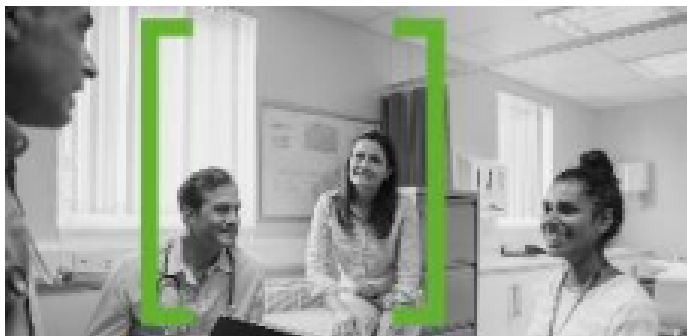


# Oxfordshire Urgent and Emergency Care integrated improvement programme 23/24



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# Oxfordshire Urgent and Emergency Care (UEC) Integrated Improvement Programme

## Preparing for winter

### Health and Overview Committee September 2023

# Objectives

We want Oxfordshire residents to live healthy, resilient and independent lives, with simple access to support and care when needed, as close to home as possible.

Primary Care to be support to deliver what people need by integrating healthcare staff across community, social care and acute to improve services within the community setting.

We will organise care so that where appropriate people are assessed and treated in their own home and experience outcomes that matter to them.

People have access to the right care the first time by simplifying the process for people and healthcare staff.

People who require urgent mental health support have access to it 24/7

People are seen more quickly in Emergency Departments

Minimise ambulance handover delays

When people are ready to leave hospital, we reduce the number of days people are in hospital away from their own home

# NHS High priority areas for Winter plan 23/24

**Single Point of Access:** Coordination of whole system management of patients in the right setting

**Urgent Community Response:** Increase volume and consistency of referrals to improve patient care, ease pressure on ambulance services and avoid transfer to hospital

**Hospital @ Home:** Increase the number of people who can be assessed and treated in their own home

**Frailty:** Improving recognition of cases that would benefit from assessment in their own home to avoid admission to hospital

**Care Transfer HUBS:** To reduce the number of days before are away from home

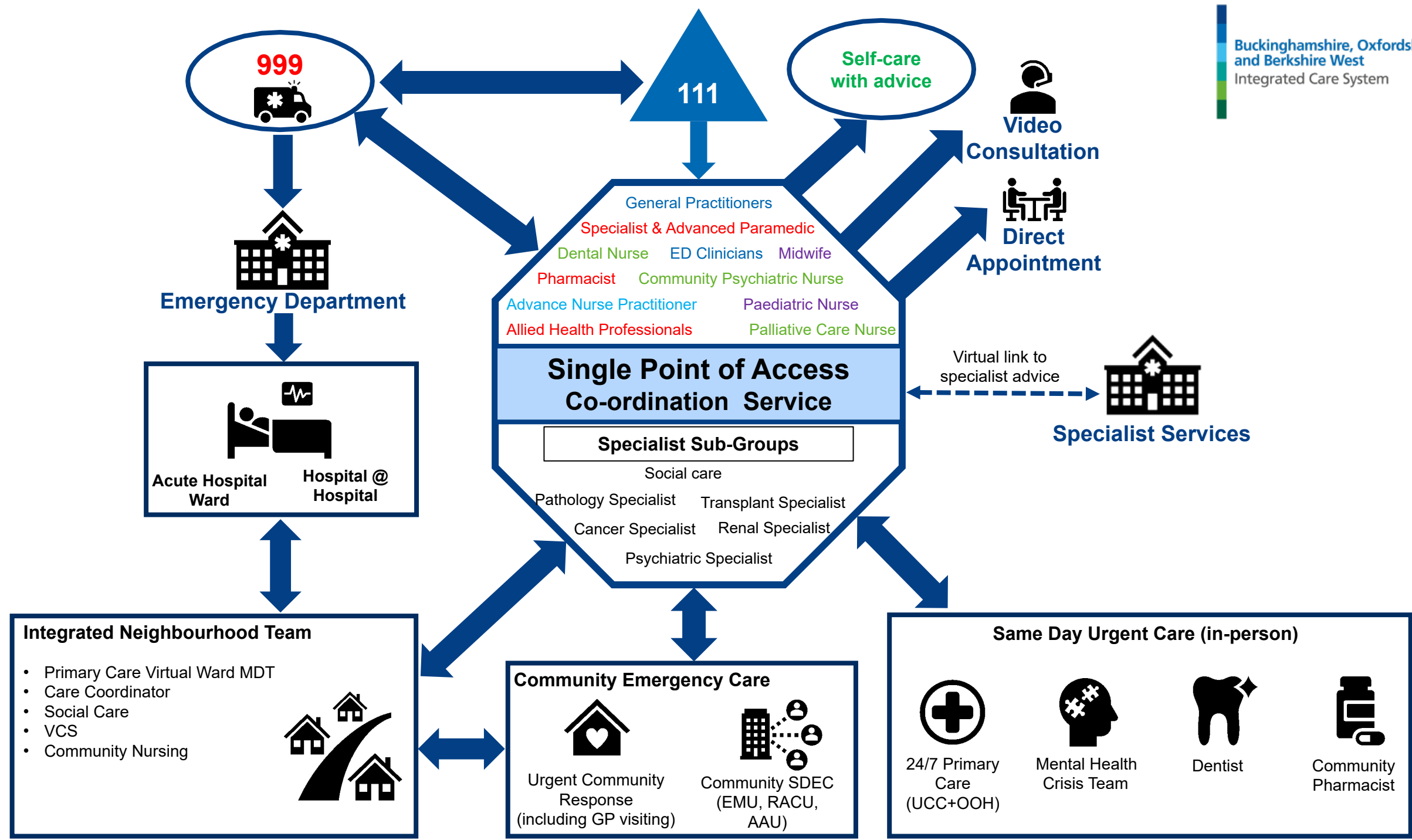
**Inpatient flow and Length of stay:** Increase the number of people returning to their own home either with or without support

**Community bed productivity and flow:** Reduce the length of stay and the number of days people are waiting to return home

**Intermediate Care demand and capacity:** remaining at home when things start to become more difficult or returning home from hospital with reablement

**Same Day Emergency Care:** strengthening the offer across all the same day assessment units to support more people who are frail to avoid an attendance at an Emergency Department

**Acute respiratory infection Hubs:** To utilise the same day assessment units and Urgent Care Centres to support the assessment of children and adults



# Support care when it is needed in the community

## Integrating local community services

- Continue the development of the integrated neighbourhood teams across Oxfordshire, by putting in a support a structure for the following teams to work together: social care, community teams (physical and mental health), primary care and acute services within a Primary Care Network (PCN)
- To increase the assessment and treatment into areas of deprivation to improve local resident's health and wellbeing

**Single Point of Access** that acts as a coordination centre and simplifies referrals process and saves time for those referring people in e.g., one single point of access for health and social care

**Urgent Treatment Centres** have a 24/7 service where Urgent Care Centres and Out of Hours working seamlessly together

**Urgent Community Response to meet demand in the afternoon and late evening and the integration of the Hospital @ Home teams to work as a single service** - falls, frailty service and palliative care

**Review and strengthen the frailty pathways across Oxfordshire** to have consistent delivery of service across all the Same Day Emergency Care (SDEC) units in the North, Oxford City and South Oxfordshire to avoid people needing to attend an Emergency Department or a 24hr admission to hospital.

# Urgent and Emergency Mental Health

## Improving access to mental health crisis care

- Implementation of health-based mobile triage response – mental health Ambulance, paramedic plus mental health clinician
- Expansion of crisis team capacity following new funding this year
- Further refine opportunities for diversion from the Emergency Departments

## Reducing length of stay in inpatient mental health beds

- Admission request triage and 72hr assessment / planning process
- Patient Flow Transformation: Establishment of full 'patient flow team' across Oxon/Bucks

## Joint Oxford Health / Oxford University Hospitals program of quality improvement pathway improvement work

- Adult and young people with eating disorders
- Improve the environment and reducing the length of time for people who attend an Emergency Department with a Mental Health issue.

# People seen more quickly in Emergency Departments (ED)



**Ambulance handover delays: Zero ambulance handover delays over 60 and reduction in ambulance handover delays 30 mins and over. All ED's and assessment areas responsive to SCAS OPEL status**



**Achieve 76% performance of the 4hr standard for all types within ED**

Improve compliance with Type 1 and all types performance in line with improvement trajectory

Review of workforce and implementation of agreed actions



**Reduce the length of stay for people in the Emergency Department and the number in the ED for 12hrs or more.**



# Increase the number of discharges from hospitals

10% reduction in the number of people who no longer meet the criteria to reside across all Oxfordshire bed bases, acute and community

Reduction trajectory of the ready for discharge list across all pathways

Implementation of Discharge to Assess (D2A)

93% of people to be discharge to normal place of residence

Further development of the transfer of Care HUB to deliver the following

Single referral route for other counties to refer Oxfordshire patients to

Welfare check on day of discharge and to co-ordinate any issues identified.

Re- procurement of short stay HUB beds

To reduce the number of beds and over length of stay

Step down from acute for further assessment

Delirium pathway

# Communications

The Winter Communications Plan aims to support the delivery of the System Winter Plan; it has two main key messages for the public & staff:

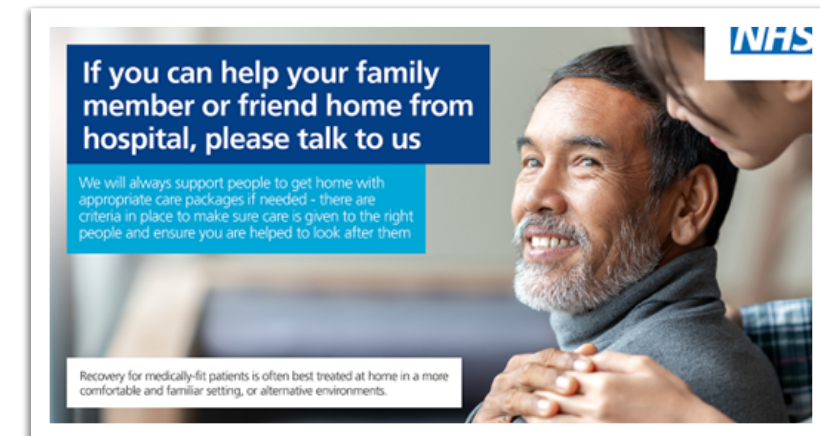
- Stay well by looking after yourself
- What to expect if you do become unwell

**Communication plan** – Communication and messaging is aimed at all Oxfordshire residents, staff and visitors but with some segmentation for specific messaging as well as differing our approach to communicating with groups for example:

- outreach to BAME communities through our local authority and our community networks
- working with community outreach workers and Luther Street Medical Centre to reach homeless people
- development of easy read materials for people with a learning disability

**Campaigns** – A number of campaigns and initiatives will be delivered as part of the winter communications plan, these include:

- Promotion of the COVID-19 and flu jab to key groups (public and NHS / Care staff)
- Self-care – what is your personal winter plan?
- ‘Help us, help you’ stay well this winter. A longstanding national campaign that is tailored locally to signpost appropriate use of services
- Encouraging NHS 111 as first port of call to accessing healthcare services
- Supporting people to stay at home (an example if this work is in the next slide)
- ‘Why not home? Why not today?’ approach - helping people to return home after a stay in hospital





## Programmes of work



**Senior Responsible Office for each priority who will oversee the programme of work with project leads for each work stream within the priority.**



## Services that require integration:

Standard operating procedure signed off by each provider outlining roles, responsibilities and accountability outlined.

Human Resources and Finance supporting the integration



## Methodology:

**Plan, Do, Study and Act** (PDSA cycle) based on NHS England methodology

Standardisation of services to deliver consistent services to the residents of Oxfordshire

Adopting evidence based and best practice

Measuring outcomes quantitative and qualitative

Feeding back to teams in real time and monthly reporting

Risk register for each priority

Cultural development

Monthly reporting on metrics and milestones

- Evaluation of the Bicester integrated Neighbourhood team, which includes patient outcomes, staff feedback and cost effectiveness
- Measuring clinical outcomes in areas of deprivation to assess impact of interventions in Oxford city and Banbury
- Impact of integrating Hospital @ homes service on capacity, Oxfordshire residents and staff
- The number of people assessed and treated following a fall at home and the number conveyed to hospital and the number requiring admission.
- Emergency Departments:
  - time lost to ambulance handovers
  - length of time people are in Emergency Departments (EDs)
  - number of days people in hospital are away from their own home

Thank you