

Workforce

Proportion of A&E staff who are senior doctors ↑ **1% pt** A&E performance ↑ **0.1-0.2% pts**

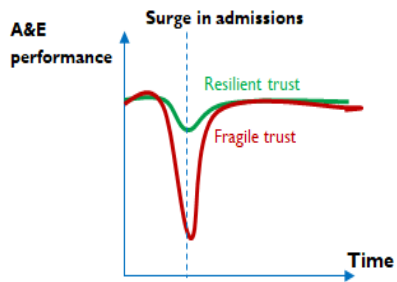
BUT we only have monthly data on substantive staff, so this is likely to be an underestimate

Oxford had 19% A&E staff as senior doctors – slightly higher than the national average of 18%

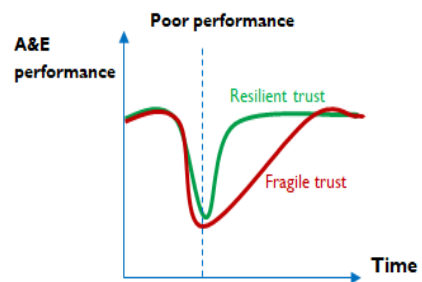
Oxford: A&E performance

Resilience

Response to surge in admissions



Bounceback from poor performance

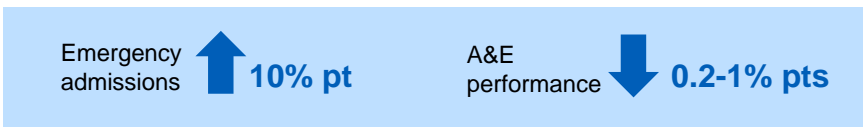


Oxford had good resilience by both measures

Oxford: A&E performance

Admissions

Daily admissions variation

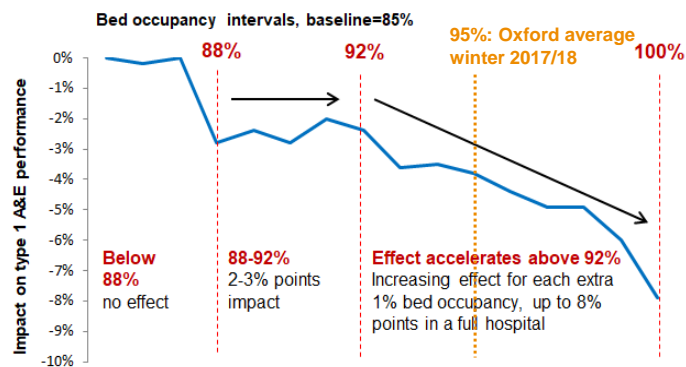


Oxford had 4% lower emergency admissions in 2017/18 than 16/17

Oxford: A&E performance

Bed occupancy: link to performance

Impact on A&E performance of changing bed occupancy from 85% to each interval



Oxford: A&E performance

Flu

Beds occupied by flu patients **↑ 1% pt**

A&E performance **↓ 0.5% pts**

High year on year growth


Nationally, in winter 2017/18 emergency admissions for flu were over **3 times higher** than the 3 previous winters.

Oxford had 1% pt higher flu cases than other trusts

Oxford had 5.3% of beds occupied by patients with flu across the winter – even higher than the national average of 4.1%

Oxford: A&E performance

Long stay patients: link to performance

Long stay patients as a share of stranded  10% pt

A&E performance  2-3% pts

4% patients



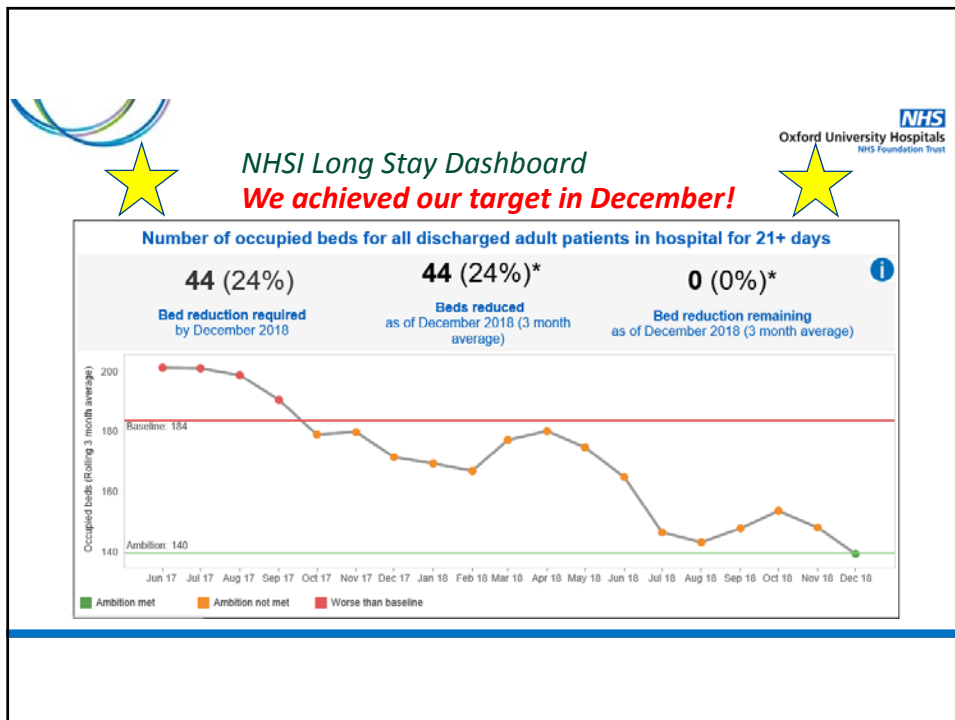
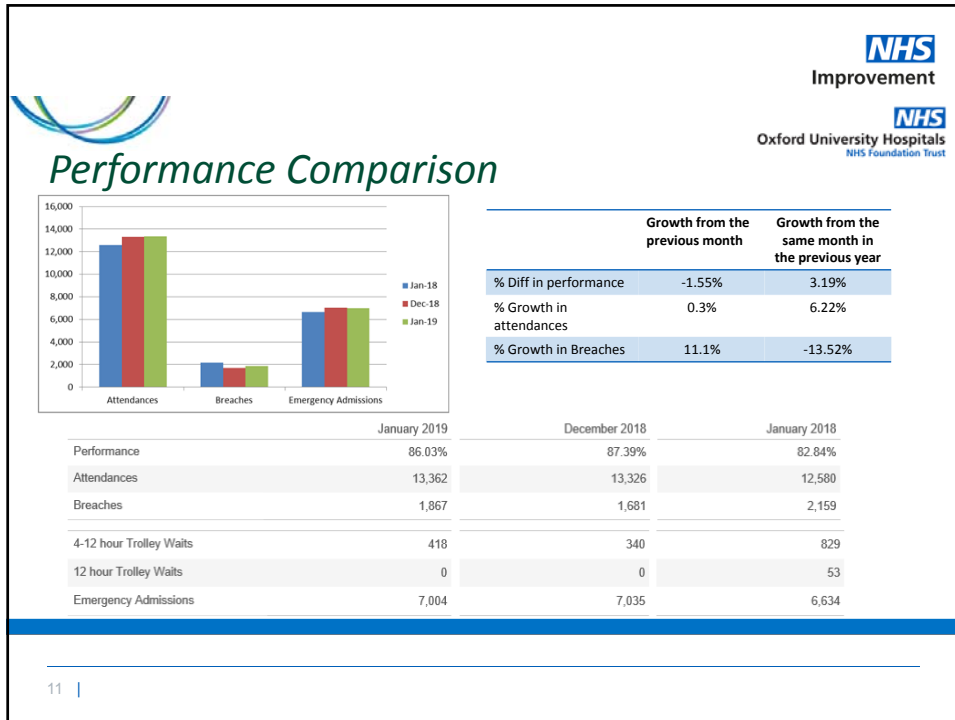
40% beds

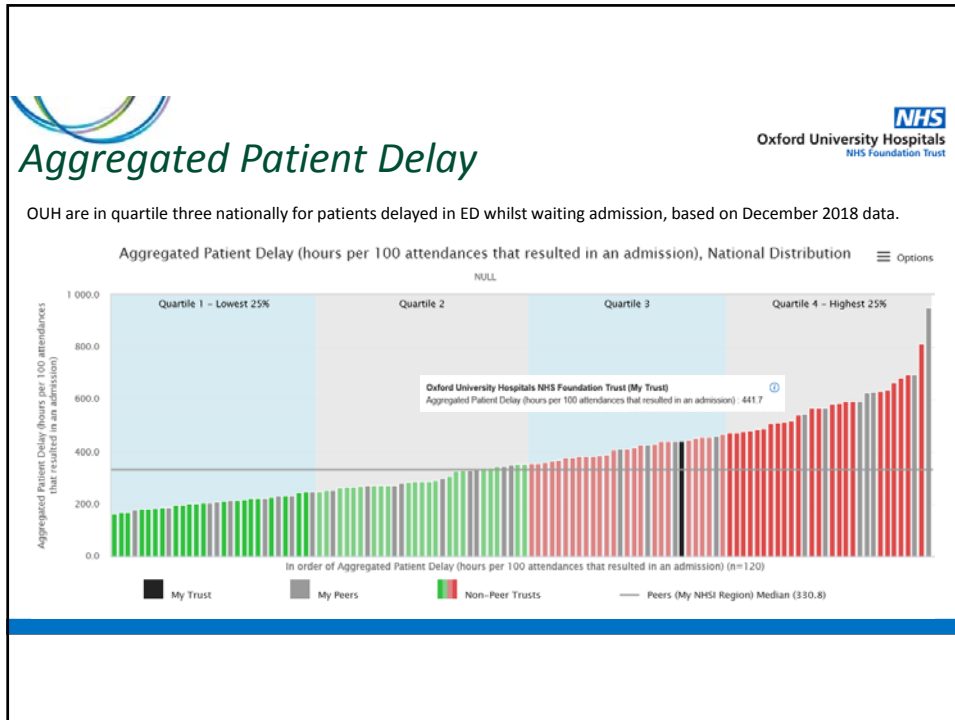


Oxford: A&E performance

Results to date...

Presentation title





More to do.....which relates largely to physical space, and reducing our bed occupancy.....

In the last 3 years

- **Patients reviewed in SEU:** 757 to 1169 per month
- **Decrease in beds:** 75 to 54
- **Decrease in admissions:** 69% to 25-30%
 - VTE Assessments: 20% to >99%
 - EiDD within 24 hours: 10% to 92%
 - Reduction in Cardiac Arrest Calls by 90%
 - 30 Day Readmission rate: **Unchanged**

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In the last 3 years

- **Increased proportion receiving operations:**
 - 27% to 42%
 - Double number of major operations (NELA)
- **Decrease LOS:** 3.2 days to 2.04
- **Ambulatory Care Patients:** 90 to 300 per month

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What has not changed

- No increase in staffing
- No increase in space – waiting room is still the same
- No increase in operating facilities
 - GIRFT suggest at least 1 more theatre
- No increase in critical care beds (NELA Criteria)
- Endorsements:
 - 594,963 total in General Surgery
 - 357,593 done by 4 SEU surgeons (72.5% within TG)

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Discharge 2 Assess Pilot

February 2019

Oxford University Hospital
NHS Foundation Trust

Proof of Concept

Discharge to assess (D2A) is a key function of the HART contract. The pilot project was set up to provide proof of concept that prescriptions of care should take place in the patient's home.

Assumptions:

- ✓ **Over prescription of care from a bed base** can lead to **increased dependency** and an over reliance on formal care.
- ✓ **Assessing a person in their own home** allows therapists and assessors to be able to see how equipment and informal support can lead to a strength based assessment and **reduce the need for formal support**.
- ✓ **Occupational Therapy** is central to safe D2A practice.



D2A Pilot

Occupational Therapist and HART assessor prescribe an initial package in a person's home on the day of discharge:

- To evidence that **fewer care hours** will be required if assessed at home
- To **avoid waits** for the larger amount of care prescribed whilst in hospital
- To ensure that **decisions about long term care** are made in a non-acute environment
- To make a case for **provision of OT resource** used for discharge assessment is embedded with HART
- To **save hours of assessment** or waits for assessment in the hospital setting
- To **improve the engagement of patients** in their own discharge planning and long term care needs
- To **improve patient experience** of the discharge process

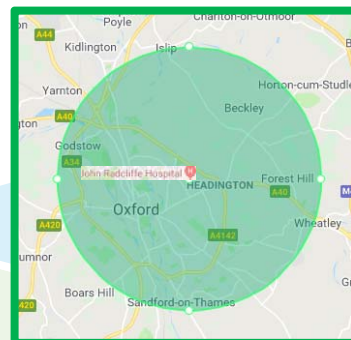
Assessment Process

- A focussed discussion was **held in each patient's home** with their family present.
- Full assessment of **assisted technology and equipment options** before care is prescribed.
- **Long-term decisions were made after the person returned home.** For example:
 1. *One patient made a decision to go to a nursing home after trying to live at home but then realised that home was not an option. A planned transfer to a HUB bed after being at home for 7 days*
 2. *The MDT was undecided about the discharge destination about another patient with cognitive problems. After he went home he was assessed D2A and help from Age UK he was able to remain with his family.*
 3. *A patient who was prescribed QDS DH care, went home with once a day care following assessment with his wife who wanted to deliver some of the care and it was found that the patient responded better to her than carers.*
- **Reassessments could be needed within 3 days of discharge** as patients are often too tired to be properly assessed first time.

Cohort

The trail consisted of **30 patients** that lived **within 4 miles of the John Radcliffe Hospital**:

- 13 from Acute
- 3 from Community hospital
- 4 already in the HART service
- 10 from Hub Beds



Case Study 1

A person was taken from **an acute setting** where he was prescribed a TDS package with the following plan:

- The person sleeps on the side of the double bed nearest the door to reduce steps need to walk around the bed. OT was able to maximise space and independence by recommending the door be hung the other way round.
- Son and daughter-in-law present also agreed to move the sofa to offer more room as it impeded the exit and entrances into the lounge when mobilising with her frame.

Outcome

This person now does not require any HART input or OT equipment / AT.

Case Study 2

A person who was in **community hospital** was originally QDS DH but at the point of D2A was QDS with the following plan.

- Equipment was ordered and delivered ready for discharge (hospital bed, shower chair).
- A Full assessment was carried out to ensure it met the person's needs.
- As care went on, the person's wife was able to manage some of the care needs so package was slowly reduced

Outcome

Following being D2A the care provision was TDS but with some reablement was further reduced to BD on the 1st of Feb with final reduction of OD

Case Study 3

A person was in a **hub bed** awaiting HART QDS DH POC.

- They were happy for the package of care to be reduced if it was safe to do so. The person's wife also provides support in between care visits.
- He has a lot of equipment in place.
- They were D2A at home

Outcome

They only needed a OD package of care and have since dispensed with the morning call. They can be discharged from the HART service.

Results

Assessing people at home rather than in a hospital yielded **very positive results**.

The people were pre-assessed prior to discharge, and again through the D2A process to determine what hours of care were expected and what could be achieved through this approach.

Estimate prior to discharge = 39 hrs/week

Actual hours after D2A assessment = 21.75 hrs/week

Total saved = 17.25 hrs/week

Next Steps

It is recommended that we build on the success of this trial by:

- **Employing Occupational Therapists** within the HART service.
- **Scale-up** by enabling team-leaders to undertake D2A roles within their areas.
- **Reviewing in 4-weeks** with a focus on scalability and challenges

What's Next?

