Oxford University Hospitals
NHS Foundation Trust

Cover Sheet

Public Trust Board Meeting: Wednesday 13 November 2024

TB2024.101

Title:	**Winter Preparedness Plan, including system approach**

Status:	**For Decision**
History:	Integrated Assurance Committee – October 2024

Board Leads:	**Felicity Taylor-Drewe, Chief Operating Officer and SRO for Urgent Care**
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Confidential:	**No**
Key Purpose:	Strategy, Assurance, Performance.

Executive Summary- Winter Plan

1. Winter challenges go beyond our Emergency Departments and Ambulance Services, and recovery requires all types of providers to work together to provide joined up care for our patients. System roles and responsibilities have been determined within the 'Winter and H2' letter[1] from NHS England to enable collaborative working and to deliver resilience. There are three key areas of operational focus outlined within these:
   - Reducing Hospital Handover Delays
   - Capacity Management
   - Supporting Frail Patients in the Community
   - Supporting People to Stay Well
2. We are in the second year of the National delivery plan for recovering urgent and emergency care (UECRP). This has helped to deliver improvements in performance in 4-hour emergency department (ED) standard and 12-hour total length of ED stay performance. OUH has consolidated its interventions in response to 4 of the 10 high-impact interventions that are relevant for acute providers.
   2.1. Reduce variation in Same Day Emergency Care (SDEC) provision by providing guidance on a variety of SDEC services for at least 12hours per day, 7 days per week.
   2.2. Reducing variation in acute frailty service provision. A Frailty team has been established to improve the recognition of cases that could benefit from specific frailty services and provide the best possible care.
   2.3. Reduce variation in inpatient care and length of stay for key integrated urgent care pathways by implementing in-hospital efficiencies and bring forward discharge processes. Continue to progress work for Clinical Pathways, further reduction in 21-day extended length of stay and implement Board Rounds as part of the 'Standard Work' programme.
   2.4. Bed productivity and flow: Improvement trajectory for 4hr performance with underpinning OUHFT UEC Quality Improvement Programme, Transfer of Care Hub is now 'mature' and will expand to 7-day working for winter.
3. Elective and cancer recovery plans for the second half of the year sit alongside the Winter Plan. The Trust's clinical activity plan focusses on maintaining and protecting elective capacity on the Churchill, NOC, West Wing and Children's hospitals as far as possible. The plan also pays particular attention to the Out-Patient and diagnostics elements of elective pathways.
4. Supporting staff wellbeing must be a priority this winter. Wellbeing Champions promote the wellbeing support available to colleagues, Mental Health First Aiders

[1] https://www.england.nhs.uk/long-read/winter-and-h2-priorities/

are available to all and listed by division on the Growing Stronger Together intranet pages and lastly wellbeing check-ins are available for all team members.

5. Robust rostering and annual leave planning to maintain senior cover seven days per week over winter, including Christmas and New Year periods, underpins the resilience within the plan.
6. Oxfordshire's health, social care and voluntary sector partners, are working together to improve care pathways and reduce length of stay in all bed bases. There is particular focus around conveyance avoidance and supporting Oxfordshire residents to receive care at home.

Recommendations

1. The Trust Board is asked to approve the winter plan.

Integrated Improvement Programme Oxfordshire Winter 24/25

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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 2024/25

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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.
- 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 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

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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 folcussing on 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.

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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.