Oxfordshire Winter Plan and Integrated Improvement Programme

1.0 Introduction

1.1 This paper outlines the programme of work in Oxfordshire works as a whole system on achieving improvements that will have the biggest impact on urgent and emergency care services.

1.2 The improvement programme focusses on learning from the previous winter and converts to a winter plan in August each year.

1.3 Both plans are developed by all the providers working across the various pathways. The plans focus on assessing and treating people in their own home, minimising emergency admissions where the person can be treated in their own home and supporting people to return home from bed-based care.

1.4 This paper covers:

- NHS high priority areas and improving quality of care
- The six main workstreams
- Implementation plan for each workstream

2.0 NHS High Priority Areas

2.1 Develop neighbourhood model of care

2.2 Improve flow through mental health crisis and acute pathways and access to children and young people's services

2.3 Improve and standardise care for those who require it on the same day

2.4 Improve ambulance response times

2.5 Improve waiting time in the Emergency Departments (EDs)

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

3.0 Lessons learnt from last winter

The lessons learnt from last winter were collated during an away day with representatives from all services working across Urgent and Emergency pathways.

3.1 Build workforce capability & confidence in delivering community-based care

3.1.1 Identify clinical system champions/leaders for supporting people at home to deliver culture change

3.1.2 Explore opportunities for weekly Multi-Disciplinary Teams (MDT) in primary care

3.1.3 Education/training programme to support new way of working

3.2 Consolidate and coordinate our resources, focusing on visiting and urgent services

3.2.1 Oxford Health to review existing OH resources/community visiting teams for on the day visiting, to identify areas of duplication, and produce proof of concept for how we can utilise this resource more effectively e.g., pilot one neighbourhood

3.2.2 System commitment to review function, capacity and capability in Hospital at Home (H@H) deployment

3.2.3 System commitment to review function, capacity and capability of Primary Care Visiting Services (PCVS)

3.3 Interventions to build capacity elsewhere in system

3.3.1 Review of insulin prescribing

3.3.2 Pharmacy/medicines optimisation team to advise other areas to review

3.3.3 Utilise learning from Adult Social Care wait list reduction

3.3.4 Alignment with development of neighbourhood services

3.4 Build care home resilience to increase staff confidence & reduce conveyances, falls & safeguarding referrals

3.4.1 Review care home support service

3.4.2 Neighbourhood development to include Care Homes

3.5 Supporting people to navigate the urgent care system

3.5.1 Agreed to develop an overarching Oxfordshire Urgent and Emergency online service to support and advise our population in accessing the right service at the right time and in the right place

3.5.2 Definitions of urgent and emergency will be added to the signposting information for the public

3.5.3 All providers of Urgent and Emergency Care (UEC) services in Oxfordshire will continue to work and engage with community, voluntary and other organisations to understand better the challenges that people face in understanding and accessing urgent and emergency care to ensure that the information provided is accessible and clear

4.0 National Guidance

4.1 January 2025, NHS England published guidance on the development of neighbourhoods. NHS England » Neighbourhood health guidelines 2025/26

4.2 In June 2025 the Government published the **Urgent and Emergency Care Plan 2025/26** (NHS England » Urgent and emergency care plan 2025/26) that prescribed expectations for the winter period of 2025/26.

4.3 In early July 2025, the **10-year health plan** (10 Year Health Plan for England: fit for the future - GOV.UK) was published.

The Oxfordshire plan is based on all publications, with the *focus on those who can be assessed and treated in their own home.*

5.0 Oxfordshire Winter Plan

5.1 Shift from Hospital to Community

5.1.1 It has been shown that 1:5 people who attend ED do not need to be there. Locally we have seen that those who do not benefit from attending hospital, have better outcomes from being assessed and treated in their own home. This is especially true when urgent and emergency care is integrated with intermediate care.

5.1.2 To deliver appropriate emergency care to more people in the community, we need to review how existing services can be delivered to meet this demand.

5.2 Development of a neighbourhood model of care

5.2 This will be coordinated through Place Based Partnership

5.3 Vaccination programme

5.3 This is being managed outside of the UEC programme

5.4 Falls prevention and management

5.4.1 Improving public knowledge of falls, risks and available support. Subgroup set up to focus on raising awareness at vaccination centres, local community centres, GP surgeries, day centres, supported living, retirements homes or any gathering of people over the age of 50 years or their carers.

5.4.2 Collating all activity relating to the various interventions related to either for the falls prevention programme or interventions post falls. Presenting a quarterly report to UEC system delivery meeting and UEC board.

5.5 Single Point of Access

5.5.1 Develop Single Point of Access (SPA) to support an increase in referrals 7 days a week 08:00-20:00hr

5.5.2 SPA to continue to reduce call waiting times over the winter months, with the aim of achieving a call answer time of less than one minute on the Health Care Professional (HCP) line by the end of March 2026

5.5.3 Increase workforce in SPA to support improved call answer times and co-ordination of on the day community-based response

5.5.4 SPA team to pull 999 calls from the stack in the morning, to reduce the need to dispatch an ambulance for those who can be assessed and treated at home

5.5.5 SPA to support calls from care homes and carers in the person's own home

5.6 Improve and standardise care for those who require it on the same day

5.6.1 To deliver appropriate emergency care to more people in the community and to ensure people do not attend hospital unnecessarily, we need to expand or have more effective use of UEC services to meet this demand

5.6.2 There is a national requirement for a zero growth in emergency admission for adults and to minimise avoidable unplanned admissions for chronic ambulatory conditions

5.7 On the day or next day services

5.7.1 UEC visiting services, Urgent Community Response (UCR) and Hospital @ Home (H@H) services to continue to develop integrated working with intermediate care to minimise delays to rehabilitation in their own home

5.7.2 Increasing capacity within H@H service, by carrying out interventions that create capacity i.e., in situations where there are two registered clinicians assessing people in their own home, to one registered person with a support person

5.7.3 Maximising the use of Same Day Emergency Care (SDEC) units, e.g. Witney, Abingdon Emergency Multidisciplinary Units (EMUs), Henley Rapid Access Care Unit (RACU), the Ambulatory Assessment Unit (AAU) at the John Radcliffe Hospital and the Rowan Day Unit at the Horton General Hospital

5.7.4 Clear pathways that are understood by both clinicians and Oxfordshire residents

5.7.5 Additional focus on those who are resident in Care Homes, to ensure they have a timely response to assessment and treatment within the Care Home

5.8 Development of Urgent Treatment Centres

5.8.1 The Urgent Treatment Centre (UTC) on the Horton General Hospital (HGH) site and the City Urgent Care Centre (UCC) on the John Radcliffe (JR) site need to prioritise redirections from both Emergency Departments they are collocated with. The community Minor Injury Units (MIUs) prioritise minor injuries.

5.8.2 The community MIUs and the city UCC to become accredited as Urgent Treatment Centres (UTCs). City UCC is ready for their accreditation assessment. The community MIU's need to see people with minor illness before they can achieve accreditation.

5.8.3 To achieve a consistent model of care within UTCs, we require consistent delivery of NHS 111 pathways for minor illness to City Urgent Care Centre (UCC), HGH UTC and the community MIUs in Abingdon, Witney, and Henley. The Directory of service to be similar for all units but the delivery will be capacity dependant across all units.

5.8.4 Integrate the medical oversight between MIUs and EMUs in Henley, Abingdon and Witney

5.8.5 Increase the provision of Radiology in community Minor Injury Units (MIU's) to reduce the need for people to return the next day for an x-ray

5.9 Improve ambulance response times

5.9.1 Reduce avoidable ambulances dispatches by Single Point of Access have direct access to the 999 stack to identify people who can be assessed at home by community services to include category 2, 3 and 4 calls

5.9.2 Minimise avoidable conveyances to the ED, to ensure those in the ED will benefit from their attendance there

5.9.3 Reduce ambulance handover delays within Emergency Departments

5.9.4 Reduce Patient Transport Service (PTS) cancellation rate from 14% to 6%

5.10 Improve waiting time in the Emergency Departments

5.10.1 A minimum of 78% of people (adults and children) assessed, discharged and transferred out of the ED within 4hrs of arrival

5.10.2 98% of people spend less than 12hrs in the ED

5.10.3 Maximise use of the Patient Transport Service (PTS) overnight crews to reduce prolonged length of stay in EDs

5.11 Improve flow through mental health crisis and acute pathways and access to children and young people's services

5.11.1 Provision of 24/7 crisis team through redesign of existing services (merger of night team and street triage)

5.11.2 New 24/7 police 136 and health professionals' advice line, reducing avoidable 136 / ED attendance

5.11.3 Expansion of crisis team capacity across Oxfordshire

5.11.4 All age, 24/7 mental health text service "SUNRISE"

5.11.5 Further refine opportunities for diversion from the Emergency Departments, including review of crisis alternatives such as safe havens

5.12 Reducing length of stay in inpatient mental health beds and reduction of Out of Area Placements

5.12.1 Involvement of Mental Health Urgent Care in Purposeful Admission and Pro-active Discharge planning group (inpatient transformation programme)

5.12.2 Review of teams with option to include patient flow into crisis team, increasing admission request triage / gate keeping

5.12.3 Improved home treatment provision with staff embedded on inpatient wards

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

5.13.1 Increasing the percentage of adult inpatients returning directly to their own home from 91% to 93%.

5.13.2 Agreed metrics and trajectories for a reduction in length of stay for people who are waiting for each pathway i.e.,

5.13.2.1 those returning home requiring support: target average delay 4.4 days

5.13.2.2 those discharged to bed-based rehabilitation: target average delay for generic community hospital bed 3 days

5.13.2.3 those transferred to long term Care Home: target average delay 9 days

5.13.3 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

6.0 Urgent and Emergency Care Assurance

6.1 In Appendix 1, the UEC assurance table has been provided by NHSE for our system to assure preparedness for the winter period 2025/26.

7.0 Conclusion

7.1 In September each year, the UEC Integrated Improvement Programme in Oxfordshire converts to a winter plan. This is based on continuing the workstreams from the previous year and test and learns carried out April to August each year

7.2 The focus is to shift hospital care to the community to expand UEC services at home and in the community

7.3 We continue to deliver interventions to support people not attending hospital unnecessarily

8.0 Recommendations

8.1 We ask that the winter plan is approved

Appendix 1 The assurance statements have been agreed by our Oxfordshire UEC Board partners ready for our winter as highlighted in the interventions and preparation in the chapters above.

Appendix 1.1: Board Assurance

Assurance statement	Confirmed (Yes / No)	Additional comments or qualifications (optional)
Governance		
The Board has assured the ICB Winter Plan for 2025/26.	Yes	August/September 2025 (*tbc*)
A robust quality and equality impact assessment (QEIA) informed development of the ICB's plan, and this has been reviewed by the Board.	Yes	At place – Oxfordshire System
The ICB's plan was developed with appropriate levels of engagement across all system partners, including primary care, 111 providers, community, acute and specialist trusts, mental health, ambulance services, local authorities and social care provider colleagues.	Yes	At place - Fully engaged with all partners across Oxfordshire
The Board has tested the plan during a regionally led winter exercise, reviewed the outcome, and incorporated lessons learned.		8th September 2025
The Board has identified an Executive accountable for the winter period, and ensured mechanisms are in place to keep the Board informed on the response to pressures.	Yes	Accountability held at Oxfordshire place UEC Board.
Plan content and delivery		
The Board is assured that the ICB's plan addresses the key actions outlined in Section B.	Yes	See next section.
The Board has considered key risks to quality and is assured that appropriate mitigations are in place for base, moderate, and extreme escalations of winter pressures.	Yes	Mitigations in place and described in Oxon UEC Risk Register.
The Board is assured there will be an appropriately skilled and resourced system control centre in place over the winter period to enable the sharing of intelligence and risk balance to ensure this is appropriately managed across all partners.	Yes	This is held at BOB ICB Level with place (Oxon)

Appendix 1.2 Winter Plan Checklist

Checklist	Confirmed (Yes / No)	Additional comments or qualifications (optional)
Prevention		
Vaccination programmes across all the priority areas are designed to reduce complacency, build confidence, and maximise convenience. Priority programmes include childhood vaccinations, RSV vaccination for pregnant women and older adults (with all of those in the 75-79 cohort to be offered a vaccination by 31 August 2025) and the annual winter flu and covid vaccination campaigns.	Yes	All partners leading on campaigns.
In addition to the above, patients under the age of 65 with co-morbidities that leave them susceptible to hospital admission as a result of winter viruses should receive targeted care to encourage them to have their vaccinations, along with a pre-winter health check, and access to antivirals to ensure continuing care in the community.	Yes	As above
Patients at high risk of admission have plans in place to support their urgent care needs at home or in the community, whenever possible.	Yes	Where possible, patients are discharged with care plans or proactive care such as virtual care / hospital at home.
Capacity		
The profile of likely winter-related patient demand across the system is modelled and understood, and individual organisations have plans that connect to ensure patients' needs are met, including at times of peak pressure.	Yes	
Seven-day discharge profiles have been shared with local authorities and social care providers, and standards agreed for P1 and P3 discharges.	Yes	Confirmed, procedures already in place.
Action has been taken in response to the Elective Care Demand Management letter, issued in May 2025, and ongoing monitoring is in place.	Yes	At ICB level.
Leadership		
On-call arrangements are in place, including medical and nurse leaders, and have been tested.	Yes	As required.
Plans are in place to monitor and report real-time pressures utilising the OPEL framework.	Yes	Opel Framework refreshed, reporting via Shrewd and governance arrangements in place

Appendix 2

Winter plan ref	Area	Outcome	Metric
5.4.2	Falls prevention	Presenting a quarterly report to UEC system delivery meeting and UEC board.	Falls group quarterly report to UEC system delivery meeting and UEC board.
5.5.1	SPA	Increase in SPA referrals	Increase to be evidenced by the end point in March 2026 / set target by end of March 2026
5.5.2	SPA	Improve call answer times	<60 secs for HCP line by March 2026
5.5.3	SPA	Increase workforce – BCF funding	Monthly report on baseline WTE prior to funding and increase in WTE during the project.
5.5.4	SPA	Increased 999 calls pulled from the stack	Increase over winter months
5.6.1	Improve and standardise care for those who require it on the same day	Zero growth in emergency admissions	Reported in monthly UEC sit rep
5.7.3	On the day or next day services	Maximising use of SDECs	Increase in activity in community SDEC's- reported in monthly UEC sit rep
5.9.3	Improve ambulance response times	Reduce ambulance handover delays within Emergency Departments	Reported in UEC monthly sit rep
5.9.4	Improve ambulance response times	Reduce Patient Transport Service (PTS) cancellation rate	from 14% to 6%
5.10.1	Improve waiting time in the ED	A minimum of 78% of people (adults and children) assessed, discharged and transferred out of the ED within 4hrs of arrival	UEC monthly sit rep
5.10.2	Improve waiting time in the ED	98% of people spend less than 12hrs in the ED	UEC monthly sit rep
5.13.1	Reduce LOS in hospital & ensure that people are cared for in the most appropriate setting	Increasing the percentage of adult inpatients returning directly to their own home	from 91% to 93%
5.13.2.1	Reduce LOS in hospital & ensure that people are cared for in the most appropriate setting	reduction in length of stay for people are returning home requiring support	target average delay 4.4 days
5.13.2.2	Reduce LOS in hospital & ensure that people are cared for in the most appropriate setting	those discharged to bed-based rehabilitation	target average delay for generic community hospital bed 3 days
5.13.2.3	Reduce LOS in hospital & ensure that people are cared for in the most appropriate setting	those transferred to long term Care Home	target average delay 9 days