Oxfordshire Joint Health and Overview Scrutiny Committee

Date of Meeting: 21 June 2018

Title of Paper: Update Oxfordshire Health & Social Care System Winter Plan 2017/18

Purpose: The following paper aims to provide the Oxfordshire Joint Health and Overview Scrutiny Committee with evaluation on the delivery of the Oxfordshire Winter Plan 2017/18. Partners in the system include:

- GP Federations
- Oxfordshire County Council
- Oxford Health NHS Foundation NHS Foundation Trust
- Oxford University Hospitals NHS Foundation Trust
- Oxfordshire Clinical Commissioning Group
- South Central Ambulance Services NHS Foundation Trust
- Age UK and the very wide range of social care and third sector providers

Senior Responsible Officer: Diane Hedges, Chief Operating Officer, Oxfordshire Clinical Commissioning Group

Update on Oxfordshire Winter Plans 2017/18

1. Introduction

In November 2017 a paper on the Oxfordshire health and social care system wide winter plans was presented to JHOSC. This document is an evaluation report of that plan.

Key priorities for the health and social care system are:

- Pathways and flow – how patients access and move through services
- Managing demand – ensuring the right services are available at the right time
- Achievement of the Accident & Emergency (A&E) four hour target – people attending A&E to be seen, treated and either discharged or admitted within four hours
- Delayed transfers of care – reducing the numbers of medically fit patients delayed in hospital
- Workforce – recruitment, development and retention of staff
- Ensuring Primary Care capacity and resilience
- Securing value for money

In line with the recently published Kings Fund report it has been widely acknowledged that the winter of 2017/18 saw the NHS in England experience extreme – and possibly unprecedented – pressures. Health Secretary Jeremy Hunt himself admitted that the pressures on the system meant it *"probably was the worst ever"* winter for the health service.

NHS England Chief Executive Simon Stevens said at the Nuffield Trust Health Policy Summit that February 2018 was probably the *"most pressurised month the NHS has seen in its nearly 70-year history"*. This report notes that substantially more patients attended A&E – roughly 5.8 million in the winter months in 2017/18, compared to just under 5.6 million the year before – an increase of 5%. Over the past five years A&E attendances in the winter months have grown by 13%.

In line with this, urgent care activity across the Oxfordshire system has continued to increase often above planned levels and as such has placed significant challenges on the system to manage patient care safely and in a timely way.

This report is presented as three stages of a potential patient journey – hospital avoidance, in hospital and out of hospital.

2. Hospital avoidance

Our hospital avoidance plans and services have helped us to support patients to remain in their own home and avoid hospital attendance or admission. This included a range of services listed below.

2.1 TV Integrated Urgent Care (IUC) 111

The Urgent and Emergency Care Review led by Sir Bruce Keogh proposed a fundamental shift in the way urgent and emergency care services are provided, improving out of hospital services so that we deliver more care closer to home and reducing hospital attendances and admissions. Put simply

"If I have an urgent need, I can phone a single number (111) and they will, if necessary, arrange for me to see or speak to a GP or other appropriate health professional – any hour of the day and any day of the week"

The NHS England Integrated Urgent Care (IUC) vision has two fundamental parts:

- For those people with urgent but non-life threatening care needs we should provide a highly responsive, effective and personalised service that delivers care as close to home as possible, minimising disruption and inconvenience for patients and their families.
- For those people with more serious or life threatening emergency care needs, we should ensure they are treated in centres with the very best expertise and facilities in order to maximise the chances of survival and a good recovery.

In line with this South Central Ambulance NHS Foundation Trust (SCAS) formed an alliance with Berkshire Healthcare NHS Foundation Trust, Oxford Health NHS Foundation Trust (OHFT) and Buckinghamshire Healthcare NHS Trust to deliver a newly commissioned IUC Service which went live from 5 September 2017 across Thames Valley.

For the first month of the service SCAS achieved call answer performance of 94.46% for the TV area as a whole, with Oxon delivering 94.34% answered within 60 seconds. The abandonment rate (patients who hang up before their call is answered) was below that national requirement of 5%.

Performance against targets fell during the winter period in part due to increased demand and patient acuity levels exacerbated by a rise in staff sickness and a requirement to support a high level of national contingency measures.

SCAS received additional funding of £100k to provide additional clinical resource. Half of this funding was used for clinicians who were sourced through their private provider delivery partner. This clinical resource was focussed on enhanced clinical assessment for A&E dispositions and 999 ambulance referrals. However it must be noted that in times of extreme pressure with call waiting to be answered, these clinicians were deployed to call answer duties. The remaining funding was used on IT equipment to enable an additional GP to work within the IUC Service. This GP was only able to provide one session for the Oxfordshire area.

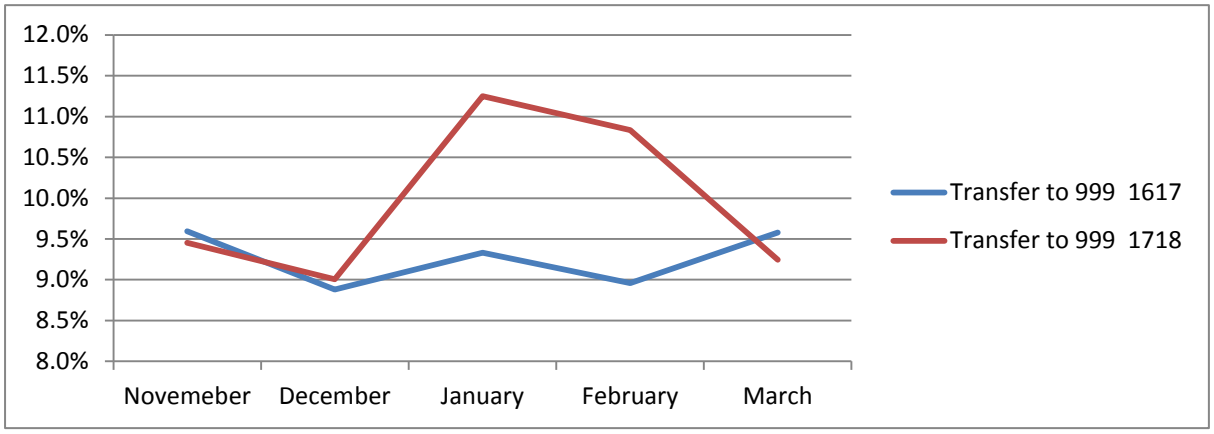
		Nov-17	**Dec-17**	**Jan-18**	**Feb-18**	**Mar-18**
	IUC Performance indicators	**Oxfordshire**	**Oxfordshire**	**Oxfordshire**	**Oxfordshire**	**Oxfordshire**
NCI-2	Abandoned calls (target <5%)	0.67%	7.53%	2.58%	1.55%	5.04%
NCI-4	Call waiting time (target 95% < 60 seconds)	93.14%	64.84%	81.85%	83.98%	64.54%
NCI-9	Transfer to 999 (target <10%)	9.45%	9.01%	11.25%	10.83%	9.25%
NCI-10	Attend Accident and A&E Type 1 & 2 (target <5%)	5.36%	4.66%	6.53%	6.33%	6.16%

The Thames Valley IUC contractual target for 999 referrals is 10%. As can been seen from the table above, January and February were in excess of this for Oxon. These months were due to demand levels and associated winter symptom acuity but also it must be noted that NHS England, made changes to the denominator metric for this target. This changed from

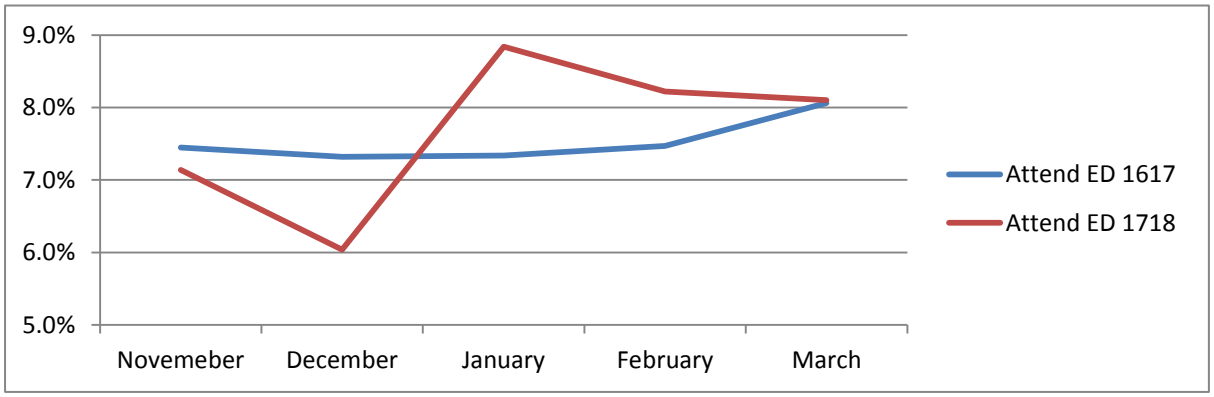
measuring the transfer rate from calls answered to calls triaged. The service tracks nationally at circa 2% lower than the national average of around 12%. Nationally this demonstrated many services being in excess of 12%. The table above clearly demonstrates an improved picture for March 2018 and this continued throughout April and May 2018. This is due to symptom acuity reducing and also more importantly to a new mandated NHSE initiative for all Category 3 and 4 (not life threatening 999 calls) ambulance disposition calls to be held in a queue for clinical validation by a clinician (GP as well as clinicians) to validate the appropriateness of an ambulance referral prior to transferring to the ambulance service. At the outset of this initiative, NHSE guidance stated that these calls can be held for up to 15 minutes, this has now been extended to 30 minutes.

A&E type 1&2 dispositions (emergencies), as can be seen above, are in excess of the 5% target, however, the IUC clinicians and the GPs are reviewing A&E referrals and a similar process for A&E dispositions is being implemented to reduce this referral rate. SCAS has implemented technological changes to the Adastra clinical record management system that is used and will enhance this further to demonstrate improvements to support the local health care economy.

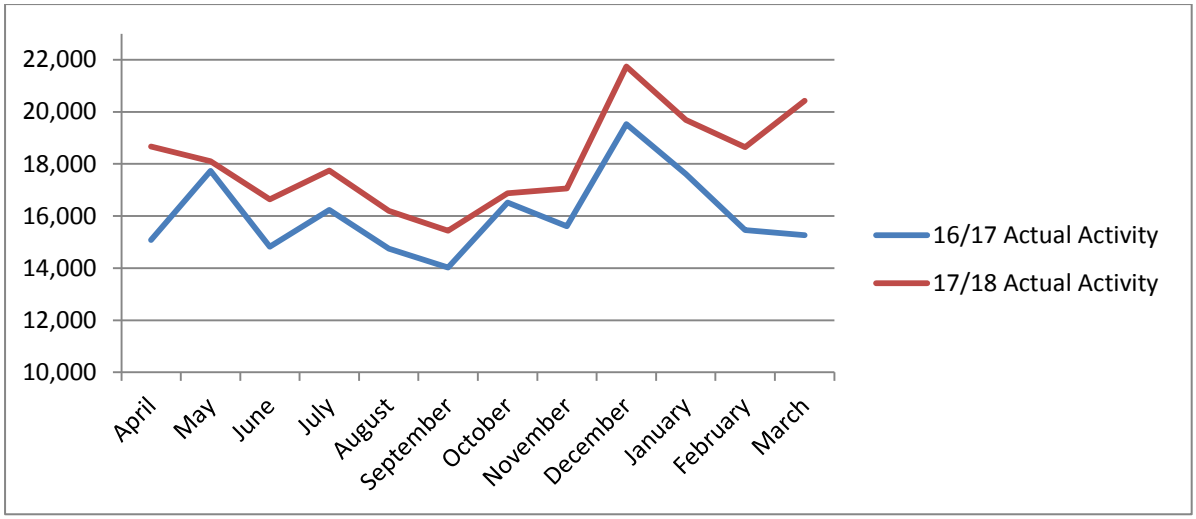
The chart below shows the percentage of calls transferred from the Thames Valley IUC 111 service to 999:



The chart below shows the percentage of calls advised by the Thames Valley IUC 111 service to attend an A&E department:



The increase in activity within the Thame Valley IUC 111 service is shown below.



Since going live in September 2017, the service has included other provision such as pharmacists, mental health practitioners, palliative care and third party providers.

The service is also working closely with partners in primary care for direct patient appointment bookings into GP access hubs and Minor Injury Units (MIUs).

There is currently an action Plan in place which is being monitored at SCAS Executive level every two weeks. The main challenges within the action plan are workforce numbers and abstractions.

2.2 Additional ambulance service support

The Oxford SOS Treatment Centre (SOS bus) ran every Friday and Saturday night in Oxford city centre with an additional service provided on Sunday 31st December 2017. A total of sixty three presentations were treated compared to a total of eighteen during the same period in 2016/17. Of the sixty three presentations only fourteen patients required further assessment or treatment at the John Radcliffe Hospital equating to a non-conveyance rate of 78%.

The Patient Transport Service (PTS) was increased between the 20th December 2017 and 15th January 2018 to support short notice discharges out of hospital sites.

2.3 Increased Services available from Community Pharmacies

A new Minor Ailment Scheme was set up to improve access to support to manage minor ailments providing care and support through community pharmacies went live in November 2017 and saw in excess of 530 patients over the winter period. Due to the success of the project the service is now being expanded to include additional pharmacies in Banbury and Oxford City from June 2018.

Oxfordshire pharmacies have also supported the wider system managing demand with interventions to diagnose and treat manage urinary tract infections (84 consultations) and increasing the use of NHS Urgent Medicine Supply Advanced Service (NUMSAS) pharmacies to provide repeat prescriptions out of hours . The NHS Urgent Medicine Supply Advanced Service (NUMSAS) commenced September 2017 in Thames Valley as an additional service to provide repeat prescriptions. It is fundamentally a service that manages a referral from NHS 111 to a community pharmacy where a patient has contacted NHS 111 because they need urgent access to a medicine or appliance that they have been previously

prescribed on an NHS prescription. During Christmas 2017 it was noted that many repeat prescriptions were still being directed to Oxfordshire OOH services and 111 were not utilising the designated pharmacies. A task and finish group was established to perform a concentrated piece of work with 111 to improve this. In January 88% of repeat prescriptions were being directed to OOH and only 12% to the pharmacies but by the end of May, following the work of the group, the balance had changed significantly with 51% being directed to pharmacies.

2.4 Primary Care

Primary care continues to face particularly challenging times with

- Shortage in workforce and difficulty recruiting staff
- Increasing demand for same-day access for urgent care
- Increasing pressure in managing complex, frail or elderly patients
- Vulnerable practices and practice sustainability.
- Areas of significant housing growth and population increase.

In order to ease demand pressures in the system, Oxfordshire Clinical Commissioning Group (OCCG) commissioned an additional 2,036 primary care appointments during the winter period. These consisted of 1,713 GP appointments and 323 ANP/Practice Nurse appointments at a total cost of £81,400. 91% of the appointments were used. Additional appointments were created through the GP Access Fund (GPAF).

2.4.1 GP Access Fund

The GP Access Fund was created to increase capacity within GP surgeries to enable primary care to meet additional needs across the county and release GP time to spend on complex patients where they can make most difference to outcomes. The services provided include:

- Weekday practice-based hub offering face-to-face services, 18:00-20:00, with at least one GP and one other clinician (nurse/HCA) in all localities.
- Saturday Hub service, 09:00-12:00, with at least one GP and one other clinician. (GP/nurse/HCA) in the city and Banbury.
- Sunday Hub service for 3 hours in the morning, with at least one GP in the city and Banbury.

The volume of appointments required is calculated at 30mins/1000 patients. Converted to appointments this equated to an additional 74,532 appointments across Oxfordshire in 2017/18.

The table below shows appointments available and utilisation against this target for the period April 2017 – March 2018 (Inc.). The utilisation (% Used against required) has now increased and being maintained to greater than 80% across all federations. Utilisation will continue to be reviewed with the aim of capacity being matched to patient need.

All Federations Analysis	Total Available	71918
	Total Appointments Used	53851
	% Total Available Appointments Used	75%
	Total Appointments Required	74532

	% Available Appointments of those required	96%
	% Used against Required	72%

2.4.2 GP workforce

There is currently a shortage of GPs and Practice Nurses in Oxfordshire, despite a number of recruitment initiatives.

OCCG is currently supporting the recruitment of an additional 20 GPs from overseas. This process is likely to take some time and may not be in place for winter 2018/19. As such there is a focus on releasing existing GP time to support the additional winter demand. As part of this a Health Care Assistant (HCA)/Practice Nurse (PN) training plan is being developed to upskill HCAs and graduate PNs more quickly, so that they can deliver more services thus freeing up GP time. Dependent on Health Education England's (HEE) timelines it is hoped that a significant amount will be delivered before the winter pressures.

2.5 Proactive Medical Support to Care Homes

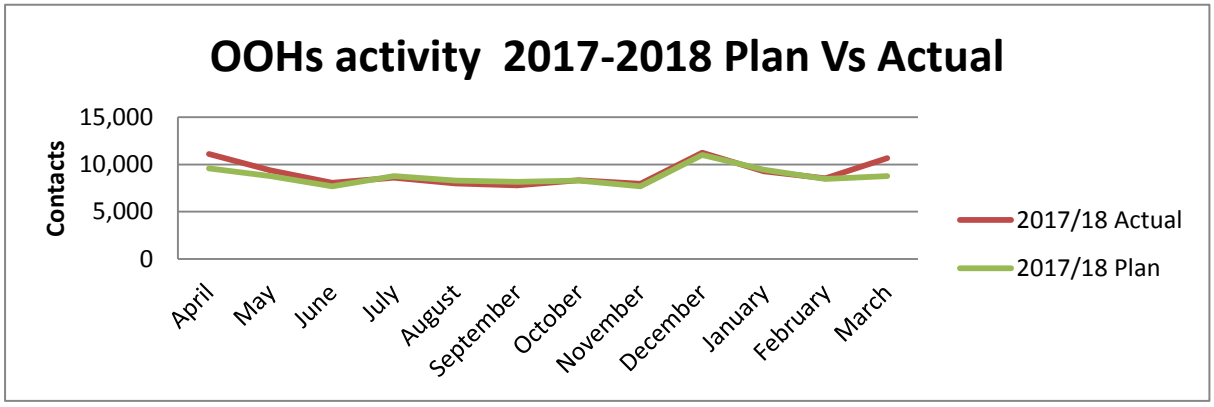
Our proactive medical support to care homes service provides additional GP time and support to care and nursing homes. A&E department attendances for patients in care homes supported by this service fell by 3% in 2017/18 compared to 2014/15; In contrast attendances at A&E from the non-participating home rose by 1%.

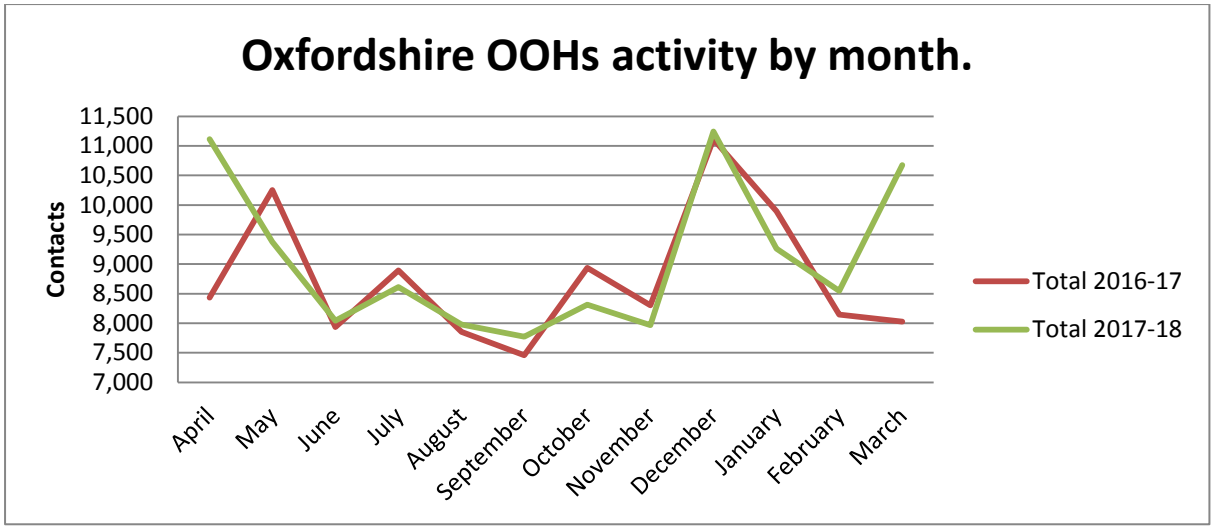
Taking the learning from this work we are now undertaking a review of all services going into care homes to see how they can be remodelled to ensure integrated working between different services and teams, ensuring services are meeting the needs of the residents. A collaborative approach is essential for success.

During this year we are aiming for 100% coverage of homes within Oxfordshire.

2.6 Out of Hours (OOH)

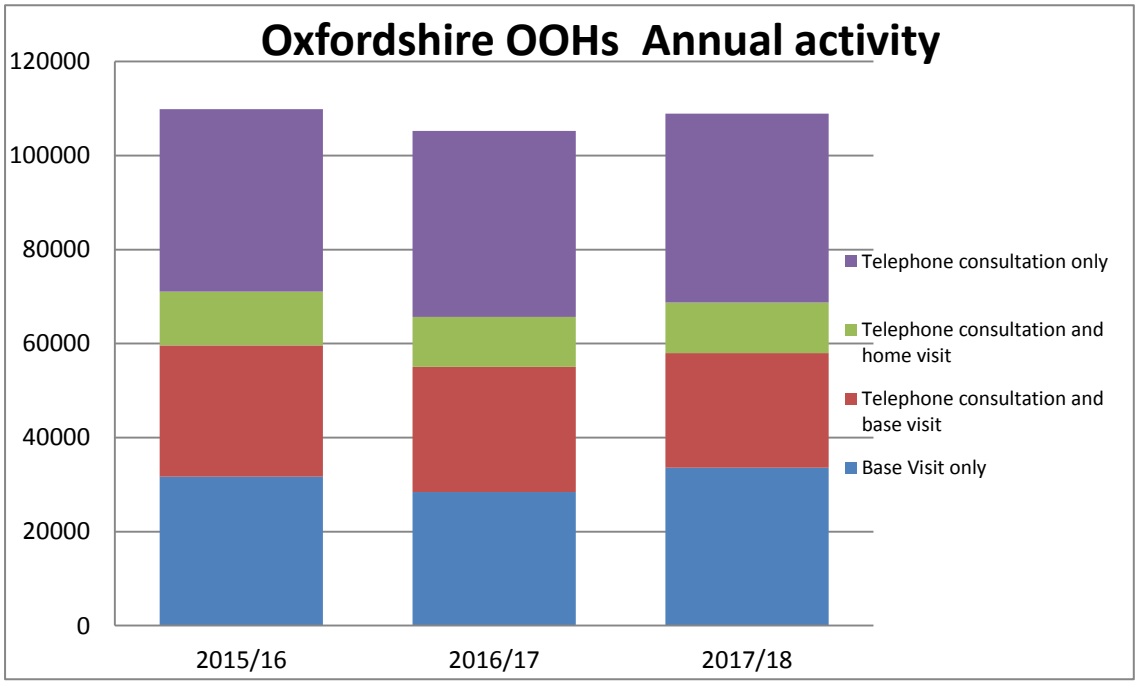
OOH activity was similar to the planned and previous year's activity levels until March 2018 when it saw a spike in contacts. This indicates that the modelling of actual and anticipated demand has been consistent; however the cold weather during March and the protracted winter had a direct impact upon demand.





Most prevalent within OOHs was the increase in base appointments, in particular the number of patients that had an appointment booked directly from 111 via the electronic link providing a seamless service. This increase in directly booked appointments compares to a reduction in patients requiring a telephone consultation from a GP prior to being given a base appointment and is an indication of the confidence that has been achieved in the 111 service.

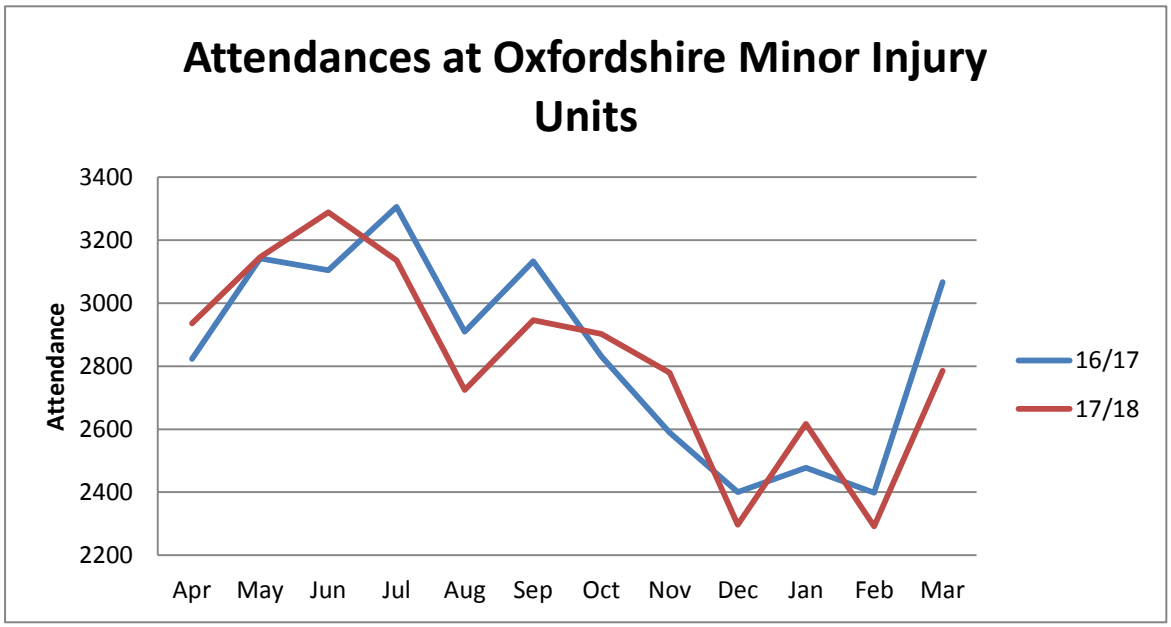
During the past two years, there has been an increased pressure on primary care and new schemes to increase primary care capacity have presented opportunities for GP's. This has challenged the ability for the service to attract GP's leading to the service being unable to cover all rostered shifts. The Trust continues to explore ways in which to encourage take up of shifts and to review different skill mixing insuring the most appropriate clinician for the patient's needs.



2.7 Minor Injuries Units (MIU)

MIU attendances were slightly lower than last year at 33,849 compared to 34,179.

This is a nurse and paramedic led service which has strong links with the Oxford University Hospitals NHS Foundation Trust (OUHFT) and the Royal Berkshire Hospital NHS Foundation Trust (RBH), this has supported the ability for the service to manage more complex presentations and complete treatment without the need to refer onwards. During the winter months activity through the MIU's is slightly lower as shown in the graph below. The seasonal variation is primarily due to the dark evenings and fewer sports related injuries. Lower patient numbers attending with minor injuries allows the MIU clinical staff to support the OOHs service and patients with minor illnesses which tend to increase during winter months.



2.8 Emergency Multi-disciplinary Units

There are two Emergency Multi-disciplinary Units[1] (EMUs) in Oxfordshire. Abingdon EMU is a 9-bed/chair unit and Witney EMU is a 6 bed/chair unit.

The aim of the Emergency Multidisciplinary Units is to provide assessment and treatment for adults with sub-acute care needs as close to patients' homes as possible. Providing medical, nursing and therapist assessments and treatments, the units are designed to offer patients a faster and more convenient alternative to admission to an acute hospital.

Our teams deliver a comprehensive assessment, acute medical diagnosis and treatment plan with ongoing care to support patients and carers during episodes of illness without acute hospital admission.

[1] There are also two ambulatory assessment units based at the John Radcliffe Hospital and Horton General Hospital (see page 19). They also assess and treat patients on a same-day basis so they do not have to be admitted to a hospital bed, which is better for patients.

Located within a community hospital site, the emergency multidisciplinary unit will rapidly assess any patient, following contact with a healthcare provider (for instance, a GP, community nurse or ambulance paramedic) who feels that further assessment is needed.

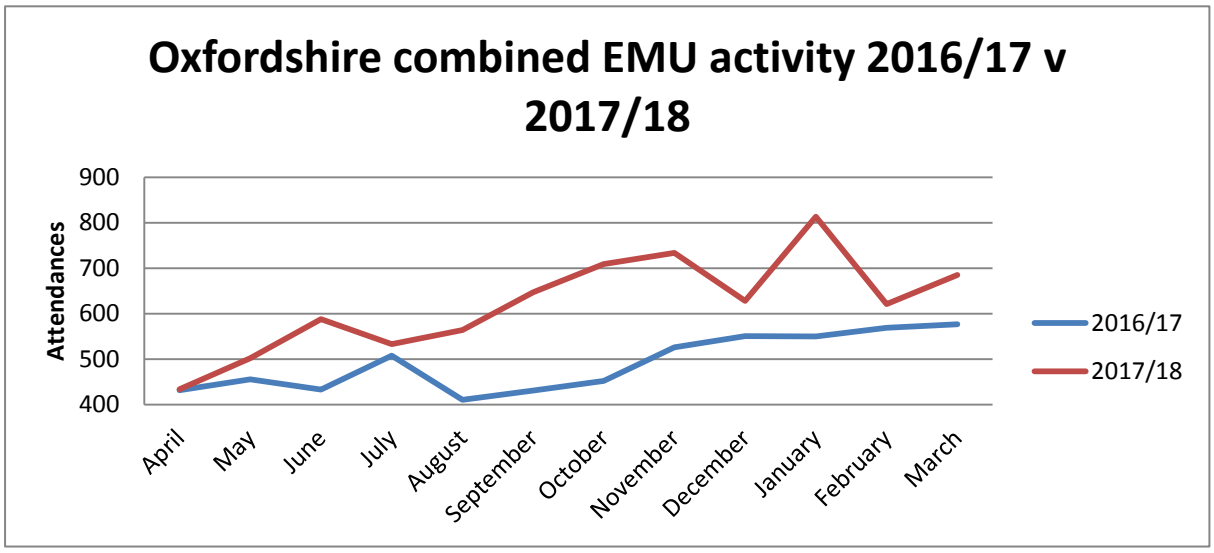
EMUs do not assess patients with suspected heart attacks, strokes, head injuries or those who may require surgical intervention. These will need to be seen at the A&E or as a direct referral to the surgical teams.

There was a 26% increase in total contacts at these units in 2017/18 compared to 2016/17. This equates to an increase of 1562 contacts - averaging 130 contacts per month for both EMUs and with each EMU having an average increased activity of 65 contacts per month.

The average monthly activity in EMUs in FY16/17 was 491 and this increased to 622 in FY17/18.

EMU Activity (Contacts)	FY17/18	FY16/17	Activity variance	% increase in Activity from FY16/17 to FY17/18
Abingdon EMU	4221	3344	877	26%
Witney EMU	3237	2552	685	27%
Total for both EMUs	7458	5896	1562	26%

Monthly activity peaked in January at 813 attendances:



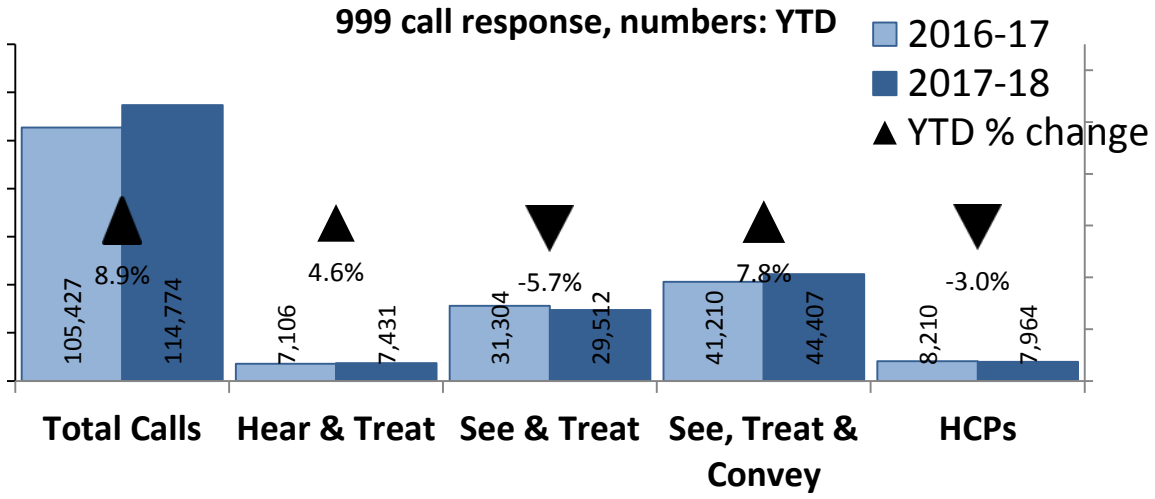
2.9 999

Nationally NHS England have been rolling out the new Ambulance Response Programme. This has meant a change in ambulance targets which came into place locally for SCAS from November 2017. The response targets were amended to ensure the correct response and vehicle was getting to the patient for their clinical needs. The response times are now measured in mean and 90th percentiles rather than percentages as previously. This has been the biggest change to ambulance targets nationally for 30 years and was well managed and successfully mobilised by SCAS. It has required major IT changes, operational policy change, coding changes, staff training, modelling and fleet mix changes.

NHSE have allowed a period of transition in achieving the new targets until September 2018 however the Trust is benchmarking well nationally against other ambulance trusts and has achieved performance at contract level across all indicators in April 2018. The Trust expects to remain on track to achieve performance by the September deadline.

There has been some changing acuity of patients over the winter period which has meant a drop in 'see and treat' activity and an increase in 'see, treat and convey'. This has been challenging for the local acute hospitals, Commissioners are working with the Trust to manage this increase through alternative pathways and additional clinical validation of 999 incidents in the Integrated Urgent Care (IUC) contract. Oxfordshire has undertaken an audit of the ambulance arrivals which will seek to give greater understanding of alternative pathways and actions we can take. The increase in levels of ambulance conveyance is a key area for us to understand for next winter's planning.

The Trust continues to work hard to recruit to vacancies and where there are gaps this is backfilled using private provider resources.



Response times for 999 calls (November 17 – March 18 inc) are shown below:

Category	Cat 1	Cat 1		Cat 2	Cat 2		Cat 3		Cat 4
Target	7 minutes	15 minutes		18 minutes	40 minutes		2 Hrs		3 Hrs
Month	Mean	90th Percentile		Mean	90th Percentile		90th Percentile		90th Percentile
November	0:07:45	0:15:42		0:15:19	0:28:21		1:32:24		2:36:41
December	0:08:34	0:15:59		0:17:35	0:33:10		2:28:43		4:18:49
January	0:07:26	0:14:15		0:16:21	0:31:33		2:02:53		3:04:14
February	0:07:07	0:13:48		0:15:55	0:29:47		1:51:53		2:57:24
March	0:07:18	0:14:10		0:17:50	0:33:39		2:06:53		3:45:38

Overall performance for Oxfordshire, Thames Valley and SCAS for 201/18:

Category	Cat 1	Cat 1		Cat 2	Cat 2		Cat 3		Cat 4
Target	7 minutes	15 minutes		18 minutes	40 minutes		2 Hrs		3 Hrs
Year to Date	Mean	90th Percentile		Mean	90th Percentile		90th Percentile		90th Percentile
OXFORDSHIRE CCG	0:07:40	0:14:54		0:16:41	0:31:39		2:00:48		3:19:23
TV Total	0:07:22	0:13:42		0:16:18	0:32:30		2:18:06		3:27:21
SCAS Total	0:07:20	0:13:21		0:17:25	0:35:05		2:22:58		3:28:33

Engagement continues between the A&E staff and the Ambulance trust to ensure delays are kept to a minimum when handing over patients. Both SCAS and OUHFT have reviewed their handover processes to improve the efficiency of handovers, in an attempt to reduce patients waiting in ambulances and release ambulance capacity for patients requiring ambulances in the community.

The table below shows the cumulative amount of time ambulances are delayed by at each A&E department by month. These figures are in hours per month and do not take into account the number of ambulance arrivals at each department.

Excess Handover	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18
HORTON GENERAL	2:02:05	2:18:32	8:48:20	19:16:35	14:44:44	5:20:19	16:23:46	22:13:18	17:58:31	50:10:02	33:43:45	3:03:01	0:00:00
JOHN RADCLIFFE	79:53:44	74:25:31	96:09:54	89:28:21	105:41:51	95:55:11	121:04:17	101:17:41	131:19:15	156:55:42	156:53:26	121:52:55	131:21:11
MILTON KEYNES GENERAL	117:43:55	88:34:24	57:25:41	67:41:01	48:23:18	22:43:29	59:52:31	72:03:07	150:01:05	231:02:57	159:42:51	124:15:05	128:07:03
ROYAL BERKSHIRE	42:52:56	53:57:34	59:16:47	57:55:48	61:53:53	60:27:19	60:50:28	55:05:31	102:10:10	161:25:41	153:10:40	148:48:24	132:25:47
STOKE MANDEVILLE	65:05:17	61:04:22	98:25:42	101:31:05	100:56:37	125:38:43	81:19:22	97:51:36	106:17:15	207:50:51	131:49:11	119:23:58	153:58:56
WEXHAM PARK	105:26:21	48:39:59	67:31:40	44:33:01	91:15:42	117:31:50	80:19:40	62:58:11	99:55:20	248:28:29	249:07:00	266:18:08	245:48:33

2.10 Mental Health Crisis Response Services - Oxford Safe Haven (OSH)

The OSH is a service provided by Mind and Elmore and offers an alternative (non-statutory) ethos in responding to mental health crisis. It is available for:

- Over 18's living in Oxfordshire
- People experiencing a mental health crisis who wish to access support and could benefit from a supportive, non-clinical environment out of hours
- People who historically may have attended the A&E in the absence of other options for accessing assessment, support and safety
- At risk of self-harm or suicide, but no immediate risk to self or others

The service does not provide for:

- Clients under 18 or living outside of Oxfordshire
- Immediate risk to self or others
- Likely to be disruptive or aggressive in an informal social environment
- In immediate need of medical treatment
- Clients who are significantly intoxicated with alcohol or drugs on arrival will not be admitted

Winter funding provided by NHS England (NHSE) has enabled OSH to be set-up and piloted for 6 months with the intention that it will be sustained and further developed. OSH is provided by Oxfordshire Mind and Elmore Community Services commenced operation in mid-March. OSH is open Friday, Saturday, Sunday 18:00hrs to 01:00hrs and is based in Oxford Health NHS FT premises on Manzil Way in East Oxford.

The main aim of the service is to improve access to, and the overall range of, crisis response services available (in particular in the evenings and at weekends) and to reduce use of urgent and emergency services (health, social care and Police) where other mental health pathways are available. Since opening the service has received 49 referrals and had 32 attendances. Service user and referrer feedback has been overwhelmingly positive including some early evidence of diversion from use of emergency services including the A&E.

Referral pathways are continuing to be expanded with the aim of progressing to self-referral by mid-June. Additionally, service users identified as 'high intensity users' of urgent and emergency services have been specifically focused on in terms of publicising the service with them and supporting their engagement with it. Again, there has been some early successes with this particular approach. Data collection regarding activity and outcomes continues and we are developing a framework for evaluating the impact of OSH using a variety of data sources.

2.11 Mental Health Assessment Hub (Littlemore Hospital site)

The assessment hub offers formal mental health assessment and can be utilised by patients of all ages with all mental health conditions and risk profiles.

Further winter funding from NHSE has enabled the physical environment of the Assessment Hub to be built on the Littlemore site and has funded two clinical staff at Band 6 for one year. A business case for further funding for clinical staff in order to be able to fully operationalise the Hub 24/7 within a defined clinical service model is being developed. The physical environment of the Assessment Hub will be completed on 6th June and handed over to the clinical service.

The Assessment Hub is comprised of two assessment consultation rooms, a comfortable waiting area, clinical office space, treatment/clinic room and toilet facilities. The two assessment rooms have been created with a number of requirements in mind (all ages and all mental health conditions) and can be used flexibly to meet a variety of needs and purposes. One of the assessment rooms has been built to the specification of a Hospital Based Place of Safety (HBPoS) and could be used for this purpose to support existing HBPoS capacity as an 'other suitable place' (Police & Crime Act 2017) where appropriate. This room is also the 'low stimulus' room and would be suitable for people who have sensory sensitivity (for example people with autistic spectrum disorders as a primary or comorbid condition).The second assessment consultation room has been designed to be a comfortable and visually appealing assessment area for young people, adults and older adults and is equipped with tele-psychiatry facilities and opportunities for distraction activities.

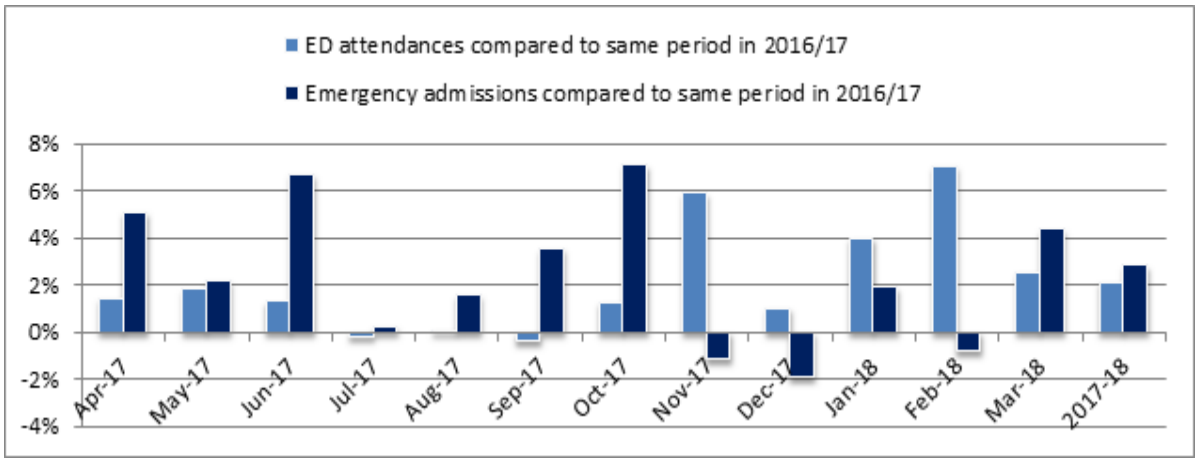
The Assessment Hub replaces the single room emergency assessment facility at the Warneford Hospital 'front door'. The future vision is to be able to undertake all emergency assessments and reviews at the Hub but also to use it flexibly to provide care and support patients who are awaiting their onward step having been assessed in the HBPoS, A&E, Police Custody or other OHFT clinical team base (e.g. awaiting admission or return home with care plan).

3. In Hospital

3.1 A&E activity

In 2017-18, growth continued in the numbers of people attending and being admitted for urgent care. As shown below, in most months of the year there were more A&E attendances and emergency admissions than in 2016/17. There was also considerable variation. The highest number of attendances per day were seen in June and November 2017 and the highest number of admissions per day in January-March 2018.

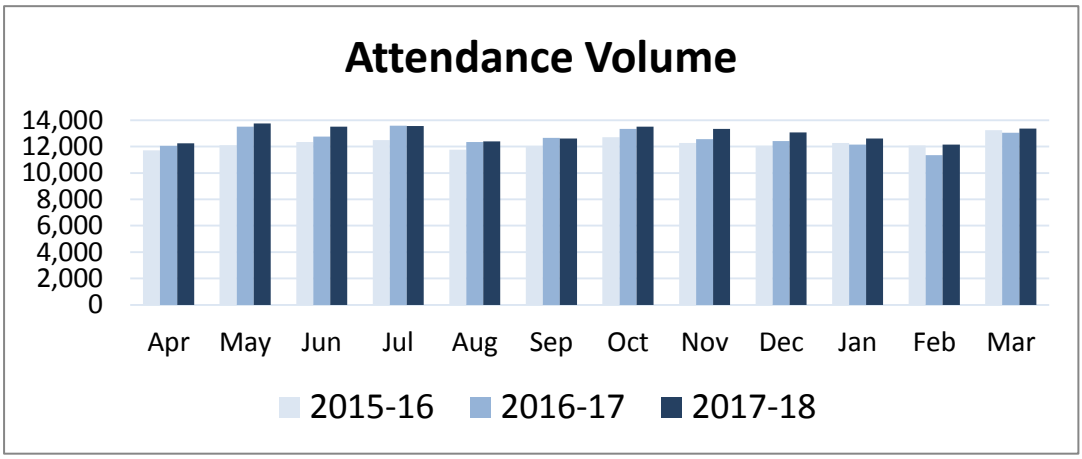
Over the past three years, emergency admissions have grown by a higher percentage than attendances, probably reflecting the ageing population that OUHFT is caring for. The below table shows OUHFT A&E Department attendances and Emergency admissions (Non-elective first finished consultant episodes) per month in 2017/18 compared to the year before:

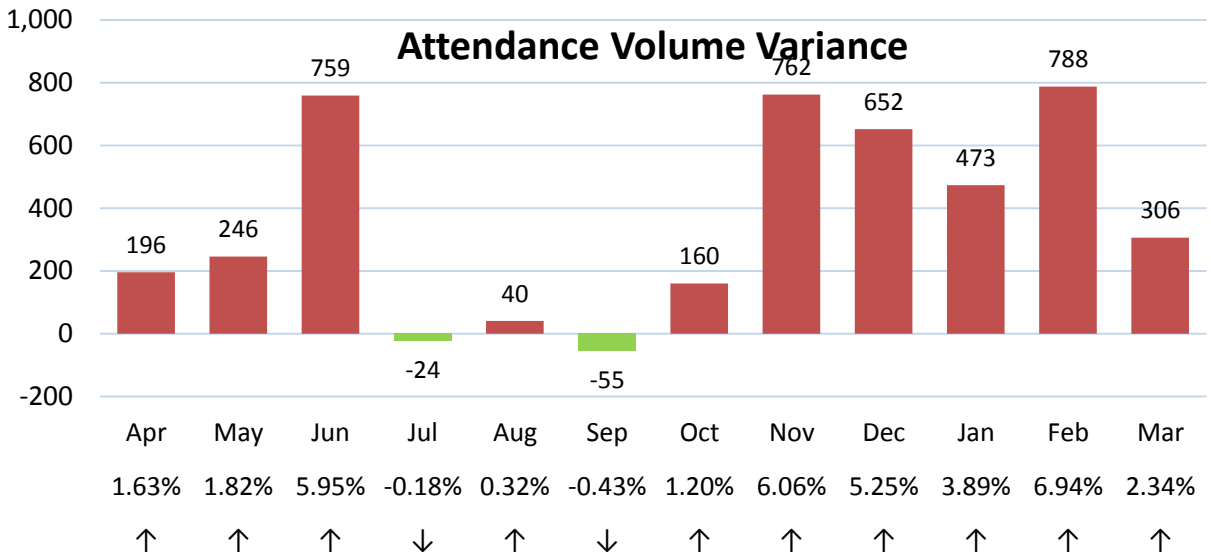


The growth seen by OUHFT in 2017/18 was above that in the NHS in England for A&E attendances (OUHFT 2.83%, England 2.21%) but lower for emergency admissions (OUHFT 2.13%, England 3.71%). This may indicate some success in local measures to provide alternatives to admission.

In November it was reported that A&E attendances for Oxfordshire patients had increased by 1.45% compared to the previous year, this has risen to 2.9% by March 2018.

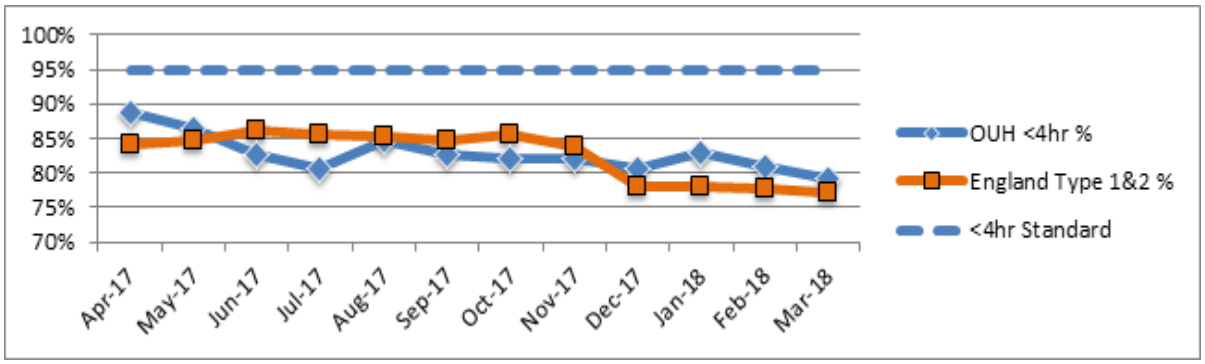
3.2 Attendances





3.3 Four hour A&E target

OUHFT has faced significant challenges in delivering the capacity required to see, treat, admit or discharge people within 4 hours of arrival at its A&E departments. The 95% 4 hour standard has not been met by the NHS in England or by OUHFT since July 2015. As shown below performance reduced during the year. The NHS in England experienced a rapid drop in performance from October 2017, with performance below OUHFT's from December in comparable A&E. The performance since April 2018 has seen some improvement particularly on the Horton Hospital site.



OUH <4 hour wait %, 2017-18, and NHS England performance for Type 1 and Type 2 A&E[1]

3.4 12 hour breaches

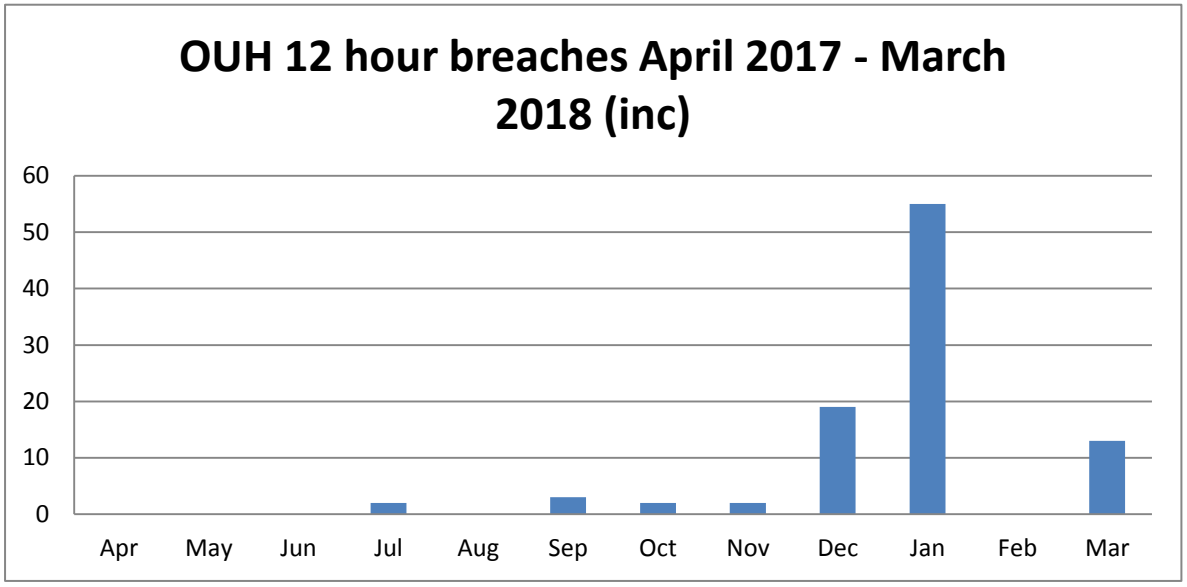
In 2017/18 the OUHFT began to experience 12 hour trolley waits in A&E. This means that there is a period of over 12 hours between the decision to admit and admission. Each breach must be reported to commissioners and investigated.

During January 2018, an unprecedented number of people waited over 12 hours in the OUHFT A&E departments after decision to admit. A further 13 patients waited over 12 hours

[1] Type 1 being 'major' Emergency Departments, as at the John Radcliffe and Horton General, and Type 2 being single-specialty departments as at the Oxford Eye Hospital.

in March 2018. These delays happened at the peak times of pressure on inpatient beds and on services conducting emergency assessment.

It was disappointing that patients waited for such long time to be admitted. Systems have been reviewed and adapted and best practice publicised in the clinical areas involved – focusing on particularly on identifying delays in admission, appropriate escalation of potential 12 hour delays and timely investigation of delays. The Oxfordshire system is also revising the escalation framework to ensure that partner organisations work together to create enough bed capacity or bed equivalent capacity in times of significant pressure.



The OUHFT has undertaken an in depth clinical review of patients waiting over 12 hours in order to establish whether any clinical harm resulted and what lessons may be learned. This review found that these patients had received high quality care with clearly documented maintenance of hydration and nutrition, safe skin checks, prevention of deterioration of pressure ulcers, evidence of clinical review, recording of vital signs, good clinical management and no delays in accessing diagnostics or treatment. The system is assured that while the experience of these patients is not optimal, OUHFT did provide safe, high quality care during these challenging periods.

3.5 Bed occupancy

OUHFT continued to have a high level of bed occupancy through the autumn and winter. Locally and nationally, monitoring began of the numbers of patients assessed as medically fit for discharge but still in hospital as inpatients. Throughout February and early March 2018, 47-57% of OUHFT's General and Acute beds[2] were occupied by patients in this category. From late summer 2017, shortages of nursing staff meant that OUHFT needed temporarily to close some inpatient beds. These staffing-related bed closures particularly affected services at the Churchill Hospital and Nuffield Orthopaedic Centre, with a staff Incentive scheme used to keep adult inpatient beds operational at the John Radcliffe, open additional beds and avoid weekend closures. This enabled the Trust to keep beds equivalent to a ward open on the John Radcliffe Hospital site.

The availability of nursing staff continues to be a challenge to OUHFT. Continuing vacancy rates among ward nurses and smaller but equally significant vacancies amongst theatre

[2] Beds where overnight care is provided, excluding maternity and neonatal care beds.

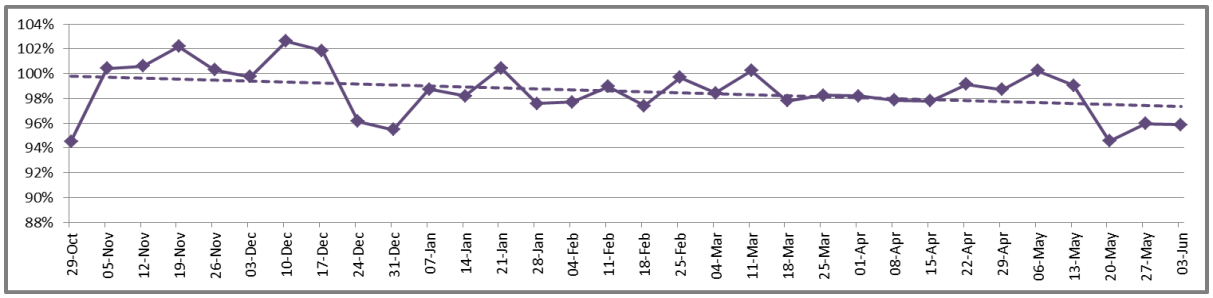
nurses are influencing the capacity OUHFT has available to treat patients requiring inpatient surgery. In concert with system partners, OUHFT is developing its plans for the coming winter which will include how best to make use of the nursing staff it has and how best to minimise vacancies.

On 2 January 2018, the National Emergency Pressures Panel (NEPP) recommended that NHS providers extend the normal reduction in elective activity seen over the Christmas and New Year period, maintaining reductions throughout the month of January where this was necessary to maintain prompt access to emergency care services. OUHFT postponed non-cancer and non-urgent planned surgery for some 100 patients per week until services were able to return to normal by 12 February.

Actions to improve urgent care and shorten waits included changes to the operation of the Emergency Assessment Unit and Short Stay Wards, improved internal communications, close work with system partners on capacity and patient flow and strengthened arrangements for bed management. Learning from experience elsewhere, arrangements were also strengthened for the provision of clinical 'Board rounds' on wards and the review of patients ready for discharge.

Bed occupancy is a key measure of pressure a system is experiencing. It is calculated from the established (funded) number of General & Acute inpatient beds (excluding day case beds, theatre recovery areas, maternity and neonatal intensive care), then adjust the weekly total (denominator) to take account of bed days lost due to short staffing. Levels of over 100% are when additional beds have needed to be opened during the week to accommodate emergency admissions.

The chart below shows the percentage bed occupancy/week October 29th 2017 – June 3rd 2018 (inc)



The National Audit Office has suggested that hospitals with average bed occupancy levels above 85% can expect to have regular bed shortages, periodic bed crises and increased numbers of health care-acquired infections. Occupancy rates for acute beds nationally have increased from 87.7% in 2010/11 to 89.5% in 2014/15 so few hospitals are achieving the 85%.

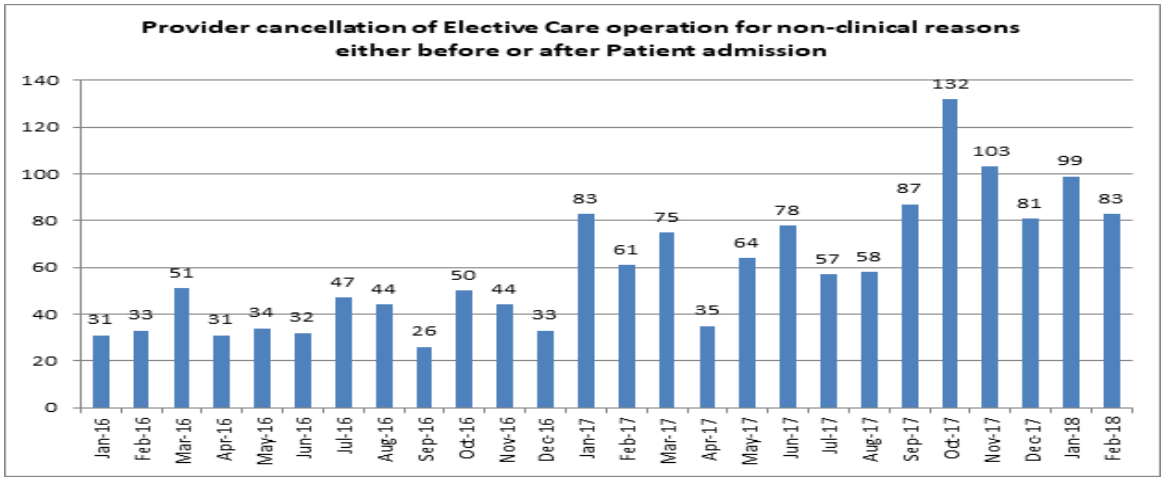
In Oxfordshire we acknowledge the challenge of achieving 85% bed occupancy and have set a local target of 92%. However, as the chart above shows we have not been below 94% since 29th October 2017. This is a key area to improve for next winter.

3.6 Cancellations

Cancellations by OUHFT for non-clinical reasons (not necessarily on the day) rose in 2017, peaking in the autumn at a time when West Wing theatres were experiencing acute

shortages of Anaesthetic Nurse Practitioners. Two of ten Churchill theatres are currently closed due to staff shortages.

These cancellations include those which took place in January and early February as recommended by the National Emergency Pressures Panel (NEPP).

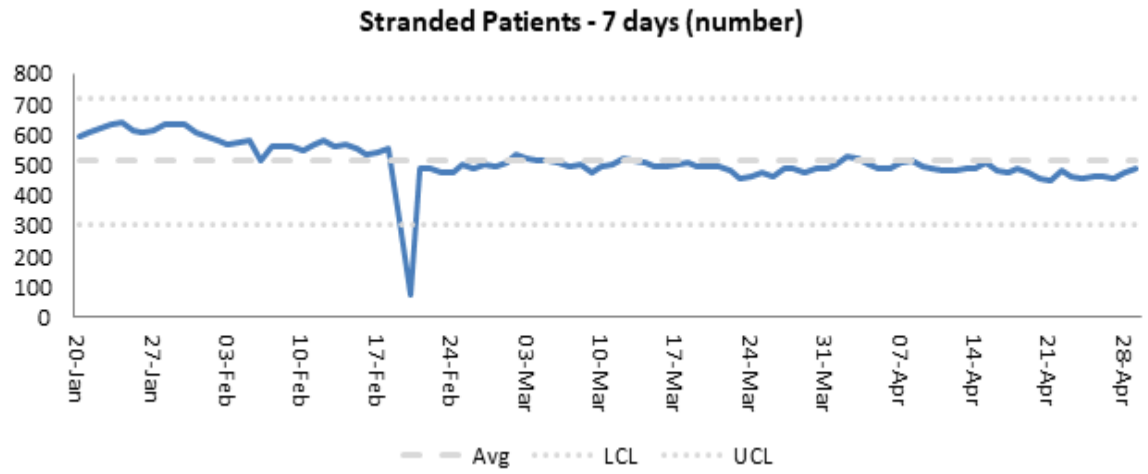


3.7 Stranded patients

During the course of the plan the system also responded to the findings of the CQC review of the Oxfordshire system and further reviews by national teams (ECIP and Dr Ian Sturgess) and adopted a *stranded patient* approach. This model works on the basis that any patient in a bed for 7 days or more is reviewed and plans checked to assure that the patient needs to remain in the bed. Where blocks are identified these are escalated to a senior officer team with the power to deploy resources; and where this level of escalation is insufficient to escalate weekly to CEOs.

This measure is gaining favour nationally as an indicator of how beds are being used, and of the efficiency of local health and social care systems at moving people on from hospital when they are medically fit for transfer. The Emergency Care Improvement Programme (ECIP) defines stranded patients as those with a length of stay of seven days or more.

Systematic weekly review takes place every Wednesday of all inpatients in OUHFT beds to identify those who have been in hospital for at least 7 days and are medically fit for discharge. A process for escalation is in place from wards to the Chief Executive. The number of patients in this group reduced from early February but with a reduction in the overall number of non-elective patients in OUHFT beds in recent weeks, have accounted for a growing proportion of OUHFT's occupied beds.

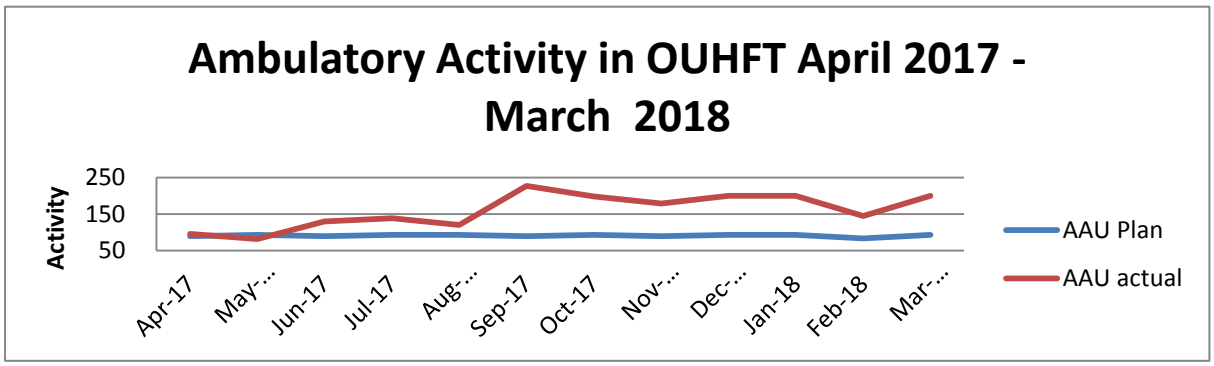


Across the South of England, there has been a slow but steady reduction in stranded patients to 48.88% (7 days) and 18.71% (21 days) (figures from NHS Improvement for 7 June 2018). OUHFT's equivalent figures are 48.86% and 21.34%. The Horton's figures are 53.51% and 24.56%, with the site having been adversely affected by problems in Northamptonshire.

Continuing focus is being given to reducing delays for this group of patients, with work including the strengthening of daily systems for ward 'Board rounds' to maximise the efficiency of discharge planning and actions.

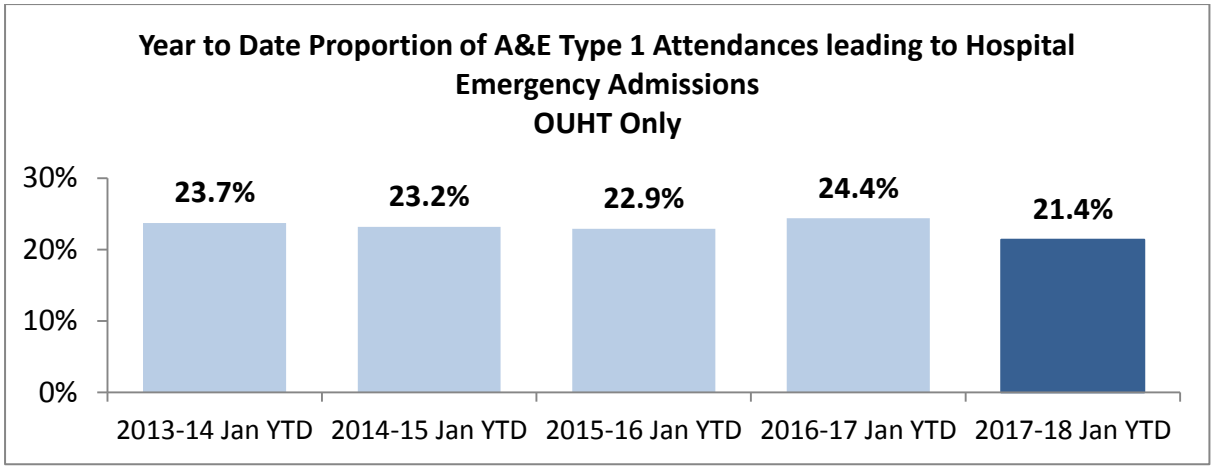
3.8 Ambulatory Care

The number of patients treated in one of the 2 Oxfordshire Ambulatory Assessment Units increased above planned levels. This activity relieved some pressure from the acute hospitals as historically these patients would have been seen in the Accident and Emergency departments.



3.9 Admissions

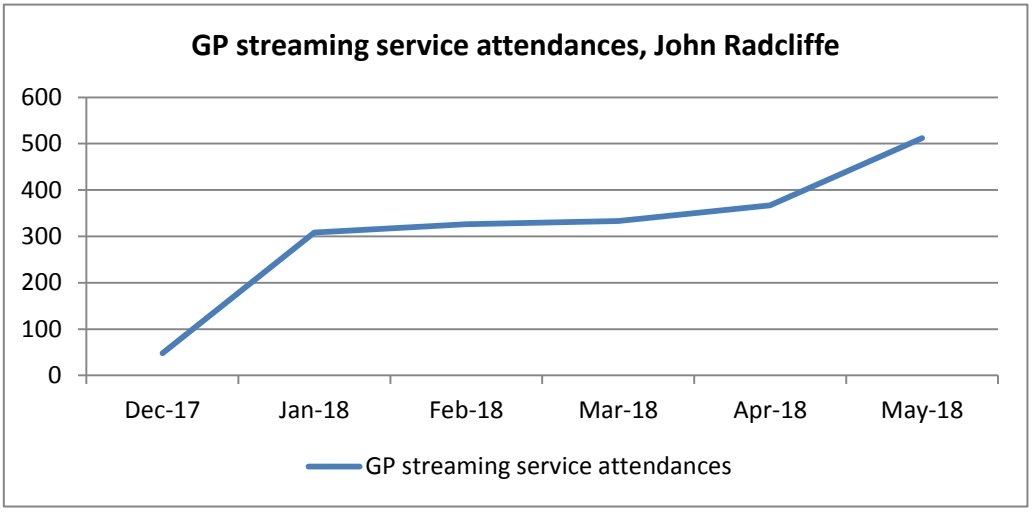
The proportion of people admitted from A&E into a hospital bed continues to decrease over time indicating that alternatives to bed based care are being implemented successfully.



The average length of stay (LoS) for a non-elective admission (NEL) reduced from 3.5 days 2016/17 to 3.3 days 2017/18.

3.10 GP streaming

Streaming of patients attending A&E who are suitable for a GP service began at the John Radcliffe for 7 days per week in January 2018 (GPs having been available on site for some weeks before that). The GP streaming team relocated to a dedicated building which opened on Tuesday, 1 May. In April, 387 patients were seen by the service. In May, this rose to 512. The service is working towards seeing up to 600 patients per month.



Actions that that have improved usage of GP streaming include having a second GP at peak periods working with the GP streaming nurses for adults; a GP working with children's triage nurses to increase the number of children to GP streaming; and the use of the Rapid Assessment and Treatment (RAT) approach with on-site GPs. Overall we must retain focus on patients who need a GP accessing them via their own practice.

4. Out of Hospital

4.1 Delayed transfers of care

At 30 November 2017 the average weekly snapshot of delayed patients in the Oxfordshire system stood at 143. The Delayed Transfer of Care (DTOC) rate (percentage of bed days

lost to delayed transfers of care) in OUHFT was 6.47%. Data indicates that this rate increases in the winter period with a fall in December (linked to Christmas) increasing in Q4. The tables below show the OUH position on delayed transfers of care for the last three years.

2015/16:

Month	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16
Bed days	3963	2781	3222	2956	3265
DToC rate	11.19%	7.60%	9.04%	8.29%	9.16%

2016/17:

Month	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17
Bed days	2674	2517	3166	3441	3448
DToC rate	8.18%	7.45%	9.04%	10.88%	9.85%

2018/19:

Month	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18
Bed days	1991	1793	1976	1959	1725
DToC rate	6.47%	5.64%	6.21%	6.82%	5.42%

*Q4 figures (months in dark blue) are derived from local data; national ratified figures not yet released

As shown above this winter, despite the pressures, Oxfordshire made very considerable progress on the numbers bed days filled by people who were medically fit to leave. Given the evidence on the risks of remaining too long in hospital beds this should have a positive impact on health outcomes.

The discharge flow plan for winter 2017/18 was based on

- Increasing Nursing Home provision, especially for people with complex dementia and other complex needs
- Scaling up short-term step down beds to create capacity and mitigate pressures elsewhere
- Increase in domiciliary care hours to support especially flow through reablement services
- Creation of a new multidisciplinary team to support discharges from short stay wards to ease pressure especially on emergency department
- Focus on those High Impact Changes that would address some of our local discharge challenges

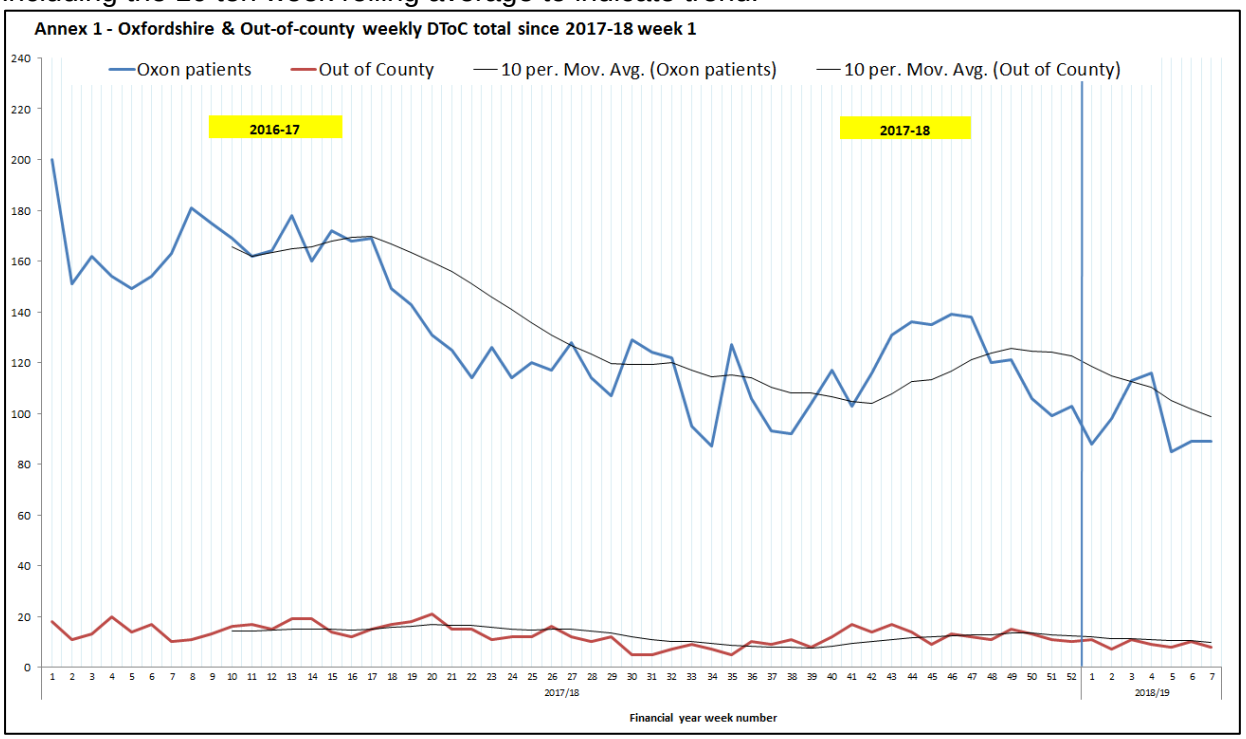
The winter plan to support discharge in full was as follows:

Increased Nursing Home provision	OCC/OCCG successfully re-procured 25 complex dementia beds but were unable to create significant levels of extra capacity. However, the level of delays fell from 21/week in November to 8/week by March. OCCG and OCC have jointly appointed to a care home post who will

	now develop plans to improve the capability and capacity of our nursing home sector during 2018-19
Increase in short-term beds	67 beds are commissioned by OCCG via OUHFT to support the step down and management of complex patients who need further assessment and support in nursing home settings prior to a final decision on discharge settings. furthermore additional beds had been commissioned from time to time to manage short-term pressures especially owing to the lack of domiciliary care pick up from reablement services. At 30/11/17 there were 94 short-term beds. This number was flexed up through winter: 99 at 31 Dec; 113 at 31 Jan; 112 at 28 Feb and 98 at 31 March. The figure will now be reduced in stages partly through improved performance across the pathways. A project is under way to look at the scope and capacity requirement across a range of short-term beds to deliver a new model prior to winter 2018/19.
Increase in domiciliary care hours	An extra 200h of domiciliary care hours were purchased in a block to improve flow through the reablement service.
New team in short stay wards	A new team was established compromising OUHFT, OHFT and OCC staff from a number of disciplines together with Age UK to support hospital discharge from OUHFT short stay wards at the John Radcliffe Hospital. Working 7 days a week as part of a dedicated team made up of OUHFT discharge liaison leads, OCC social workers, OHFT lead community therapists and OUHFT therapy leads the team was tasked to find new ways of supporting people to get home when they might otherwise be queueing for bed-based pathways. Age UK have particularly worked with patients and families to identify what would work for them. Their patient focussed approach has enabled some people to move home when they would otherwise have been waiting, and has acted as the oil in the wheels of complex processes in other cases. They have made effective links in the community outside of formal discharge pathways and been able to follow up people that they have supported home. Lessons learnt are currently incorporated by OUHFT in a Home First approach to be piloted in the A&E during 2018/19.
High Impact change: Trusted Assessor	A trusted assessor model for people discharging from acute to community hospital has been developed and refined. This matches patients to beds without a secondary assessment and has contributed to improved flow into the rehab beds. Additionally OCC has piloted a trusted assessor approach with intermediate care providers.
High impact change: Complex	OCC and OHFT have developed a joint approach to

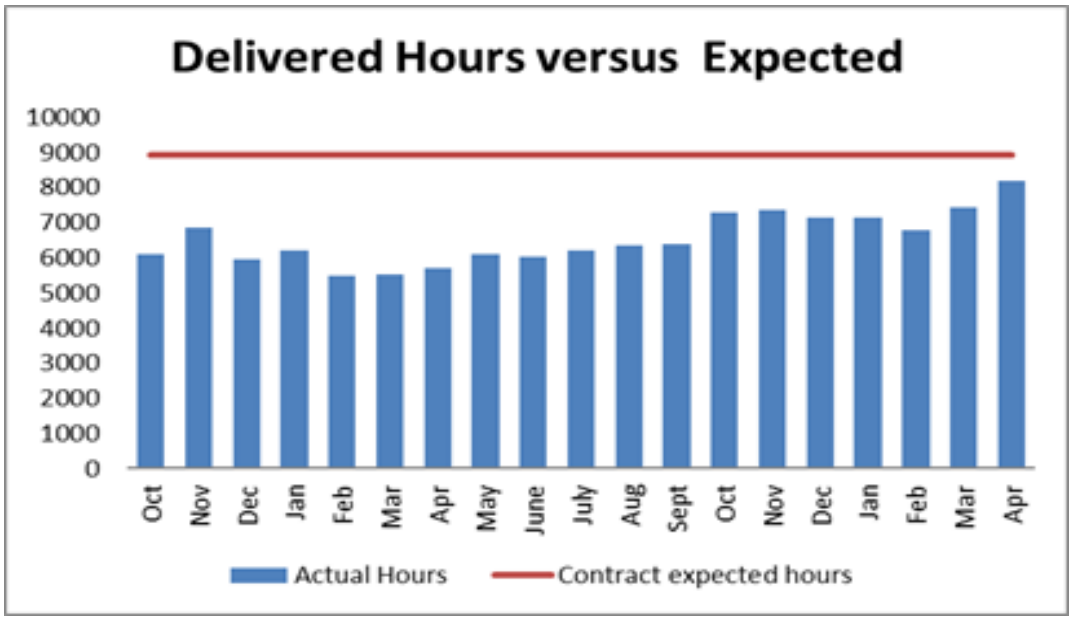
discharges	assessment and care planning for people in community hospital who have complex needs such as relating to housing, family dynamics and best interest approaches. This has proved very successful to the point that by adopting an anticipatory approach with social care colleagues the OH discharge liaison leads have reduced housing and equipment delays to virtually zero and reduced "choice and family delays" from 15-20 a week to <5 per week. OUHFT have worked with the City Council around the Trailblazers initiative to improve outcomes for people needing housing support to discharge from hospital. Both OUHFT and OHFT have developed a daily call for patients in the continuing healthcare pathway and this escalates into the wider stranded patient escalation process. Divisional nursing leads for OUHFT and OHFT meet colleagues from social care and commissioning each week and this process means that complex patients are known and can be problem-solved by senior officers. Any problems that cannot be resolved to move the patient on are escalated by OUHFT Chief Nurse to system CEO weekly. Other than out of area patients in our system no cases have needed to be escalated.

Winter performance in OUHFT for 2018-19 for delayed transfer of care patients was improved over previous years and did not spike to the same extent in Jan and Feb. Performance was not as strong in community hospital beds which were disproportionately impacted by delays in the reablement pathway, but the work of stranded patient reviews has supported an improvement since March. The table below shows DToC rates over time including the 10 ten week rolling average to indicate trend.

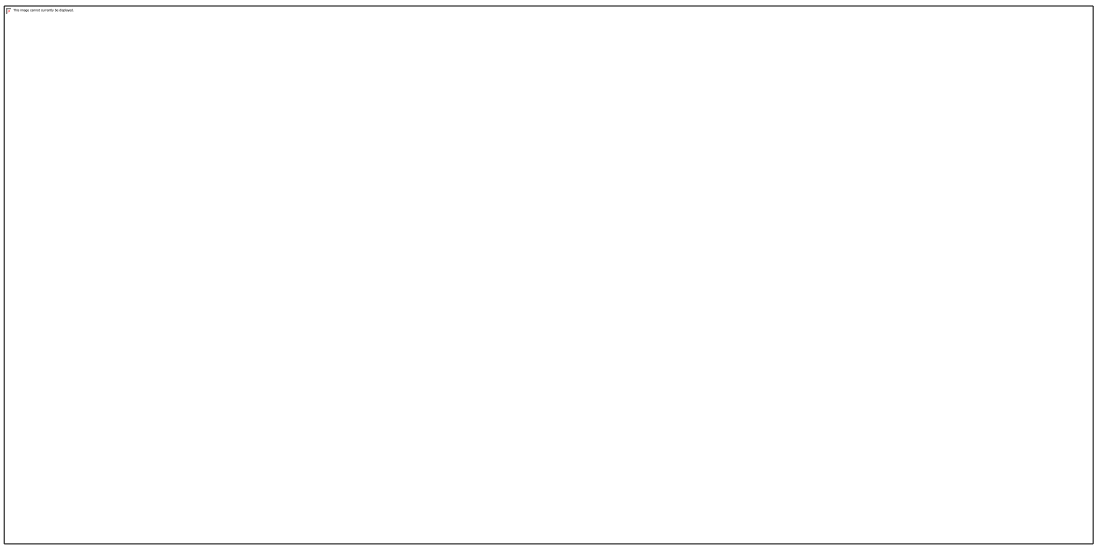


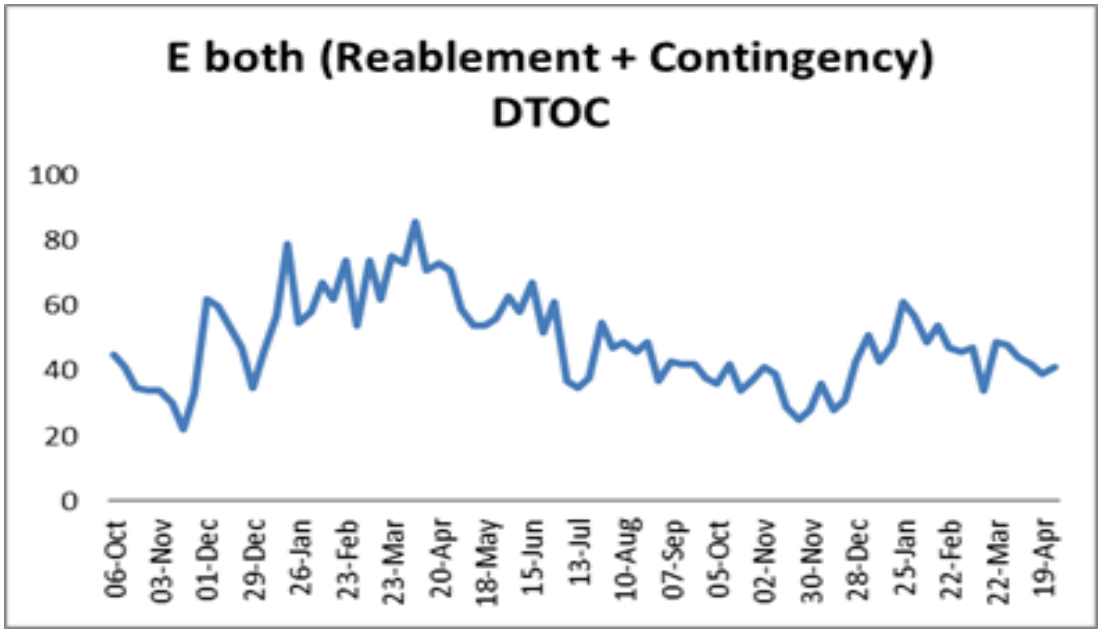
4.2 The Home Assessment Reablement Team (HART)

It is recognised that the HART service has not been delivering at full capacity. In recent months the % of contracted hours has increased (92% in April) however for the life of the contract 73% of contracted hours has been delivered.



Service capacity can affect the speed we can put care in place, so timelines of the new package starts, particularly people in hospital. In April 62% of cases were picked up on time - 49% from hospitals and 76% from the community. DTOCS attributable to HART are recorded as 'both' delays in recognition that the service is provided by an NHS provider. They remain overall on a downward trajectory from February to mid-March.





Whilst the performance of the contract has been improving, and associated DTOCs are on a downward trajectory, the service has not performed to full capacity over the winter. To mitigate this £1.9m was invested to provide additional provision to support hospital flow and to mitigate for under capacity in the Home Assessment & Reablement Team. This provision included 30 care home beds to support people requiring larger packages of support at home; 10 beds for people awaiting a care home placement; and additional community reablement packages delivered by Oxford Health Foundation Trust.

In recognition of the challenges to flow presented by under capacity in the HART pathway, the hospital social work team have focused on supporting discharges for people who have been waiting more than 30 days for discharge with HART. This focused work facilitated additional discharges since Christmas (22 in April for example) and has helped people by avoiding deconditioning attributable to delayed discharge. This approach is planned to continue.

In addition, system partners have been working closely to support OUHFT in delivering an internal HART improvement plan. Performance against the contract has improved, the service delivered 92% of contracted hours available in April 2018; this is the highest level to date. Work is ongoing to support this to ensure that people's reablement goals are maximised and that levels of ongoing care that people need upon completion of reablement is correct.

4.3 Care home support

The care home support service proactively supports residents to return to their care home after a stay in hospital and also works directly with care homes to avoid admission.

The team visits the John Radcliffe Hospital 3 times a week (there is an average of 5-10 residents in an acute bed at any one time) to support the discharge of existing care home residents to their care home and provide support to the Horton Hospital as required.

The team is also trialling the red bag vanguard in the 18 Order of St John's care homes (the resident going to hospital has all their belongings and information about their care in a red

suitcase which remains with them throughout their stay.) CCG have provided the funds for the red bags.

We are running a small project in one nursing home with a pro-active GP to improve access to pro-active care plans and the early detection of deterioration, working with GPs, SCAS and EMU.

5. Reflections

Nationally it is acknowledged that the 2017/18 winter crisis was the worst ever for the NHS. In Oxfordshire, as nationally, we experienced an increase in urgent care activity above that planned for putting unprecedented stress on our workforce and services. In responding to this demand lessons have been learnt that will inform plans for winter 2018/19.

5.1 What went well

The health and social care system partners have worked together to identify opportunities to improve flow out of hospital by developing a person-centred approach focussed on people's strengths (e.g. Age UK work in short stay wards) and a 'Home First' culture. This has been supported by dedicated social work support in A&E and a 3rd sector pilot in ED to enable patients to return home. This has resulted in a pragmatic and effective approach without the organisational boundaries which has been well received by patients and carers.

There was whole system focus to reduce the number of 'stranded' patients and significant improvements were identified from the adoption of a high quality, consistent, multi-disciplinary team (MDT) approach (e.g. OCC-OH work in community hospitals and OUHFT-OCC work around stranded patients).

Increasing the number of non-clinical staff available porters, cleaners, drivers etc.) has supported patient flow through the urgent care pathway and subsequent discharge. Additional transport enabled greater uptake of ambulatory services. Incentive schemes targeting nurses, GPs and SCAS staff were put in place providing additional resources to patients. Business cases will be produced with the aim of securing these initiatives in future years.

The improvements in delayed transfers of care, which has been a very long standing and intractable issue for the system should be acknowledged as a significant step forward and give renewed confidence and impetus that we can work together effectively as a system to support best outcomes for patients.

5.2 Lessons learnt

- In a recent system CQC review a lack of leadership alignment across organisations was identified. This was apparent in the differing approaches to the right way to mitigate acute bed capacity and the absence of resolution on how to achieve an effective Discharge to assess (D2A)/reablement model.

- There are several pinch points in the patient pathway. Activity in primary care and MIUs is not mitigating the demand in A&E and there is no effective real-time toolkit to support operational management of demand & capacity across the system.

- During the winter there was a continuous period of high level escalation (6 months x OPEL 3, 7 days at OPEL 4) which exposed a lack of alignment between locally

developed processes and OPEL escalation framework (e.g. call sequencing) and a system with no capacity to 'turn on' at escalation OPEL3/4.

- System partners experienced workforce difficulties relating to both vacancies and sickness; this was exacerbated by the increasing demands for clinicians to input into additional services (GP streaming, 111 clinical validation etc.). The need to address this through joined up ways of working was agreed.

- The reablement service was not delivering at the required capacity and we had not optimised flow in or out of the service.

- Patients from other areas were often stranded in Oxfordshire acute or community beds awaiting discharge or repatriations into external systems; regular, intensive 'policing' and escalation of these issues was required to facilitate these patients returning home. The same issues applied to Oxfordshire patients in beds out of the county.

The key dilemma for our Oxfordshire system is to design services that best serve patients – giving the best outcomes whilst achieving quickest recovery. In doing this the workforce shortfalls on home care provision, reablement and qualified staffing mean we need to find better ways of using the resources we do have. In this last winter we opened many more nursing home beds with multi-disciplinary cover and also beds in the Community hospitals. Our learning was that we spread the therapeutic and social care staff too thinly to support these beds and on each transfer we need to resettle patients, restart processes and prolong the episode. As a result we did not achieve the level of patient flow through the beds we would hope for. Our approach for next winter must be to look at the individual strengths each of our patients have, their preferences, the resources around them such as family and friends, even familiarity with their own setting eases the recovery process. We then need to match our resources to support the patients to return to their own homes as rapidly as they can. The clinical evidence is very strong that we will support the patients in regaining (or retaining) their greatest independence if we take this approach. There is a risk, that our prior efforts to fill workforce gaps with bed based alternatives – albeit in the community perpetuate the risks of decompensation. The transformational priorities we are setting ourselves in the AEDB seek to take the "home first" approach and draw on the blend of services in each of our local communities to provide creative solutions to workforce challenges. Every day that we have patients waiting for a service that we cannot staff exacerbates the issues for the patient but also potentially adds to their long term support needs.

5.3 Priorities for 2018/19

The A&E Delivery Board (AEDB) have agreed a number of priorities some of which will be taken forward by the Winter Plan group (a sub-group of the AEDB).

The priorities are:

- Frailty - mobilisation of a community frailty model to avoid unnecessary attendances and admissions and an acute frailty pathway approach when admission is indicated.
- Home First - embed new initiative to avoid admission and support people in their own homes. Collaboration with the third sector will be a key part of this.
- Self-funders – reducing the amount of time people wait in hospital whilst sourcing self-funded care.

- Mental Health & Urgent Care – ensuring timely access to a range services to optimise outcomes for patients.
- Locality based planning framework – using local knowledge to design and develop services for a specific population.
- Demand and capacity - ensuring the right services are available at the right time.
- Winter Plan

The following actions have been agreed to support this.

- **7 day working** – more collaborative working to ensure consistency in patient flow 7 days per week,
- **Forward planning** – share learning and continue to strengthen the daily 8:30 operational system call to improve daily and forward planning for discharges.
- Informed by the demand and capacity planning work we aim to **improve forward planning for known days of system pressure** e.g. first 2 weeks of January. Specific review of staffing profiles during these periods.
- **Establish a System Wide Winter Group** to meet regular to coordinate planning and also to ***strengthen links of communication at a senior level during times of pressure and escalation***.
- Agree **System KPIs for Winter** e.g. target discharges per day.
- **Build intelligence to recognise changes** in trends and anticipated pressure points to support more effective planning. Share learning from SCAS from 999 conveyance profiling.
- Refresh **Oxfordshire System Escalation process** with local action cards for each partner organisation to define individual actions and resources to maximise flow.
- **Improve community/primary care links to support earlier discharge-** strengthen our system communication and coordination to facilitate.
- **System risk management** – including improving knowledge of patient prior to admission/attendance. Share learning from review of readmissions.
- Develop **neighbourhood resilience** to support patient care of patients at home where appropriate. Review of assets within each neighbourhood to support care closer to home.
- **Communication**- across the health and social care system to *optimise our urgent care pathway to support care closer at home and* delivering the 'Home First' principle whilst avoiding 'bed based deconditioning'.

Our Winter Plan Group is already meeting and taking these actions forward with clear direction from the AEDB.