

Urgent and Emergency Care update for HOSC

Oxfordshire

August 2026

1. Oxfordshire Context

This document describes the work carried out over the previous year, including answers to the questions from HOSC committee members.

Urgent and emergency care (UEC) services are fundamental to ensuring people receive timely, safe and clinically appropriate care when they need it. National priorities, including the NHS 10 Year Health Plan, Medium-Term Planning and Financial Framework and national UEC planning requirements, reinforce the shift towards prevention, neighbourhood and community-based care, while protecting emergency services for those with the greatest clinical need.

The most significant area of focus and transformation will be the continued shift towards integrated community-based care. This brings primary care, acute providers, community services, mental health services, voluntary sector partners and councils together with shared outcomes and responsibility for improving health.

An aspect of this relates to how we meet the urgent care needs of adults with complex needs, children and young people. We continue to work together to increase the number of people who can be appropriately assessed and treated in their own home, reduce avoidable ambulance conveyances and avoidable hospital attendances, strengthening alternatives to admission and accelerating discharge.

As an Oxfordshire system we have a good history of working collaboratively and have developed working relationships that have resulted in positive changes across the Oxfordshire health and social care system. We will continue to develop UEC services to meet the increasing demand for health and care. Without this collaborative way of working, the growth in demand will continue to outpace available resources, leading to increased pressure for all providers.

2. Current State and progress against improvement programme

Our ambitions over the last few years are as follows.

- Prevent avoidable deterioration, ambulance conveyance, emergency department attendance and hospital admission;
- Provides timely assessment and treatment closer to home wherever clinically appropriate;
- Make urgent care easier to access and navigate;
- Protects emergency services for those who need them;
- Supports safe and timely discharge from hospital; and

- Reduce unwarranted variation and health inequalities while improving productivity and value.

Current pressures are across all providers; primary care, community services, hospitals and ambulance services and have increased each year. There is no one pathway that is experiencing a greater operational challenge in relation to demand and workforce.

In the community, services are challenged with people who are more complex, adults with frailty/long term conditions and children and young people with complex needs. The fact we are working hard to keep people in their own homes and to discharge patients home quicker adds to the demand and means we require a highly trained workforce to manage the complexity we are now treating outside of acute hospitals. Workforce within District nursing remains under significant pressure due to a variety of reasons, workforce capacity and existing funding does not meet all on the day demand. Oxford Health NHS Foundation Trust (OHFT) has recruited above establishment to meet same day demand. The trust continues to work with Thames Valley Integrated Care Board (TVICB) to see how this can be resolved.

Within the hospital setting, the Emergency Department (ED) at the John Radcliffe Hospital and Horton General Hospital has seen greater attendances in June and July this year, for both adults and children.

All services balance safety and quality with the increase in demand. This varies from the daily management of resources to continuously reviewing and developing pathways to meet the needs of Oxfordshire residents. We measure outcomes through our monthly situation report slide deck which covers all the pathways within UEC. An extract of this slide deck is in appendix 2 of this paper. In addition, we present a heatmap and productivity slide deck every quarter. All of these are reviewed at the Oxfordshire UEC Board.

2.1 John Radcliffe Hospital Emergency Department

- April to July, activity is up by **2.0%** compared to the same period last year, but this masks very different levels of activity in April and May vs June and July compared to the previous year.
 - Attendances in April and May 2026 were lower than the same periods in 2025/26 (-3.3% in April and -1.2% in May), and since then growth has been much higher month-on-month in **June** and **July** (+7.4% and +5.5% vs than the same months last year).
 - Growth for adults was +1.7% and for children it was +3.2%.
 - Growth is higher from non-ambulance arrival methods (walk ins + other categories): +5.9% (adults) and + 3.7% (children), with the increases observed also much higher in June and July vs April and May.

- Attendances via ambulance for April to July 2026 are lower compared to 2025.

2.2 Horton General Hospital Emergency Department

- April to July, activity is up by **6.2%** compared to the same period last year. Growth has been much higher each month but particularly in **April** and **May** (+8.0% and +8.3%, respectively). Growth in June and July vs the same period last year remained high but at a lower level (+4.8% in June and +3.8% in July).
 - Growth by adults (+4.2%) and children (+15.1%) in the period April – July 2026. Paediatric growth has been very high in April, May and July compared to 2025/26.
 - Growth is higher from non-ambulance arrival methods (walk ins + other categories): +6.6% (adults) and +16.7% (children).
 - Attendances via ambulance for April to July are lower compared to 2025.

Acuity increased during the months of June and July, this is mainly thought to be directly related to the heatwave. This has been challenging for all services, who have also had to deal with high sickness levels.

Length of stay for those 12hrs and over in both emergency departments increased up to December and reduced from January to April 2026 with a slight reduction from May to July 2026. However, conversion rate to admission continues to reduce gradually from 19% to 17%.

We had aimed to reduce the number of medical patients in speciality beds (i.e., non-medical beds) to improve the flow of people through the elective pathways. Although we were aiming for a greater reduction, from July 2025 to July 2026 there has been an 11% reduction. There was a 23% reduction in the length of stay for medical patients in speciality beds which is a significant improvement.

2.3 Community Services

2.3.1 Single Point of Access (SPA _Partial BCF funding)

Between April and July 2026, SPA managed rising telephone demand while maintaining improved responsiveness. Calls offered increased from 2,031 in April to 2,829 in July, and calls answered rose from 1,648 to 2,572 over the same period.

- Calls offered increased by approximately 39% over the four-month period.
- Call answering improved despite higher demand, with July recording the highest number of calls answered.
- Abandoned calls reduced from 383 in April and 385 in May to 183 in June, before rising to 257 in July; this remained below April and May levels despite increased call volumes.
- Average call-answer times remained close to the 30-second target: 30 seconds in April, 34 seconds in May, 38 seconds in June and 31 seconds in July.

Overall, the data indicates increased use of SPA alongside improved operational resilience and access for patients, carers and healthcare professionals.

2.3.2 Minor Injury Units (MIU)

Minor Injury Units activity increased by 3% between May and July 2026 compared with the same period last year. A high proportion of patients attending Henley MIU are from outside Oxfordshire, predominantly from Reading and the surrounding areas. This is partly because local MIUs in those areas operate by appointment only, whereas Oxfordshire MIUs offer a walk-in service, with some patients redirected via NHS 111. The service managed to maintain performance against the 4-hour wait target at 95% or over since April 2026.

2.3.3 General Practice Out of Hours Service (OOHs)

General Practice (GP) Out of Hours activity increased significantly in July 2026, with around 1,500 more cases than in the same month last year, exceeding forecast levels. Activity in April and May was broadly in line with the previous year, but June saw 833 additional cases, representing a 10% increase. This increased demand led to more 'comfort calls' to advise patients when the service was nearing closure and to redirect them to in-hours GP practices where appropriate. In many cases, patients no longer required GP contact because their symptoms had resolved; however, others still needed to speak with a GP or clinician to receive advice or be signposted to the most appropriate service.

Recruitment of Emergency Practitioners and Advanced Clinical Practitioners is having a positive impact by strengthening the non-medical workforce supporting the GP Out of Hours service. However, recruitment of both substantive GPs and in-house bank GPs remains challenging. Operationally, the service has continued to rely on agency GPs, and this has been further affected by changes to pay arrangements and the use of staff working through limited companies.

2.3.4 Urgent Community Response (UCR)

Urgent Community Response (UCR) activity increased overall between April and July 2026. Two-hour response referrals rose from 1,377 in April to 1,451 in May and 1,608 in June, before reducing to 1,473 in July. UCR continued to account for more than half of all same-day care referrals throughout the period: 56% in April, 54% in May, 56% in June and 54% in July.

Self-referrals and referrals from carers remained the most common referral route, with 495 referrals in April and 470 in May. From June, this was reported as a combined category, with 548 referrals in June and 498 in July. SCAS crew-with-patient referrals were the next most common source, with 201 in April, 188 in May, 188 in June and 172 in July.

Across all same-day care referrals, District Nursing remained the most common preferred pathway, with 725 referrals in April, 706 in May, 794 in June and 744 in July. The UCR two-hour visiting response pathway also increased overall, from 589 referrals in April to 674 in May and 763 in June, before reducing to 690 in July.

UCR performance against the two-hour visiting response standard remained consistently above 95%, with performance of 98.48% in April, 97.29% in May, 98.46% in June and 99.16% in July 2026.

2.3.5 Support to South Central Ambulance Service (SCAS) - taking referrals from 999 service (from the stack) – BCF funded.

Urgent Community Response (UCR) currently supports South Central Ambulance Service seven days a week, 8am–12pm, by identifying suitable people (Category 3 and 4 cases) who have called 999 and are on the 'stack' awaiting assessment in the community. This service will be extended from 4 hours to 12 hours per day, Monday to Friday, from 1st October 2026.

Between April and July 2026, the stack service managed 1,099 patients. Activity peaked in May and June, at 308 and 301 patients, before reducing to 266 in July; this remained above April activity of 224 patients.

- Average daily activity remained broadly consistent, ranging from 7.46 patients in April to 10.03 in June and 8.58 in July.
- In July, 151 patients were taken off the stack, compared with 156 in June and 164 in May.
- People more appropriate for an ambulance crew are handed back to SCAS reduced to 115 in July, compared with 145 in June and 144 in May, although this remained above April's 94.
- Signposting or onward referral reduced to 17 patients in July, compared with 18 in June and 25 in May, but remained above April's 6.

UCR visits for people who have called 999 remained consistent in July, with 75 visits compared with 73 in June, 92 in May and 74 in April, showing sustained need for rapid community assessment despite lower overall stack volume.

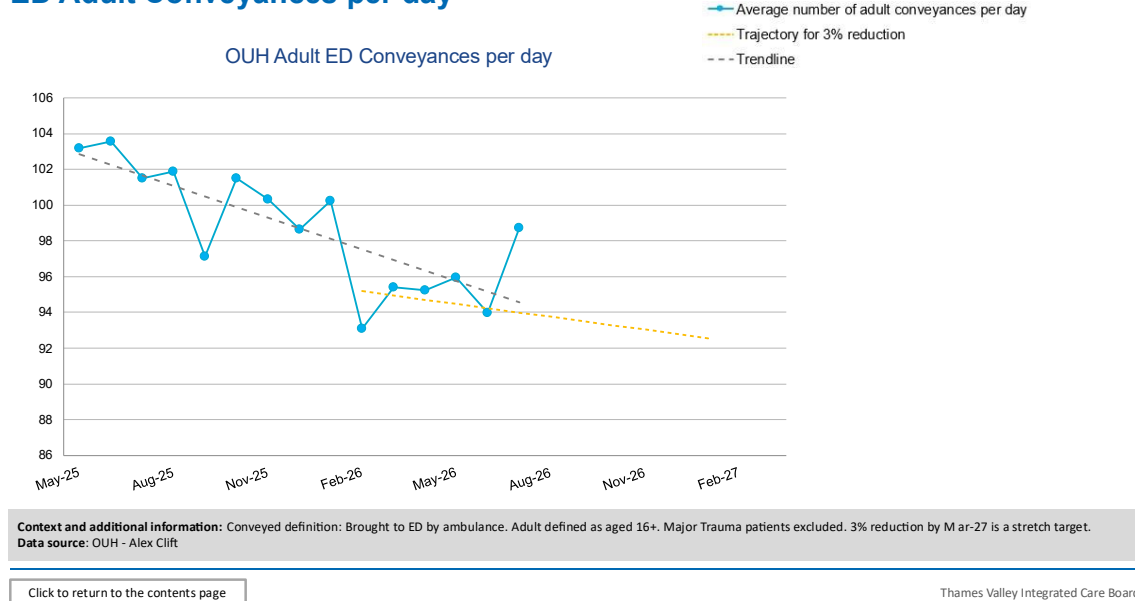
Overall, July shows a moderated but active stack position, with sustained clinical intervention, continued patient flow and fewer hand backs than in May and June 2026.

3.0 Shift from Hospital to the Community

3.1 Ambulance Conveyances

We set out to maintain or reduce ambulance conveyances to the Emergency Departments. As described above, this gradually reduced over the year, and we continue to see a reduction in ambulance conveyances from April - July 2026. Figure 1.0 on the following page illustrates the decrease in ambulance conveyances. However, we have observed an increase in the number of people who self-present to both Emergency Departments. We are working with South Central Ambulance Service (SCAS) to review all contacts with the 999 service for one week to see if they turned up to the Emergency Department (ED) after triage and assessment by SCAS.

Conveyances from Oxfordshire care homes has reduced by 18%, with a 26% reduction in emergency admissions from care homes. Oxford Health (OHFT) are supporting Care Homes with the Care Home Support Service and providing direct assess to the Single Point of Access for further advice and triage should it be required.

Figure 1.0 Ambulance conveyances for adults to Oxfordshire EDs**ED Adult Conveyances per day****3.2 Ambulance Handovers**

The average time to ambulance handover in the Emergency Departments reduced from 17 minutes to 15 minutes and 50 seconds. We have seen improvements in the excess handover times, and we continually work together to improve processes to minimise any ambulance handover delays.

3.3 Zero Growth in Emergency Admissions

We aimed to achieve zero growth in emergency admissions to general medical and gerontology wards. We achieved this in addition to a 4% reduction in emergency admissions. We monitor emergency readmissions, outcomes from assessing people in their own home and working across pathways to continuously improve to maximise outcomes for people.

3.4 Fall Prevention Programme

Falls remain a significant driver of urgent and emergency care demand in Oxfordshire, particularly for older people living with frailty or reduced mobility. However, the current performance picture suggests progress in some higher-risk pathways.

The Emergency Departments have also seen a reduction in the number of people conveyed by ambulance following a fall. However, at the same time, there has also been some increase in people walking into ED following a fall, suggesting that these may be different cohorts.

The work on prevention, community response and public messaging will continue alongside work with care homes and ambulance pathways. Overall, Oxfordshire's performance indicates progress in reducing more serious falls-related escalation from care homes and ambulance conveyance, but further work is needed to understand

and respond to falls-related walk-in attendances and to demonstrate the impact of current falls prevention services.

This work is being addressed through a monthly system-wide falls group attended by health, adult social care, district councils and voluntary sector partners, with the aim of reducing falls and falls-related admissions to hospital.

The programme has two core workstreams:

- Communications and engagement
- Measuring the impact of falls services

The communications workstream is focussed on practical prevention measures for residents, carers and community partners, including how to reduce falls risk, what support is available, and when urgent and emergency care is the correct response. This is particularly important considering the increase in falls-related walk-in attendances to ED.

The impact workstream is focused on strengthening how partners measure whether falls prevention activity is reducing avoidable harm and urgent care demand. To date, it has been difficult to demonstrate the impact of the full range of falls prevention services across the county. Partners are therefore developing a clearer methodology, drawing on learning from Integrated Neighbourhood Team evaluation, to link commissioned falls services with indicators such as ambulance conveyance, ED attendance, emergency admission, care home activity and community-based support. This will help the system understand where current activity is working and where further targeted action is needed.

Alongside work to reduce ambulance conveyance and care home admissions, residents and carers need clear information on how to reduce falls risk, what community support is available, and when urgent or emergency care is the right response.

One of our strategic providers has completed an independent review of people who have fallen whilst on the Home First pathway. This has resulted in several additional actions being put in place to support reducing the falls risks whilst people are in a recovery phase in their own home.

3.4 Hospital @ Home (Virtual ward) – BCF funded

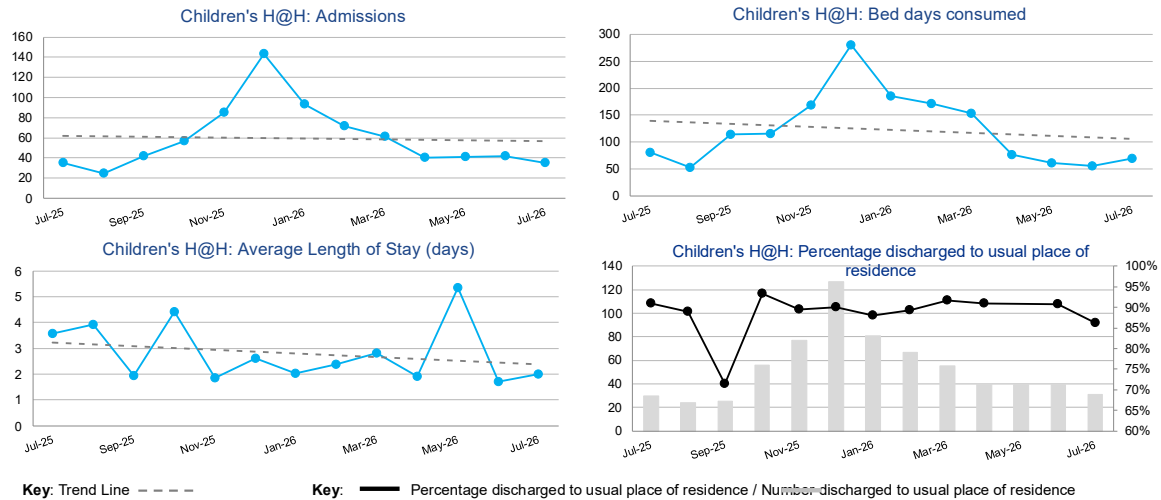
Our aim was to deliver appropriate urgent care to more adults and children in their own homes (including care homes) and to avoid inappropriate or unnecessary conveyances to the hospital setting.

3.4.1 Children's Hospital at Home

The service is a partnership between the acute paediatric team in OUHFT and OHFT's Children's community nursing team. They worked together to increase the number of children they cared for over the winter months (Figure 2.0 following page). This helped to reduce emergency admissions for children and, for those who were admitted, reduced their length of stay in hospital.

Figure 2.0 Children's hospital @ Home service

Children's Hospital at Home



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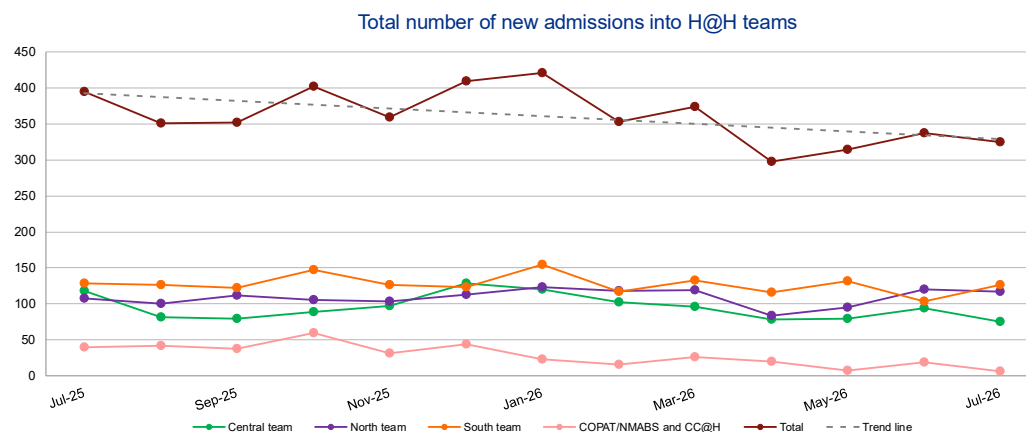
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3.4.2 Adult Hospital at Home

Over the last 6 months, this service has seen a reduction in the number of people they are caring for but an increase in acuity (how ill they are). Most people assessed and treated in this service are complex and frail. In this service, we have seen progress and improvements in how people are treated for heart failure and respiratory disease. The service continues to develop and safely provide hospital level care in the person's own home.

Figure 3.0 Number of admissions to Adult Hospital @ Home service

Hospital at Home: Number of Admissions



Context and additional information:
Data source: OUH – Pedro Lopes & Aswathy Nair

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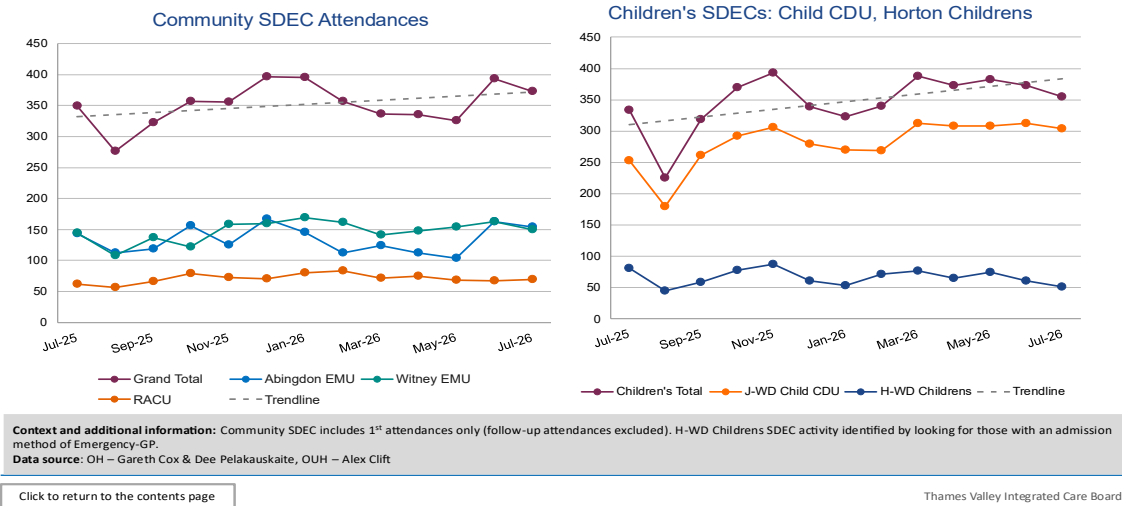
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3.5 Same Day Emergency Care (SDECs)

Since April to July 2026, we have seen an increase in the number of people assessed in the following units: Frailty: Abingdon Emergency Multidisciplinary Unit (EMU), and Henley Rapid Access Care Unit (RACU). Children's Clinical Decision Units (CDU) at the John Radcliffe and Horton General Hospitals. This is illustrated in Figure 4.0 below.

Figure 4.0 Community SDECs and Children's Clinical Decision Units

SDEC Community & Children's Attendances

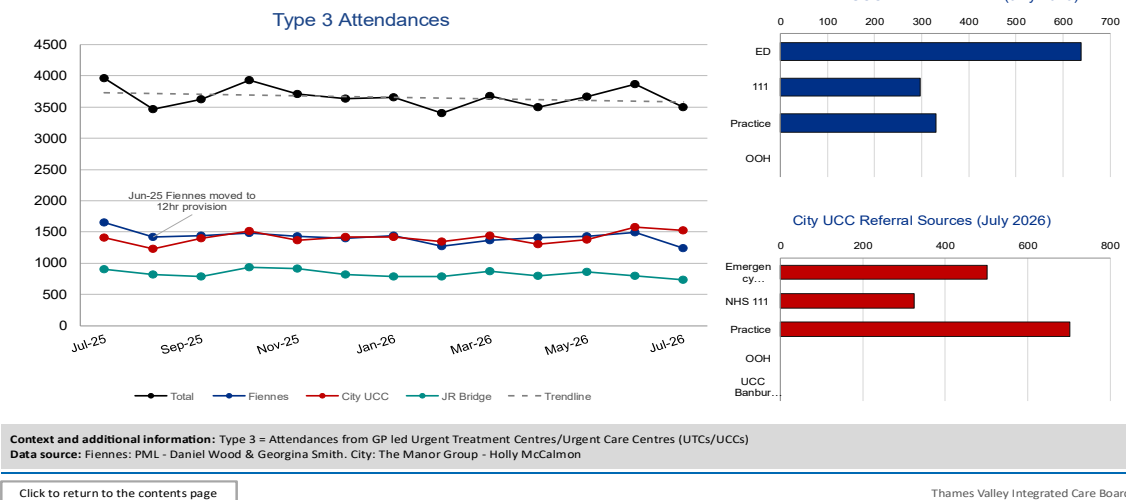


3.6 Urgent Treatment Centres

The Urgent Treatment Centres (UTCs) on the Horton General Hospital site and on the John Radcliffe site both have a consistent model of care and are working to ensure a consistent delivery of NHS 111 pathways. Both units are designated Urgent Treatment Centres and focus on those who are redirected from the Emergency Departments, referrals from NHS 111 but also support Primary Care where capacity allows.

Figure 5.0 Urgent Treatment Centre activity

Urgent Treatment Centres



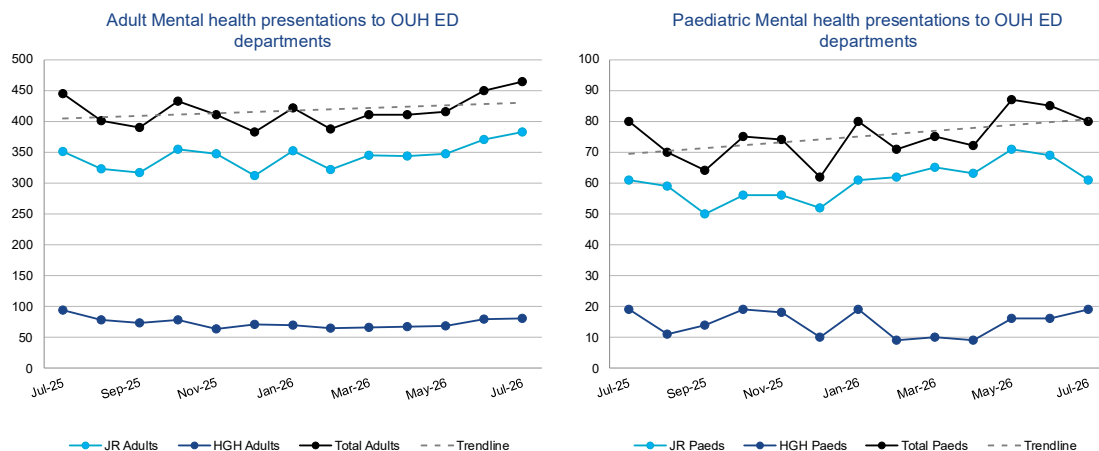
4.0 Mental Health

4.1 Mental Health in ED

The number of adults with a mental health issue has fluctuated throughout the year but there has been an 11% increase in children and young people who have attended ED with a mental health issue (Figure 6.0 below). However, OHFT have observed improved flow through mental health crisis and acute pathways and access to children and young people's services.

Figure 6.0 Mental Health ED Attendances

Mental Health ED Attendances



Context and additional information: Patients with a mental health referral, chief complaint, diagnosis or "self-inflicted injury" injury intent (Matching national MH ECDS criteria). Paed's < 18.
Data source: OUH - Alex Clift

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4.2 Reducing length of stay in inpatient mental health beds and reduction of out-of-area Placements

OHFT has an inpatient transformation programme that focusses on reducing length of stay.

The Better Care Fund has supported the utilisation and optimisation of the following services.

- Personality Disorder In-reach Team (PDIT)
- Use of one-off Flexible Use Fund to unblock practical barriers to discharge
- Care Home discharge / liaison team
- Connections integrated support workers and Housing Officer embedded within the Inpatient social work team (adult MH) and access to step-down / step-up beds

4.3 Evaluation of Integrated Neighbourhood teams

We are working with the department of public Health at Oxford University to evaluate the impact of Integrated Neighbourhood teams (INTs) in areas of significant

deprivation within Oxfordshire. To date the evaluation has been completed for the two INTs in Banbury but the Oxford city has yet to have this completed.

In Banbury we carried out a retrospective observational study, looking at data from 12 months before and 12 months after the INT interventions. The data was collected from the INTs, OUHFT, Primary Care and Hospital @ Home services. This is continued to be worked on.

Both INTs in Banbury saw a reduction in ED attendances, Hospital admissions and Primary Care contacts post INT interventions. INTs were associated with positive service-specific changes in healthcare utilisation across GP, A&E, inpatient care, and Hospital at Home. We are working on the INT data for OX3 and the data for Children and Young People will not be analyzed until next year. We are hoping to have this review completed by October 2026.

5. Demand, Capacity and Patient Flow and Waiting lists

The daily focus is ensuring we have systems in place to effectively triage referrals and managing the existing capacity to meet the needs of those who require an assessment either in their own home or in the nearest appropriate clinical environment. These assessments can be on the day or the next day depending on the individual's needs.

To maintain safety, we have escalation process in place for when there is not the capacity to meet the on the day demand. Visiting services such as Hospital @ Home proactively review who they are visiting to see who can wait until the next day to accommodate a person who needs to be seen that day.

Within Oxfordshire, as issues (bottlenecks) arise, we discuss them on our daily morning system call. Should the need arise during the day, further escalation calls are organised. If we do not have a resolution and the issue is too large to resolve, we will set up a weekly taskforce group with representatives from all aspects of the pathway. We review the issues and develop interventions, which we pilot and evaluate. If interventions do not work, we review again until we have a solution.

5.1 Analysis of demand across pathways

Similar UEC pressures are observed across England. Over the summer months, we saw an increase in acuity and demand across all services. The impact of the heatwaves continued over July and August. Each year we estimate the demand expected over the forth coming winter. The Oxfordshire system will have to also carrying this out for the summer period to predict demand during potential heatwaves.

As mentioned previously, the Emergency Department continue to see an increase in attendances. There are times when the Emergency Department has an increase in attendances over a short time leading to overcrowding. As a result, some people may be temporarily cared for in a corridor within the ED. In May 2026, OUHFT have set up a 'corridor care elimination' taskforce to reduce and eradicate episodes of corridor care. OUHFT compares favourably for this metric when compared to similar multi-site trusts. Since 25th June 2026, OUHFT had no episodes of reportable ward corridor

care. Staff and patient experience are core improvement drivers and in addition to the national mandated metrics.

5.2 NHS 111

The data below in table 1.0 lists the number of NHS 111 referrals by pathway. Most NHS 111 pathways continue to be directed to the Oxfordshire Emergency Departments (EDs).

Table 1.0 Number of NHS 111 referrals by pathway

Month	ED	Urgent Care combined	SDEC	District Nurse SPA	UCR	Primary Care CAS	All referrals	Outside ED share
Jul 2025	2,418	1,197	24	44	30	54	3,767	35.8%
Aug 2025	2,354	1,117	16	44	35	30	3,596	34.5%
Sep 2025	2,428	1,011	23	46	67	27	3,602	32.6%
Oct 2025	2,642	1,134	25	28	83	38	3,950	33.1%
Nov 2025	2,495	1,059	19	22	80	25	3,700	32.6%
Dec 2025	2,473	1,136	29	36	115	42	3,831	35.4%
Jan 2026	2,497	1,151	19	38	90	31	3,826	34.7%
Feb 2026	2,061	1,020	14	26	77	22	3,220	36.0%
Mar 2026	2,261	1,254	14	28	105	20	3,682	38.6%
Apr 2026	2,307	1,351	7	43	72	34	3,814	39.5%
May 2026	2,453	1,458	16	28	103	29	4,087	40.0%
Jun 2026	2,582	1,375	17	45	96	30	4,145	37.7%
Jul 2026	2,605	1,395	17	51	102	38	4,208	38.1%
Available total	31,576	15,658	240	479	1,055	420	49,428	36.1%

This is also displayed in Figure 7.0 which illustrates the number of referrals to the EDs is greater than other Urgent treatment pathways. We are working with the two Urgent Treatment Centres to ensure that we have maximised the pathways from NHS 111, to take some of the pressure off the Emergency Departments.

Figure 8.0 (next page) shows the monthly number of referrals by type of service. We have reached out to SCAS NHS 111 control centre to see if how we can support their triage and clinical advisory service, to improve referrals to non-ED locations.

Figure 7.0 NHS 111 referrals to ED and other Urgent treatment pathways

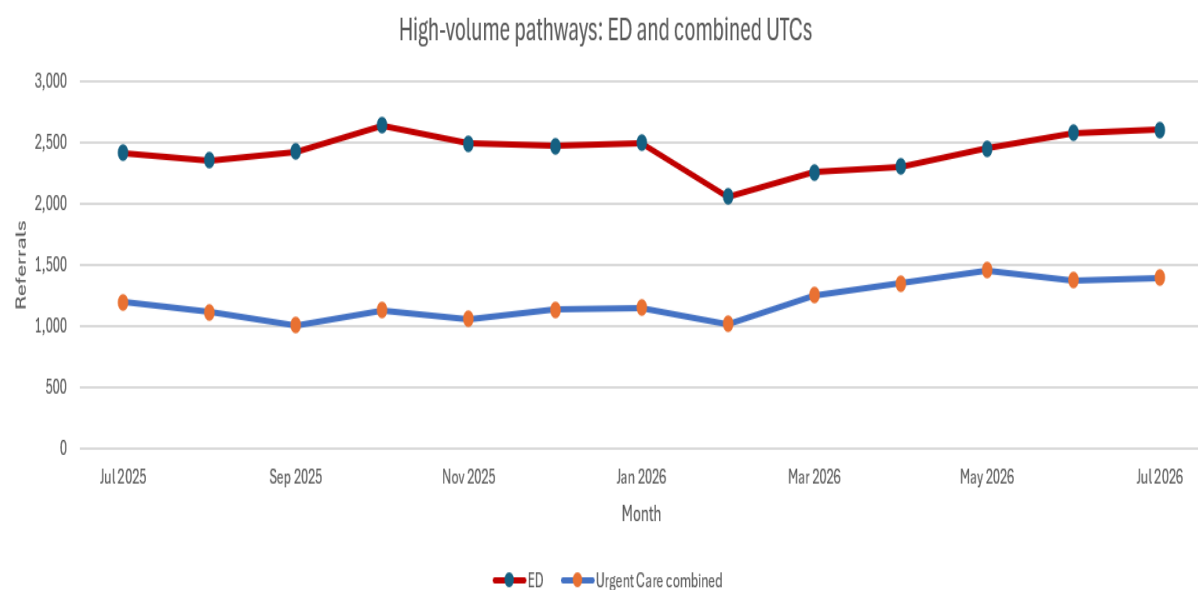
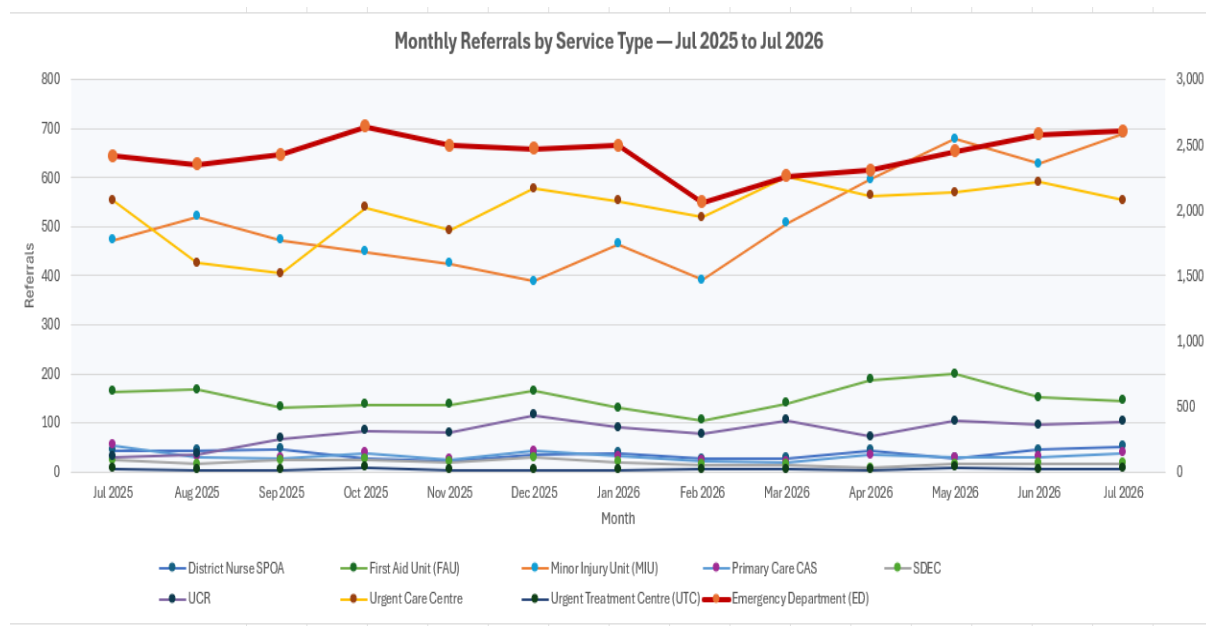


Figure 8.0 monthly referrals by service type

5.3 Population Health

Oxfordshire is working with Thames Valley ICB to continue the use and development of connected care to deliver our population health analytics. In data for Oxfordshire shows the following.

- Population for 80yrs plus will have increased by 21% in 5 years.
- Those with long-term conditions and frailty are growing fastest.
- Most complex 5%, use approximately 30% of resources (ED attendances, bed days, GP/community contacts).
- Inequality in our most deprived communities.

Population Health Management (PHM) underpins neighbourhood planning and delivery by using shared data and analytics, overlaid with local intelligence and community insight, we can identify people at risk of deterioration, prioritise proactive interventions and reduce unwarranted variation in outcomes. Primary Care, Public Health, social Care and health providers are working together to Identifying risk earlier and coordinating support around priority cohorts. We continue to develop integrated community services that prevent avoidable hospital use and support recovery at home. In areas of significant deprivation, we continue to reduce the health inequality gap by working with local communities to understand the access issues they face when accessing healthcare and providing education on how to manage their long-term conditions.

6.0 Hospital Discharge and Delayed Discharges

6.1 Reduce length of stay in hospital and ensure that people are cared for in the most appropriate setting

Throughout the year we have carried out various reviews of why people are delayed in hospital. We have assessed where there are process gaps and opportunities to improve. One area reviewed, related to people not returning home on the day they were due to be discharged. One of the actions following the review, led to changes in how we communicate across the various services and the individual person and their family. In addition to escalation of potential delays with equipment house cleans etc.

We have also reviewed why we are seeing an increase in the number of people transferring to long term placements. The outcome of the review was that they were all appropriate.

There has been an increase in the number of people returning home with reablement. People who do not require a large reablement package of care, rarely wait more than one day but those with more complex needs and where additional training is required they wait an average of 5 days.

People who require rehabilitation in a community hospital continue to transfer to these units within 3 days. However, if a person requires a more specialised rehabilitation, then the wait is longer, 8-18 days delayed.

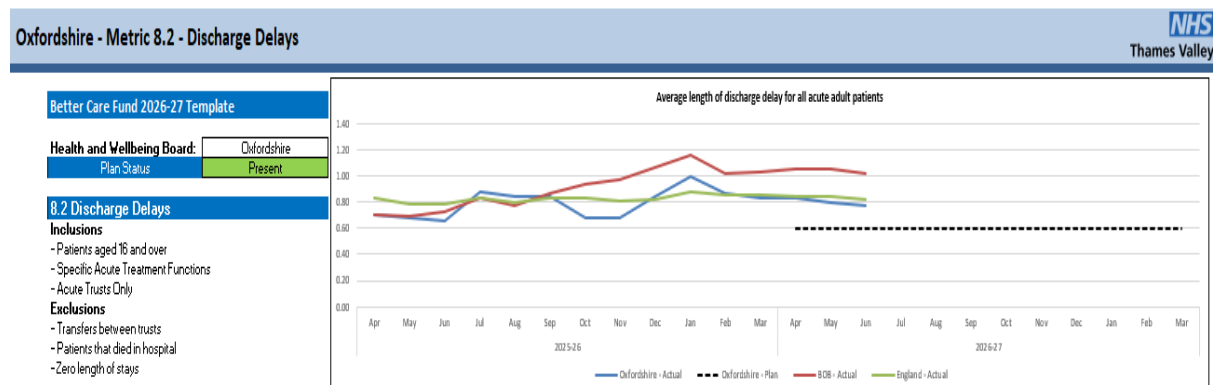
We have seen a reduction in the number of days for people waiting for long term placement, from 15 to 13 days.

No more than 0.6% of people Medically Optimised for Discharge (MOFD) for 21 days or more. Reduce length of stay for those in bed-based rehabilitation, generic and specialist neuro rehabilitation

6.2 Hospital Discharge and Delayed Discharges

Improving hospital flow and reducing delayed discharge remains a key priority for Oxfordshire. The system continues to support high levels of discharge activity and maintain a Home First approach with the aim of enabling people to return home as soon as this is safe and appropriate. Overall length of stay for General Medicine and Geriatric Medicine emergency admissions has remained broadly stable at around eight days, but delays for people who no longer need acute hospital care remain a significant pressure.

Discharge performance has not improved at the same pace as admission avoidance. During 2025/26, bed days lost to discharge delays increased across pathways, and the average length of delay increased from 5.6 days in 2024/25 to 5.8 days in 2025/26, against a target of 5 days. Current in-year reporting also shows continuing pressure, with May 2026 performance showing an average delay per discharge of 0.8 days against a 0.6-day target; 86.6% of people discharged on their discharge-ready date against an 88% target; and an average delay of 6 days for those not discharged on their discharge-ready date against a 5-day target. The number of delayed discharges in OUHFT are like the rest of England but at a lower level than surrounding counties (Figure 9.0 below).

Figure 9.0 Discharge delays Oxfordshire compared to England

The causes of delay vary by pathway. For people returning home with support, delays are often linked to the complexity of care packages, including double-handed care, acute therapy, equipment, reablement capacity and coordination between hospital discharge teams and community services. For people requiring bed-based rehabilitation, delays relate to availability and flow through intermediate care beds. For people moving into long-term care, delays are more likely to be associated with complexity of need, family choice, availability of suitable placements and decision-making processes.

The current position suggests that delays are not attributable to one single part of the system. Acute therapy capacity, social care capacity, community provision, housing, workforce, equipment, medicines, transport and family choice can all contribute, but local analysis indicates that aspects relating to complex cases are also a significant factor, particularly for people returning directly home and those transferring to long term placements.

To address both capacity and process, the system response enhances Home First and Discharge to Assess pathways while strengthening reablement and intermediate care. By leveraging the use of OPTICA (NHSE's real-time discharge planning tool) for improved task tracking and escalation, teams gain clearer visibility into discharge tasks, unblock delays, and accelerate decision-making for complex cases. This ensures teams can pinpoint bottlenecks, establish clear action ownership, and maintain momentum against discharge-ready dates.

For people with more complex needs, timely and clear information provision is also important in supporting safe discharge and reducing avoidable delay. This includes ensuring that people, families and carers understand the discharge pathway, the role of Home First and reablement, what support will be provided, any chargeable and non-chargeable elements of care, and what will happen if needs change after discharge.

6.3 End of Life Care

Over June and July 2026, we have reviewed the people who were discharged from hospital with Discharge to Assess (D2A) and known to palliative care teams but not end of life (imminently dying). We focused on the experience of the individual, their carers/family and the care providers.

It was clear that we needed to change this pathway, to one where greater support was available should the person deteriorate. Over the summer we have piloted this group of people being discharged with OUHFT's CARE (Crisis Assessment Response) team and referred to community palliative care teams once they are at home. To date this is working well, but a thorough review will be conducted considering the person and their cares/family's views.

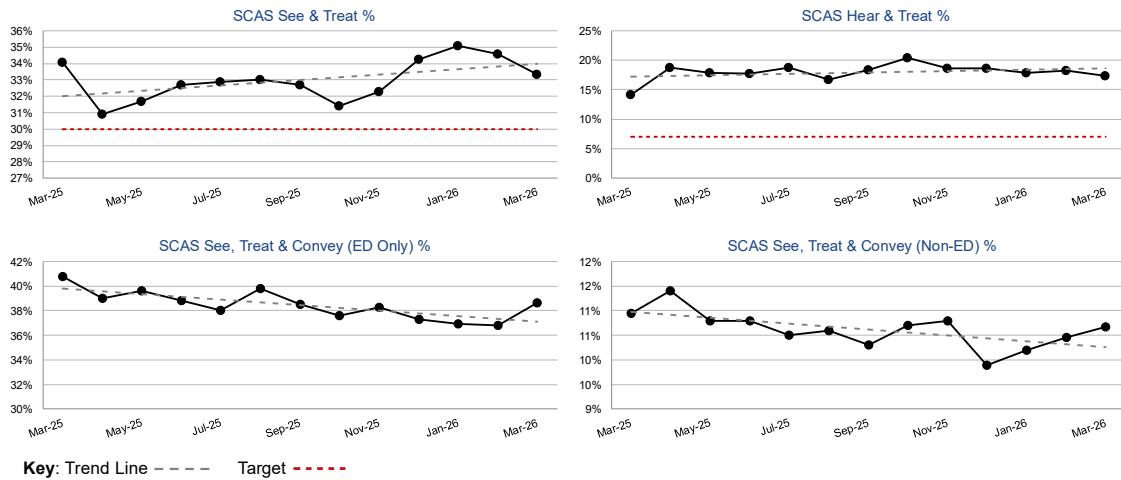
The pathway for those who are palliative or end of life and the difference between specialist and community palliative care will be described and communicated to all health care professionals within Oxfordshire

7.0 Summary

In summary Oxfordshire has observed a reduction in ambulance conveyances but a steady increase in the number of people who present at the ED's. Alternatives to ED are continuously being reviewed and developed with both NHS 111 and 999 service. We continue to focus on assessing and treating people where appropriate in their own home. The number of people delayed in hospital has not reduced as expected over the summer months but has remained at a similar level to late spring. We continue to work on reducing length of stay across the various pathways. The INTs in Banbury have shown post INT interventions, there is a reduction in Primary Care contacts, ED attendances and hospital admissions.

Appendix 1 Additional Oxfordshire data for UEC pathways

SCAS: See & Treat, Hear & Treat



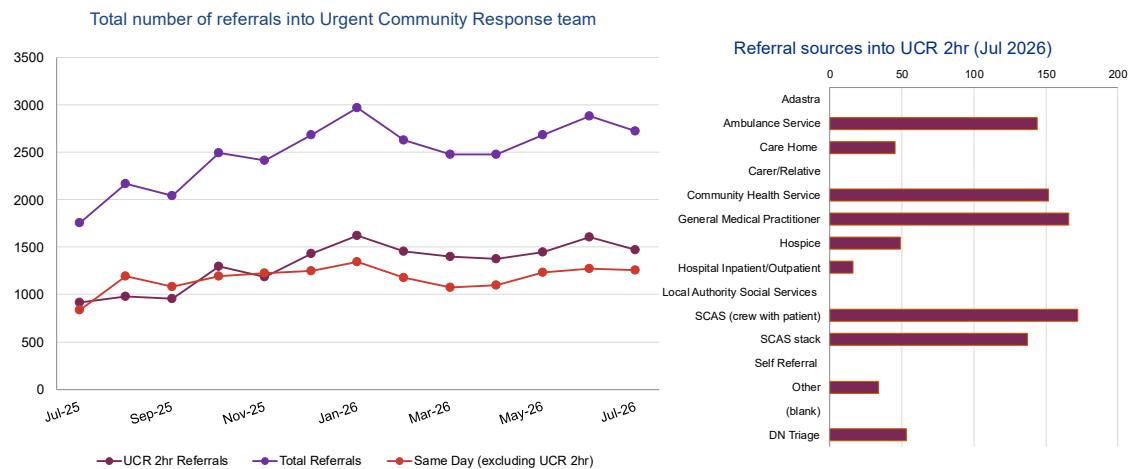
Context and additional information: SCAS dispatch area = North. Targets provided by Andrew Battye.
Data source: SCAS - Andrew Battye

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Single Point of Access (SPA) - Same day urgent care demand



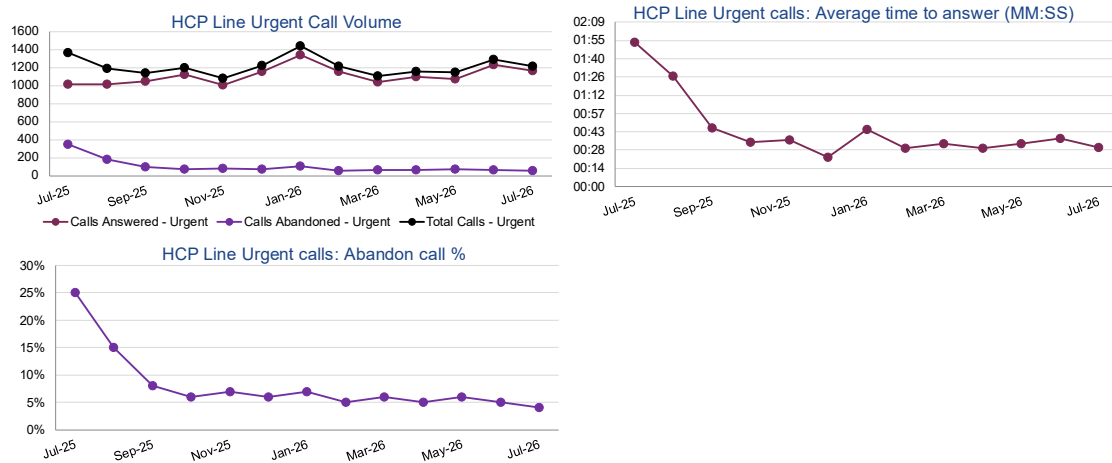
Context and additional information:
Data source: OH – Gareth Cox & Dee Pelakauskaitė

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Single Point of Access (SPA) – HCP Line Urgent calls



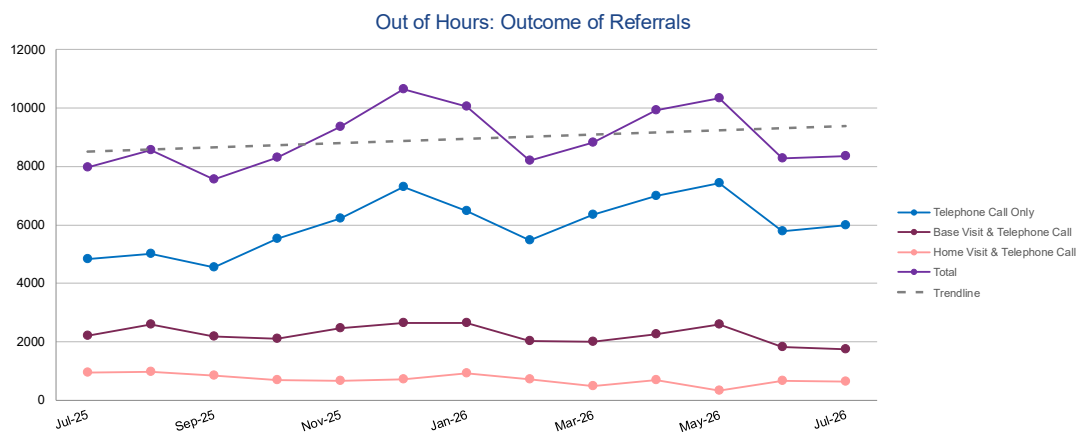
Context and additional information: Healthcare Professional (HCP) line.
Data source: OH – Gareth Cox & Dee Pelakauskaite

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Out of Hours Referrals



Context and additional information:
Data source: OH – Gareth Cox & Dee Pelakauskaite

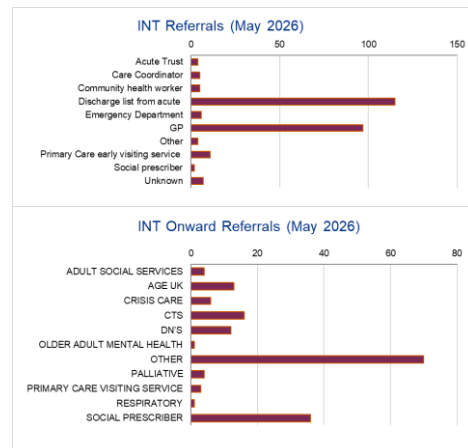
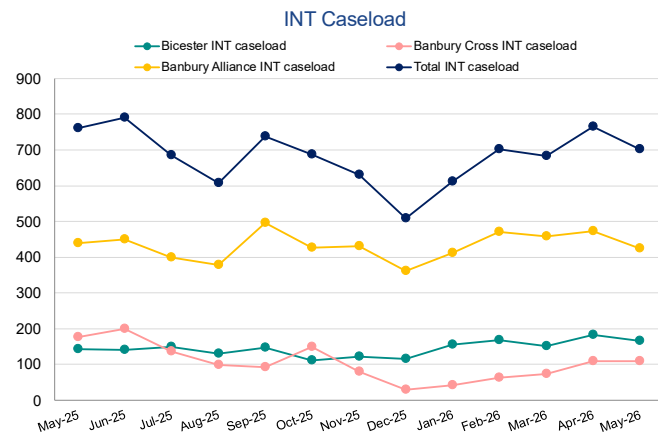
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Integrated Neighbourhood Teams (INTs)

INTs included: Bicester, Banbury Alliance & Banbury Cross



Caseload definition: Patients with an INT stay at any point during the month

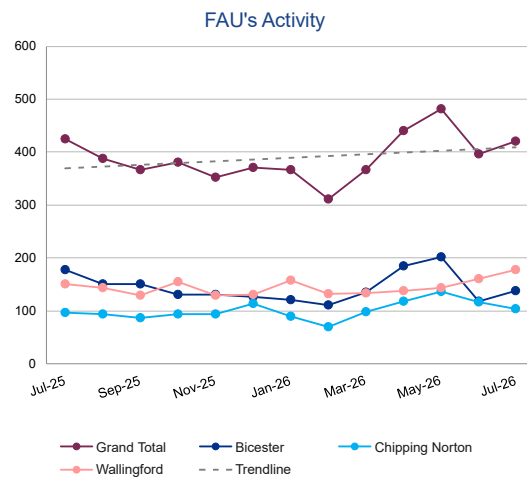
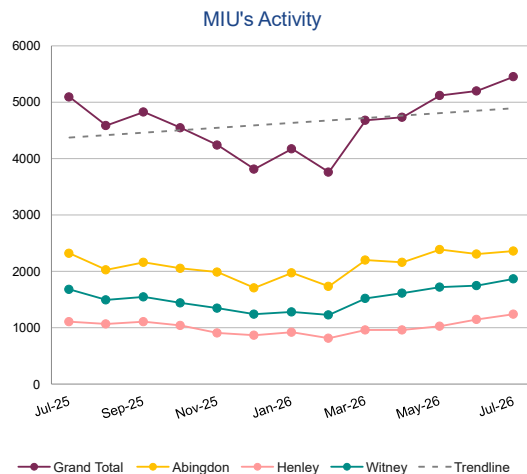
Context and additional information: OX3+ data to be incorporated soon. INT referrals uses admission dates; INT onward referrals uses discharge dates. Banbury Cross data incomplete.
Data source: Bicester INT (Jodie Loverock-Pates), Banbury Alliance INT (Hayley Wilkinson), Banbury Cross INT (Amanda Walters)

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MIU's and FAU's



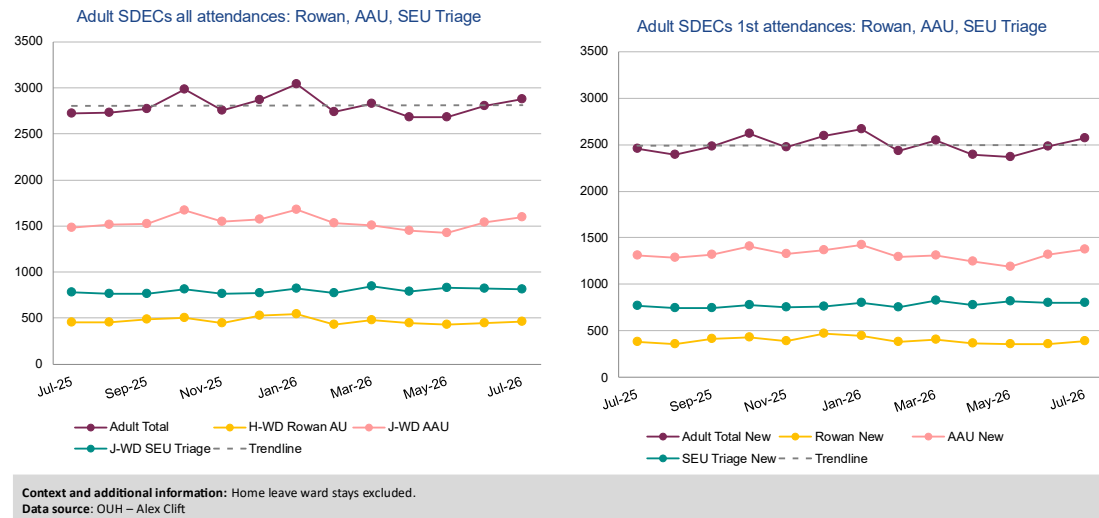
Context and additional information: Chipping Norton FAU only includes CNIPCS activity i.e. those with a referral source of 111.
Data source: OH - Gareth Cox & Dee Pelakauskaite, Chipping Norton - Lindsay Rudeforth (SCAS), Wallingford - Simon Nash (BOB ICB)

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SDEC Acute Attendances

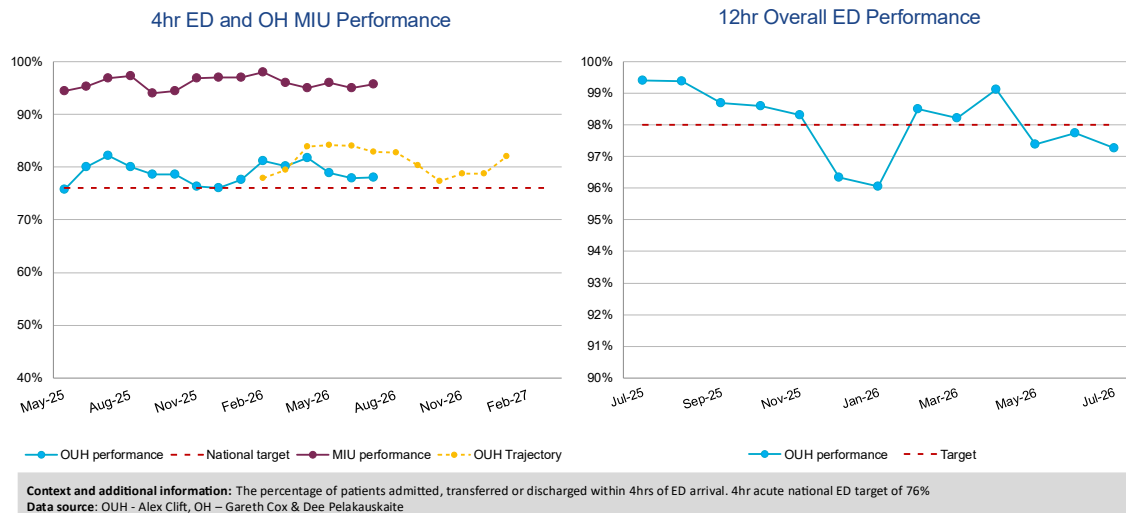


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ED and MIU 4hr Performance

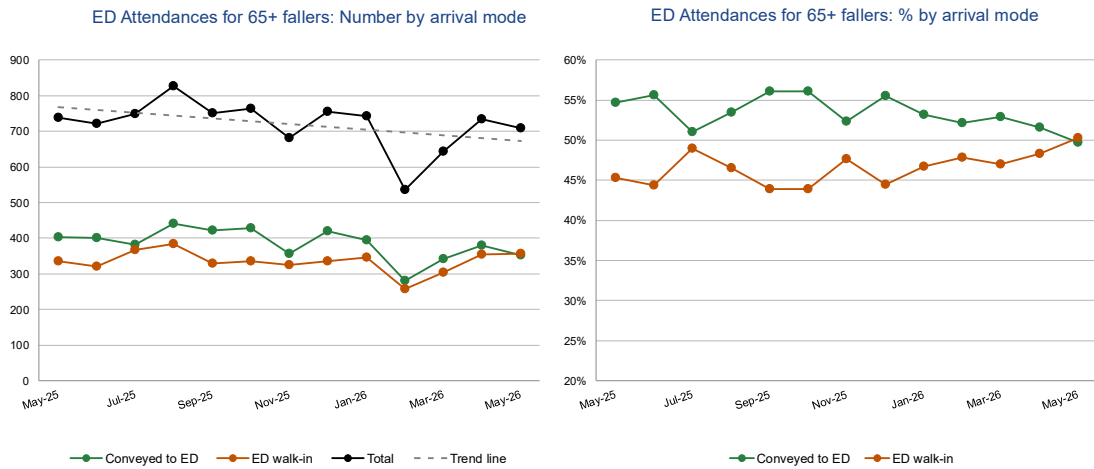


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ED Attendances for fallers aged 65+: By arrival mode



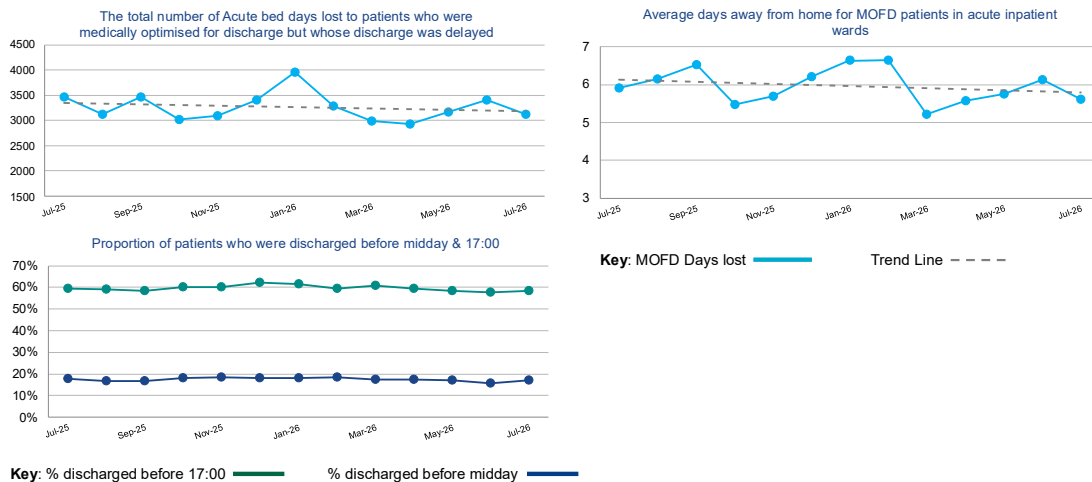
Context and additional information: Conveyed definition: Brought to ED by ambulance. Criteria: ED Injury Mechanism of 'Fall - Tripping', 'Fall - Slipping' or 'Fall from height of less than one metre'
Data source: OUH - Alex Clift

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Total number of bed days lost for delayed discharges (OUHFT)



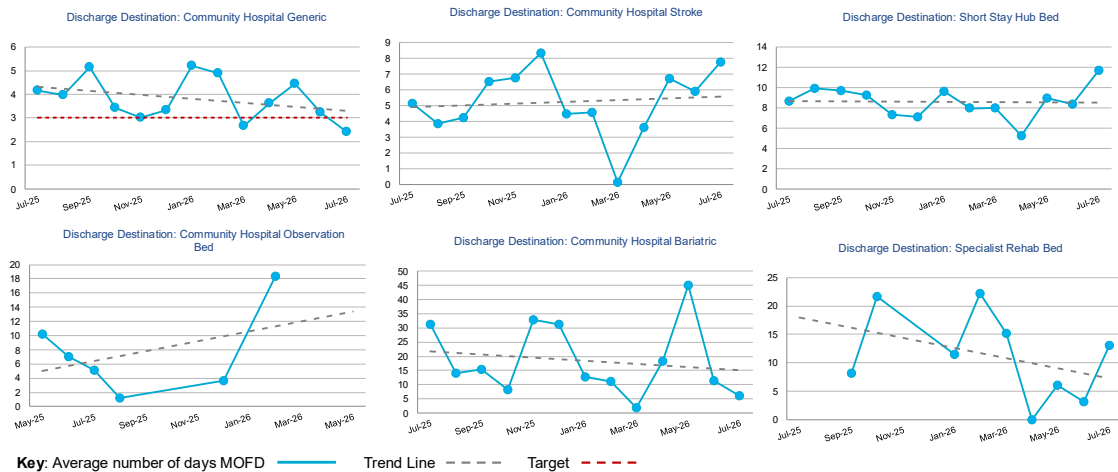
Context and additional information:
Data source: OUH - Alex Clift

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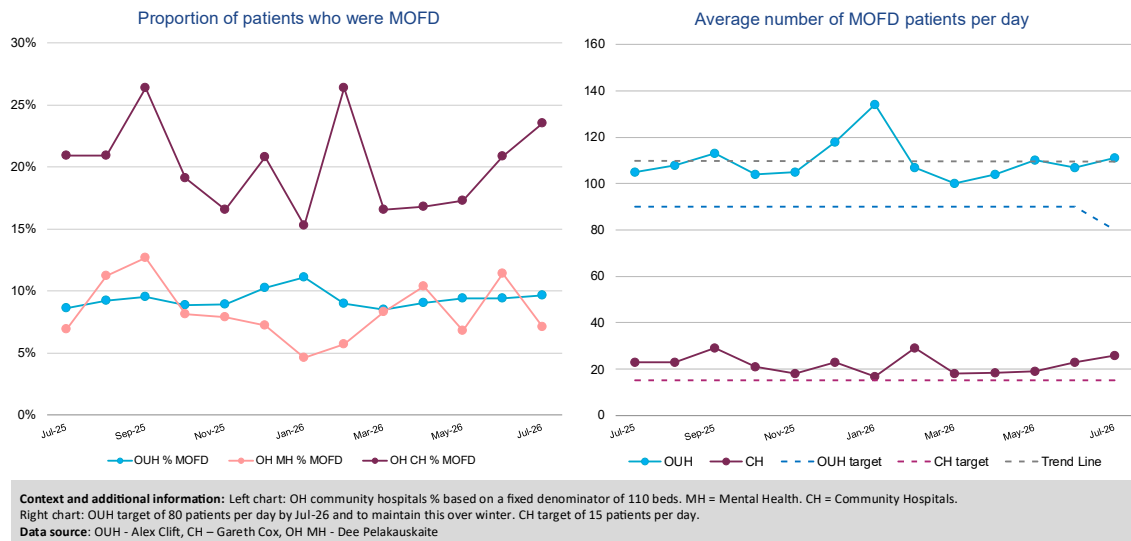
Days away from home for OUHFT MOFD patients: Pathway 2 breakdown


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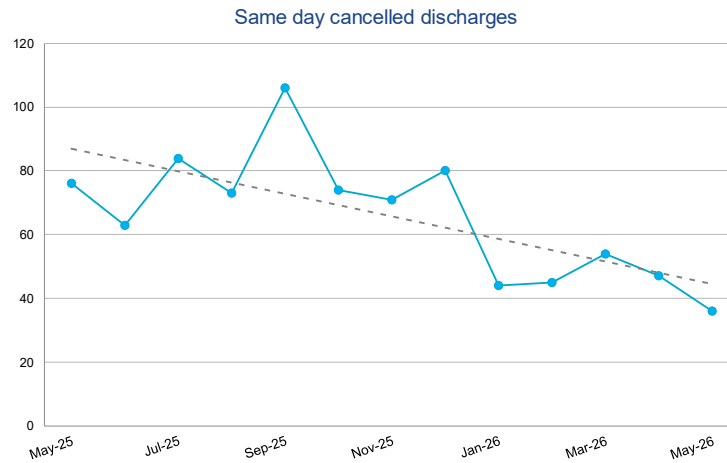
Proportion of patients who were MOFD and average number of MOFD per day


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Same day cancelled discharges OUHFT



Cancellation reasons
(Latest month)

Reasons	HGH	JR	NOC	Total
NMFD	2	11		13
Medical intervention	1	8		9
Equipment delay	1	1	1	3
Property readiness	1	2		3
Family Concerned	1	1		2
Back to Toc		1		1
Declined provider		1		1
Family not ready		1		1
Operational process/Admi/Ward (OUH)	1			1
Provider capacity		1		1
Provider refused to pick Up		1		1
Total	7	28	1	36

Context and additional information: This data is unvalidated
Data source: OCC – Alice Brough

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