Oxfordshire Urgent and Emergency Care integrated improvement programme 23/24

Buckinghamshire, Oxfordshire and Berkshire West
Integrated Care System

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Oxfordshire Urgent and Emergency Care (UEC) Integrated Improvement Programme

Preparing for winter

Health and Overview Committee
September 2023

Objectives

Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

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.

System working managing on the day pressures

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Operational Pressures Escalation levels (OPEL) framework NHS

- Procedure to manage day-to-day variations and surges in demand across Health and Social care
- Provides a consistent approach 7 days a week to maintain quality and patient safety
- Sets clear expectations around roles and responsibilities to manage times of increased demand
- OPEL 4 is the highest level of escalation – challenges the delivery of comprehensive care

Daily OPEL status

- The Ambulance service, patient transport service, Mental Health services, social care, acute trust and community services report their OPEL status every morning.
- The ambulance service and the acute trust review their OPEL status a regular intervals over each 24hrs e.g., every 2-3 hrs
- OPEL levels vary from 1-4

Oxfordshire system daily review and response to OPEL

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- **Monday to Friday**
- 08:30hrs Oxfordshire system virtual call with representation from the following
    - South Central Ambulance Service for 999 calls and Patient transport service
    - Oxford Health representatives from community hospitals and services – Out of Hours, Urgent community Response and Hospital @ home
    - Adult Social care including brokerage from the county council, Home First and senior team leaders
    - Oxford University hospitals NHS Trust (OUHFT) operational services, discharge team, Hospital @ Home and CRISIS Care
    - Mental Health – patient flow team
    - Ad hoc basis depending on the issue raised : children's social care and Primary Care
- **Saturday – Sunday and Bank holidays**
    - 10:00 System partners join the OUHFT operational meeting
    - Further meetings throughout the day if they are required

Response to OPEL

- Over the last two months, the Oxfordshire system has varied between OPEL 2 and 3, much of the time sitting at OPEL 2.
- Last winter the Oxfordshire system was on OPEL 3 and only once went to OPEL 4 for one day.

- OPEL per organisation provides a clear overview of where the pressures are. These cover multiple points across a provider/pathways and is rarely related to just one issue.

- **The areas the regular impact on OPEL status are as follows;**
    - The number of people waiting for an inpatient beds is greater than the number of people being discharged.
    - Delays in people being seen in an emergency department.
    - Workforce across hospitals and community services
    - Capacity to meet surges in demand and continuous increases in demand

- **Increase in OPEL status**
- When OPEL pressure are 3 across organisations or there is a risk of the OPEL status deteriorating, escalation calls are organised throughout the day to agree further actions to improve the position
- The additional system calls continue until the issue has either resolved or we have reached the point where the risk has been reduced.

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

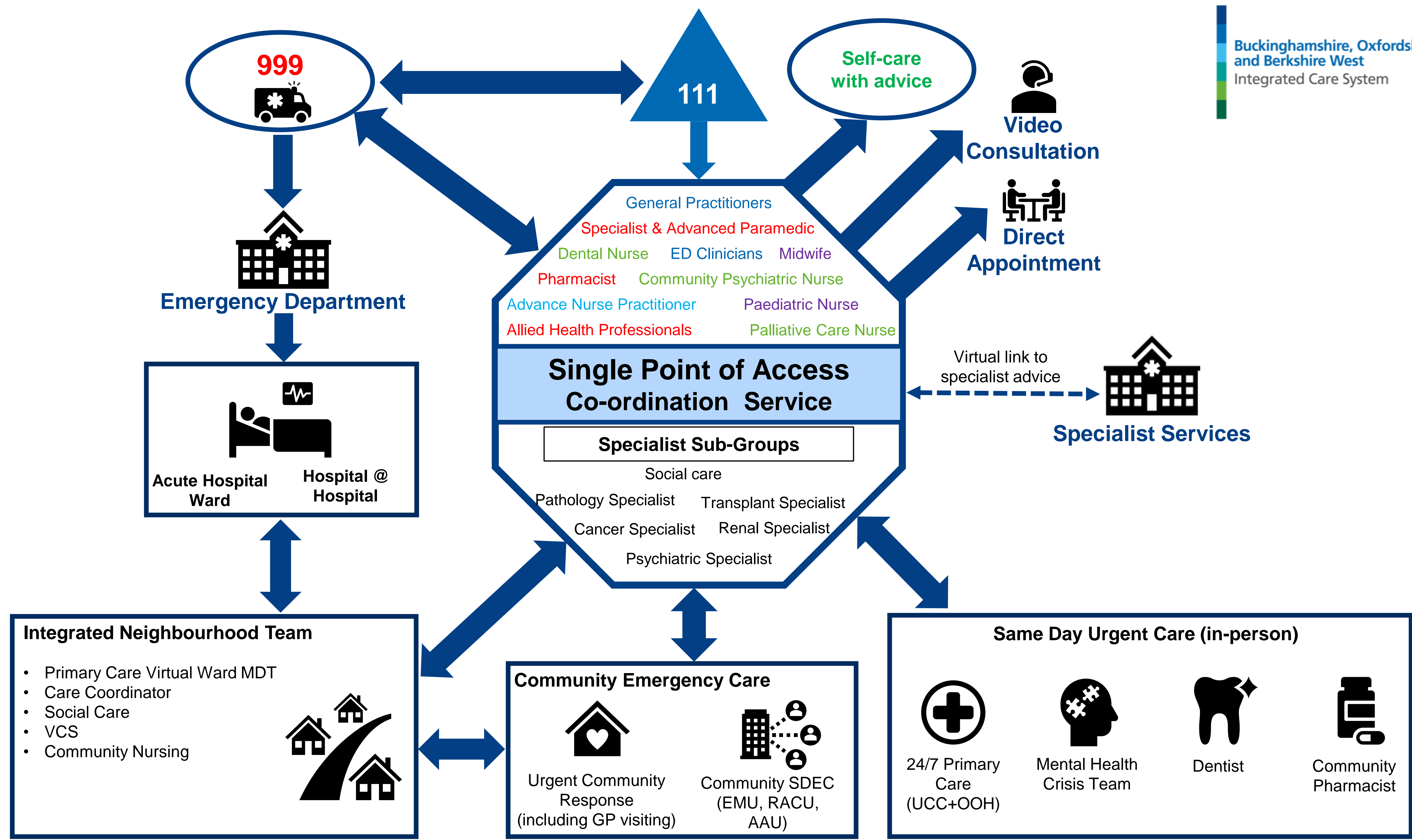
Inpatient flow and Length of stay: Increase the number of people returning to their own home either with or without support

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



999
111
Self-care with advice
Video Consultation
Direct Appointment
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Emergency Department
General Practitioners
Specialist & Advanced Paramedic
Dental Nurse
ED Clinicians
Midwife
Pharmacist
Community Psychiatric Nurse
Advance Nurse Practitioner
Paediatric Nurse
Allied Health Professionals
Palliative Care Nurse
Single Point of Access
Co-ordination Service
Specialist Sub-Groups
Social care
Pathology Specialist
Transplant Specialist
Cancer Specialist
Renal Specialist
Psychiatric Specialist
Virtual link to specialist advice
Specialist Services
Acute Hospital Ward
Hospital @ Hospital
Integrated Neighbourhood Team
Primary Care Virtual Ward MDT
Care Coordinator
Social Care
VCS
Community Nursing
Community Emergency Care
Urgent Community Response (including GP visiting)
Community SDEC (EMU, RACU, AAU)
Same Day Urgent Care (in-person)
24/7 Primary Care (UCC+OOH)
Mental Health Crisis Team
Dentist
Community Pharmacist

Support care when it is needed in the community

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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

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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)

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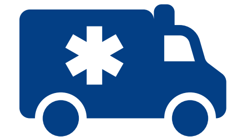
Ambulance handover delays: Zero ambulance handover delays over 60 and reduction in ambulance handover delays 30 mins and over. All ED's and assessment areas responsive to SCAS OPEL status

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.

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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:

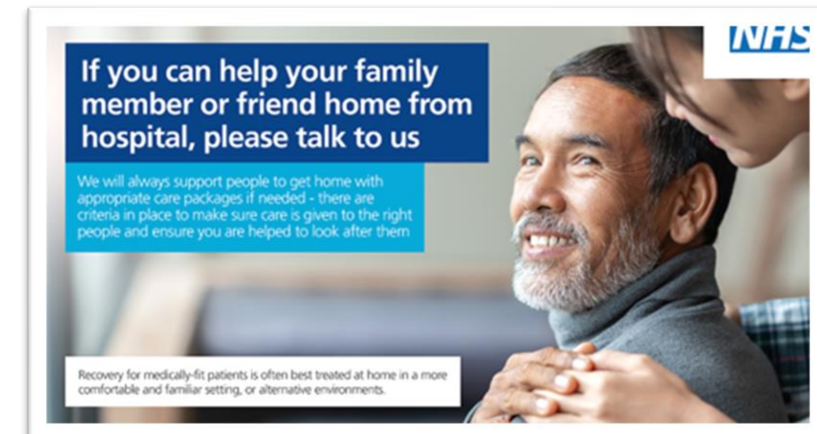
- Stay well by looking after yourself
- What to expect if you do become unwell

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



Governance

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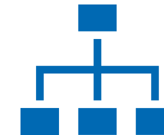
Programmes of work

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

Key area of risk – management of surges of infection

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- **Infection**
- Over the last 12 months, we managed increases in Covid, flu, strep A and various other viruses.
- This winter we are planning for the similar surges in demand across adults and children's.

- **Managing on the day demand**
- We have developed pathways where people of all ages can be assessed on the day protecting primary care and the Emergency Departments

- **Protecting patients**
- We at time do have to temporarily close some beds if there is a risk new admission may be exposed to an infection.
-
- **Patient flow out of hospital**
- There are time when a diagnosis of flu or Covid will delay the persons discharge if they are transferring back to or are a new admission to a care home.
- People who are returning home are rarely delayed because of a diagnosis of infection unless they become too unwell to return home
- People transferring to a community hospital are supported onto this pathway by placing them in a side room.

Key general areas of risk

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- Demand continues to grow beyond the additional capacity created over the winter period resulting in minimal impact in reducing overcrowding in the Emergency departments.
    - The increase in the number of people being assessed and treated in their own home will meet the present increase in demand but potentially not meet any further surges in demand.
- Increased levels of staff sickness affecting all providers potentially resulting in the ability to manage demand.
- Delays to the implementation of the improvement programme: Potentially delay in cultural and pathway changes that do not happen at the pace required.
- Further strikes by professional group, may potentially have an impact on the delivery of elective and planned care despite plans to mitigate this.

Evaluation

- 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