NHS
Buckinghamshire, Oxfordshire and Berkshire West
Integrated Care Board

Buckinghamshire, Oxfordshire and Berkshire West Joint Overview and Scrutiny Committee

Winter Plan, Oxfordshire

Introduction

1. This paper outlines the programme of work in Oxfordshire for the winter of 2024/2025
2. The papers cover:

   - Southeast Regional winter plan
   - Areas of achievement in Oxfordshire.
   - Oxfordshire winter plan

Winter plan 2024/2025

3. **Key Operational Focus Areas:**

   - **Supporting frail patients in the community**
     - delivering frailty transformation at scale – people are assessed in the right place to meet their needs
     - Maximising the number of people who can be assessed and treated in their own home, continue to increase in line with monthly trajectory for Hospital @ Home.
     - Adopt the ReSPECT model for personalised clinical care and to implement a consistent risk stratification approach for frail patients this winter.
   - **Reducing Ambulance Handovers**
     - maximum handover time of 45 minutes - move to a mandated handover at 45 mins. Most handovers to take place within 15mins of arrival.
   - **Capacity Management**
     - Reducing time spent in an emergency department and all assessments units across Oxfordshire, achieving at least 78% of the four-hour standard and 2% or less spending 12hrs or more in the department.
     - 95% of people discharged from the acute Trust directly to their own home
     - Review General & Acute core and escalation bed capacity plans to ensure sufficient beds are available throughout winter.
     - Review surge capacity across community services
     - Embedding the ReSPECT model for personalised clinical care
   - **Mental Health**
     - Reducing inappropriate mental health placements
     - Reducing Length of stay across Mental Health inpatient beds

Challenges

4. Workforce and funding remain a challenge this winter.

5. In preparation for winter, we need to build on existing progress and develop the pathways further to create winter surge capacity.

Supporting frail people in the community - Hospital at Home

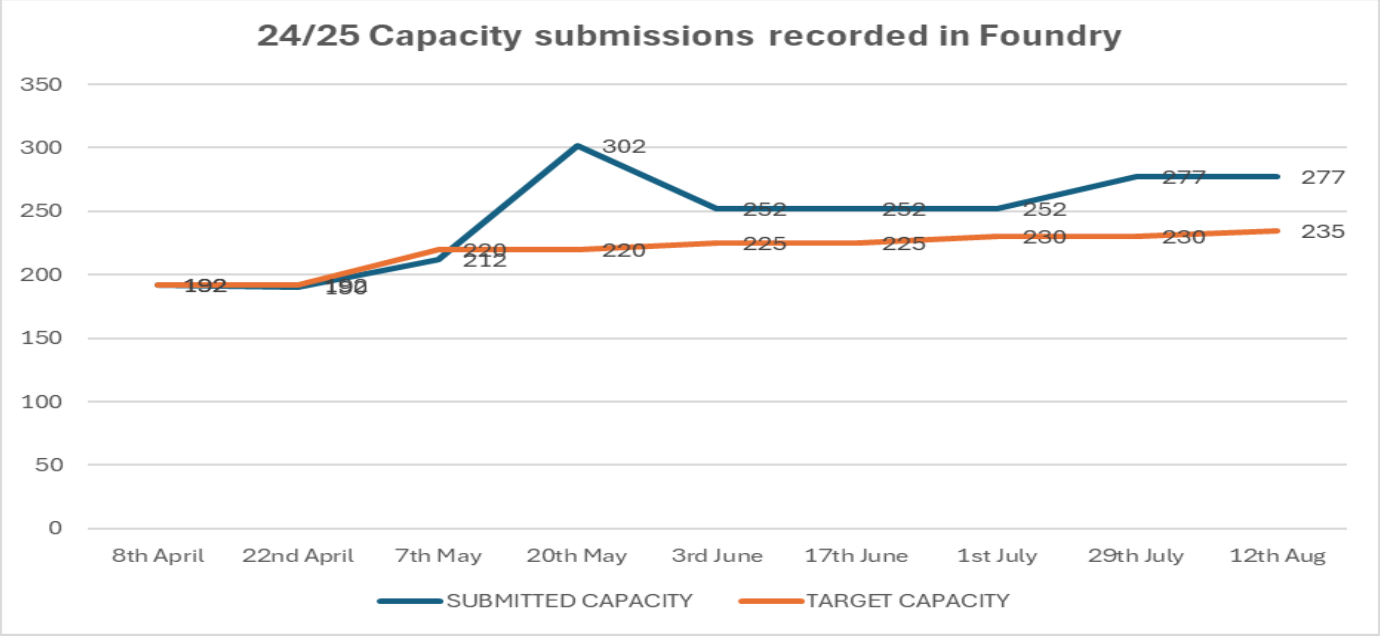
6. December 2023, Oxfordshire merged the two Hospital @ Home teams into one team covering north, city and south Oxfordshire. This has resulted in an integrated team with single oversight of all people being cared for in the H@H service across Oxfordshire.

7. Figure1.1 and 1.2 below shows that the service is above target since May 2024.

Figure 1.1 **The number of patients the service(s) can see at any one time**

	24/25 Capacity submissions recorded in Foundry								
Date	**8th April**	**22nd April**	**7th May**	**20th May**	**3rd June**	**17th June**	**1st July**	**29th July**	**12th Aug**
Children's VW	12	12	12	12	12	12	12	12	12
PMLH@H	30	18	40	40	40	40	40	40	40
Oxon Acute VW*	150	160	160	250	200	200	200	225	225
SUBMITTED CAPACITY	**192**	**190**	**212**	**302**	**252**	**252**	**252**	277	**277**
TARGET CAPACITY	*192*	*192*	*220*	*220*	*225*	*225*	*230*	*230*	*235*
Difference (N)	0	-2	-8	82	27	27	22	47	42
Difference (%)	100%	99%	96%	137%	112%	112%	110%	120%	118%

8. Figure 1.2 The number of people cared for in Hospital @ Home services per months against trajectory.

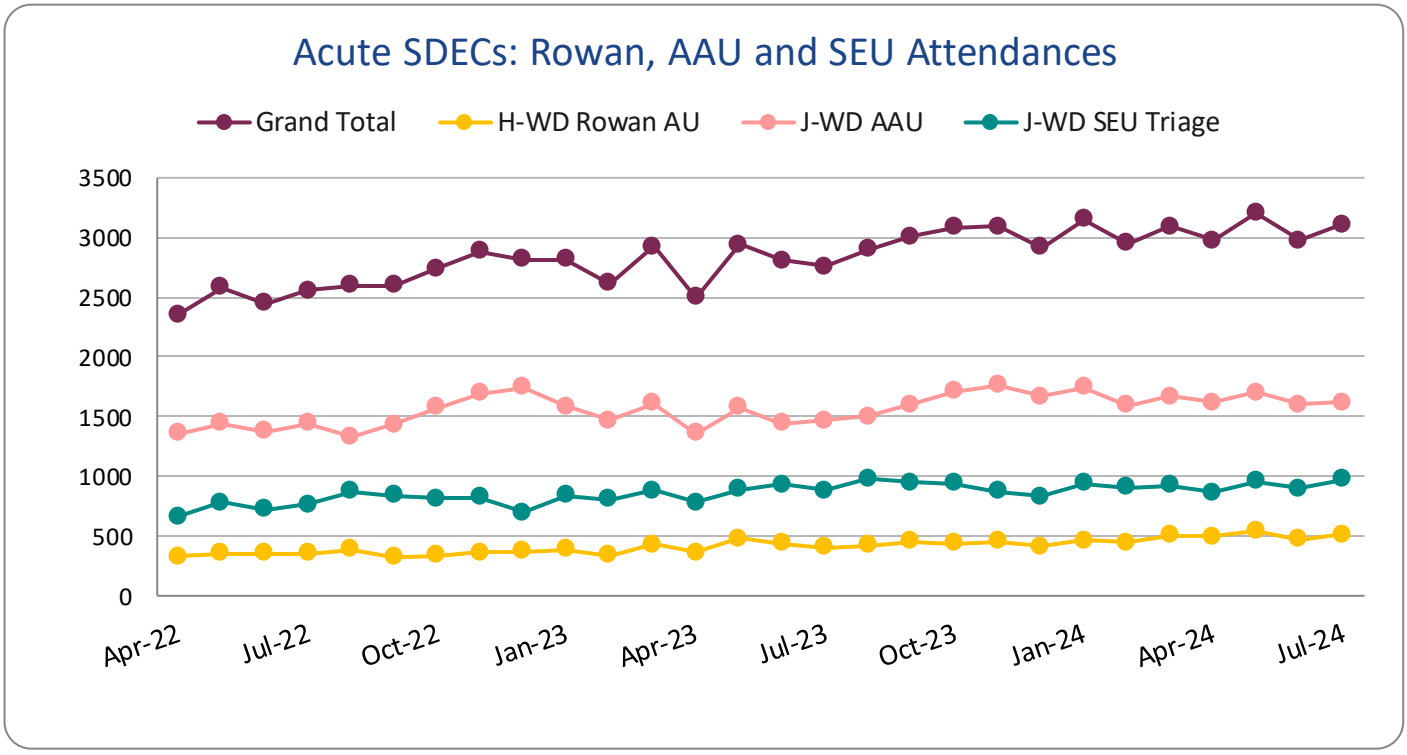


9. Over 2024/25, the Hospital @ Home team will move to extending their working hours from 20:00 to 22:00hrs across the whole county 7 days a week. This will create additional visiting capacity over the winter months.

10. The Same Day Emergency Care Units in the community and hospital setting support the referrals from healthcare professionals across Oxfordshire and the Hospital @ Home teams to see people who require further assessment and diagnostics. This avoids people requiring an Emergency Department attendance or admission to hospital.

11. Figure 1.3 on the next page, illustrates the increase in activity across the acute Same Day Emergency Services (SDEC) in the John Radcliffe and Horton General Hospitals. This creates capacity for people.

Figure 1.3 Increase in activity in Same Day Emergency Services (SDEC)



Supporting frail people in the community – Discharge to Assess

12. 2023/2024, Oxfordshire Social Care has continued to develop Discharge to Assess both supporting people returning directly home from hospital (figure 1.4) but also supporting people who require reablement to maintain them staying in their own home (Figure 1.5). Figure 1.6 illustrates how many people are returning to independence following reablement.
13. Figure 1.4 Outcomes for Discharge to Assess

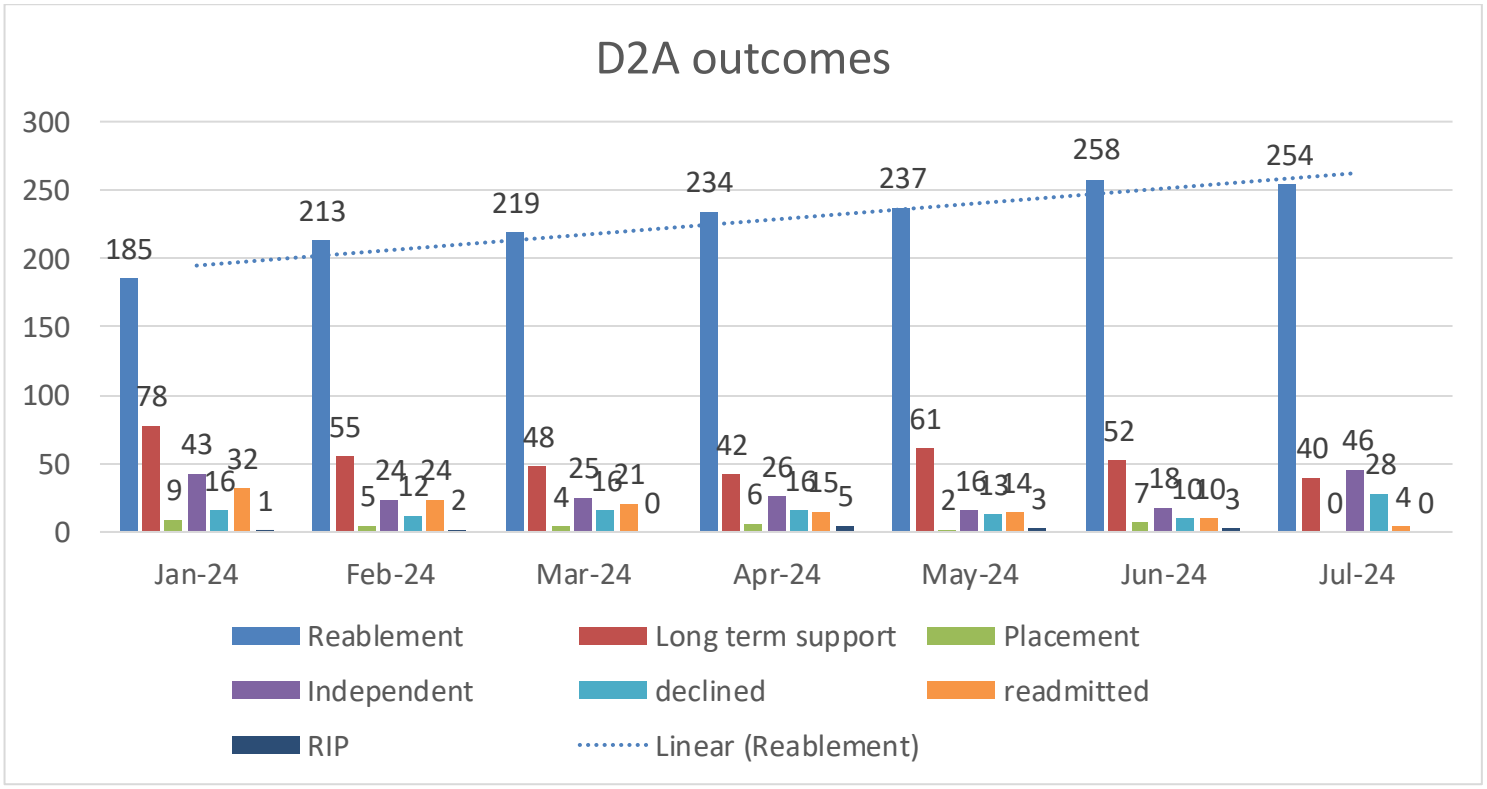


Figure 1.5 Increase in the number of people per month who have been maintained within their own home.

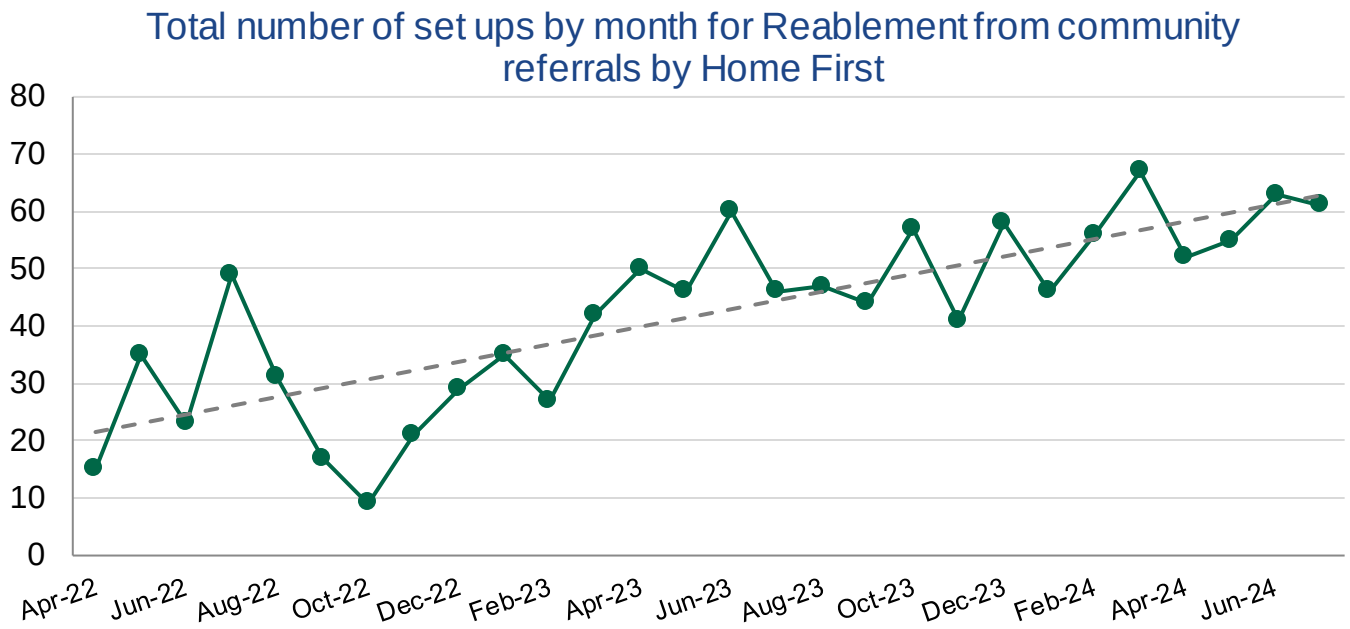
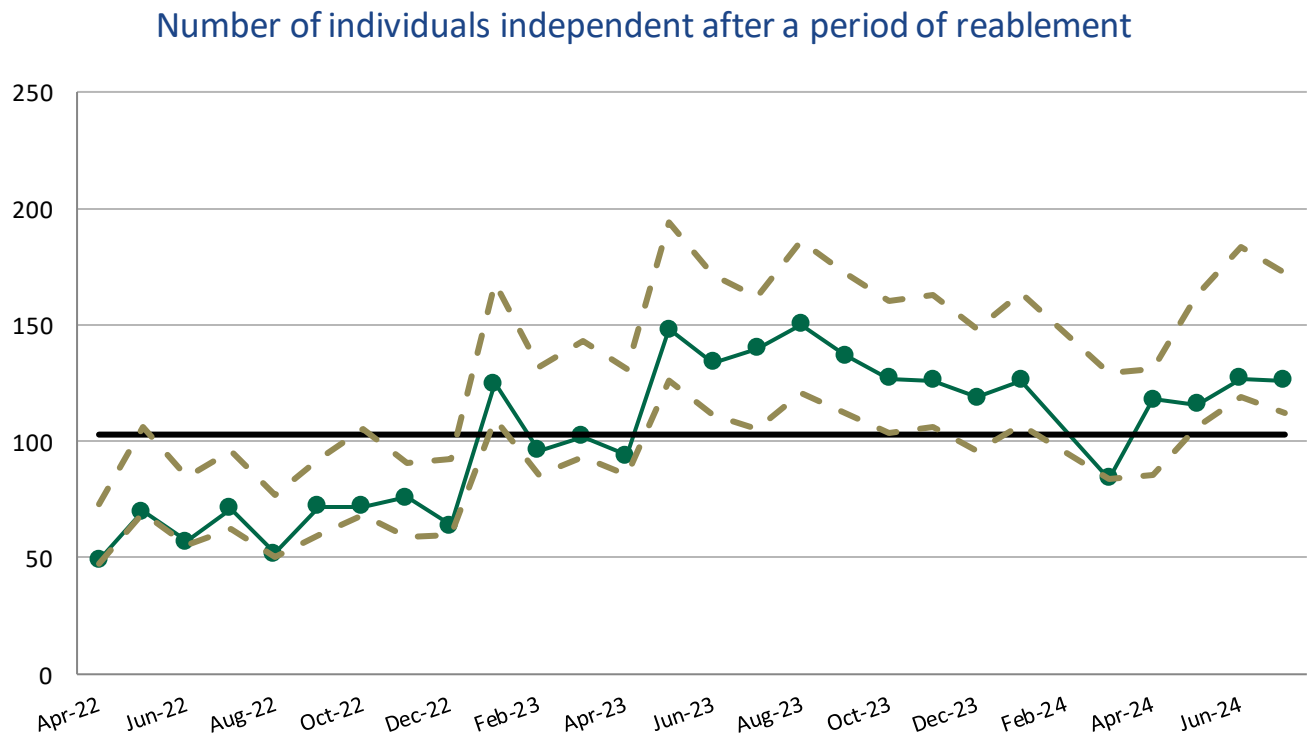


Figure 1.6 Increase in the number of people per month who are independent after reablement



14. Discharge to assess also supports people who have high needs such as those recovering from delirium and who need 24/7 care for a short time. This short-term intensive support with D2A, has meant that more people can now be supported in their own home with a quicker recover, instead of transferring to a step-down bed.

15. The Discharge to Assess team are reviewing how addition surge capacity can be delivered during the winter months, when there is an increase in the number of people requiring larger reablement packages of care.

Winter Plan

Supporting frail people in the community

16. Develop Single Point of Access (SPA) to support all health care professionals to refer people who can be assessed and cared for in their own home.

17. Expand capacity within Hospital @ Home teams to provide consistent cover until 22:00hrs 7 days a week.

18. Hospital @ Home working closely with Integrated Neighbourhood teams with a view to discharge people earlier to them but to support remotely.

19. Integrating Urgent Community Response with the overnight visiting service to delivery service that provides more home visiting capacity in the evening and overnight.

Supporting frail people in the community – Integrated Neighbourhood teams (INTs)

20. Oxfordshire has integrated Neighbourhood teams across Banbury, Oxford City, Bicester, Wantage and Witney. During the winter months these will continue to be developed to address the following.

21. To reduce health inequalities by reducing morbidity and mortality in areas of concern, stroke, heart failure and respiratory disease.

22. Continue to develop an integrated approach across Primary Care, Community and acute services for those with the highest need and based on the local population needs.

23. Local population health data has dictated some INTs need to focus on people with Mental Health, alcohol and substance misuse or the needs of children.

24. Coordinated care mainly for those who meet the frailty criteria – especially those just discharged from hospital where additional assessment and support will maintain them safely in their own home.

Supporting frail people in the community – ReSPECT

25. The ReSPECT process can be for anyone but will have increasing relevance for people who have complex health needs, people who are likely to be nearing the end of their lives, and people who are at risk of sudden deterioration or cardiac arrest. Some people will want to record their care and treatment preferences for other reasons.

26. ReSPECT and decision-making conversations happen between a person, their families, and their health and care professionals. These conversations help create an understanding of what is important to the person.

27. Patient preferences and clinical recommendations are discussed and recorded on a non-legally binding form which can be reviewed and adapted if circumstances change.

28. The ReSPECT process creates personalised recommendations for a person's clinical care and treatment in a future emergency in which they are unable to make or express choices.

29. Implementation will start within the community and then the acute Trust.

Reducing Ambulance Handover delays

30. Focus on referring people from the ambulance stack in the control room directly to Single Point of Access (SPA) to avoid an ambulance being deployed where another team can access and treat the patient.

31. Ambulance crews to refer appropriate patients to SPA where they can discuss the person with a clinician to see if Urgent Community Response or Hospital @ Home can carry out further assessment s or treatment.

32. Reducing ambulance handovers, the majority of which to be achieved within 15 mins.

33. Maximum handover time of 45 minutes: prepare to move to a mandated handover at 45 mins

34. Improve process for signing off ambulance handovers in real time to improve data quality

Increasing capacity - Acute Care

35. Improving streaming, direction and initial assessment of people as they arrive in the Emergency Department.

36. Continue to focus on reducing the length of time people spend in the Emergency Department, 2% or less with a length of stay 12hrs and over.

37. Achieving at least 78% of the 4hr standard.

38. Further development of the children's Emergency pathways to improve flow and quality of care.

Transfer of Care HUB

39. Continue to reduce the number of days people are away from their own home and increase the number of people returning directly home from the acute Trust to 95%.

40. Expand cover from 6 days a week to 7.

41. Focus on reducing Length of Stay across all Oxfordshire bed bases.
    - Improve communication with people and their carers pre and post hospital discharge
    - Digital integration to improve information sharing
    - Working closely with Integrated teams to ensure all those who can be supported at home do so at the earliest opportunity.

Discharge flow

42. Referring people who require support to return home at the earliest opportunity.
43. Improving communication with people and their carers prior to discharge and within the first 48hrs post discharge.
44. Intense approach to reduce length of stay across all Oxfordshire step down beds.
45. Improve approach and timely access to step down care across community hospital and short stay HUB beds

46. Review the impact of discharge to assess on Oxfordshire residents.
47. Social Care reviewing plans to deliver surge capacity for the expected increase in double handed care over January to March 2025.
48. Hospital @ Home and Urgent Community Response reviewing how to create additional capacity to support Health Care professional referrals for people who require assessment in their own home.

Mental Health – Reducing Length of stay

49. Embed new BCF schemes agreed for 24/25 (additional embedded housing workers).
50. Continue to realise value from 23/24 BCF / ADF schemes (step-down housing/embedded housing workers, discharge liaison support into care homes; inpatient personality disorder intervention/discharge team; one-off flexible use fund).
51. Design and implement national requirements for 'purpose of admission' and '72-hour assessment' within inpatient care with the aim of further LOS improvements and decreased delays.
52. Implement revised national MH OPEL triggers and actions.
53. Improved integration of Mental Health into the TOC Hub to assist with discharge pathways and admission avoidance to older adult MH inpatient care.
54. Introduction of enhanced MDT / senior oversight process for adults with LOS over 60 days and older adults with LOS over 90 days.
55. Inappropriate out of area placements- trajectory to reduce to 2 people at any one time in out of area inappropriate placements.

Future work and next steps

56. The progress across the various Urgent and Emergency Care pathways will continue to be sustained and developed further over the winter.