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Oxfordshire Winter Plan 2017 – 2018

Health and Social Care Winter Resilience Plan

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North


North East


Oxford City


South East


South West


West

Introduction

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The Winter Plan will…

- Provide organisational resilience across Oxfordshire against the anticipated system-wide priorities identified by Oxfordshire's A&E (4 hour) Delivery Board and System Flow Board.
- Describe and Provide reassurance on management structures within and between organisations
- Embed good practice and resilience principles in every day practice to bring evidenced improvement in compliance with Constitutional targets and benefits to patients when the system is facing challenges due to increased demand and/or reduced capacity over the winter period.

The system promises to…

- Utilise the System-wide Urgent Care Strategy including a well-established online escalation dashboard (Alamac report)
- Undertake Daily Teleconference Call (as per OPEL framework or when requested by a provider when necessary) to enable rapid resolution of issues as well as leading the reduction of delayed transfers of care and reducing unnecessary admissions.

Taking into consideration lessons learnt from Winter 2016-2017 and guidance received from NHSE & NHSI in July 2017 (gateway ref. no. 06969), the plan is aligned into the following 4 categories:

Wider System Preparation	Front Door	Flow	Discharge
• 2 to 26	• 27	• 28 to 30	• 31 to 35

Priorities

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Oxfordshire System Flow Board: Key Priorities

- Pathways and flow
- Demand
- A&E 4 hour target
- Workforce
- Value for money
- Primary care capacity

Priorities listed in the document embedded below were agreed by system-wide Chief Operating Officers (COOs) following a visit from the National Hospital to Home team in May 2017. A weekly COOs meeting is taking place where pressing operational issues and strategic priorities are discussed.

Appx. 2

Appx. 3

Priorities for winter planning target Workforce issues with nursing staff, targeting available beds and utilising effective alternatives

A&E (4 hour) Delivery Board: Key Priorities

- Winter Planning
- Workforce & Number of beds available
- Impact of Integrated Urgent Care 111
- Delayed Transfers of Care
- Impact of Ambulance Response Programme (ARP)
- Out of Hospital Urgent Care Access
- Primary Care streaming in ED

Summary of Winter 17/18 Initiatives

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Area	Initiative	Start Date	Lead Organisation	Impact
Pharmacy	Minor Ailment Scheme PGD for UTI Management NUMSAS	November 2017 November 2017 September 2017	OCCG OCCG NHS England	Managing Demand Reduce ED attendances
Care Homes	Medication Review Specialist Continence Prescribing Service Improving Nutrition Care Home Support Service Proactive GP Support	Winter 2017/18 October 2017 Winter 2017/18 Winter 2017/18 Winter 2017/18	OCCG OCCG OCCG OH OCCG	Admission avoidance Cost effectiveness Quality of Care
Primary Care	Increase in Hours of Provision	December 2017	OCCG	Reduced demand in ED
Flu	Flu Vaccinations for at risk groups Flu Vaccinations for Social care workers	October 2017 October 2017	OCCG OCC	Reduce admissions Improve patient outcomes

Summary of Winter 17/18 Initiatives

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Area	Initiative	Start Date	Lead Organisation	Impact
Flow	Trusted Assessor	October 2017	OUH/OH	Reduce LOS
	Primary Care Streaming	December 2017	OUH	Reduce ED admission Improve patients outcomes
Discharges	Complex Discharges	August 2017	OH	
	Hospital at Home	November 2017	OCCG	
	Third sector Initiative	Winter 2017/18	OCCG	
	Therapy Support to HART	October 2017	OUH	Reduce LOS Improve patient outcomes
	200hrs of Contingency care	October 2017	OCC	
	Procurement of further 200hrs of Contingency care	Winter 2017/18	OCC	Reduce admissions
<u>Proposals under consideration:</u>				
SOS BUS		November 2017	SCAS	Reduce ED attendances
PTS support to ED		November 2017	SCAS	Reduce 999 demand Improved flow
Third sector initiative		Winter 2017/18	OCCG	Reduce social admissions Reduce LOS
North East Oxfordshire Pilot for non-registered staff		Winter 2017/18	OCCG	Improve patient outcomes

Lessons learnt/challenges: Winter 16-17

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Care Home market supply and demand – including affordability

Collective leadership and involving the whole system in winter planning as well as people at all levels.

Risks should be identified early - the system should be less "reactive".

Clinical leadership crucial for improving hospital flow and discharges.

Lack of flow in the system

The domiciliary care/reablement system is highly susceptible to a downturn in capacity at critical times of the year
(e.g. Christmas, Easter, bank holidays).
We need a system-wide workforce plan.

The above challenges and lessons learnt were identified and discussed over a series of conversations with system partners in February 2017.

System challenges: as Identified in CQC Preparation

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We do not have the workforce available to meet the current demand: What are we doing?

- An 86% increase in the amount of home care purchased between April 2011 and April 2017.
- Investment from the improved Better Care Fund to increase the average hourly rate we pay home care providers.
- Worked with partners to develop a Workforce Strategy
- Investment in Home care agencies with training on values based recruitment
- NHS are using new apprenticeship models to help to make these roles more attractive in the medium term
- Collaboration on recruitment into care roles between private sector and various NHS entities is in its infancy
- Innovative HART recruitment campaign

A bottle neck in the reablement service leading to delays in people being discharged from hospital: What are we doing?

- Commitment not to revert to old behaviours of creating duplicate services
- Reablement Outreach Team review cases to ensure there is no over commissioning of care
- Improved Better Care Fund money used to commission 30 HART mitigation beds
- Increase in D2A additional service providing up to 24hr care in people's homes for 6 weeks
- HART are working to ensure they are fully staffed

System challenges: as Identified in CQC Preparation

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High level of Delayed Transfers of Care: What are we doing?

- Agreement to jointly commission (OCC & CCG) a single pathway out of hospital for people going home
- Discussion about Intermediate care and Hub beds being consolidated in one place with one key provider partner
- Range of new admission avoidance models – 'community frailty/LTC teams' and Urgent Treatment Centres
- Pilot a rehabilitation pathway for Community Hospitals (ambition - can we achieve 'zero waits'?)
- The procedures to transport people home have been improved

Fragile Care provider market: What are we doing?

- Investment in business support to agencies
- Increase in the rate we pay providers to encourage them to remain in the market
- Refreshed investment in outcome based support plans
- Decision to explore the council introducing a small, flexible internal service

Lack of Winter acute beds response – as agreed at the System Flow Board on 13th October

Other system-wide preparation

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Breaking the cycle week

- Chief Operating Officers committed to a system-wide Breaking the Cycle week beginning on 6th November 2017. Leading organisation – OUH
- Similar approach as the one during the Perfect week 2015
- In preparation, every organisation was asked to submit the Ask & Offer to OUH, who will then arrange a series of preparation meetings. Once the Breaking the Cycle week is over, all organisations will reflect on what went well and will identify areas for improvement. Outcomes of the Learning session (planned a week after) will inform the changes to be made to the Winter plan.

Communications

- Oxfordshire's Winter Communications plan (appx. 4) was approved by A&E Delivery Board in September.
- A&E Delivery Board agreed a budget for promotional campaigns

Winter 16-17 performance

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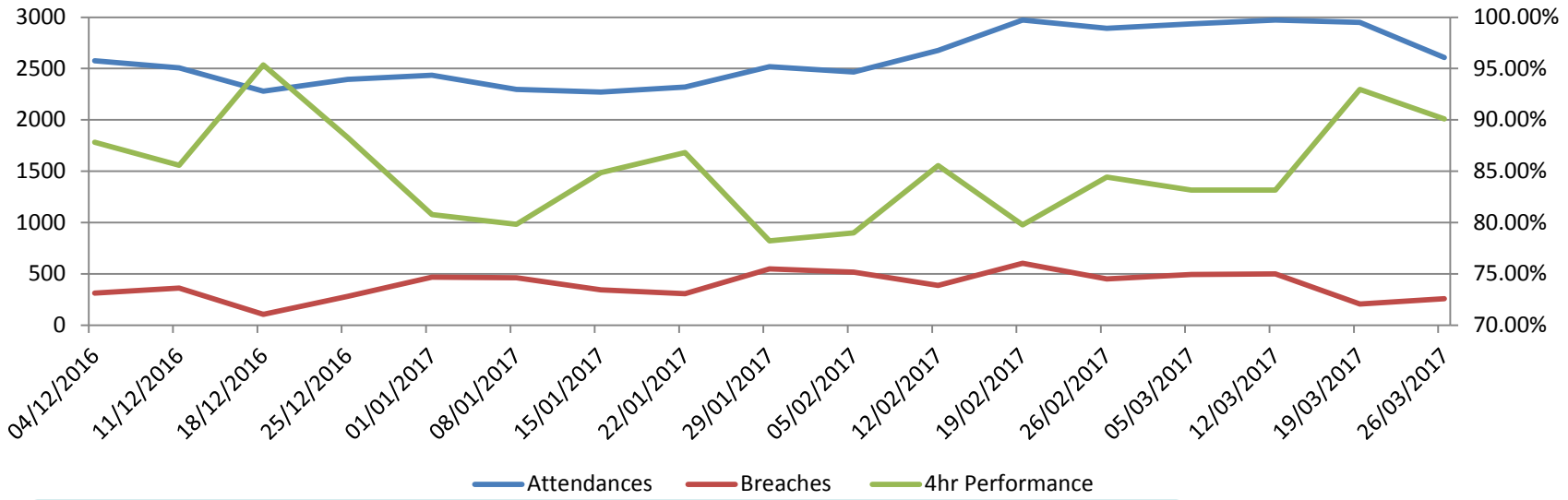

Key Findings:

- The biggest rise in attendances in the 3 days after Christmas is in the age category of 18-59.
- From the 24th the average LOS in A&E will rise drastically and will likely peak just after new year's day.
- The increase in LOS with go from an average of 2:30 to nearly 4 hours.
- NELs peak in the 3 days after Christmas, and will return to normal levels prior to new year's.
- The 26th and 27th will see the largest increase in minors attendances, which will again peak around the New Year period.
- There is little to no trend in the Major attendances.
- Two North Oxfordshire practices (West Bar and Horsefair) had the most attendances at A&E during this time.
- Oxford City practices contributed the most attendances during this period.

Xmas & New Year Demand Modelling

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	Attendances 16/17	2% Additional	Predicted Attendances 17/18
20-Dec (Wed)	316	6	322
21-Dec (Thu)	333	7	340
22-Dec (Fri)	296	6	302
23-Dec (Sat)	271	5	276
24-Dec (Sun)	321	6	327
25-Dec (Mon BH)	292	6	298
26-Dec (Tue BH)	376	8	384
27-Dec (Wed)	443	9	452
28-Dec (Thu)	334	7	341
29-Dec (Fri)	308	6	314
30-Dec (Sat)	334	7	341
31-Dec (Sun)	309	6	315
01-Jan (Mon BH)	355	7	362
02-Jan (Tue)	413	8	421
03-Jan (Wed)	344	7	351

A&E Demand Modelling

- Current year on year growth in A&E attendances in 2%
- Applying this to the winter period for this year shows an average increase per day of 7 additional attendances
- Utilising the attendances from 2016/17 and the additional anticipated demand provides identification of spikes in attendances
- Expected peaks include 26/27th of December and 1st/2nd of January

Current performance: System wide

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System performance is monitored on a monthly basis at A&E (4 hour) Delivery Board. A system wide task and finish group was formed to agree and source metrics and data to support the system.

The Dashboard targets key metrics that act as "early Warning" indicators for Demand, Capacity and Flow. The dashboard also contains additional standards regarding achievements of targets in the Oxfordshire System.

Please see slide "Escalation and on-call arrangements" for a description how performance is monitored on a daily basis and what arrangements will be in place for Winter 2017 – 18.

A&E Delivery Board Performance Report

		Target	2017/18 Apr	May	Jun	Jul	Aug	YTD
Demand	ED attendances not above 16/17 outturn on month-by-month basis		172	238	768	-27	5	1178
	Emergency admissions not above 16/17 outturn on month-by-month basis		-121	-346	-245	-391	-258	-712
	111 - Total Activity		18545	17695	18348	17745	16204	103979
	111- % Transferred to All Clinicians (5.22)	30%	31.36%	24.11%	29.74%	28.48%	28.89%	27.54%
	111 - Number Referred to A&E	5%	1420	1381	1565	1406	1287	8127
	111- % Referred to Primary Care		57.36%	45.72%	51.34%	50.54%	51.48%	50.95%
	GPAF: Appointments Utilised	95%	2872	3855	3629	3964	3883	18203
	Total 999 Incidents		6440	7064	6722	6951	6650	33827
Capacity	Average Daily Beds Available - Acute (G&A Only)		91	71	60	58	70	70
	Average Daily Beds Available - Community Beds		3.4	3.5	3.9	3.7	4	3.7
	Average Daily Beds Available - Intermediate Care Beds		1.8	1.6	2.3	2	2.6	2.1
	Non-bed Capacity - HART delivered hours	8440	5691	6106	6039.75	6217.95	6348	6131
	GPAF: Appointments Available	6211	3843	5108	4850	5599	5684	25084
	% of OOH Shift un-filled	2%	3.7%	5.6%	8.9%	12.1%	13.2%	8.7%
Flow	Deliver a 15% cumulative reduction in DToC in OUHFT quarter by quarter, so 110 by Q1, 93 by Q2, 79 by Q3 and 67 by Q4				178			
	DToC Trajectory head count performance against trajectory (Starts in August)		154	181	178	169	114	
	CHC eligible patients moved on within 7 days of assessment decision (48 hours not yet available)		75%	45%	63%	55%		59%
	Where the patient is not fit for transfer to D2A bed CHC assessment will take place within 7 days			60%	78%	61%		66%
	Where the patient is fit for transfer to D2A bed the assessment will take place in that bed.			100%	100%	80%		92%
	Average Length of Stay - Community Beds	24	38	27	29	30.5	36	32.10
	Average Length of Stay - Intermediate Care Beds							2800%
	Average Length of Stay - Hub							
Additional Standards	**OUHFT 4 Hour Standard Overall Performance**	95%	88.84%	86.40%	82.78%	80.76%	84.78%	84.63%
	4 Hour Performance (Type 3 MIU/FAU)	95%	96.63%	95.37%	97.14%	96.98%	97.62%	96.63%
	Total AAU Attendances (inc EMU)		1184	1142	1244	1199	1123	5892
	Total Pick Ups - HART		176	177	175	197	174	1124
	Red 1	75%	75.7%	74.1%	70.4%	74.4%	70.5%	72.9%
	Red 2	75%	70.7%	69.9%	68.2%	70.0%	69.1%	69.6%
	Red 19	95%	94.1%	91.6%	91.0%	93.0%	92.4%	92.4%
	PTS - Planned Discharges %	35%	33.9%	30.1%	29.7%			31.2%
	Acute Discharges		6681	5490	6898	5477	5458	30,004
	Discharges before 12noon %	33%	19.2%	19.1%	19.1%	19.5%	18.7%	19.1%
	Conversion Rate from A&E	25%	25.0%	23.8%	22.7%	22.3%	24.2%	23.6%

Current performance (DTOC)

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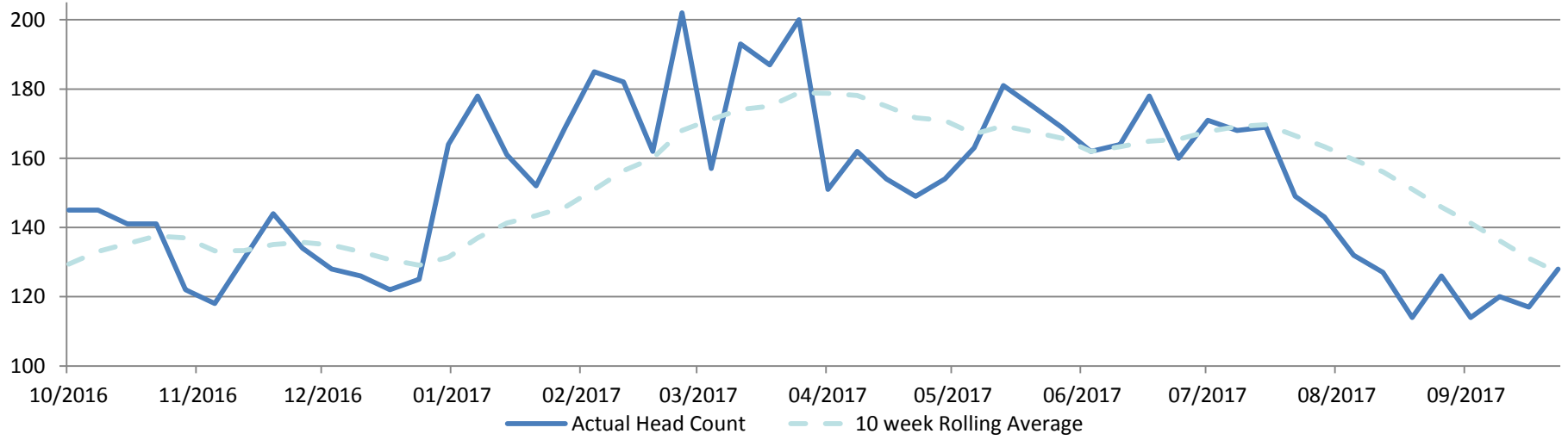
Oxfordshire DToC Head Count from weekly snapshot and 10 week rolling average (13/10/16 - 05/10/17)



DToC Weekly Snapshot - Head Count

- The Oxfordshire weekly snapshot shows…
  - The total number of delayed patients rose and remained high between January and July 2017.
  - There has been a drastic reduction across the Oxfordshire system in the last few weeks (from July 2017)
  - This has returned the system wide position to below where is was in the same period in 2016.
  - Based on the trend from the previous years it is expected there would be a rise in the head count in Oxfordshire through the winter period. Our agreed trajectory is 99 in November to 83 in March.

Current performance (DTOC)

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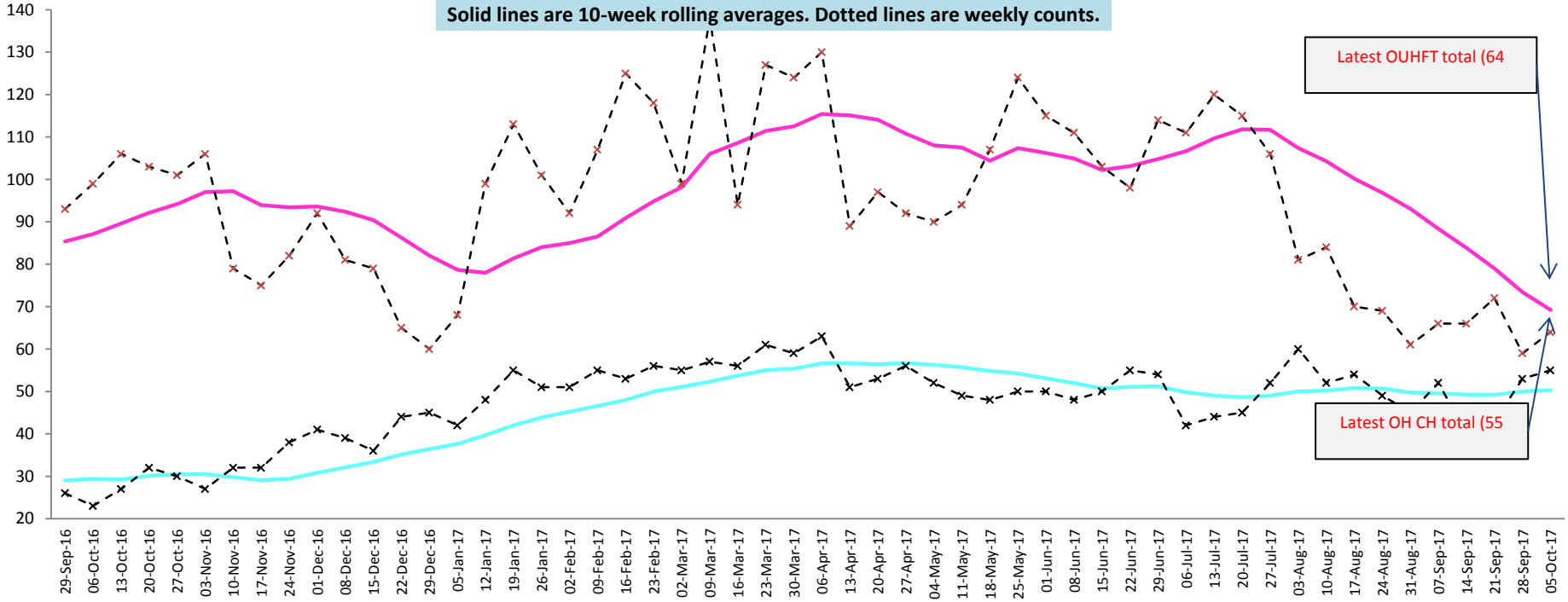
Chart 2a: Delayed transfers of care at OUHFT and at OH CH
Solid lines are 10-week rolling averages. Dotted lines are weekly counts.



DToC Weekly Snapshot – Head count by Trust

- The Oxfordshire weekly snapshot by trust shows both NHS Trusts in Oxfordshire have risen quite sharply over the last year
- OUHFT Head Count is now 50% of the highest point during the previous 12 months
- OHFT Head Count is still higher than earlier in the year.
- The sharp drop in head count at the end of July 2017 was mostly contributed to by OUHFT who reduced the overall head count by a large proportion.

DTOC Trajectory

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151: Aug-17 ✓ - 145

137: Sept-17 ✓ - 120

109: Oct-17

99: Nov-17

97 :Dec-17

97: Jan-18

96: Feb-18

83: Mar-18

Reduction in System wide Head Count

Escalation and on-call arrangements

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Winter Daily Dataset

- Currently the dataset used for daily escalation status determination is a report provided by Alamac (appx. 5).OCCG is in the process of designing a dataset especially for Winter, which would allow to spot risks and challenges earlier. A new dataset will include monitoring of stranded patients, bed occupancy levels, ambulance handover delays etc.

Daily Escalation in line with OPEL Framework

- We have agreed numerical triggers which used to form the basis of the daily escalation declaration, in line with the Operational Pressures Escalation Levels (OPEL) Framework that takes place at 11:00am Monday to Friday. These sets out the procedures across Oxfordshire, incorporating all health and social care organisations to manage day to day variations in demand.
- These triggers provide a consistent and co-ordinated approach to the management of escalation across Oxfordshire where local escalation triggers (appx. 6) have been applied since 2015.
- OCCG Directors on-call will have a training session in November 2017

OUH ED escalation framework now revised and restarted in September 2017

- Weekly system-wide reporting has been developed and monitored carefully within the Trust and through AEDB.
- Focus is on maintaining minors flow both 'in' hours and 'out' of hours – ring fenced staffing and supported by physiotherapy and pharmacist
- Focus on escalation and immediate action which is critical to create and manage flow from ED.

Repatriations

- South Central Onward Care Procedure March 2017. Escalation process in place for repatriations with ongoing monitoring. Escalation to CCG/NHSE and robust mechanisms are required between operational teams across counties to ensure patients are not unnecessarily delayed in their transfer of care to community and social care facility closer to their home.
- Funding of dedicated role to ensure a system whereby no patients are delayed whilst waiting to be repatriated back to their original ward/ DGH with tighter escalation process.
- Priority Northamptonshire to increase presence on HGH site, agree pathways and expectation, agree escalation process to be in place for Winter. Meeting to progress 11/10/17

Business continuity & Winter plans

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OCCG	OUH	OH	Social Care	SCAS
Available from OCCG upon request	Available from OCCG upon request	Available from OCCG upon request	Available from OCCG upon request	Available from OCCG upon request

Director on Call Rota

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Held by OCCG; available upon request

New Initiatives: Pharmacy

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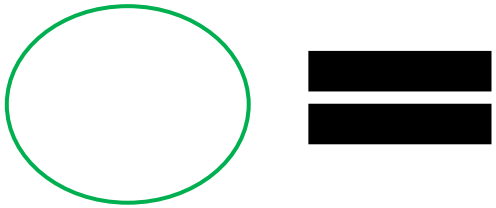

Anything within the green circles are the areas anticipating impacts as a result of the planned initiatives during the winter period

Minor Ailment Schemes and PGD for management of UTI in place through community pharmacies – review and expansion of current schemes to increase availability for winter. This service is profiled to the DOS to maximise uptake.

Managing Demand Reduce ED Attendances

Managing Demand Reduce ED Attendances

Review and re-profiling of Directory Of Services (DOS) to maximise use of Community Pharmacy completed in August 2017. Pharmacy Choose Well Scratch Card Campaign will start in November 2017

Pharmacy services

NHS England in partnership with 111 and the DOS in Thames Valley (Berkshire, Buckinghamshire and Oxfordshire) will go live with the National Urgent Medicines Service Advanced Service (NUMSAS) on Monday 25 September 2017. Pharmacies continue to register to provide the service so the geographical spread of participating pharmacies will increase over the coming weeks. The multiples Boots and Tesco's are starting to register their stores.

New Initiatives: Care Homes

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Pharmacists in Care Homes to support with complex patients and polypharmacy

Medication Review:

This work is underway and prioritises care homes according to non-elective admission rate amongst other criteria. Identifying residents at risk of hospital admission due to adverse drug reactions and reduce inappropriate "polypharmacy"

Admission Avoidance

Specialist Continence Prescribing Service:

Work has begun to commission this service to ensure that all patients with catheters are reviewed by specialists and that any issues are dealt with in a timely manner. Aiming to avoid emergency hospital admissions due to blocked catheters and catheter-related urinary tract infections.

Admission Avoidance
Cost Effectiveness
Quality of Care

Improving Nutrition:

We have a dietitian in post to support both practices and nursing homes to eliminate inappropriate prescribing of nutritional supplements and to promote the *Food First* message.

Quality of Care

New Initiatives: Care Homes

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Enhancing health in care homes

Admission avoidance

Care Home Support Service

Commissioned from Oxford Health Foundation Trust. The Service was first introduced in 2010 as a two year pilot, the provision and commissioning of the service has subsequently continued. We are seeking to focus the support provided by the service to support discharge and management of complex patients so as to improve the capacity and capability of the nursing home sector.

Proactive GP support to Care Homes

Those care homes that have been supported by a GP who has signed up to the scheme there have been demonstrable and significant reductions in NELs; coverage of homes is around 55%. Further work is underway to develop a model of support that will be deployed during 2017/18 to care homes that will enable similar reductions in NELs from those care homes not covered by the scheme.

Oxfordshire County Council is working with CCG and system partners to reduce the number of admissions from care homes. Recruitment underway for a senior joint post overlooking Care Homes. Initiatives include working with the Care Home Support Service to provide support to homes with highest admission rates. Funding dementia specialist nurses to provide additional short-term support to homes when they accept someone with challenging behavior related to dementia.

Appendix 8 – Care Home phone support pilot scheme

New Initiatives: Primary Care

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Primary care: Possible increase provision in hours using slippage in the winter months

Support practices to be sustainable over the winter months	Use of resilience support to those practices highlighted as in need of support	Maximum provision and utilisation of GP access appointments Out of Hours GP appointments offered by the Federations through the Hub model. Services during the week will be scheduled based on reviews of peak out of hours activity and high demand periods in practices. GP services will be available during core hours over the winter period.

Reduced Demand in ED

In Hours

Possible increase in provision

The CCG is commissioning an additional GP appointments on key pressure days that may be delivered through practices or GP access hubs. We expect to also provide additional GP access hub appointments over the winter period to ensure that primary care capacity is maintained over the winter period.

Out of Hours

Federations Hub model (GPAF) Services during the week will be scheduled based on reviews of peak out of hours activity and high demand periods in practices.

Oxford Health Out of Hours service (winter plan – appx. 9) Demand and capacity planning to meet the requirements on days of expected increased demand.

Weekly meetings will be arranged to ensure all these items are being covered off. To provide essential assurance that the service is effectively planning for winter pressures a regular brief weekly update will be provided to commissioners on a regular basis

New Initiatives: Flu

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Flu vaccinations

Action Plan in place to demonstrate how all groups of patients who are entitled to influenza vaccine this season will be able to access a vaccination. This year the system will also be funding Flu vaccination programme for Social Care workers (appx. 10) i.e. domiciliary care and care home workers (approx. 6226 people).

Actions to address low uptake:

Flu vaccinations action plan – appx. 11

Flu vac programme comms plan – appx. 12

Improve Patients outcomes
Reduce Admissions

Oxford health has been commissioned to increase the provision of influenza vaccination for school aged children to include reception and year 4. As this occurs within school hours, it enables school nurses to vaccinate larger numbers of children within specific clinics in school.

Continue the use locality groups to highlight key messages and resources

Communications Plan underway to promote awareness of flu campaign and key NHSE 'stay well this winter' resources through locality groups, GP bulletin and use of social media. Use disease specific leaflets in key areas such as hospital outpatient clinics link with pharmacy.

Dial in to weekly teleconferences to monitor activity and vaccine uptake – use this information to identify practices who are not performing well

Use Immform to monitor activity and identify practices who are performing below the expected level & use last year's cover data to identify key practices where uptake was low and increase communication with these practices, assisting in removing barriers to uptake

Provide maternity services with key resources and materials to support discussions between midwife and women to highlight importance of flu vaccine.

Staff will be asked to sign the forms confirming that flu vaccinations were offered when they decline the vaccination

New Initiatives

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Trusted Assessor

OCC are working with Order of St John (major block provider of care home beds) to pilot a care home trusted assessor model to facilitate access across Oxfordshire to 18 homes October 2017

Agreement of OUH OH Acute to Community trusted assessor model (appx. 13) to be implemented from 16/10/2017

Discharge patient cohorts (appx. 14) and criteria (appx. 15) for use of step down beds

Reduce LOS
Improve Patient Outcomes

OUH MDT decision of needs on discharge → OUH discharge liaison team and SPA agree discharge destination → OHFT Community hospitals accept recommendations and admit the patient

Complex Discharges

Complex Discharges Task & Finish group was set up in August 2017 to improve the way complex discharges are managed; the group is meeting monthly.

The Group is focusing on ensuring consistent approach in applying the Choice policy across the county; purchasing dementia/EMI beds, setting up a complex patients management team and exploring the possibility of extending the scope of Extra Care housing. Learning will be [illegible] the Breaking the Cycle week (w/c 6th November 2017).

Reduce LOS
Improve Patient Outcomes

Terms of Reference – appx. 16

New Initiatives

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Hospital at Home

- Hospital at Home - In advance of Winter 2017/18, we are working with providers to develop effective and universal pathways for referrals and standardised working protocols.. The desired outcome of this work is improve patient pathways and to work collaboratively with all providers and have a proposal acceptable to all which is equitable across Oxfordshire.

Reduce LOS
Reduce Admissions

Third Sector Initiative

- To reduce social admissions and improve discharge we are working with the third sector to support at risk patients such as those living alone, housing, benefits, dementia, self funders. In line with evidence from the hospital to home service is provided by Age UK in St James' University Hospital in Leeds. The service has two arms, one works with patients attending A&E to avoid admission to a hospital base ward, the other provides support to patients who have been admitted to hospital and need support in the discharge process.

Reduce LOS
Reduce Admissions

North East Oxfordshire Pilot for Non-Registered Staff

- Multi organisational training delivered to non-registers health and social care workers
- Initial sessions are based around "Identifying Deteriorating Patients"
- Targeted workforce includes:
  - Domiciliary Care workers
  - Care Home Staff
  - Carers

Reduce LOS
Reduce Admissions

New Initiatives - SCAS

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SOS Bus

- A dedicated ambulance vehicle stationed in the centre of Oxford to care for and respond to alcohol related incidents and minor injuries. The vehicle will be crewed by minimum of 2 SCAS clinicians, a RAF emergency nurse and a SCAS non-clinician. The vehicle will attempt to See and Treat as many patients as possible without then referring these patients onto the A&E department
- Cohort of patients: Alcohol related incidents including minor injuries. Most likely young adults but not restricted to any age range
- Timescale for Go-live: Friday 10th November 2017 - Monday 7th January 2018 every Friday and Saturday evening from 22:00 - 05:00 and major event days (e.g. new years eve)

Reduce ED attendance; reduce demand 999 demand

Increase PTS Support to ED

- Dedicated Discharge vehicles during core hours Monday to Friday to support the acute Trusts and the pull of discharges and transfers back into the community as well as supporting increased activity out in the community hospitals. Resource to be managed directly by the OUH Bed Managers team with the crew recording details of journeys on paper and these being entered retrospectively onto our system for data collection and reporting purposes.
- Timescale for Go-Live (subject to funding approval): Monday 30th October 2017 - Friday 2nd March 2018
- Impact: This would largely impact A&E and EAU within the OUH sites however will also support discharges out of medical and surgical wards as required and determined appropriate by the OUH team. (A&E 4 hour target, NEPTS Discharge Pick Up). This would give greater resilience and make it less likely that any patient journey will be declined, as well as faster discharges out of the acutes to assist with patient flow, pressures at ED and other critical departments within OUH sites.
- Cohort of patients: Patients requiring transport for discharge out of A&E, EAU and other critical wards across OUH sites

Improved flow

Front door

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New process in place for receiving and managing ambulance stream

- inclusive of timely observations and cue cards. Implementation of the Medical Rapid Nurse Assessment (mRNA), supporting and enhancing the RNA process introducing a senior decision maker at times of surge. On-going review of the nursing and medical staffing models to ensure they are sufficient to meet dynamic clinical need, responding to the varying levels of patient acuity and activity in the Emergency Department. Deployment of safer care bundle, handover review between lead clinician and Senior Nurse.
- All patients who present via ambulance services are triaged and assessed within 15mins of arrival. In addition to this, patients are signposted as Sepsis, trauma over 65yrs etc. This is to ensure that the high risk patients are seen by senior decision maker within 30 mins or earlier of arrival.

4hr performance

Mental Health Capacity and Crisis Management

- Patients presenting to the Emergency Department with mental health conditions requesting specialist input are reviewed by the Emergency Department Psychiatric Service (EDPS). Patients are seen within 60 minutes in JR and 90 minutes in HGH once the patient is fit for assessment.

4hr performance, Improved Pathways

Clinical Coordination Centre

- Available to primary care clinicians, ambulance clinicians and to clinicians supporting care settings such as care homes and community hospitals. Operates for extended hours seven days a week. Senior clinical decision makers accept calls directly proactively working with referring clinicians to better determine the appropriate service, timing and venue of care, aiming to avoid reactive, non-patient-centred hospital attendance whenever appropriate e.g. Ambulatory Assessment Units (AAUs) on the same or the following day with pre-arranged diagnostics, rather than attend EAU or ED immediately, unscheduled and without prior workup.
- From October - Mobile phone held by a consultant in Acute Medicine, Trauma, Gastro, Emergency Surgery, ENT, Plastics, Cardiology, Oncology and Urology 0900-2100 7/7

Reduce Admissions

Primary Care Streaming

- Phased Implementation from December 2017
- Primary Care Streaming - It is imperative that the OUHFT fully embraces the potential that ED Streaming brings, given the requirement to provide sustainable Urgent Care and to achieve 90% of the performance standard in 2017, maintaining this as a minimum until achieving 95% by March 2018. Recruitment has commenced for Acute Interface GPs, offering portfolio job plans.

4hr performance

Community and intermediate care services respond to requests for patient support within 2 hours

- The re-tendered Urgent Response and Telecare Service is up and running. New service started with DANA on the 18 Sept

Reduce Admissions

Improving Patient Flow

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4hr Performance, LOS Reduction, Improved patient flow and outcomes

OUH Urgent Care Pathway 2017/18 – Improving Patient Flow Plan

- Presented to September A&EDB & outlines the case for a continuation of the transformation in Urgent Care. Adoption of good practice in patient flow (the ability of systems to manage patients effectively and with minimal delays as they move through stages of care) is essential. The drivers for change are growth in both *need* and *demand* for 'hospital services' together with a change in the nature of each. This detailed plan describes pragmatic delivery of the on-going requirements of a safe and responsive urgent care service which demonstrate an emphasis on value-adding activities, given known workforce and financial constraints.
  - Pre hospital pathway support – to primary care, SCAS.
  - Physician in reach into ED (between peak ambulance arrival period 1300 – 2000hrs) and streaming direct to specialty. In addition at times of extreme congestion there is an urgent need for streaming of patients direct to specialty following triage in the ED to avoid over-crowding and to improve patient care and experience. A standard operating procedure covering those specialties that interface most frequently with ED is in place.
  - ED Staffing – Acuity and Dependency exercise completed and expected to demonstrate increase nursing needs and increase consultants at peak times in order to enhance capacity for timely management of patients in ED.

Introduction of Emergency Frailty Team

- Integrated team from HART, Acute Hospital at Home and therapists
  - AAU medical support
  - Active in reach to ED, EAU and AAU to assess frail patients quickly, and 'Discharge to Assess'

Improving Patient Flow

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ED Paediatrics

- Attendances by children to ED in Oxfordshire are about 25% of all ED attendances and are increasing annually. Following collaborative work between the Emergency Department and Paediatric Medicine there is a proposal to reconfigure the Paediatric Emergency Department (PED) to integrate relevant specialist resources. The case for change is one of an improvement in performance, a reduction in admissions and improved quality – addressing CQC requirements of improvements to privacy and confidentiality, patient flow and multi-disciplinary working. The proposal is at an early stage and requires further work, but offers the prospect of improved value, performance and patient experience. In the immediate term an additional PED navigation nurse with no clinical duties at the busiest times of day between 12.00-24.00 will work alongside the Paediatric/PED consultant to manage patient flow.
- Paediatric Navigational Nurse with no clinical duties to work mid day to mid night to manage flow alongside the PED Consultants (25% of ED activity is children)

4hr Performance, Improved patient flow and outcomes

Full Capacity Protocol

- A Full Capacity protocol has also been implemented. This effectively means that a patient awaiting admission from ED or EAU would to sent to the admitting ward at times of extreme pressure, to 'board', pending the discharge of another patient.

SAFER Bundle

- SAFER implemented with MRC; NOTTS and SUON divisions. OCCG visited some wards within MRC and NOTTS to review how SAFER was implemented and how it had been embedded.

Improved patient flow and outcomes

Expand resus capacity

- This will expand the capacity in resus and ambulatory major capacity access to dedicated imaging to ensure fastest possible diagnosis and treatment to reduce congestion

Reconfigured medical model

- Acute (first 48 hours), Complex (multimorbidity) and Ambulatory (same day) Medicine.

Improved patient flow and outcomes

Improving Patient Flow

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Real Time Bed Management

- Real Time Bed Management system not in place. OUH working with Cerner and IM&T colleagues to review Cerner bed board. Once agreed it will take at least 6 months to implement. – no timescale commitment given.

Management and monitoring bed occupancy and stranded patients

- Discharge coordinators in EAU to support achievement of 12 hour policy

Monitored through daily SitRep

Reconfiguration of Acute General Medicine with named consultants supporting:

- Acute Medicine (EAU and short stay wards)
- Complex Medicine (including Frailty)

End of Life

In Hours	Out of Hours
• End of Life Matron Service • Katharine House Hospice • Marie Curie Night Service • Fast track Coordination of Marie Curie Night Service (in hours) • Sobell House Hospice • Sue Ryder • Kate's Home Nursing • Lawrence Homes Nursing • CRUSE	• Urgent Care Out of Hours service • Hospital at Home • Marie Cure -> Fast Track Coordination • Sobell House Hospice

Discharge

Medication on Discharge

- Implement "one stop" ward rounds whereby TTOs and ordering of test are undertaken at the time of review rather than after the ward round.
- In addition, TTO listing is now live in Trauma and stroke units (JR site) and 7C. The ePMA discharge summary has been updated for the new process i.e to show TTO list has been signed off by the doctor. This enables the TTOs to be physically handed over to the patient. This pilot will be rolled out across the trust.

Discharge

Oxfordshire Clinical Commissioning Group

Seven-day discharge capabilities

- Oxfordshire is committed to improve the availability of health and social care services 7 days per week, particularly where they support discharge and prevent unnecessary admission. The system carried out an exercise to scope to what extent the 7 day working arrangements are in place and the findings were as follows:
- 1. All organisation have plans in place to extend routine working across a 7 day week;
- 2. OUH is a National Early Implementer for 7 day working. The Trust ensures that ward rounds take place twice a day (inc. weekends and Bank Holidays). Availability of diagnostics and pharmacy has been increased at weekends and there are plans to extend further;
- 3. The majority of Oxford Health services operate 7 days per week from 8.00 a.m. to 10.00 p.m. as a minimum;
- 4. Adult social care has recently improved operations at weekends across acute and non-acute inpatient bedded areas, within emergency multidisciplinary units and Emergency Departments.
- 5. A number of care agencies and residential care providers have a more flexible approach supporting the system at the weekend and particularly during high demand holiday periods.
- 6. Oxfordshire is working with NHSE as part of the Winter Review Group to develop Standardised Operating Procedures for Discharge.

Discharge

NHS
Oxfordshire
Clinical Commissioning Group

Discharge to Assess

- "Home First" approach when discharging patients from hospital and utilising D2A principles to facilitate discharge for more complex patients - the model is implemented with HART (Hospital Assessment and Reablement Team) being the primary service for assessing people returning to their own homes. Where HART has insufficient capacity, people who would have used this service are being discharged to Hub beds or to another home care agency, DANA, that has been specifically commissioned to provide increased support to HART service. The new model is provided by OUH and is integrated into the Discharge & Liaison Hub and works to improve flow out of hospital and also prevent admissions through the community based service. There have been significant mobilisation problems relating to recruitment and staffing the new service and the system has dedicated significant resource from within the BCF and iBCF to mitigate the resulting pressures and support flow. HART performance mitigations action plan as of September 2017 embedded and trajectory (reduction of DTOCs due to delays in HART) below:

	RAG	Aug			Sep			Oct			Nov			Dec		
		Targ	Act.	Var.	Targ	Act.	Var.	Targ	Act.	Var.	Targ	Act	Var	Targ	Act.	Var.
HART		60	47	-13	58	41	-17									
Total		151	**145**	-6	137	**120**	-17	109			100			97		

CHC Assessment beds

- Continue to purchase dedicated CHC D2A beds for those people who checklist for full assessment in line with the National Framework. These beds will be within the hub bed stock to support the onward assessment and discharge of anyone who does not fulfil CHC criteria on assessment. These beds will be used to deliver the target that no more than 15% of CHC assessments taking place in hospital.

EMI bed model

- CHC and Adult social care budgets will be used to purchase block beds using an established and successful model; looking to block purchase beds in few locations across the county, so that appropriate medical and other support can be built in. The contracting model will build in a Trusted Assessor mechanism to ensure timely flow into vacancies and will have agreed escalation and support protocols to avoid unnecessary NELs

Discharge

Oxfordshire Clinical Commissioning Group

Complex needs beds model

- In addition to the EMI beds, there is a gap of beds for people with complex behavioural needs and/or high level of physical disability. The demand is lower, but these are often the most complex discharges. See slide 23 (new initiatives – complex discharges) for more info.

Hub and hub beds

- Discharge and liaison hub based at the acute trust, overseeing and co-ordinating flow out of hospital, to be extended and will manage dedicated step down beds that will be used as D2A function to assist flow where patients are medically fit for discharge, but do not have rehab needs.

Therapy Support to HART

- Therapists working as part of the MDT team within HART

200hrs of contingency care

- Provider – OH. Started w/c 9th October 2017. OCC is exploring possibilities to procure further 200 hrs of contingency care

Discharge

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Early discharge planning

- Early engagement of patients with relatives and/or carers in hospital for discharge decision and planning;
- Early planning in the community in preparation of a hospital discharge.

OUH	Oxford Health	Social Care
Discharge planning starts on the day of the admission; patient is also given a "Planning your discharge" leaflet upon admission. Daily board round with the MDT reviewing the EDD and providing regular communications with families to agree discharge plans are in place. Carers are kept informed of expected date of discharge and ward staff refer and discuss patients with community team during the discharge planning process. Contact assessment (Section 2) sent within 48 hours.	Discharge planning starts on the day of admission. Daily board rounds with the MDT reviewing the EDD and providing regular communications to families/carers to agree discharge plans. Weekly review of all patients who are MDT-fit and awaiting support to return home or onward placement.	Social workers involved in MDT for daily board rounds where EDD is set and reviewed. Social care input provided on discharge plan where required. If care is required, planning begins for sourcing once contact assessment (Section 2) is received. Two new social work posts to work with MDT in "Front door" 7 days per week identifying/arranging alternatives to admission & intelligence re those people who will need social work involvement once medically fit.