Integrated Improvement Programme Oxfordshire winter 24/25

Buckinghamshire, Oxfordshire and Berkshire West
Integrated Care System

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Requirements for winter 2024/2025

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

Achievements in 2023/24

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- **Out of hospital Care**
- Integrated one Oxfordshire Hospital at Home Service, increasing capacity to assess and treat more people in their own home, slide 4 and 5.
- Increase in the number of people seen in Same Day Emergency Care (SDEC) Units Slide, slide 6.
- Integrated Neighbourhood teams in Oxford City and Banbury- focus on areas of deprivation to improve earlier detection of deterioration and improve quality of life
- Further improvements to MH crisis support within the community and to NHS 111 which have resulted in people not needing to be seen in an emergency department
- Increase in the number of people receiving mental health crisis care in their own homes avoiding a hospital conveyance and potential admission.
- Reduction in the number of people following a fall been attending an Emergency Department

- **In hospital care**
- Increased bed capacity within OUHFT over the winter months
- Development of additional assessment space collocated to the JR ED
- Implementation of plan to increase senior clinical decision makers in the overnight period in JR ED.
- Improved performance of the 4hr Emergency Department standard, achieved 78% in March 2024.
- Both Urgent Care Centres working 7 days a week

Hospital @ Home – compliance against trajectory

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24/25 Capacity Trajectories

Capacity = target number of beds i.e. number of patients the service(s) can see at any one time

Oxfordshire	Apr 24	May 24	Jun 24	Jul 24	Aug 24	Sep 24	Oct 24	Nov 24	Dec 24	Jan 25	Feb 25	Mar 25
	192	220	225	230	235	240	245	250	255	260	265	272

24/25 Capacity submissions recorded in Foundry

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

NB: 20th May submission includes Hospice Outreach for the first time, but their submission was inaccurate.

***Oxon Acute VW date includes:**

- Central, North & South H@H
- Sue Ryder
- Home Hospice
- CARe Team
- COPAT
- Covid Care @ Home
- Hospice Outreach (as of 20th May)
- Stroke ESD

Increase in the number of people who are seen in SDEC and Hospital at Home

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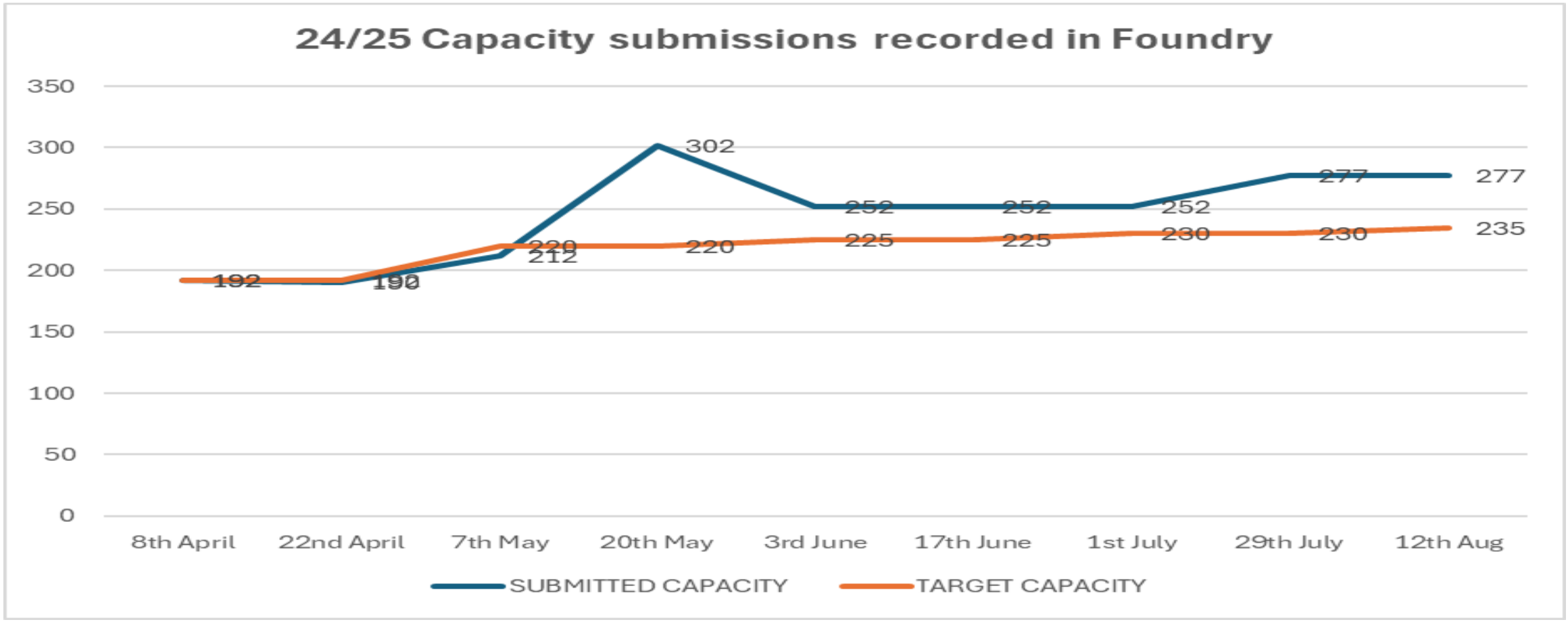
Number seen in Hospital at Home against trajectory



Increase in activity across Same Day Emergency Care services (SDEC)

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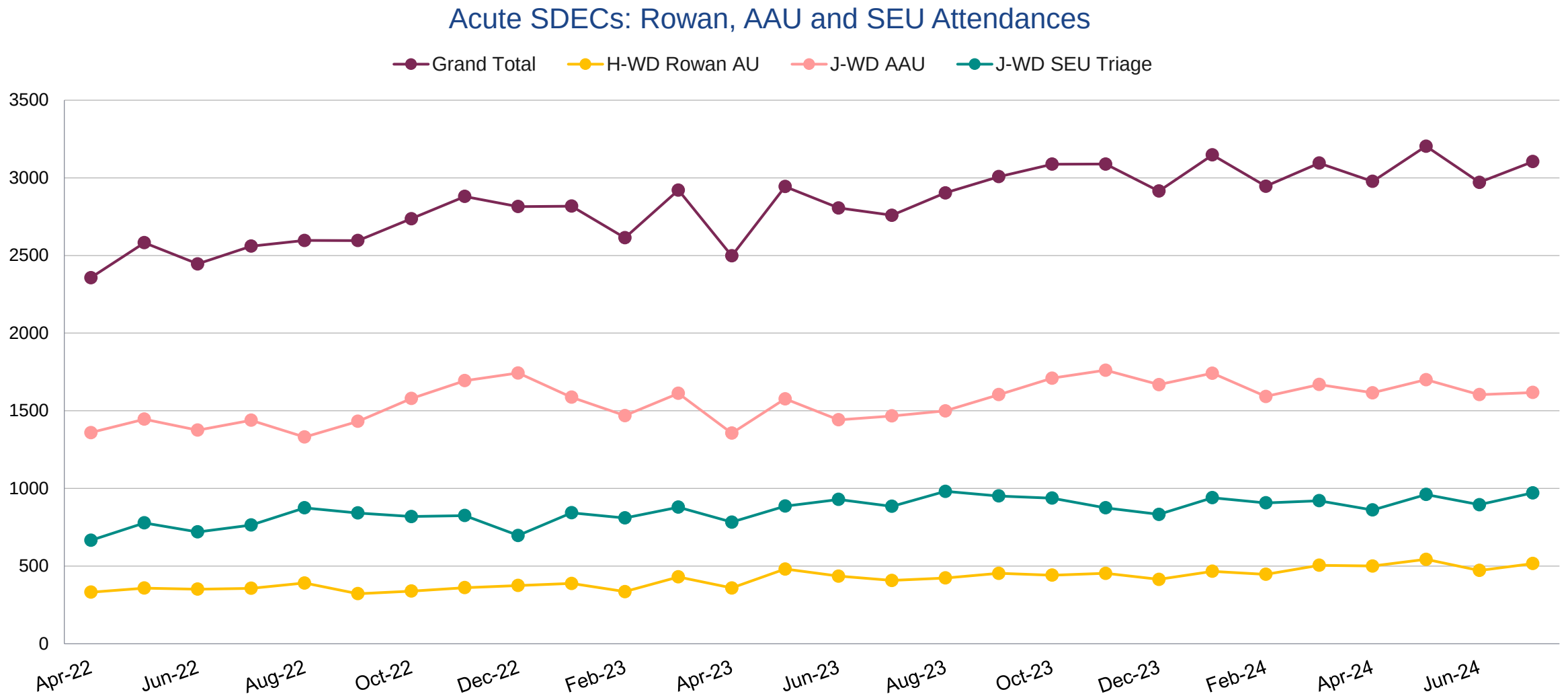

Achievements in 2023/24

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- **Discharge**
- There is a reduction in the number of bed days lost to people who to their own are waiting to return home and a reduction in the number of days people are away from home.

➢ **Reablement outcomes to independence have increased** to above 70% again with an additional 13% of people having a reduction in support totalling 83%.

➢ **D2A Outcomes remain good** – most people are moving into reablement pathway, reduction in number of readmissions.

➢ Trusted Assessor Pilot with providers has been successful and continues to grow.

➢ Reduction in hours from start of reablement to end of reablement remains good at 52%

- Effective weekend discharge teams have increase weekend discharges mainly on a Saturday.

- Expansion of Transfer of Care HUB to include all Oxfordshire patients in out of county beds, providing us with an overview of reducing their length of stay

Activity level for Reablement (D2A), related to Admission Avoidance

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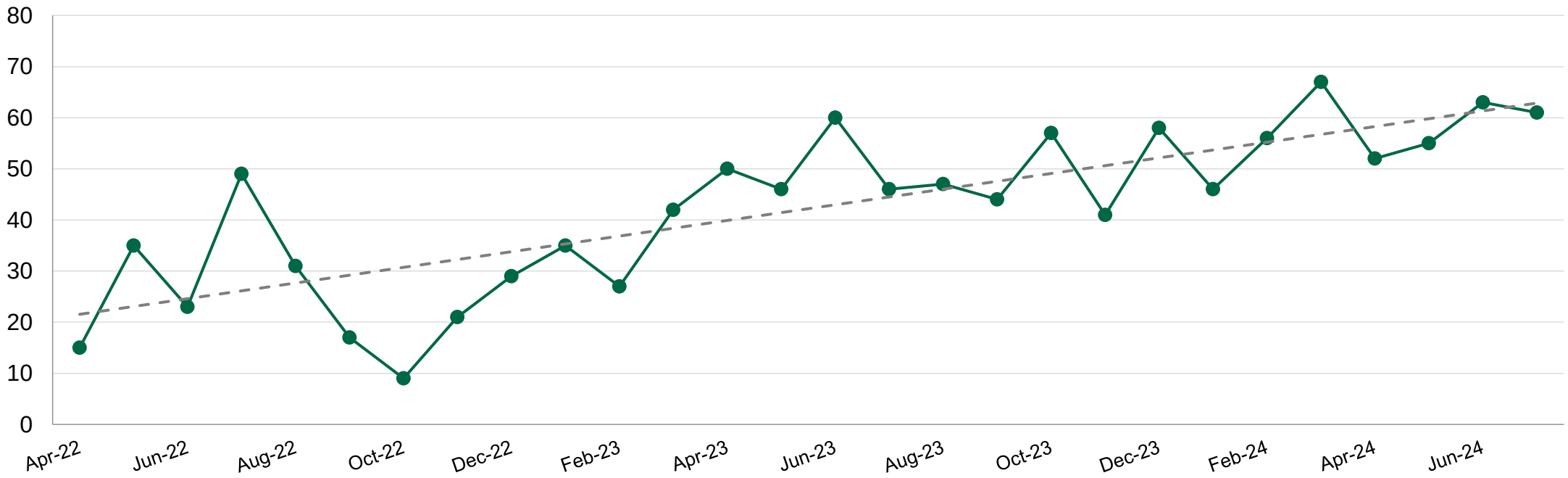
Total number of set ups by month for Reablement from community referrals by Home First



Key: Set Ups ——— Trend Line - - - -

D2A Outcomes

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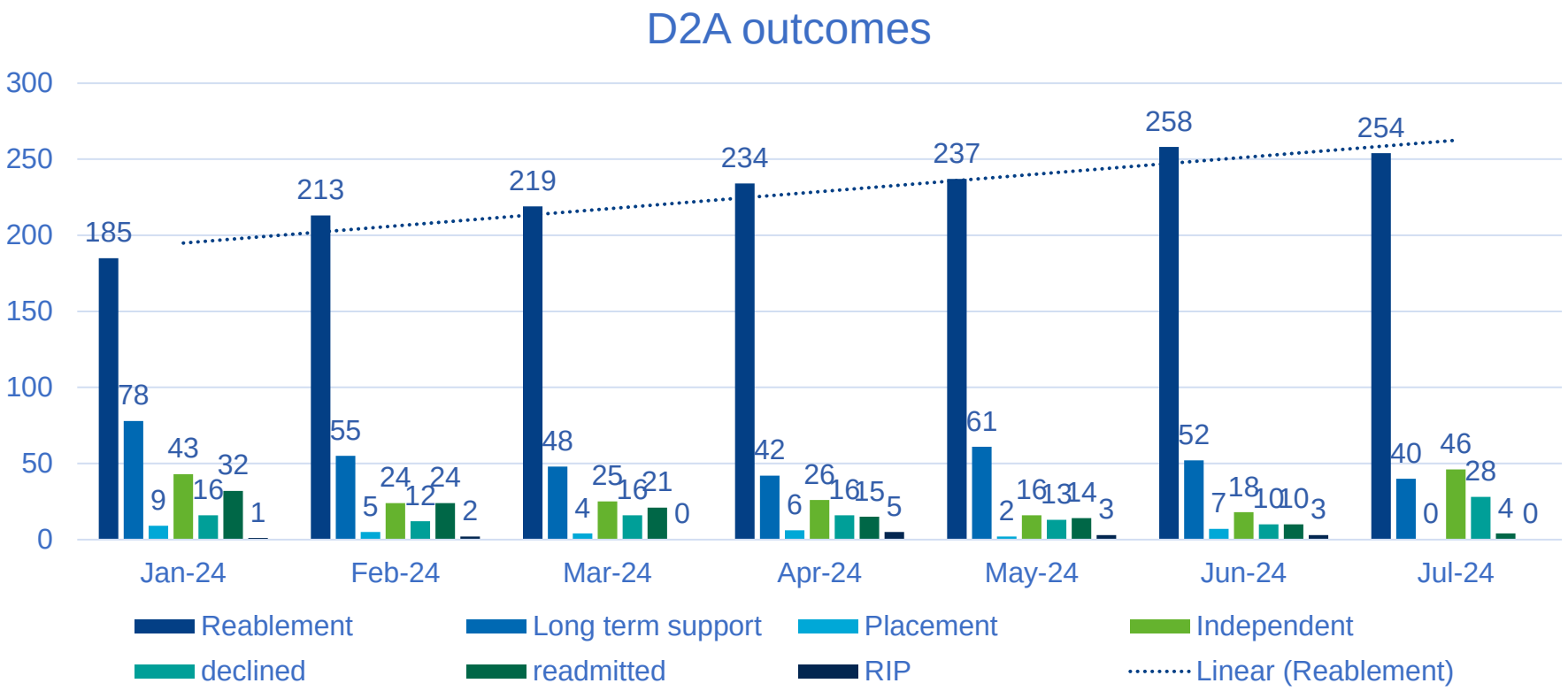

Number of individuals independent after a period of reablement

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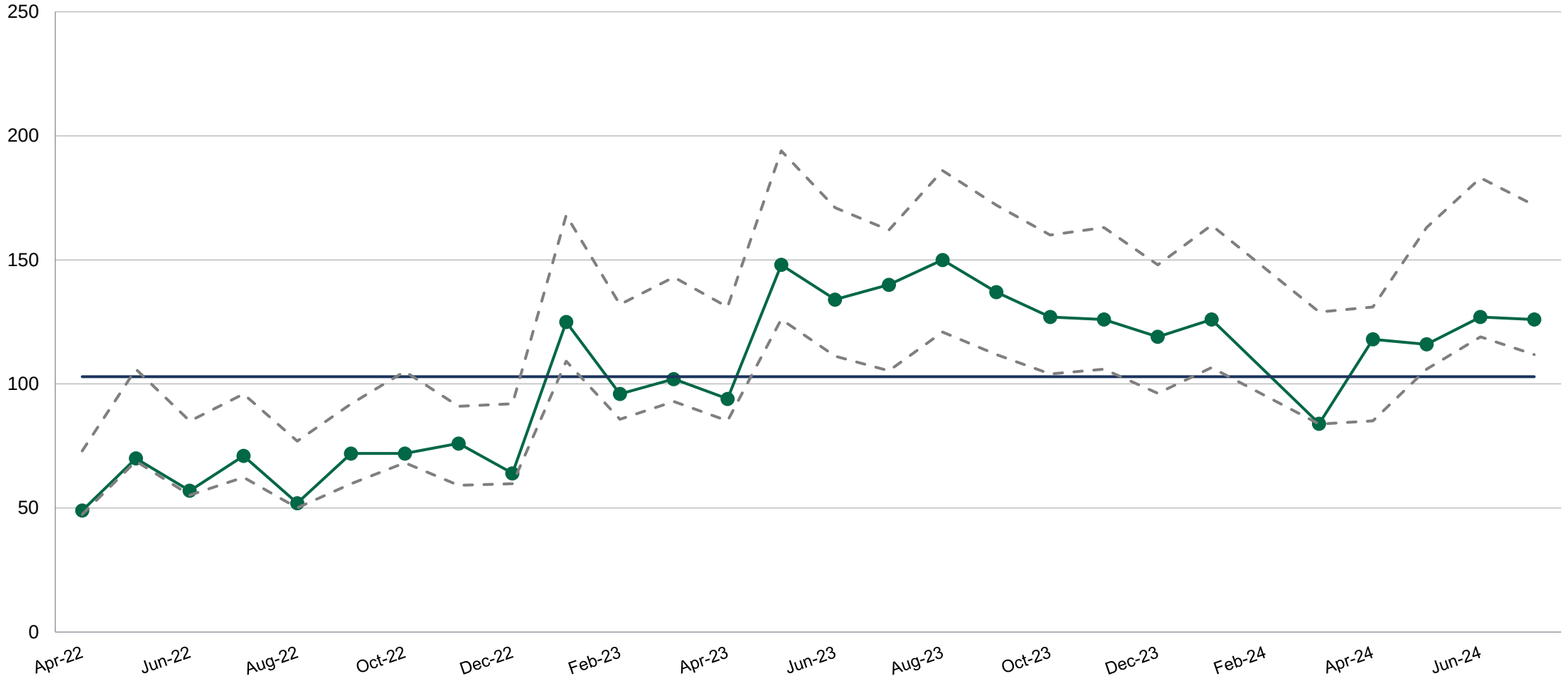
Number of individuals independent after a period of reablement



Reduction in the number of days people are delayed waiting to return home.

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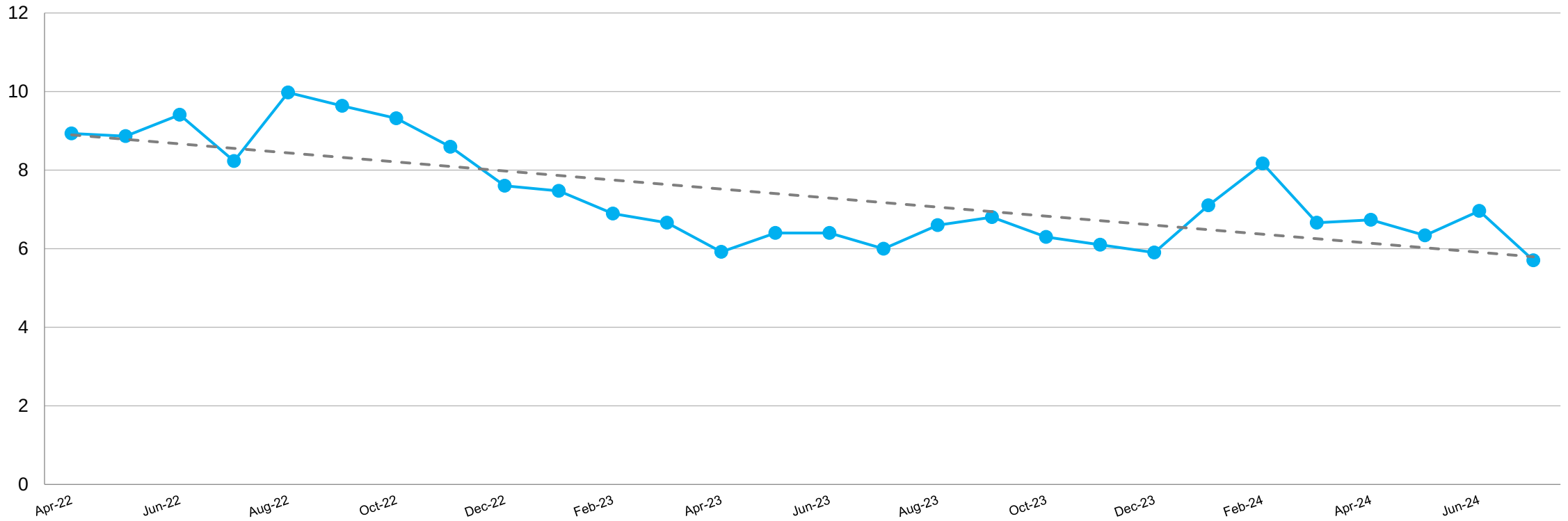
Average days away from home for MOFD patients in acute inpatient wards



Days away from home for delayed discharges for OUHFT inpatients

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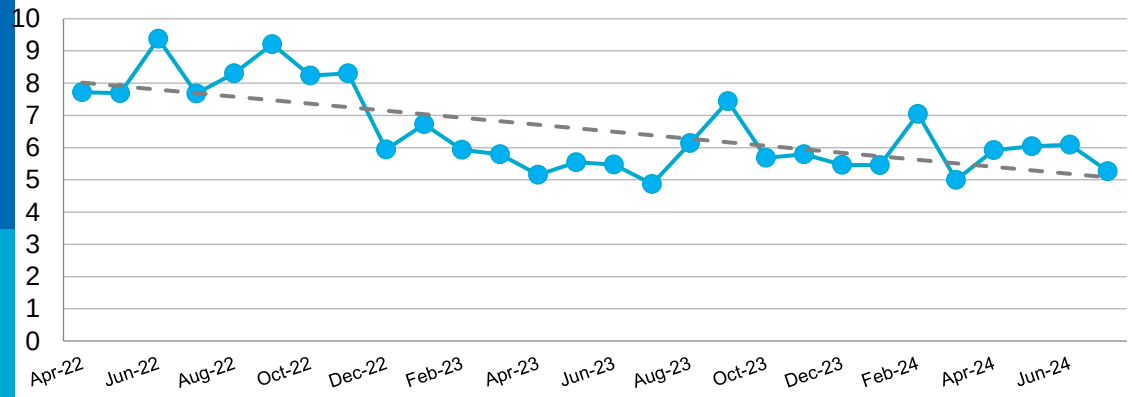
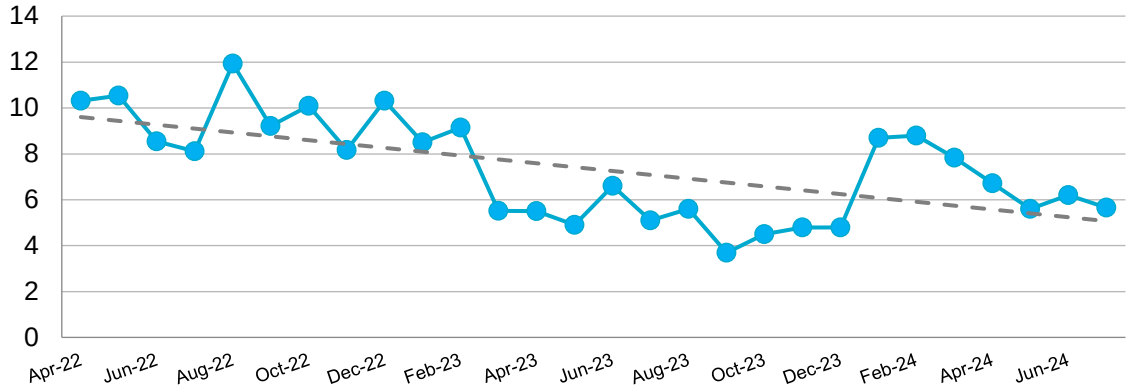
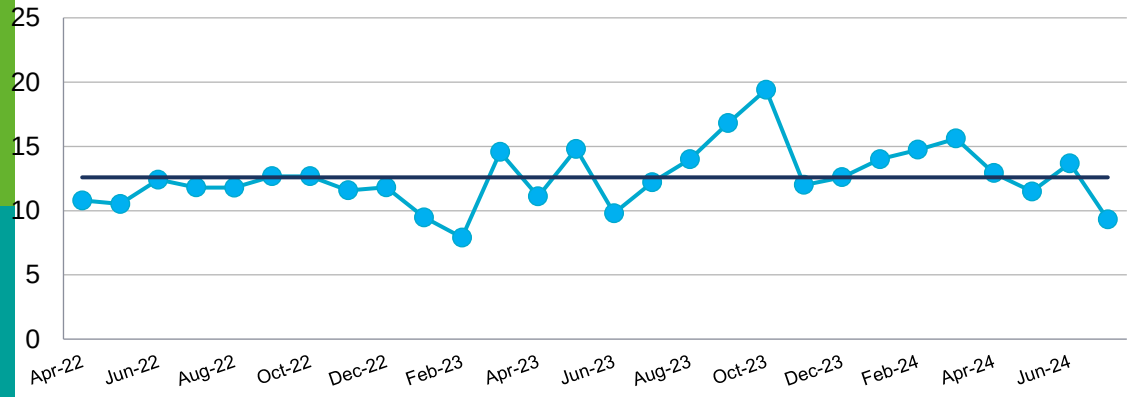
Average number of days MOFD - Pathway 1



Average number of days MOFD - Pathway 2



Average number of days MOFD - Pathway 3



Key: Avg. number of days MOFD — Trend Line - - - - Mean ——

Achievements in 2023/24

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- **Mental Health**
- Crisis team expansion from City to North and West Oxfordshire providing home treatments from those leaving inpatient MH beds.
- Out of hospital Care team and access to step down and the housing officers have provided support for the homeless pathway from MH beds.
- Overall length of stay is continued to reduce, and the number of days delayed had reduced.
- Additional MH support to Care homes supported people requiring placements reducing their delay
- Reduction in inappropriate Mental Health Placements
- Reduction in the total number of people delayed and the number of days delayed for those in MH inpatient beds

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Winter plan 2024/2025

Supporting frail patients in the community

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- **Expand capacity to meet increasing demand over the winter period.**
- Develop Single Point of Access (SPA) to support all health care professionals to refer people who can be assessed and cared for in their own home.
- Expand capacity within Hospital @ Home teams to provide consistent cover until 22:00hrs 7 days a week.
- Hospital @ Home working closely with Integrated Neighbourhood teams with a view to discharge people earlier to them but to support remotely.
- Integrating Urgent Community Response with the overnight visiting service to delivery service that provides more home visiting capacity in the evening and overnight.

Supporting frail patients in the community- Integrated Neighbourhood teams

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- Oxfordshire has integrated Neighbourhood teams across Banbury, Oxford City, Bicester, Wantage and Witney. During the winter months these will continue to be developed to address the following.
- To reduce health inequalities by reducing morbidity and mortality in areas of concern, stroke, heart failure and respiratory disease.
- Continue to develop an integrated approach across Primary Care, Community and acute services for those with the highest need and based on the local population needs.
- Local population health data has dictated some INTs need to focus on people with Mental Health, alcohol and substance misuse or the needs of children.
- Coordinated care mainly for those who meet the frailty criteria – especially those just discharged from hospital where additional assessment and support will maintain them safely in their own home.
- Develop and report on metrics for INTs to assess clinical and cost effectiveness.

Supporting frail patients in the community-ReSPECT

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- The ReSPECT process can be for anyone but will have increasing relevance for people who have complex health needs, people who are likely to be nearing the end of their lives, and people who are at risk of sudden deterioration or cardiac arrest. Some people will want to record their care and treatment preferences for other reasons.
- ReSPECT and decision-making conversations happen between a person, their families, and their health and care professionals. These conversations help create an understanding of what is important to the person.
- Patient preferences and clinical recommendations are discussed and recorded on a non-legally binding form which can be reviewed and adapted if circumstances change.
- The ReSPECT process creates personalised recommendations for a person's clinical care and treatment in a future emergency in which they are unable to make or express choices.
- Implementation will start within the community setting and then the acute Trust.

Reducing Ambulance Handovers

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- Focus on referring people from the ambulance stack in the control room directly to Single Point of Access (SPA) to avoid an ambulance being deployed where another team can access and treat the patient.
- Ambulance crews to refer appropriate patients to SPA where they can discuss the person with a clinician to see if Urgent Community Response or Hospital @ Home can carry out further assessment s or treatment.
- Reducing ambulance handovers, the majority of which to be achieved within 15/30 mins.
- Maximum handover time of 45 minutes: prepare to move to a mandated handover at 45 mins
- Improve process for signing off ambulance handovers in real time to improve data quality

Increasing capacity – improving flow

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- **Acute Care**
- Improving streaming, direction and initial assessment of people as they arrive in the Emergency Department
- Continue to focus on reducing the length of time people spend in the Emergency Department
- Further development of the children's Emergency pathways
- Continue to reduce the number of days people are away from their own home

- **Transfer of Care HUB**
- Achieve 95% of people in acute care returning to their own home
- Expand to working from 6 days to 7 days a week
- Focus on reducing Length of Stay across all Oxfordshire bed bases.
- Improve communication with people and their carers pre and post hospital discharge
- Digital integration to improve information sharing
- Working closely with Integrated teams to ensure all those who can be supported at home do so at the earliest opportunity.

Increasing surge capacity – Improving flow

- **Discharge flow**

- Referring people who require support to return home at the earliest opportunity.
- Improving communication with people and their carers prior to discharge and within the first 48hrs post discharge.
- Intense approach to reduce length of stay across all Oxfordshire step down beds.
- Improve approach and timely access to step down care across community hospital and short stay HUB beds
- Review the impact of discharge to assess on Oxfordshire residents.
- Social Care reviewing plans to deliver surge capacity for the expected increase in double handed care over January to March 2025.
- Hospital @ Home and Urgent Community Response reviewing how to create additional capacity to support Health Care professional referrals for people who require assessment in their own home.

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Mental Health – reducing Length of stay

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

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Thank you

Questions?