DTOCs offer a significant challenge to systems, as patients attending A&E who require admission may be delayed until a bed becomes available leading to long waits and breaches of the 4 hour standard, patients awaiting onward transfer may decompensate and require further medical support to become fit for discharge again and the cost of a patient being managed within a hospital bed is frequently more costly than community based care, particularly when there is no medical need for the patient to remain within hospital.

Strenuous effort across health and social care providers, supported by OCCG, has resulted in the number of DTOCs reducing in 2013/14 but these are in line with drops in previous years below), and the system continues to experience over 120 delays per week since April. Actions identified within the Winter monies bid are designed to continue the effective discharge of patients and maintain flow through OUH and into community or domiciliary care.
The discharge policy developed last year represents best practice and has been reviewed by ECIST. However, in July a meeting was called with Chief Operating Officers (COOs) to escalate the issue due to the continuing slow progress in reducing the overall numbers of delayed patients – there has in fact been improvement, particularly when viewed against the backdrop of sharply increased attendances and admissions at the front door of OUH.

The COOs agreed a remedial action plan including the following key actions:

- A rapid escalation policy to director level within each organisation to unblock discharge issues as they occur.
- Better information to support understanding of the underlying reasons for delays, including analysis of length of stay and service level data from the Single Point of Access and Supported Hospital Discharge Service. This data will support the development of action plans accordingly.
- A system wide demand and capacity plan to be developed – this is a core recommendation from ECIST and essential to being able to reliably predict demand and hence forward plan capacity against it and avoid delays. The first draft of this plan has been produced, for review at a system wide workshop on the 20th September.
- Audits of delayed patients in OUH and OH to assess adherence to the discharge policy and identification of problems with placing them in the onward step of their pathway. These audits have been completed and reports have been received by OCGG for both organisations. Actions informed by these audits will be planned at the workshop on the 20th September.
- Research conducted by Professor David Mant and Dr. Karen Kearley to understand the drivers of increased demand at front door. Their initial report has been produced and further audits are underway. Action planning, informed by their analysis of activity will follow.
- A review of dedicated resource and leadership within each organisation and strengthening of the discharge steering group. A dedicated full-time lead has been appointed across OH and OUH.

The discharge remedial plan is incorporated in the urgent care recovery and improvement programme and will be managed through the Urgent Care Board. The ongoing quality issues raised through DTOC will also be addressed through OUH and OH contract meetings.
For this Winter, a range of services will be in place to reduce delayed patients. Dedicated discharge co-ordinators will be embedded in each acute and trauma ward within the John Radcliffe and the Horton. These staff will work with nursing and therapy staff to plan the safe and effective discharge of patients at the earliest point, improving flow across the hospital. Such patients will be further supported by additional investment in domiciliary care and a range of equipment and assistive technology to ensure that patients social needs are met to enable them to return home or remain in the community longer.

Additional staff will be provided for the Supported Hospital Discharge Service, which provides social care with nursing support to reduce discharge delays. This provides short term support for people being discharged and settled back at home. A number of additional Occupational Therapists are being recruited to support the assessment and discharge of patients in a timely manner and support patients in their own homes.

8. Winter monies bid

In July, NHS England announced that £250m of non-recurrent funding would be made available to support organisations during Winter 13/14 that had experienced significant pressures or had struggled to maintain performance during Winter 12/13. The area team had previously approved committal by OCGG of the 70% marginal acute tariff savings, which have in previous years been used to support Winter pressures, to support CCG initiatives across the year, such that this funding is not available to support Winter pressures locally.

Oxfordshire requested funding of £10.2m and were one of 53 successful bids, receiving the full amount sought. This amount is the second highest nationally, with CCGs receiving on average £4.17m and recognises both the pressures that Oxfordshire experienced last year and the range of actions that will be undertaken locally to ensure high quality, safe services this Winter. It is also reflective of the engagement and leadership that locality GPs had in prioritising workstreams to meet the needs of their patients.

The Urgent Care Board led the development of the Winter monies bid, to ensure a strategic approach was taken to:
- identifying the key risks to the system in maintaining patient flow
- that funding would support the system in meeting key performance indicators such as the 4-hour A&E standard
- that planned services and spend had demonstrable outcomes
- that success of the funding could be clearly monitored, managed and proven

ECIST supported the bid by reviewing and advising on where best practice nationally would support local plans. Each of the workstreams were scrutinised individually and ECIST offered advice and challenge to ensure that plans would achieve the desired outcomes and were at all times focussed on the management of patient flow and delivery of high quality, safe services. ECIST were particularly supportive of local initiatives that offered step up care such that patients could be supported in the community, plans that provided skilled nursing and social care in-reach to patients.
homes and those that promoted early senior clinical decision making to ensure patients were streamed along the most appropriate pathway for their care.

Winter monies workstreams will be incorporated into the urgent care recovery and improvement plan which is the responsibility of the Urgent Care Board; the overall accountable officer is the chair of this board and Director of Commissioning and Partnerships within OCCG. Performance of the system over Winter will be monitored via the Urgent Care dashboard which covers national and local targets and indicates overall system performance. Additionally, specific Key Performance Indicators for each workstream have been identified to monitor performance and success.

UCB was supported by commissioners within OCCG who consulted extensively with its partners across health and social care to identify a range of services that would benefit from short-term funding to support patients being cared for in the community or enabling admitted patients to be returned home as soon as possible. Locality GPs were engaged to identify key actions that would benefit their patients and locality groups further prioritised the actions to ensure that the final submission identified the most effective solutions for Oxfordshire.

The Winter monies bid will support care of the frail elderly, patients with dementia or long term conditions by providing quicker senior clinical decision making at the front door to avoid admission, improve patient experience and patient flow at ED. Additional clinical and social care resource will support effective discharge, reduce decompensation of patients waiting for assessment and improve flow into the community.

Community based clinical and social care provision will be increased to support rapid assessment close to home and step up care to avoid admission via Emergency Multidisciplinary Units. Patients with Ambulatory Care Sensitive (ACS) conditions, long term conditions and those with mental health issues, including dementia will be supported to remain in their own homes with increased provision of social care equipment and technology and increased primary care triage and support. This will be supported by a communications package to support patients accessing care appropriately and includes clinical navigators embedded within A&E and other services to ensure that patients are channelled to the most appropriate service to meet their needs, first time. Recruitment for additional staffing is underway for many services and in some cases trusts have recruited to post at their own risk, in preparation for Winter.

GP localities and their patients will benefit from more rapid access to assessment, closer to home including greater provision of step up beds in community hospitals to avoid unnecessary attendance or admission at A&E, increased numbers of district nurses and nurses within Hospital at Home, an intensive nursing service that supports patients up to four times daily in their own home and greater numbers of social workers and domiciliary care staff to ensure that patient’s needs, not just their medical demands, are treated holistically.

The specific plans that Winter monies will support are shown in Appendix 1.
9. Winter monies governance

A rigorous governance process is being drafted to ensure that the allocation of funds will support the specified projects. OCCG Finance and Investment committee will oversee the process for distributing Winter monies funding.

The governance process will include a requirement for business cases to be submitted by the relevant organisation for each individual workstream, which will be assessed by the Urgent Care Board to ensure they are an appropriate use of funding, have specific outcomes identified linked to wider system initiatives and are achievable. The business case criteria includes a robust evaluation of the need for the service, its fit with wider strategic plans and the identified outcomes and measurable specific Key Performance Indicators KPIs, so that all organisations are clear as to why actions are being taken and the benefit that they will bring. In addition, OCCG’s proposal is that business cases are developed into contract variations for existing services to provide better control over delivery and achievement of the KPIs.

Governance for the Winter monies includes the development of specific KPIs and milestones to measure progress of the projects and also ensure integration with Trust KPIs, such as the four-hour standard. Principle constraints or dependencies have been identified for each project, so that organisations are clear where potential risks lie and the mitigating actions that are in place to reduce such risks. A programme manager is being identified, who will be supported by the Urgent Care Team to ensure integration with resilience plans and other system wide work, and report to the Urgent Care Board, to ensure that the Winter monies projects will be delivered in a co-ordinated, effective manner across organisations.

10. Risks

There are a number of risks with regard to the coming Winter and use of Winter monies. The principle risk is that, with an increasingly elderly and frail population, patients seeking to access urgent care will have increased in volume compared to last year, be equal or higher in their acuity and corresponding needs for both health and social care and therefore overwhelm the ability of the system to maintain performance standards and provide optimal care.

Significant effort has been invested in learning from last Winter, identifying actions that were successful in maintaining patient flow and areas for improvement. In-depth provider reviews have informed plans for this year, with the Urgent Care Board established to co-ordinate and deliver care. Healthier at Home and other frameworks have been established to support management of patients in the community or ensure safe, rapid return to home after care in hospital. The daily teleconference calls and online dashboard allow monitoring and rapid escalation of issues across organisations to ensure safe, effective care is delivered. The agreement reached by the Urgent Care Board to permit directors on call to commit resources across organisations will ensure swift resolution when difficulties occur.

A key risk to management of performance over Winter and delivery of the Winter monies bid is the resource and capacity within the CCG urgent care team. Co-
ordinating the system to respond to daily challenges is a significant demand on staff, particularly during peaks in demand where teleconferences may be held three times daily with rapid action meetings in between. The challenge of ensuring system resilience, in addition to managing QIPP performance, maintaining oversight of urgent care recovery and improvement programme and driving through the Winter monies workstreams, including the development of business cases, will be considerable. Existing staffing may be insufficient to meet the demands of Winter this year.

If delivery of the Urgent Care Improvement plan, Healthier at Home or other plans are unsuccessful, there is a risk that patient care will be compromised, both in terms of waits experienced within A&E for assessment or admittance to a bed and in terms of patients remaining in bedded care longer than necessary due to lack of capacity in the onward step of their pathway. Investment in community based services to support alternatives to attendance or admission at A&E has been provided. Additional nursing teams, rapid access to primary care and additional equipment to maintain patients in their homes has been provided.

Failure to achieve the four-hour standard or significant increases in Delayed Transfers of Care will lead to poor patient experience and decrease the capacity of the system to manage increased demand. Plans within the Winter monies bid have been specifically designed to ensure patient flow from the entry point into acute care to discharge, with substantial investment across both health and social care.

Patients may be admitted unnecessarily due to pressure to meet the four hour standard. Additional resource has been committed to rapid assessment units such as the Surgical Emergency Unit, to ensure that patients are able to be assessed, treated and discharged in a safe, timely manner.

There is a risk that staffing may be reduced due to inclement weather or seasonal illness, such as influenza. All organisations routinely develop contingencies to manage such incidents as part of their Winter and escalation plans. A further risk is that the Department of Health very recently announced plans to link eligibility to apply for Winter funding in 2014/15 to trusts achieving a 75% rate for staff flu vaccinations in 13/14. The Urgent Care Board is leading a comprehensive strategy to ensure sufficient staff are vaccinated this year to allow Oxfordshire to bid for funds next Winter.

There is a reputational risk to OCCG and its partners that having received such a substantial amount of funding to manage Winter pressures, plans are unsuccessful and both patient experience and achievement of national standards are not maintained. Rigorous governance framework and programme management surrounding the Winter monies, with oversight and leadership from the Urgent Care Board, will ensure that plans are achievable, have demonstrable outcomes and will provide benefit to patients and the system.
11. Summary

The length of seasonal pressures and the high acuity of patients caused Oxfordshire to experience substantial pressures last Winter. Staff responded effectively and in many cases accepted a level of risk to maintain patients in their own homes or the community that would not usually be desirable. Levels of Delayed Transfer of Care and achievement of national KPIs such as the four-hour standard were sub-optimal due to the consistent demand placed upon local services. The system as a whole has undertaken significant review of performance last year, identified key priorities within and across organisations for this year and has established senior leadership in the form of the Urgent Care Board.

New programmes to support the frail elderly have been established which deliver co-ordinated care across health and social care. The system has learned from national best practice and has applied many of the recommendations made by the ECIST and King’s Fund reviews. Co-ordinated plans have been developed, with significant involvement of GP localities and other clinical staff, to ensure a robust response to pressures this year.

Substantial Winter funding has been successfully applied for; a rigorous governance framework will ensure that workstreams within the Winter monies bid can be clearly monitored, have demonstrable outcomes that are linked to local and national priorities and will provide additional benefit to patients and services in Oxfordshire.
Appendix 1 – Services to be provided via Winter monies

- Additional primary care / Emergency Care Practitioner capacity to provide urgent response for home visits for patients at imminent risk of admission – 3 whole time equivalent (wte) GPs, 9 wte ECPs, 5 wte drivers for five months (OH and OCCC)

- Additional social workers and primary care assessment capacity in the community - 9 wte social workers available 7/7 for six months. (OCC and OH)

- Twelve additional community hospital beds for step up (rapid assessment and admission avoidance) care, including diagnostics and therapy for five months (OH)

- Increased community nursing provision (27wte for six months) to support vaccination of housebound patients, End of Life and post-acute care (OH)

- Increase senior clinicians at A&E, Emergency Assessment Unit (EAU) Medical Assessment Unit, Surgical Emergency Unit (SEU) assessment services- c. 9 wte consultants for six months. (OUC)

- Increase capacity in EAU, SEU and wards - 12 EAU spaces, 65 SEU and ward beds. (OUC)

- Additional nursing provision within joint health / social care Supported Hospital Discharge Service- 5 wte for six months (OUH, OCC)

- Occupational Therapy assessment of patients for discharge and of patient’s home- 12 additional wte for six months. (OCC and OH)

- Social worker to support Emergency Multidisciplinary Units (community based assessment centres)- 12 wte 7/7 for six months (OCC, OH)

- Increased delivery of equipment and assistive technology to maintain patients within their own homes. (OCC and OH)

- Additional domiciliary care, especially overnight to support patients being maintained within their own homes and support 7 day discharge (OCC and OH)

- Dedicated discharge support coordinators for acute medical and trauma wards- 0.5 wte per ward and 2 wte community co-ordinators for six months. (OUH and OH)

- Increased management capacity to support frail elderly, LTC, DTOC and urgent care programmes over Winter (OCCC)

- 111 Emergency Department /Minor Injuries Unit (MIU) navigator, to channel 111 referrals (0800 – 2200, 7/7 for six months) to MIUs and increased Out of Hours (OOH) provision to manage 111 demand. (OH)
• Early Discharge (ED) clinical navigator to manage primary care referrals to rapid assessment / ED- 5wte nurses for six months. (OUH)

• GP triage in ED linking to community based teams (weekends for six months). (OUH)

• Additional ambulance service capacity for six months- one 999 unit, two GP urgent referral units and two wte hospital liaison officers (SCAS)

• Additional non-emergency patient transport to support early discharge from acute settings- c. 20 additional journeys per day) and rapid assessment in community settings- c. 15 per day for six months and increased PTS provision to manage demand. (SCAS)

• Delivery of social marketing / comms targeted at specific populations to stimulate behaviour change and support appropriate use of services (OCCG)

• Paediatric Emergency nurse Practitioner ENP for ED- 5.5 wte for six months (OUH)

• GP triage in ED linking to community based teams at weekends for six months. (OUH)

• Senior clinical lead to resolve issues in supported discharge pathway- 1.75 wte for six months (OUH)

• Provision for increased ED activity and management strategies based on outcomes of Prof. Mant research (OUH)