NHS
Thames Valley

Oxfordshire Urgent and Emergency Care Winter Plan

August 2026

1.0 Introduction

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 Oxfordshire health and social care system focusses on integrated working across, ambulance providers, voluntary sector, Oxford Health Foundation NHS Trust (OHFT), Oxford University Hospitals NHS Trust (OUHFT), General Practices, home care providers, care homes, Principle Medical Limited (PML), and adult social care at Oxfordshire County Council and district councils.

2.0 Our Ambition Winter 2026/2027

We continue to develop pathways that enable people to receive the right care, in the right place, first time.

We are continuing to work on the development of neighbourhoods to strengthen prevention and care closer to home, streamline people's access to alternatives to hospital, and supporting hospitals to focus on those who require emergency or specialist care.

3.0 Areas of Focus for the Oxfordshire 2026/27 Winter Plan

- Neighbourhood development: Focus on early intervention and prevention-based approaches e.g. frailty support to prevent falls to gradually reduce risks in the community that can lead to unplanned admission and improve integrated urgent care access across community, social care and primary care services when same day care needs arise.
- Reducing ED attendances and emergency admissions
- Community services: Maximising on the day triage/assessment in the person's own home accessing Single Point of Access, Urgent Community Response and Hospital at Home teams
- Reducing emergency admissions by 10% by 2029
- Mental Health: SCAS MH Crisis pathway/guidelines and avoiding people with no physical health needs but have a mental health need attending an Emergency Department

- Ambulance Services: Reducing Cat 2 response times, maximising hear and treat, reducing conveyances to ED, and achieving ambulance handovers under 45 minutes
- Intermediate Care: Reducing length of stay for those who require support to return home and bed occupancy within frailty cohort bed bases

4.0 Standards to be Delivered

- **Oxfordshire residents:** I want to tell my story once within one connected NHS. I have one team looking after me. They speak to each other and work together for my best interests.
- **Single point of Contact:** People are triaged through Single Point of Access/Clinical Assessment Service, with the following outcomes:
    - provided with advice
    - directed to community pharmacy
    - directed to a local Urgent Treatment Centre (UTC) or Same Day Emergency Care unit (SDEC) (sometimes via patient transport if required)
    - navigated directly to assessment at home
- **Hospital at Home services & Urgent Community Response**: If someone falls or deteriorates, an Urgent Community Response (UCR) team arrives within 2 hours. Instead of being rushed to an acute bed, the person would be admitted to a Virtual Ward / Hospital at Home service.
- Follow on from Hospital at Home or Urgent Community Response teams will be via community teams and primary care working together to put anticipatory care plans in place.
- If attendance at hospital is necessary, the person will be transferred to the appropriate clinical assessment area.
- If a hospital admission was needed, when they are ready to return home, the person is discharged rapidly under a single Home First model (Discharge to Assess).
- Wider Primary Care Services: people are directed to urgent dental care, optometry's Minor Eye Condition Service, or the expanding role of community pharmacists as independent prescribers.

5.0 Metrics and outcomes

The Oxfordshire system has metrics that are used to monitor the impact of the Winter Plan and our year-round integrated improvement programme.

The Oxfordshire UEC System metrics are a combination of the following:

- NHS Oversight Framework 26/27 metrics

- BCF Core Metrics 26/27
- Locally determined metrics

All metrics will have a baseline established with agreed targets and trajectories (where possible and relevant). These metrics will be reported in the monthly boards and local governance routes within provider services.

Table 1.0: Winter Plan Interventions and Outcomes

Issue	Intervention	Outcomes
5% of residents account for ~342,000 hospital bed days per year.	Developing the foundations for neighbourhood approaches with a focus on complex needs and frailty in areas where integrated neighbourhood teams (INTs) are not yet present. Improve the integration of visiting services responses within a neighbourhood	Reduction in emergency admissions by 10% by 2029.
Reducing inappropriate ambulance conveyances	OHFT SPA extending taking call from the 999 stack from 4 hrs a day to 12hrs a day Monday to Friday Continue to develop guidelines with ambulance service to improve outcomes for residents	Point prevalence audits of conveyances to ED. Completion of people with MH crisis and chest pain guidelines
Achieving ambulance handovers under 45mins	Review ambulance handover delays and process that led to the delay	Zero ambulance handover delays over 45 mins
Overcrowded ED Prolonged length of stay up to and over 12 hrs	November 2026: Increasing capacity to take referrals directly from	**< 5%** of Type 1 ED attendances waiting over

	the 999 stack and increasing visiting capacity	12 hours for admission for those with frailty
Minimise conveyances from Care Homes	Care homes with direct access to SPA	Maintain low conveyance rate from care homes
Eliminating corridor care in the Emergency Department	OUHFTs programme of work that focusses on this	Zero corridor care
Reduce the number of people who are delayed in hospital.	Reducing LOS for those who require support to return home from hospital	20% reduction in the number of people in hospital waiting to return home
Identification of those who may be End of life within bed-based care	Identification of those with complex needs and have been admitted to hospital 2-3 times in the previous months.	People are supported to die in a place of their choice
Moving to zero out of area placements for MH patients	Focus on reducing the length of stay within MH inpatients beds	Zero out of area placements for MH patients

6.1 Neighbourhood Development

We are using population health intelligence to identify and proactively support people at greatest risk of deterioration with a particular focus on adults with frailty, people with complex needs, and children and young people.

Over the longer term, we will strengthen integrated neighbourhood and community-based health and care to improve proactive, preventative support, to reduce risk and prevent avoidable admissions. Alongside we will enable p people to be assessed, treated and supported at home, or closer to home, wherever appropriate at times when an urgent care need arises –this will include Urgent Community Response, Hospital at Home/virtual wards, intermediate care, Home First and Discharge to Assess, supported by effective clinical and social care decision-making and coordination.

We will work across the full breadth of primary care, NHS 111, community, ambulance, mental health and acute services to strengthen clinical navigation and create more integrated pathways. We will seek greater consistency in access, referral and assessment arrangements, including appropriate use of NHS 111 direct booking and Single Points of Access.

Community Services

Integrated Single Point of Access (SPOA) and clinical assessment services will support integrated working and timely assessments within the community setting. We will continue to develop how we work together to reduce duplications in assessments and home visiting and maximise direction to clinics/unit-based services for those who are ambulatory.

- Maximising capacity with the Same Day Emergency Care (SDEC) units
- Integrating Urgent Community Response (UCR) across visiting services for on-the-day or next-day assessments
- Maximising Hospital at Home capacity by carrying out regular review of those in the service to create capacity for more people to be assessed and treated in their own home
- Continue to increase the number of people being assessed for their care needs in their own home to improve people's quality of life.
- Continue to develop Single Point of Access seven days a week and working with the Out of Hours service to provide the Health Care Professional advice line 24/7

6.3 Integration

- **Integrate visiting services:** to optimise home visiting services where adults and children need to be assessed and treated in their own home, directing those who are ambulatory to clinic/unit-based settings. Using Connected Care to improve communication within neighbourhood teams/primary care to help identify high-risk people within the community setting by creating alerts for those who have accessed emergency or urgent care services.
- **Through neighbourhood working** to gradually reduce risk in the community and improve access to integrated urgent care to reduce demand on primary care, avoidable secondary care admissions, emergency department attendances and within social care, the number of hours required for long term care.
- **Adult social care**: to work with strategic providers to increase the percentage of acute and rehabilitation adult discharges followed up within 72 hours and remaining in the community 12 weeks after reablement.
- **Ambulance services**: to focus on those with the greatest emergency need by maximising the number they virtually assess, working with community clinical advisory services to support the most appropriate service to assess the person in their own home, reducing inappropriate conveyances to ED and for those who are conveyed, achieving ambulance handovers under 45mins

6.4 Mental Health

OHFT are working with South Central Ambulance Service (SCAS) to maximise the use of the 24/7 CRISIS mental Health phone line to support SCAS crews with triage and the most appropriate pathway for those in a mental health crisis.

OHFT are continuing to develop the provision of 24/7 crisis team through expansion existing services. This is expected to be countywide by November 2026. It includes a professional advice line 24/7 for the police and health professionals, both of which work to ensure people in a mental health crisis are assessed and treated in the most appropriate setting.

Mental Health teams working collaboratively with neighbourhood teams and primary care to improve access to both services for those with a significant mental health condition.

SCAS MH Crisis pathway/guidelines have been developed to avoid people with a mental health need, but no physical health needs, attending an emergency department.

OHFT are working on reducing the length of stay for adult inpatients and minimising out-of-area placements for mental health patients.

OHFT also provide additional support for an all ages via a 24/7 in-house resourced mental health text service called ChatHealth.

OHFT MH services are continuing to work on refining opportunities to for people to be assessed in places such as safe havens. This also involves increasing the staffing capacity across community services and the mental health hotline in response to increased demand. There is continued focus on safety / crisis planning for high intensity users or urgent / emergency care services.

6.5 Acute Hospital Flow

We work with South Central Ambulance Service to support them achieving response times to those who have urgent life treating conditions (Category 2 response times), maximising hear and treat, reducing conveyances to ED, and achieving ambulance handovers under 45mins.

We need to achieve the following:

- 10% reduction in emergency admission by 2029 for frailty cohorts
- 10% reduction in ED attendances, acute admissions and Primary Care contacts for High Intensity users.
- Reducing ambulances conveyances to ED
- achieving ambulance handovers under 45mins
- Achieving the 4 and 12 hr standard for EDs
- Eliminating corridor care within the Emergency Departments

6.6 Discharge Standards

- Continued focus on people returning to their own home to identify any gaps or delays in processes. Working with people, their families and carers to identify the most appropriate discharge destination to meet their needs.
- Reducing length of stay for those who require support to return home and bed occupancy within frailty cohort bed bases.
- In relation to mobility, working with people in the community to improve their level of independence and quality of life.
- For winter, the focus will be on reducing the number of people who are delayed in hospital, reducing average delay across discharge pathways and ensuring that discharge remains safe, person-centred and supported by appropriate community services. This aligns with the Better Care Fund delivery plan, which supports the community, reablement, equipment, technology enabled care and intermediate care capacity needed to deliver sustained improvements in hospital flow.

7.0 Oxfordshire System Governance

All the providers within Oxfordshire, including SCAS and the patient transport service, meet virtually Monday to Friday at 08:30 to share information on UEC pressures and escalations. Actions are taken to resolve issues as they arise for any aspect of the pathway.

The need for further calls during the day is agreed or people can use this group to communicate with throughout the day if a decision to hold an escalation call is required after the morning meeting.

The winter plan is monitored monthly through the Oxfordshire Urgent and Emergency board. At time of escalation the key stakeholders of this group will meet on a more frequent basis.

8.0 Risks and Challenges

The Oxfordshire Urgent and Emergency Care system recognises the following potential risk that may impact on the winter period 2026/27:

There is concern that after seeing an increase in demand over the summer months, the system will not have the capacity or time to recover before we experience the expected increase in demand over the winter months. We will continuously monitor and adjust our plans as the needs change.

Appendix 1: Oxfordshire Place Assurance

The tables below highlight the local assurance as per the NHSE Winter Assurance Checklist published on 17th July 2026:

Section B: 26/27 Winter Plan checklist			Confirm (Y/N)
Prevention and vulnerable cohorts			
1	1.1	The Board is assured that those eligible have access to priority vaccination programmes, including childhood vaccinations. This includes 1. RSV vaccination for pregnant women, older adults aged 75 years and over, and older adult care home residents; 2. pneumococcal vaccination for all adults aged 65 years and over and children and adults in a clinical risk group; 3. the annual winter flu and COVID-19 vaccination campaigns.	Yes
	1.2	The Board is assured that a risk-stratified approach is in place to identify individuals at increased risk of winter-related deterioration or admission, including those with co-morbidities that leave them susceptible to hospital admission as a result of winter viruses, younger people with significant co-morbidities, and other vulnerable cohorts. Targeted interventions are in place, including vaccination, pre-winter health checks, personalised care planning, access to antivirals where appropriate, and community-based support to reduce avoidable admissions and support continuing care in the community.	Yes
Flow, occupancy and discharge			
2	2.1	The Board is assured there are clear operational plans and daily processes to reduce avoidable bed occupancy and improve patient flow seven days a week, including pre-winter review of bed demand and capacity, delivery of model discharge pathway requirements, and executive oversight of required and actual daily discharges, patients with no criteria to reside by pathway, discharge performance and long discharge delays.	Yes
	2.2	The Board is assured that system partners have agreed and implemented measures to eliminate corridor care, with defined patient safety thresholds, supported by coordinated patient flow, discharge and escalation arrangements, with system level oversight and mitigation of risk during periods of increased demand.	Yes
	2.3	The Board is assured that discharge planning is being undertaken jointly with local authorities and social care partners, with effective system discharge coordination arrangements, clear processes to identify, escalate and resolve discharge delays, and real-time visibility of demand and community capacity.	Yes
	2.4	The Board is assured that providers have baselined current discharge arrangements against the model discharge pathway, identified gaps, and agreed improvement actions across acute, community and social care partners.	Yes
	2.5	The Board is assured that pre-Christmas and holiday-period occupancy reduction plans have been agreed and will be implemented.	Yes
Demand, capacity, and surge management			
3	3.1	The board is assured that whole system demand and capacity modelling has informed winter planning and that tested surge and extreme surge response arrangements are in place to support safe operational delivery during periods of increased demand.	Yes
	3.2	The Board is assured that workforce, NHS 111 and mutual aid arrangements are sufficient to respond safely to sustained periods of increased demand.	Yes
	3.3	The Board is assured that bed escalation capacity arrangements have been agreed and tested across system partners.	Yes

Community Health Capacity			
5	5.1	The Board is assured that sufficient urgent community capacity, including UCR, Virtual Wards, Hospital at Home and community diagnostic interventions where applicable, has been commissioned, is monitored and utilised effectively to support admission avoidance and discharge, with appropriate escalation arrangements in place and access to senior clinical decision-making through SPOAs at least 12 hours a day, 7 days	Yes

Whole System Response			
6	6.1	The Board is assured that a system wide approach is in place to optimise the use of out-of-hospital capacity and admission avoidance pathways to reduce avoidable admissions and support timely discharge.	Yes

Appendix 2: Thames Valley Integrated Care Board Assurance

Sections 4,7 and 8 requires assurance from Thames Valley ICB:

Primary Care, NHS 111 and admission avoidance		
4	4.1	The Board is assured that anticipated general practice demand has been assessed, and that: •sufficient capacity has been commissioned, including for surge periods (e.g. ARI hubs) •robust escalation process are in place •through the IUC Clinical Assessment Service (or equivalent), sufficient capacity will be commissioned for out of hours general practice, including weekends and bank holidays.
	4.2	The Board is assured that practices are compliant with contractual requirements, including opening hours, use of online consultation, clinically urgent same day appointments (working towards 90% target) and practices making 1 appointment per 3,000 registered population available to NHS 111 for direct booking.
	4.3	The Board is assured that PCN enhanced access appointments are available and that PCNs make available to NHS 111 any unused on the day slots as per DES requirements.
	4.4	The Board is assured that unscheduled dental care delivery is monitored as part of the mandated number of urgent dental care appointments.
	4.5	The Board is assured that for community pharmacy, demand, activity and capacity has been assessed, including sufficient out of hours provision across the ICB footprint; and delivery of Pharmacy First and the Discharge Medicines service.
	4.6	The Board is assured that the NHS 111 Directory of Services profiles are accurate, regularly reviewed, and aligned to available capacity across primary care and community services.
	4.7	The Board is assured that for all provision, both in and out of hours, there will be communications activity to ensure the public is aware of what services are available.

Leadership, operational grip and resilience		
7	7.1	The Board is assured that on-call arrangements are in place and have been tested. Staff on-call have access to medical and nursing leaders for urgent advice if needed.
	7.2	The Board is assured there will be an appropriately skilled and resourced operating model for system co-ordination over the winter period to enable the sharing of intelligence and risk balance to ensure this is appropriately managed across all partners.
	7.3	The Board is assured that tested command, control and escalation arrangements are in place, including OPEL reporting, EPRR arrangements and clearly defined leadership responsibilities.
	7.4	The Board is assured that mutual aid arrangements, business continuity plans, severe weather preparedness arrangements and industrial action contingencies have been reviewed and tested where appropriate.
	7.5	The Board is assured thatplans are in place to support staff welfare through periods of high demand.