Oxfordshire Health Overview and Scrutiny Committee
Urgent Care Update January 2017

Background[1]

Nationally there has been considerable focus on performance in hospitals during the winter period. Demand for urgent care services is rising and financial pressures are growing and this is replicated in Oxfordshire. We continue to see rising attendances and emergency admissions compared to previous years and the resources required to meet the needs of all our residents continue to rise.

The NHS Constitution sets out that a minimum of 95% patients attending an A&E department in England must be seen treated and then admitted or discharged in under 4 hours. This is commonly known as the four-hour standard. National data shows that the overall number of attendances has been increasing each year. In 2003/4 there were 16.5 million attendances rising to 22.3 million in 2014/15, a rise of more than 35%.

Although attendances have increased over time, for many hospitals this is not the primary factor impacting on waiting times. A&E is in constant interaction with other departments or organisations (for example, to request diagnostic tests, beds and/or to transfer patients.) A&E performance is therefore dependent on processes and capacity in other hospital departments, and the rest of the health and care system. The four-hour standard is an indicative measure of how well the urgent care system is performing in delivering care to patients.

Patient flow through the health and social care system continues to be challenging. When beds are not available people who need to be admitted to hospital end up waiting in A&E; once people are admitted, they can sometimes get stuck in hospital when they are fit to leave. This is well rehearsed feature of the Oxfordshire health and social care economy. Whilst we have made progress we still have much more to do and we continue to have patients at risk of infection or loss of mobility in hospital beds who are fit for discharge because we do not have the right services in place to support this discharge. Sometimes the social care they need cannot be put in place quickly enough or there is often a shortage of care home beds and limited home care services in some areas.

System Collaborative Working to Improve Performance

The introduction of A&E Delivery Boards was made by NHS England, NHS Improvement and ADASS (Association of Directors of Adult Social Services) in August 2016. The Boards replace local System Resilience Groups. These groups are designed to focus primarily on Urgent and Emergency Care and are attended at the executive level by member organisations.

Alongside local system improvement, the Board is mandated to oversee five improvement initiatives. These initiatives relate to streaming, flow and discharge and represent actions that the best health systems have already implemented and include a focus on outcomes and processes:

1. Streaming at the front door to ambulatory and primary care. This will reduce waits and improve flow through emergency departments by allowing staff in the main department to focus on patients with more complex conditions.

2. NHS 111 – increasing clinical call handler capacity in advance of winter. This will decrease call transfers to ambulance services and reduce A&E attendances. Calls to 111 are approximately 205,000 per year for Oxfordshire.

3. Ambulances – Dispatch on Disposition and code review pilots. This will help the system move towards the best model to enhance patient outcomes by ensuring all those who contact the ambulance service receive an appropriate and timely clinician and transport

[1] What's going on in A&E? Kings Fund March 2016

response. The aim is for a decrease in conveyance and an increase In 'Hear and Treat' and 'See and Treat' to divert patients away from the Emergency Department.

4. Improved flow – "must do's" that each Trust should implement to enhance patient flow. This will reduce inpatient bed occupancy, reduce length of stay, and implementation of the SAFER bundle will facilitate clinicians working collaboratively in the best interests of patients. These are a combined set of principles for adult inpatient wards e.g. Consultant review before midday, all patients having an expected date of discharge, assessment of patients and discharge earlier in the day.

5. Discharge – mandating 'discharge to assess' and 'trusted assessor' type models. All systems moving to a 'Discharge to Assess' model will greatly reduce delays in discharging and points to home as the first port of call if clinically appropriate. This requires close working with local authorities on social care to ensure successful implementation for the whole health and care system.

The Oxfordshire A&E Delivery Board Improvement Plan sets out 41 initiatives designed to support the whole-system through the winter from the beginning of October through to the end of March. Each of the 5 workstreams has Executive Level Senior Responsible leadership and management through the monthly A&E Delivery Board meetings.

Key initiatives include:

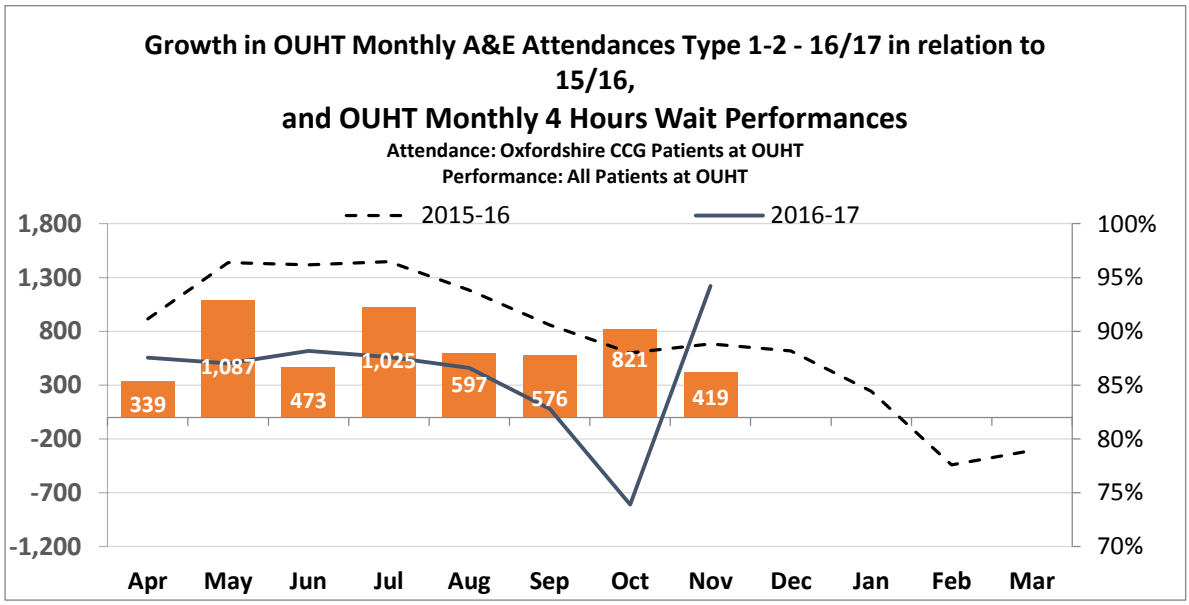
- **Increasing Same Day Urgent Primary Care Access** – GP Access Fund plans are being mobilized to increase available appointments in primary care. Coordination between OOH and GP federations is needed to align plans and optimise workforce.
- **Acute Clinical Coordination Centre** – first phase implementation from October 2016 to provide secondary care clinical support to GPs and paramedics both in and out of hours with an emphasis on supporting patients at home wherever possible and increasing the use of alternative (ambulatory pathways) such urgent clinic reviews.
- **Ambulatory Pathway** providing urgent assessment and treatment of adults who are unwell– There has been rapid expansion of the ambulatory by default pathway on both the JR and Horton sites to provide an ambulatory emergency care service 12 hours a day 7 days a week. This has resulted in an increasing proportion of patients going though the ambulatory pathway without requiring an admission.
- **Increasing 111 calls to clinical adviser** – Increasing clinical input (including GP, mental health, dental and pharmacy) in managing 111 calls would help people get the right advice or treatment in the right place, first time. There is a requirement to increase for 22% to a national interim threshold of 30% (or higher) of calls transferred to a clinical adviser by 31st March 2017.
- **Comprehensive Directory of Services.** The Directory of Services (DoS) is a national web-based directory developed by the Department of Health and populated locally, listing health, social care and third sector services. This supports triage of patients to appropriate local services outside hospital where appropriate. Ensuring the accuracy of the DOS is important to ensure callers are streamed to the most appropriate service and only A&E when clinically appropriate.
- **The Ambulance Response Programme** – This is a national programme to improve outcomes and experiences of patients contacting the 999 service. Ensuring appropriate conveyance of patients and increasing 'hear and treat' and 'see and treat' where appropriate.
- **Implementation of Improved Flow Initiatives -** Within the acute setting there has been phased roll out of the SAFER bundle and 'red and green day' initiatives. Effective implementation will help to reduce bed occupancy, improve performance and enhance patient care.

1.2 Local context

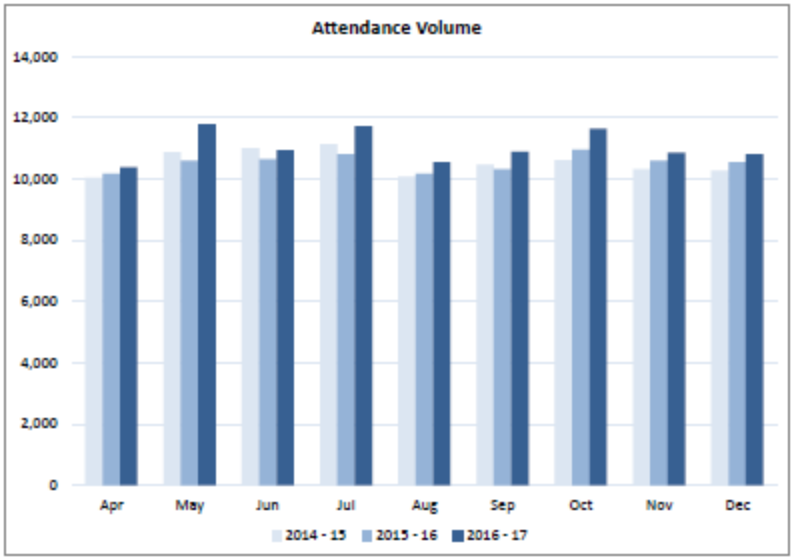
A&E attendances and performance

In Oxfordshire the number of people using A&E has risen by 8.14% compared with last year or an additional 8750 patients have attended this year to date compared to last year. The proportion of patients admitted when attending ED stands at 27.5% in November. The conversion rate for November 2016 is higher than November 2015 by 1.6% (25.9% in Oct 15).

Year to date performance at the end of November was 85.90% of people transferred out of A&E within 4 hours against the 95% target. Clinicians report increased demand from frail, older people with chronic, long term conditions. In essence demand increased from patients who were, older more frail and sicker than seen in previous years, this is evidenced by a 5.04% (year to date) increase in attendances against last year's position.

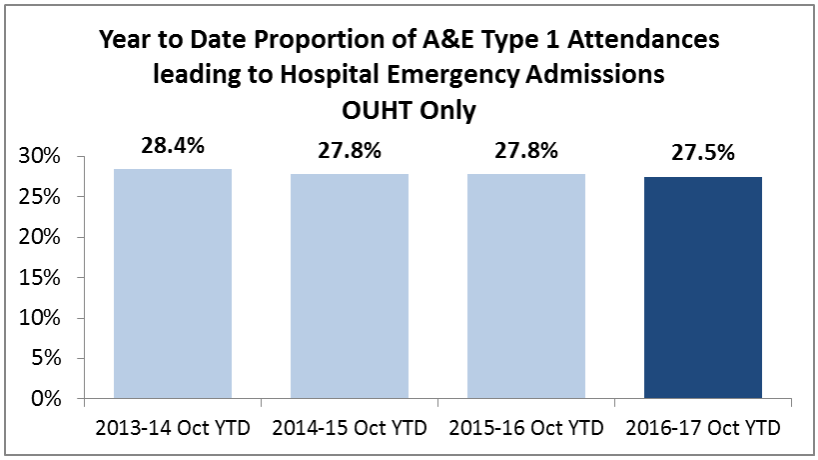


Financial Year by Month Comparison



The number of people needing to be admitted from A&E into a hospital bed has decreased slightly over time (vs national trend of increase), with rates tending to be highest in the winter. Those waiting for admission tend to wait in A&E longer than other people. This is

particularly a problem in hospitals when the bed occupancy rate is already high as there is more limited bed availability.



OUH have had no 12 Hour Wait breaches following a 'decision to admit' throughout 2016/17. This ranks in the best performing trusts in the country. The national average is 0.7 breaches per month (this equates to roughly 2 breaches every 3 months).

Significant deterioration of A&E performance was seen in September and October 2016. Review and diagnosis indicated that reasons for this included:

- Increase in 'minor' breaches in ED (i.e. presentations not immediately life threatening). Attendances had increased by 5.9% during this period however there had been a significant increase in minor breaches of 123%.
- Staffing and patient flow issues. It was recognised that alignment needed is for demand and capacity.
- Increased capacity required for discharge flow in reablement and community hospital capacity.

To enable the recovery of performance at the same time as meeting demand increasing implementation of a 4 hour immediate action plan was instigated within OUHFT.

The Trust instigated an internal Daily Escalation Process to support capacity and flow with 7 day 3pm calls with CEO/Deputy CEO's. An Escalation rota 8am to 6pm weekdays; ED/Operations Coordinator – Senior Clinical Operations lead – Divisional Bronze Lead – Divisional Silver Lead – Gold Lead and 8.30am and 2.30pm site based operational planning meeting.

There has also been development of visual display dashboards to provide relevant and timely information to inform daily decisions to improve quality of patient care and enable utilization of resources more effectively. There is a live operational dashboard; daily 8am, 2pm and 5pm and improved business intelligence through the use of a daily retrospective performance report and both weekly and monthly performance reports and trend analysis

Initiatives to improve flow and performance included:

- Review of A&E management and staffing to speed management and discharge of minors
- Implementation of automatic acceptance policy from A&E to wards
- Instruction of tertiary specialities to only accept patients direct to their service facilities, not A&E, unless traumatic or airway compromised
- Ensuring two assessment beds remain available 24/7 and six beds available at 10am and 10pm in the Emergency Ambulatory Unit. Patients are treated with appropriate,

integrated support as a day case patient and through on ongoing outreaching support directly into patients' own homes where appropriate.

- Ensuring that no patients, unless clinically indicated, to remain in EAU or SEU beyond 12 hours
- Ensuring two discharges from wards per morning to the Discharge Lounge by 10am
- Prioritising ITU step down towards; all transfers of "green" patients to be completed within 4 hours
- Deploying pharmacist in the Discharge Lounge 10am to 2pm to support timely discharge
- Radiology to give equal priority to patients in A&E and A&E admissions in wards to support earlier transfer from A&E to admission
- Daily review of all non-tertiary/critical care patients with a length of stay in excess of 7 days
- Implementation senior medical review of all inpatients by midday
- Increasing Intermediate Care Bed (ICB) capacity from 55 to 85 (including 12 CHC beds)
- Fast track ward discharge cleans
- Resident Consultant Paediatrician deployed in HGH A&E out of hours and weekends
- Resident Consultant Anaesthetist deployed in HGH A&E out of hours and weekends
- Senior Trauma doctor deployed in HGH A&E out of hours and weekends.

System Escalation

Good surge management requires health and social care partners work together to resolve pressure system-wide. Health and social care organisations have been working more closely in recent years to solve short term surge in parts of their system for the benefit of their whole population.

The A&E Delivery Board approved the new whole-system Operational Pressures Escalation framework in October 2016. This clarifies the roles and responsibilities of all the statutory agencies when there are surges in demand for urgent care.

The framework provides a nationally and consistently set of escalation level, triggers and protocols to set clear expectations around roles and responsibilities and enables local systems to maintain quality and patient safety. The escalation framework has 4 status alerts – OPEL 1 to 4. Throughout the winter so far the Oxfordshire status has remained in OPEL 2 & 3. OPEL 4 is the status when all actions have failed to contain pressures and deliver capacity to deliver comprehensive emergency care.

Figures published by NHS England for the period 1 – 27 December show that:

Around a third (50) of the 152 trusts that sent data into NHS England declared an OPEL 3 or 4. Of those, seven were OPEL 4s. In total, 201 OPEL 3 or 4s were declared between 1-27 December, of which 15 were OPEL 4s.

Whilst there were significant pressures felt across our Oxfordshire system the most recent South Central A&E performance report (unvalidated December data) shows OUH performance in December as second best across the region at 91.34% (range 91.43% - 74.65%). OUH reported best performance w/e 25th December at 96.26%. Daily Oxfordshire systemwide health and social care escalation teleconferences were held throughout this period as needed (in line with the Escalation Framework) to coordinate system working and

collaboration in managing system pressures. All partner efforts and participation is recognised as important in managing this.

Repatriation

The Oxford University Hospitals NHS Foundation Trust (OUH) receives a significant number of patients beyond its local catchment area because it provides specialist tertiary services and as part of extensive Networks Major Trauma Centre and Vascular Arterial Hub. The Trust requires clear principles and guidelines to enable patients to be repatriated to their local hospital or appropriate NHS facility within a specific timeframe. It is important that patients are speedily returned to their local hospital so that NHS organisations can provide the best possible experience and outcome for all its patients.
Effective and timely repatriation will maximise bed availability and thereby maximise accessibility of specialist tertiary services. Waiting times, cancellations and delays to specialist tertiary admissions will be minimised. Repatriation of patients requires NHS Trusts to work in partnership in the best interests of patients, families and friends.

To improve communication and reduce delays in patient transfers between Trusts, OUH produced a revised Repatriation procedure. This has been agreed through the Local Provider Forum.

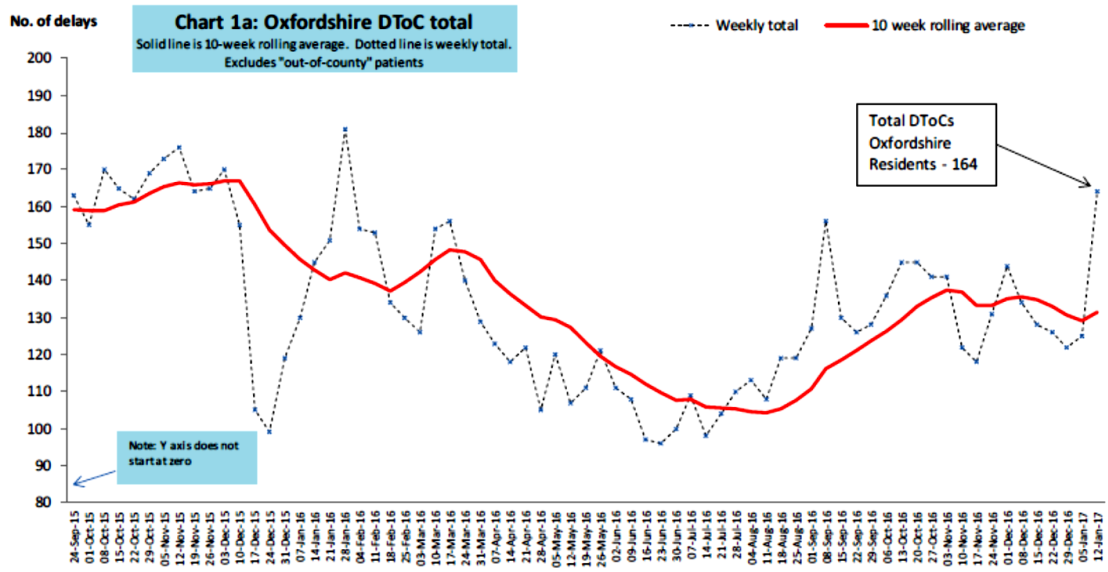
Further work is needed to ensure consistency in implementation of this procedure across all local trusts in line with national frameworks. This remains a priority for the Oxfordshire system.

Delayed Transfers of Care (DTOC)

Delayed transfers of care, occur when a patient is ready to depart from care and is still occupying a bed. Our work on improving delayed transfers of care has a clear interface with the ability of the Trusts to flow people through our beds. According to NHS England, a patient is ready to depart when:

1. A clinical decision has been made that patient is ready for transfer and
2. A multi-disciplinary team decision has been made that patient is ready for transfer and
3. The patient is safe to discharge/transfer.

As HOSC will know from prior reports longer stays in hospital can have a negative impact on older patients' health, as they quickly lose mobility and the ability to do everyday tasks. Keeping older people in hospital longer than necessary is also an additional and avoidable pressure on the financial sustainability of the NHS and local government. NHS guidance is that patients are moved out of acute hospital as soon as it is clinically safe to do so. It is important to achieve the correct balance between minimisng delays and not discharging a patient from hospital before they are clinically ready.



The Oxfordshire DTOC plan has continued to implement the *Breaking the Cycle* initiative reported to HOSC at its meeting in December 2015. The average number of Oxfordshire patients who were medically fit for discharge but unable to leave hospital was 161 per week from April to December 2015. By July 2016 this figure had reduced to 109 but it has now increased back to 122 as at 12 January 2017.

The delays occur across Oxford University Hospitals NHS FT (OUH), community hospitals managed by Oxford Health NHS FT (OH) and to a lesser but persistent extent in neighbouring acute trusts such as Royal Berkshire Hospital (RBH). There is a persistent pattern that high numbers of people waiting to go into community hospitals which is matched by a high number (in recent weeks around 40) looking to move out of OH and into the community, many of whom are waiting for reablement.

The DTOC action plan has delivered a number of improvements to the discharge pathway:

- **April 16.** The consolidation of the command and control hub set up by OUH and funded by OCCG. The hub has retained 55 intermediate care beds funded jointly by OCCG and OUH
- **May 16**. The increase of the amount of home care purchased by Oxfordshire County Council by 270 hours per week under the *Help to Live at Home* contracts.
- **July 16**. The agreement of a new system wide Choice policy.
- **October 16**. The new contract for an integrated reablement service ("HART") commissioned jointly by OCC and OCCG and provided by OUH.
- **Dec 16**. The development of a discharge to assess pathway for people who might meet the thresholds for continuing healthcare with 12 extra beds funded by OCCG and provided as part of the OUH intermediate bed stock.
- **Jan 17**. New intermediate care beds managed by OCC opened on the Townlands site in Henley with investment from OCCG. These should particularly support discharge for Oxfordshire patients in the Royal Berkshire Hospital in Reading.

Nevertheless the system has remained under significant stress and there have been a number of issues and responses:

- The new reablement service provided by OUH has not been at full staffing capacity. OUH has held recruitment events to address this and new staff have started in January.

- There was a withdrawal from the home care provider market in November which created a significant short-term pressure. OCC has purchased 10 additional beds as part of the OUH intermediate bed stock as a short term measure to address this. OCC have subsequently agreed contracts within the *Help to live at Home* framework with two new providers.
- OCC will buy up to 17 interim beds for people who are waiting for a care home placement, have no further rehabilitation needs but where there is nowhere immediately available for them to go to.
- CCG funding additional beds to enable continuing healthcare assessments to be undertaken outside the hospital setting

These inputs have helped manage the number of patients delayed in our system but the number remains high. The number of delayed bed days per 100,000 of population reduced to 506 in August 2016; then increased back to 897 in October; but has since stabilised at 760.

Delays at this point are driven by 4 key areas

- The number of people in both acute and Oxford Health NHS FT community hospital settings waiting for reablement support. This should be a short-term problem addressed largely by the current recruitment.
- The underlying availability of domiciliary care owing to workforce pressures in Oxfordshire
- The underlying availability of nursing home capacity, especially in relation to people with complex dementias
- Patients self-funding their onward care who are unable to move: this is also related to both the domiciliary care and nursing home issues above

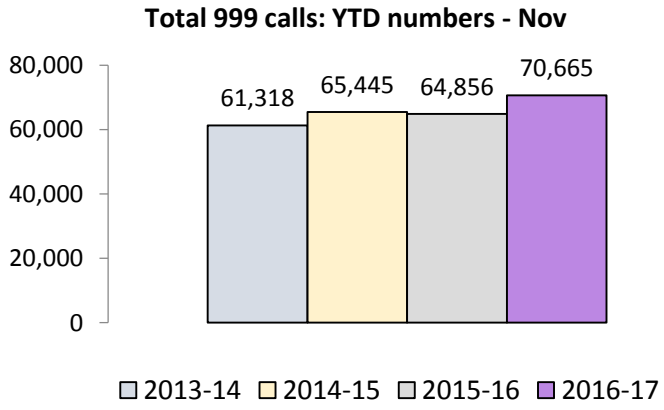
Since September 2016 the work to reduce delayed transfers of care has formed one of the workstreams for Accident & Emergency Delivery Board (AEDB) and the DTOC Action Plan has been refreshed to address national and local priorities as follows:

National priorities	
Area	**Progress**
A 'home first: discharge to assess' pathway is in operation across all appropriate hospital wards	• The reablement pathway is crucial in delivery of this requirement. This is being reviewed in January.
Trusted assessor arrangements are in place with social care and independent care sector providers	• It has become clear from discussions in the system that we need to improve the common understanding of pressures and patient's requirements across health, social care and the independent sector. • There is a strong commitment to work together. We have local examples of how arrangements built on trust improve patient flow and experience: e.g. OH older adult mental health teams supporting nursing homes, the OH Care Home Support Service and the medical and therapy cover offer by OUH to the intermediate care beds that they have purchased. • These initiatives need to be built into trusted assessor protocols with the independent sector

At least 90% of continuing healthcare screenings and assessments are conducted outside of acute settings	• The OCCG discharge to assess beds for people who might be entitled to continuing healthcare will support this. In Q3 OH assessed 71% of patients outside of hospital.
A standard operating procedure for supporting patients' choice at discharge is in use, which reflects the new national guidance	• In place July 16.
Local initiatives	
Area	**Progress**
Ensure enough community hospital capacity and throughput	• OH has agreed a trajectory to reduce length of stay with OCCG. OH plans a "perfect week" to review its internal pathways in February
Increased provision for people with more complex needs	• OCCG has met independent providers to scope out the potential to extend capacity through external support to nursing homes. At present the lack of underlying capacity is undermining that
Management of self-funder delays	• This is being investigated as part of pathway reviews in January 2017.

At its most recent meeting on 19/1/2016 AEDB concluded that our discharge pathways should be reviewed to ensure that patients are receiving the right care at the right time, and that we are deploying the resources in the discharge pathway most effectively. This is being reviewed and will be reported back to AEDB at its meeting on 28/2/17.

Ambulance 999 Activity and Performance



Demand for 999 services continues to grow in activity this year. Over the winter period (October – December), Oxfordshire saw an increase of 20.79% in Red 1 and an increase of 26.79% in Red 2 (life-threatening) call demand in Oxfordshire compared to the same periods in 2015/16. Despite this significant increase, SCAS outperformed many other ambulance services across the country.

Oxfordshire 999 Performance:

	Red 1incidents within 8 minute target – threshold 75%	Red 2 incidents within 8 minute target – threshold 75%	Red 19 incidents within 19 minute target threshold 95%
October 2016	67.9%	71.2%	92.3%
November 2016	70.7%	72.3%	92.0%
December 2016	71.4%	70.5%	91.2%

Since June 2012, ambulance trusts have been given eight minutes to respond to the most urgent cases, and nationally no more than 25 per cent of these calls should be responded to outside this time.

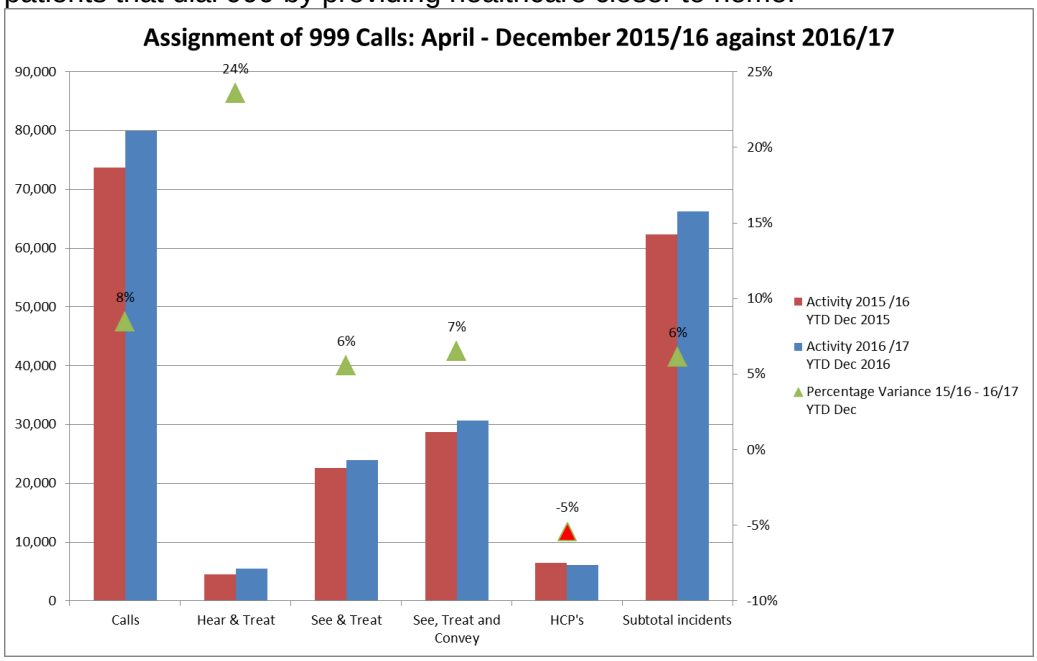
National data shows that this standard was met until 2013/14 but nationally for all subsequent years has been missed. In the most recent national data, performance remains poor, with 32 per cent of calls in September 2016 being responded to after eight minutes

SCAS continue to fall behind the national trajectory for performance due to higher activity and difficulties in resourcing. Actions are underway but are yet to have anticipated full impacts.

One of the continuing aims within the transformation of the ambulance service into a mobile healthcare provider is to increase the number of patients that the ambulance service can hear and treat, where advice is provided over the phone with appropriate signposting and see and treat, where the patient is seen by an ambulance clinician and then either treated within their home or referred to the most appropriate care. Oxfordshire's performance during the winter period is shown below:

	Hear and Treat	See and Treat	See, Treat and Convey
October 2016	10.1%	38.1%	51.8%
November 2016	8.9%	38.2%	52.9%
December 2016	7.8%	38.5%	53.7%

As shown within the table above, SCAS continues to only convey approximately half the patients that dial 999 by providing healthcare closer to home.



Patient Transport Service

SCAS provides the Patient Transport Service (PTS) for Thames Valley (including Oxfordshire, Berkshire and Buckinghamshire), Milton Keynes and Hampshire.

Our Patient Transport Service (PTS) has provided non-emergency transport across Buckinghamshire, Berkshire, Hampshire and Oxfordshire for more than 40 years. We provide transport for people who are unable to use public or other transport due to their medical condition and include those who are:

- attending hospital outpatient clinics
- being admitted to or discharged from hospital wards
- needing life-saving treatments such as radiotherapy, chemotherapy or renal dialysis or DVT treatment.

Our non-emergency PTS provides much needed support to patients and is an extremely important part of our service. In 2015/16 we undertook 513,787 patient journeys.

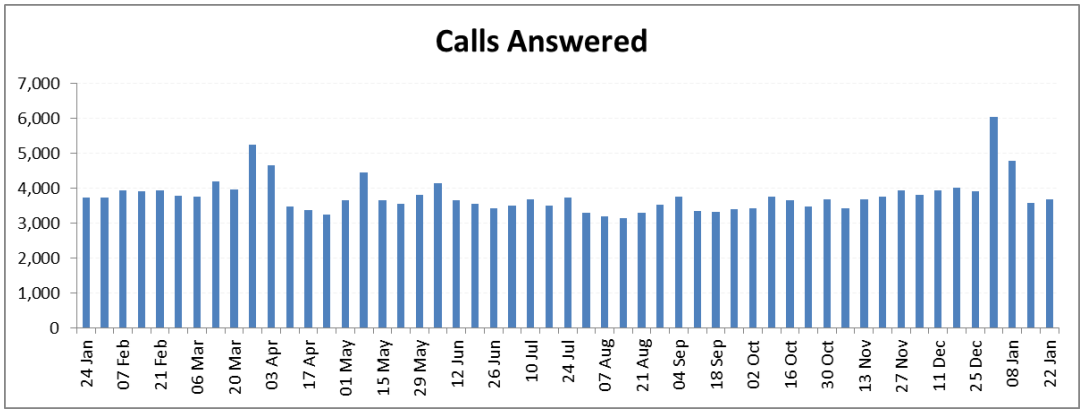
In December 2016, SCAS and Oxfordshire CCG, working closely with our partners across the Thames Valley region realigned the service provision to improve the discharge and transfer part of the PTS provision, this has enabled the Oxfordshire system to be able to respond to the higher demand for the hospital beds, improving the experience of patients returning home or transferring from the acute hospital to ongoing care.

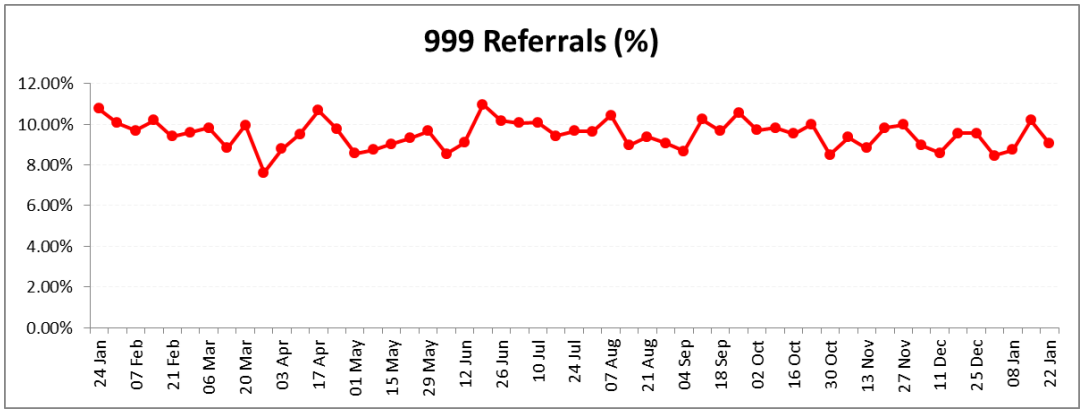
NHS 111

SCAS also currently provides the NHS111 service in Oxfordshire. The NHS111 service signposts callers to the most appropriate service for their needs through NHS Pathways triage and clinical advice as required. In 2016/17, SCAS provides this service for the South Central region (excluding Milton Keynes) and Bedfordshire. Through the virtualization of our Clinical Contact Centres (CCC), a more resilient call answering service is provided. SCAS are currently one of the top performing NHS111 services in the country.

Within our Clinical Coordination Centres, we are also trialing new ways in supporting and accessing patients, this includes trials with clinician assessment by video conferencing for patients in Nursing and Care Homes as well as direct appointment booking for NHS services.

Over the winter period we saw an increase in demand, especially over the festive weeks. Despite this increase, 111 calls that became 999 ambulance responses remained low as did the 111 calls that were referred to the A&E department, ensuring that all patients received the most appropriate advice despite the high call volumes as demonstrated in the graphs below:





Next Steps

This paper provides an update the urgent and emergency care system over the last 6 months, with a specific reference to A&E performance and DToCs. It is recognised that there is significant challenge across the urgent and emergency care system both nationally and locally. However Oxfordshire has seen improved performance on waiting times since November and we need to ensure this improvement is sustainable.

We also need to offer more support to patients to find appropriate alternatives to A and E where their needs could be met in primary care or minor injury services. We need greater clinician advice in 111 services to direct patients appropriately. In future we want to expand the use of pharmacies and pharmacists to offer quick access to advice and potentially offer wider range of services.

There are a number of collaborative initiatives underway to further improve system flow and patient care that will continue to be progressed and implemented. The next step is a thorough evaluation with a view to revising plans going forward into next year.

Sara Wilds
Oxfordshire CCG Head of Urgent Care and Medicines Optimisation
24th January 2017