Public Document Pack

Oxfordshire Joint Health Overview & Scrutiny Committee
Thursday, 24 September 2020

ADDENDA

7. System-wide update on the COVID-19 response and recovery (Pages 1 - 30)

10:40

Winter Plan attached.

This item will provide a report on the key issues for the Oxfordshire system. Update including:

- Some key learning/changes delivered during the COVID-19 response stage
- NHS – update on “restart” activity e.g. primary care services
- Winter planning, which will include flexibility for a second COVID wave

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OXFORDSHIRE SYSTEM
Winter Plan
2020-21

OXFORDSHIRE COUNTY COUNCIL

Oxford Health NHS Foundation Trust

NHS South Central Ambulance Service NHS Foundation Trust

NHS Oxford University Hospitals NHS Foundation Trust

NHS Oxfordshire Clinical Commissioning Group

Oxfordshire ageUK

Overview

Working together to plan for winter

As we look ahead as a system to winter 2020/21, with the challenges of COVID-19, flu, increased demand and workforce constraints, it is clear that we need to work together as a one system, building on our collaborative working during the first wave of the pandemic response. As such, as a system we are working as One Team, working to a Single integrated plan across our different organisations.

Our plan, summarised in these slides, focuses on the following key elements:

1. Our Shared Objectives
2. Our System Priority workstreams
3. Organising ourselves to deliver these
4. How we will measure success and keep track across the system
5. Communications
6. Detailed Annexes

"Working together as one team,
supporting and protecting our staff
to deliver integrated and equitable care, close to home
for all those we serve this winter"

Lessons learned from last winter and COVID-19 response

Reflections from across the system

To inform the development of our priorities this year, we have undertaken various learning exercises across the system, identifying elements to take forwards from last winter and/or the response to the first wave of COVID-19. Examples of lessons learned across the system include:

1. ED; Front door & Ambulatory Care – Continue providing direct access to ambulatory clinicians to support patients in the community and nursing homes. Continue providing dedicated patient transport for JR ED overnight to facilitate transfer home after assessment in ED out of hours.

2. Home First – Build on whole system approach to supporting patients to continue rehabilitation at home

3. Care Homes – Care home cell comprising system partners including care homes worked well to identify issues and design system response. Winter brokers supported the hospital service with 7 day a week service. This proved helpful for weekend follow up and ensuring planned discharges proceeded

4. Mental Health – Establishment of 24/7 Helpline; increase in delivery / uptake of digital solutions; Mental Health urgent care remained resilient and delivered BAU and additional services throughout; learning from trial of 'MH A&E' based away from JR/HGH; OMHP Safe Havens continued BAU with additional service offer where F2F not possible.

5. Primary Care – Provision of centrally funding COVID19 clinics to support demand in primary care

6. Acute Care – Embedding learning about a) how to cohort patients across ED, wards and intensive care settings; b) escalation levels to respond to changing shape of pandemic c) how to safely maintain non-COVID-19 care and green pathways; d) how to safely protect, support and redeploy staff to meet demand

Our Shared System Objectives this winter:

1. Ensure the Best Possible Care, Safety and Experience for all of our patients and service users:
    - *Safely manage and protect patients from Flu and COVID-19 across all settings*
    - *Maintain non-COVID-19 'Green' pathways and delivery of non-COVID-19 patient care*
    - *Proactively manage demand and capacity*
    - *Work with patients to ensure the best possible safety, care and experience*
2. Deliver Care in the Right Setting, close to home to support our population:
    - *NHS 111 First*
    - *Home First*
3. Be Digital by Default:
    - *Utilising remote monitoring, virtual consultations*
    - *Linking our information across the system to support collaborative work and integrated care*
4. Increase the scale and pace of our work to Reduce Inequalities
    - *Prevention, protection from COVID-19 and inclusive recovery and service delivery*
    - *Utilise data to identify and progress priority groups and localities.*
5. Protect, look after and Support our Staff
    - *Looking after staff wellbeing*
    - *supporting vulnerable staff*
    - *protecting staff from COVID-19 and flu*

Our Priority Workstreams

To support us in delivering our shared priorities, we are organising our work across the following programmes of work:

Safely manage Flu; COVID 19 and non-COVID pathways

Flu Vaccination & COVID-19 Best Practice

Ensuring high uptake of flu vaccination for all staff and appropriate patients across Oxon; follow national guidance to protect & manage COVID-19 and ensure delivery of non-covid care (green pathways).

Providing care in the right place, close to home

NHS 111 First

Enhance NHS 111 services to ensure patients receive care in the most appropriate setting and minimise inappropriate ED attendances (for children and adults)

Home First

Reducing length of stay in bed based care: Implement national metrics for discharge pathways; Providing assessment and care in the patients own home; Enhanced care in care homes; Improving outcomes and experience

Providing specialist and tailored support to support health and wellbeing

Mental Health Learning Disability and Autism

Expand and improve mental health services and services for people with learning disability and/or autism (for children and adults)

High Intensity Users

Identifying and supporting high intensity users of health and social care services; developing bespoke MDT plans with social prescribing to manage complex needs

Long Term Conditions & Inequalities

Supporting patients to manage their own conditions, close to home, through remote monitoring technology; and providing tailored access and support. Include particular focus on BAME and high risk groups.

End of Life Pathway

Providing specialist support for all patients on an End of Life pathway; with a single point of access

Protecting, supporting and training our staff

Being Digital by Default

Flu Vaccinations Programme

Who is eligible:

- In 2020/21, those eligible for vaccination will be expanded to include:
  - household contacts of shielded
  - school year 7 age children in secondary schools
  - health and social care workers employed through Direct Payment or Personal Health Budgets to deliver domiciliary care to patients and service users.
- At a later stage in the flu programme, vaccine stock and plans to be released to include 50-64 year olds not at risk eligible group.

Where the vaccine will be provided:

- 85% GP practices, are Covid safe and plan to hold flu clinics on site. Remaining practices are planning off site clinics.
- Discussions on-going with LPC and LMC around Care Homes Support (CHS), to ensure resident and staff uptake achieves targets.

How we will ensure uptake & safe delivery:

- Sufficient vaccine has been ordered.
- There is a target of 75% vaccine uptake across all groups; the communication team are working with flu leads to plan a focused campaign to encourage increase target ambition reached across all cohorts.
- A detailed Oxfordshire Flu Plan is in place; this is reviewed and progressed at weekly stakeholders meeting. Additional meetings aligning BOB Flu plans in place.
- Guidance has been released (21.8.20), stating the need for single use PPE items for each encounter, for example, gloves and aprons is not necessary and that a sessional mask and hand hygiene between each patient is required

NHS 111 First

Objective

We will implement NHS 111 First to ensure that patients receive the care they need in the most appropriate setting, by:

- Being prepared for a second surge of COVID-19
- Developing Urgent and Emergency Care services that minimise the risk of nosocomial infection
- Assuring the public that the NHS is open and that it is safe to seek help when needed
- For the public to telephone NHS 111 or use 111 on line before attending an ED.
- GP practice or NHS 111 (both on line and telephone)
- To improve patient experience by minimising time spent in healthcare settings

Overview of model

- A new system is being introduced for people who need urgent – but not emergency/life threatening – NHS care
- In situations where they need urgent advice they can contact NHS 111 by phone or online, at any time of day or night, for advice.
- If needed, a clinician will make a referral to the most appropriate area for the patient to be assessed.
- People turning up at ED without a referral from NHS 111 will be triaged and seen as normal. Information will be provided to the patient about how they can access NHS 111 going forward.

Home First

Objective

- Home First is primarily about people having their needs assessed in their usual place of residence, or own home.
- This can either be as soon as they are safe to leave hospital or if they have been triaged as requiring assessment whilst at home .
- The main objection is to:
  - Maximizing independence
  - enables people to be return home earlier

Overview of model

- Collaborative working though a virtual MDT has been created with OUH/OH /OCC and third sector carry out a daily review of people who have been identified as having a rehabilitation need
- To meet patients expectations by respecting that time matters.

- People are provided with support to get them to where they want to be with the correct provision of care to meet their immediate and longer term needs.
- This is a system wide project and therefore is innately different to all previous discharge to assess models. Broad skill sets will avoid duplication of provision and produce improved outcomes and capacity.

Mental Health

ADULT / OLDER ADULT mental health:

- Pathway improvements for older adults in bed-based care with admission requests to MH inpatient care
- Continue with flow transformation work within inpatient services, including maintaining bed numbers with additional procurement through private sector and addition of 'case manager' role for those admitted to private beds to ensure timely flow (subject to additional investment for winter period)
- Step-down house bid included within NHS Charities Together submission – to address homelessness within inpatient services (and increased complexity / risk within this cohort) – outcome awaited
- Maintain 24/7 MH Helpline (all ages) and transition to sustainable model by Jan 2021
- Ensure clinical capacity within Police 'street' Triage service in response to further increase in S136 detentions in Oxon; implement hospital-based Place of Safety contingency plan where demand exceeds available POS capacity
- OMHP: further develop virtual services to widen reach and access; introduce flow targets with each partner, focusing on people moving on positively in an appropriate time scale freeing up spaces for new service users and prioritising those with highest most immediate need.

CAMHS:

- Pilot of 72hr admissions to CAMHS inpatient care for 'crisis' admissions – will assist with flow and reduce pressure from other system partners
- Ensure CAMHS crisis capacity is sufficient to cover additional demand including that seen via the MH Helpline
- Pathway improvements re CYP and adult eating disorder patients, across/between acute Trust and OHFT

- LD / ASD:
- Plan being developed with Primary care to support with uptake of annual health checks.
- LD service will share our comprehensive nursing assessment to support with this as well as potential LD nursing time attached to surgeries
- Continued links with OUH to support with effective discharge for those with LD in hospital more than 48 hours
- LD service linking with hospital at home to support with admission avoidance

High Intensity Users

Objective

- Identifying and supporting people who access Primary Care, 111, 999 or Emergency Departments on a frequent basis by identifying the underlying reason behind their frequent contacts with health care.

- To support the most vulnerable and socially marginalised people in Oxfordshire high intensity users of health and social care services; developing bespoke MDT plans with social prescribing to manage complex needs

- To reduce time spent in health care settings and increased support at home

Overview

- Identification of high intensity users for 999, 111, Primary Care, Community Services and the Emergency departments.

- A multidisciplinary review with the person, followed by a supportive plan agreed with the person that will meet their needs

Long Term Conditions

Diabetes

- **Primary Care** – Diabetes Locally Commissioned Service (LCS) for primary care. Directs primary care to focus on a RAG risk stratifying strategy (based on NHS East of England guidance) to inform their prioritisation of people for diabetes review. Supports personalised care planning and continued Diabetes MDTs at PCN level.
- **Education** – Virtual diabetes patient education is now being delivered by OUH (Type 1) and Oxford Health (Type 2).
- **Patient records** – Specialist Diabetes Nurses at OUH and Oxford Health applying for access to other organisation's systems to get full view of patient record including HIE.
- **Patient support** – 7 days a week helpline for patients with emergency queries is in place since COVID-19
- **Other** – 2 potential project bids for NHS Charities Together. Community podiatry (Oxford Health) clinics have re-opened and Multi-Disciplinary Footcare Team (OUH) clinic has continued to operate throughout COVID. Active Oxfordshire Go Active Get Healthy Diabetes physical activity programme commissioned for another year

Respiratory:

- **Integrated Respiratory Team** – The Integrated Respiratory Team pilot operating in the City and North part of the county ended on 30th June – full evaluation underway. However, as part of the COVID-19 response five IRT posts have been extended until end of Dec 2020 to operate within the Oxford Health Community Respiratory Service and work across the whole of Oxfordshire. The extended IRT posts are fully OCCG funded. Key outcomes: respiratory education for all primary care teams, optimisation of respiratory medication for airways disease, pulmonary rehabilitation and alternatives to face-to-face for respiratory and post-COVID patients, reduce risk of admission and readmissions to hospital, optimise and coordinate breathlessness management and palliative care for end stage lung disease
- **Mobile respiratory diagnostics unit** – business case enabling lung function testing and timely diagnosis for COPD and Asthma in the community in line with COVID-19 infection prevention and control – particularly with OUH lung function testing severely depleted. This mobile unit proposal would require investment.

Cardiovascular Disease:

- **Integrated cardiology Service (ICS)**– continued provision of services closer to home for appropriate patients, service expansion progressing. Increased targeting of program to disadvantage and at risk populations
- **Heart Failure (HF)** - working with a system reform approach, expand access to the appropriate Community HFN/ICS support to patients with HF with preserved ejection fraction (HFPEF). Including phone and video appointments.
- Expansion of alternative modes of service delivery for cardiac rehabilitation

Personalised Care:

- Personalised care and supportive self-care training programme recently published for primary care healthcare professionals to uptake. Training will be delivered virtually by the OCCG personalised care and self-care training team.
- OCCG personalised care and self-care training team working with Oxford Health specialist teams (Respiratory, Diabetes, CHC) on joint-training delivery to primary care and training for OH staff

End of Life Pathway

Overview

- NHS Charities Together project bid submitted to train community healthcare professionals in Advance Care Planning including independent DNACPR signatory competency, thereby providing significant support to primary in advance care planning.
- Oxfordshire Palliative Care Network (OPCN) is developing a proposal for county-wide palliative care coordination.
- Directory of services being developed to support care coordination.
- Sue Ryder continuing to operate integrated hospice at home model in South Oxfordshire.
- The EOL support lines for healthcare professionals and patients/carers have been wound down following the first wave of COVID due to very low usage. However, the phone numbers used remain dormant and could be re-activated if required.
- Katharine House Hospice back to normal hospice specification, however the extra beds from COVID-19 Response Centre specification remain at the hospice should this be required. If reverting back to Response Centre specification, additional funding will be required.

Health Inequalities

Overview

- Placeholder
- Public Health colleagues to be contacted for input

Focus on Children – prevention and urgent care

Prevention Activities

- A joint Health and Education 'Return to School' group has been established which will continue to meet over the coming months and will monitor and address any challenges across the system as they emerge.
- An updated 'NHS Offer' is on the Schools Intranet site to support the return to schools.
- Health Visiting service is running a winter campaign to provide additional information to parents on managing minor illnesses at home.
- School Health Nurses are integral to delivering the flu programme in schools.

Children's Urgent Care

- Most children who present as unwell will not have COVID-19 – assessment of children will largely continue in the normal way using existing clinical pathways.
- OCCG GP clinical guidelines for paediatric common illnesses will be re-sent to GPs. This includes an updated guidance for fever in light of COVID-19.
- Children's ambulatory pathway being developed to ensure children are assessed closer to home.
- OCCG is supporting GP practices with capacity planning for winter by modelling the likely numbers of children who will need to be seen in 'hot' rooms (if potentially infectious) over the winter months.
- A Primary Care triaging protocol for seeing 'hot' children will be developed to risk assess and manage the seasonal peak of feverish children.

Oxfordshire Alliance - Bid Narrative 2020

Oxfordshire's health, social care and voluntary sector partners as an alliance we are bidding together for funding aimed at supporting the wider NHS and voluntary community dealing with COVID-19.

Videos and films to ensure post shielding patients and the general population can access information on a range of subjects for all different age groups	Active Hospital aims to change the physical activity culture within our hospitals in order to reduce the multiple negative impacts of hospital deconditioning	The Phone friends proposal enhances the support available from the presently un-funded telephone befriending service, to Oxfordshire people who consider themselves as being 'lonely'.	Communication software to support children and young people with speech and language difficulties to aid them achieve positive health outcomes during Covid -19	**Project to improve outcomes for high-risk, marginalised people who are high intensity users of emergency care**
The Rehabilitation After Critical illness and Hospitalisation (ReACH) COVID-19 project seeks to maximise the opportunity for rehabilitation and recovery for residents of Oxfordshire who survived critical illness and hospitalisation following a diagnosis of COVID-19.		Mental health housing with connection support to support people with high needs and histories of entrenched or repeated homelessness to live in their own homes	Connect people with the full range of support available in their local community to help build confidence and re-enable them. The proposal is to build capacity in Age UK's Oxfordshire Hospital Discharge Support (HDS) team and the My Community Link volunteer team, so they can better able to respond to the surge in demand arising from COVID-19, as well as supporting the Home First aspiration and Discharge to Assess project work	

How we will keep track across the system

Operation Pressure Escalation Levels - OPEL

- OUHFT, OHFT, OCC and SCAS are report their OPEL status on a daily basis
- This is a list of triggers that describe the demand on each organisation
- It helps to manage the day to day variations in demand across the health and social care system as well as the procedures for managing significant surges in demand.
- It provides a consistent set of escalation levels, triggers and protocols, for system partners.
- Sets clear expectations around roles and responsibilities for all those involved in escalation in response to surge pressures at local level by all system partners.

Regional and Oxfordshire System visual view - Shrewd

- Cloud-based system which allows a view of admissions, discharges, 999 conveyances, Out Of Hours, Social Care, Community Hospital beds.
- The ED information is updated through out the day and the remaining system requires a manual daily update directly to SCHREWD.
- OPEL status will require to be a manual update
- Develops a simple view of health pressure which works in real time across the whole system
- Provides oversight and assurance for operational management
- Significantly reduces time spent on conference calls and system reporting, due to whole system oversight.
- Increases response time to whole system pressure
- Alerts set on key performance indicators
- Improved cohesive approach; helping all parts of the system detect and respond to pressure

Communications

The Winter Communications Plan aims to support the delivery of the System Winter Plan; it has two key messages for the public & staff:

- Stay well by looking after yourself
- What to expect if you do become unwell

- Campaigns – A number of campaigns and initiatives will be delivered as part of the winter communications plan, these include:
  - Promotion of the flu jab to key groups (public and NHS / Care staff)
  - Self-care – what is your personal winter plan?
  - 'Help us, help you' stay well this winter. A national campaign that is tailored locally to signpost appropriate use of services
  - Introduction of NHS 111 First
  - 'Why not home? Why not today?' – Homefirst approach
- Communication strategy – Communication and messaging is aimed at all Oxfordshire residents, staff and visitors but with some segmentation for specific messaging as well as differing our approach to communicating with groups for example:
  - outreach to BAME communities through our local authority and community networks
  - working with community outreach workers and Luther Street Medical Centre to reach homeless people
  - development of easy read materials for people with a learning disability
- Evaluation – This will consist of:
  - Flu vaccination uptake which is monitored by PHE who issue data divided by target group
  - Quantitative and qualitative analysis of media coverage, social media engagement & reach
  - Post winter campaigns awareness using take to be monitored by PHE who will issue data divided by target group
  - Re-call survey of campaigns

Communications

Winter communications at a glance. . . .		
October:	• Media launch and introduction of Winter Team and system working (5 October) • Launch and implementation of public, NHS & care staff flu immunisation campaigns including production of films to show how easy it is to get your flu jab • Encourage people to get help early before your condition worsens – your local pharmacist & GP practice can provide help and support • Preparing for winter: 'have you got a winter plan?' – encouraging everyone to prepare and plan for winter eg stock up on essential medicines from your local pharmacy / supermarket. 'This year it is more important than ever for everyone to have a winter plan.' (Help us help you - HUHY) • Work with NHS staff to implement a 'Why not home? Why not today?' message to support Homefirst	PROACTIVE MEDIA & SOCIAL MEDIA
November:	• Continuation of winter plan theme • Launch of NHS 111 First to encourage people to contact NHS 111 and their GP if they need urgent care • Launch Oxfordshire Advice Card to include COVID-19 and NHS 111 First information • Maximising spread of preparedness message in the workplace by working with local businesses and communities (HUHY) • Promotion Better Health campaign (HUHY)	
December:	• Promotion 'Every mind matters' national campaign tailored to Oxfordshire services • Segmentation and sign-posting of services to cover proper use of A&E, access to GP services, MIUs, NHS 111 & Pharmacy – reinforcing NHS 111 First messaging (HUHY)	
January:	• Isolation and loneliness – 'look after yourself encourage and your neighbour' target community groups to support neighbours and develop a mental health awareness campaign	
February:	• Segmentation and sign-posting of services to cover proper use of A&E, access to GP services, MIUs, NHS 111 & Pharmacy – reinforcing NHS 111 First messaging (HUHY)	

OXFORDSHIRE SYSTEM WINTER PLAN 2020-21

Detailed Annexes

Winter Schemes funded 2019/20

Pro. No.	Projects	Supplier /Provider	Allocated Funding	Funding source	Payment route	Progress	Update
P1	Winter incentive payments (Neuro)	OUH	£340k	NHSI/E	NHSP		5 beds open on SSIP, 9 on the trauma ward at the HGH, intermittently opening 5 beds on neuro blue and avoiding planned flexing down of beds on neuro purple and 6A as required.
P2	Winter incentive payments (Trauma)	OUH	£340k	NHSI/E	NHSP		
P3	Winter incentive payments (Critical Care)	OUH	£136k	NHSI/E	NHSP		
P4	Emergency Department Psychiatric Service	OH	£60k	NHSI/E	PO		In January - approx. 300 referrals, 80% referred were assessed, at JR 90% within 1 hr and at Horton 85% with 90 mins.
P5	Night sit and live in carers	OCC	£60k	NHSI/E	PO		TBC
P6	7 day discharge weekend working - therapists	OUH OH OCC	£31.4k £26.1k £14.7k	NHSI/E	NHSP PO PO		Service is fully operational, All staff have been recruited to for acute therapies, community therapies and social work Activity from 07/01 - 28/01, 59 unnecessary admissions avoided.
P7	Refurbishment of existing space to deliver increased ambulatory footprint at the JR from 18 to 28 assessment spaces	OUH	£1400k	NHSI/E	Capital		Phase 1 (Ward 4B) due to complete 6th March. Weekend 7th/8th March AAU move from 4C to 4B. Phase 2 (4C) works start 9th March and due to complete 9th April. These are the earliest dates that can be achieved due to long lead items.
P8	Increase in paediatric ED capacity at the JR from 7 to 12 cubicles	OUH	£950k	NHSI/E	Capital		Works commenced on site on the 06 Jan 20 with completion scheduled by 29 Feb 20, this however is dependent on the delivery of key components which will be confirmed by 07 Feb 20
P9	SOS Bus	St John's	£20k	CCG	PO		Currently reviewing SOS bus service. Service has seen significant drop in activity last 2 weekends. Looking at reducing cover and cover future dates e.g. Mayday Fresher's Week.
P10	MIND support worker in ED	MIND	£20k	CCG	PO		The MIND worker is present in the ED on a Friday evening from 1600hrs to 1900hrs
P11	AGE UK to support 3 Community hospitals with discharges	Age UK	£25k	CCG	PO		Support mobilised in Didcot Hospital & flow of referrals established; mobilising in Wallingford and Witney next week.
P12	Specific transport provision to support ambulatory discharges for adults out of hours	SCAS	£25k	CCG	PO		Initial two week pilot started – change of supplier to SCAS
P13	Working with HART to enable discharge of patients	Age UK	£25k	NHSI/E	PO		Age UK team attending daily HART meetings and flow of referrals established to support discharge from HART and to reduce demand for low level support from HART. They also attend the 12:00hrs huddle in the JR Monday to Friday to support additional discharges

Current additional proposed schemes Winter 2020/21

Organisation	Scheme Name	Brief Description of Scheme	Funding required (Y/N)	Cost (can include separate financial breakdown)
OCC	7-day brokerage	a bid for £42k for 20 weeks of 7 day a week brokerage cover	Y	£42k
OH	Provision of additional primary care capacity at weekend	This will match the additional primary care capacity provided during the weekend. Suggest it is needed for 17 weekends Nov to Feb and provision of face to face and visiting.	Y	£400k
Primary Care	Point of care testing by primary care	Point of care testing for flu etc. to inform care and need for referral to secondary care	Y	£200k
Oxford Health	Coaguchek self-testing device	Purchase coaguchek machines for patient self-testing of INRs, increasing patient self-actualisation, reducing infection spread during C-19 and reducing demand on the District Nursing service during the winter pressures period	Y	£32K
OUH	PTS - Settling in service	PTS vehicle available 21:00 - 07:30 to take patients home from ED	Y	£30,780
OCC	Trusted Assessor	TBA	Y	TBA
All	Comms funding	TBA	Y	£25K
OCC	Connections Support	TBA	Y	TBA
OCC	Age UK discharge support	TBA	Y	TBA

Risks and mitigations

Risks	Mitigations	Monitoring arrangements
Patient demand for urgent care is higher than planned resulting in insufficient capacity within system	**NHS 111 First** • Enhance NHS 111 services to ensure patients receive care in the most appropriate setting and minimise inappropriate ED attendances **Home First** • Reducing length of stay in bed based care; providing assessment and care in the patients own home; and enhanced care in care homes **High Intensity Users** • Identifying and supporting high intensity users of health and social care services; developing bespoke MDT plans to manage complex needs **Long Term Conditions, Inequalities and End of Life Pathway** • Supporting patients to manage their own conditions, close to home, through remote monitoring technology • Providing specialist support for patients on an End of Life pathway, with a single point of access **Clinical services** • Organising clinical areas to ensure safe cohorting of patients to support safe social distancing and to create additional respiratory surge capacity	**Acute:** • Demand by Clinical Service Unit (CSU) • Remote monitoring by CSU • Virtual consultations by CSU **Community and primary care setting:** • Demand by Minor Injury, First Aid, Emergency Medical Units, community assessments and rehabilitation bed based care • Remote monitoring by locality team and PCN • Virtual consultations by out of hours and by clinical service **Social Care:** • Demand on Domiciliary care and long term placements • Virtual consultations by social work team
Staffing availability is lower than planned due to sickness or shielding, resulting in system capacity for urgent care not meeting patient demand	**Flu Vaccination** • Ensuring high uptake of flu vaccination for all health and social care staff and appropriate patients across Oxon **Workforce plan** • Implementation of medical and nursing workforce plan **Infection prevention control** • Adherence to national guidance and implementation of Infection and Prevention Control Plan by acute, social care and community settings	**Acute:** • Capacity by CSU and LoS by inpatient area and critical care • Non-COVID protected capacity • Staff vaccinated from 'flu by ward/CSU/ Directorate • Workforce planned vs actual • Sickness (COVID, 'flu and Shielding) **Community and primary care setting:** • Capacity within assessment and bed based rehabilitation units • LOS in rehabilitation bed based care • COVID positive & non COVID patients within rehabilitation beds • Staff vaccinated from 'flu by community services and bed based rehabilitation units **Social Care:** • Long term domiciliary care and long term placements • LOS in short stay HUB beds • Management of COVID 19 outbreaks • Staff vaccinated from 'flu by service team

Primary Care - Covid & Non Covid Activity Plan

Supporting primary care to meet the demand of winter and the possibility of a second surge in COVID secure environments

Overview & Principles:	• The COVID-19 plan for primary care for any future wave will follow the overarching strategy of the first peak with the aim of trying to maintain as much non COVID19 services as possible. • It is unclear if the acuity will follow the pattern in the first wave, whether there will be more or less impact on primary care and so we will continue to monitor available modelling and data to ensure we are able to adapt accordingly. • We will continue with the principle of seeing COVID19 patients in dedicated space as much as possible.
Providing safe and effective care:	• Continuation of total triage to assess who needs to be seen face to face • Maintaining the increased use of online and video consultations • Creating COVID19 secure environments with the provision of screens, social distancing measures, and furnishings and flooring that adhere to infection control standards • Patients to wait in cars rather than in waiting rooms • Effective use of PPE • Provision of largest ever flu vaccination programme • Re- purposing of additional appointments to better support practices eg ; phlebotomy and feverish children • Increased use of remote monitoring where appropriate
Providing safe and effective COVID19 care	• Building on good practice from wave one • Identification of 'hot' rooms in general practice • Additional capacity through COVID19 clinics based in North, City and South of Oxfordshire • Supported by a visiting service for those unable to travel to the clinics sites • Ability to flex capacity to other conditions such as feverish children or respiratory conditions
Workforce	• Daily reporting to be re-introduced to understand day to day pressures on workforce • All practices have undertake a risk stratification of workforce • CCG holding list of GPs who would be keen to return to work to support response • Recruitment of almost 100 additional roles for primary care through the PCNS by 31 March 2021
PPE	• All practices using PPE in line with national guidance • All practices able to receive a regular supply of PPE through National PPE portal • Daily reporting to check on PPE supplies • Additional supplies of PPE available through the National Supply Disruption Service

OH Community Covid & Non Covid Activity Plan

Organising our clinical areas to ensure safe cohorting of patients; to support safe social distancing and to create additional respiratory surge capacity:

Overview & Principles:	Urgent and ambulatory care services have and will continue to manage patients where appropriate and safe within their own home setting to limit the need for patients to leave home. Where patients need to be seen within a base setting patients are encouraged to phone first to make an appointment via 111 for urgent care needs and discouraged to walk into bases without having first been clinically assessed. Clinical settings are managed to ensure social distancing and covid safety, this does mean that on occasion is clinically safe the patients may be asked to wait in their own car. Community Services The covid-19 plan for any future wave will follow the overarching national guidance of the first peak and identify priority services We will monitor demand and activity on priority services to ensure they can continue to provide a service We aim to provide ongoing business as usual for all services where possible through any second wave
Providing safe and effective non-COVID-19 care:	UAC - Patients requiring urgent care out of hours or via the Minor injury units are requested to call first, where possible and safe patients are consulted via either the telephone or by digital consultation. The services can prescribe via electronic prescriptions if required. • Patients who need to be seen face to face within a base will be assessed for covid symptoms and managed within the appropriate setting depending on symptoms. Bases have consulting areas for non covid and covid positive patients in order to keep patients safe. Community services - All patients will be phoned for pre covid assessment before visiting and any suspected covid patients are visited as last visit of the day to minimise cross contamination Home visits will be kept to a minimum with more digital consultations being offered where possible
Providing safe and effective COVID-19 inpatient care:	• All patients will be tested for covid prior to admission • All inpatient areas will follow local and national infection prevention and control guidelines • All patients will be cohorted to minimise transmission of covid 19 • Visiting arrangements will be closely controlled to protect patients and staff
Organisation of	All services have been identified as essential, high priority, medium priority or low priority services, based on patient need and vulnerability
Providing :	A list of care tasks has been developed so all services understand their high priority tasks such as giving insulin daily or end of life care. These tasks will be protected and carried out without fail. Enhanced 7 day community services to keep patients safely at home and avoid unnecessary admission Proactive prevention to address health inequalities ahead of winter (e.g. pulmonary rehab) Tehmeena know what we want to do- might not be enough to add in here. Rapid access to a multi-professional post COVID rehabilitation team

SCAS Covid & Non Covid Activity Plan

Organising our clinical areas to ensure safe cohorting of patients; to support safe social distancing and to create additional respiratory surge capacity:

Overview & Principles:	• Ensure safe and effective service from 999, 111 and PTS. • Increasing staffing within both Clinical and non clinical • Creating Covid Surge Escalation Plan • Utilisiation additional support from both Military and Fire and Rescue Service
Providing safe and effective non-COVID-19 care:	• Sourcing Additional PTS resource overnight to facilitate additional Discharges overnight. • Providing additional 4x4 support for any inclement weather • Embedding and Improving Patient Pathways to wards with in the acute and community to avoid Emergency Department when clinically appropriate • Utilising additional Clinical decision making support from Consultants on Ambulatory Assessment Unit.
Providing safe and effective COVID-19 care:	• Ensuring PPE is managed centrally and distributed locally as per learning from first wave • Adhering to national transport guidelines • Adherence to National Ambulance REAP and Escalation plans • Implementation of local REAP Covid Plan
Additional Support	• Agreement in place with Military for recall of original staff who assisted in first wave to be deployed with SCAS within 2 weeks to provide: 1. PTS driving Assistance 2. 999 driving Assistance 3. Control Centre Dispatch Assistance • Oxfordshire Fire and Rescue Service to provide additional Staff to 999 for driving Assistance
Additional Service :	• SCAS is currently developing an Adult Critical Care transport Service to cover Thames Valley and Hampshire and Isle of Wight in collaborative with the Critical Care Network. • This will provide 12 hour a day 7 days a week transport service across area. • Doctor lead working with Paramedics • Transporting patients within region to ensure Critical Care Capacity across region. • Based at Oxford John Radcliffe and Southampton University Hospital • Plan to be live for Winter

OUHFT Covid & Non-Covid Activity Plan on a Page

Organising our clinical areas to ensure safe cohorting of patients; to support safe social distancing and to create additional respiratory surge capacity:

Overview & Principles:	• The COVID-19 plan for any future wave will follow the overarching clinical strategy of the first peak. • It is unclear if the acuity and admissions to intensive care will follow the pattern in the first wave, so we will continue to monitor available modelling and data to ensure we are able to adapt accordingly. • We will continue with the principle of cohorting COVID-19 patients and non-COVID-19 patients on specified wards, and as far as is possible, on specified sites.
Providing safe and effective non-COVID-19 care:	• **Inpatient Care:** The Nuffield Orthopaedic and the Churchill sites will be categorised as non COVID-19 sites. • **Elective capacity** will be maintained on the NOC, Churchill, children's and West Wing • **Critical Care:** Neuro Intensive Care and Churchill Intensive care will care for patients who require level 3 care and do not have COVID-19.
Providing safe and effective COVID-19 inpatient care:	• The John Radcliffe building (JR1 and JR2 stack) and Horton General Hospital will have patients who are suspected and confirmed COVID-19. • Patients who have suspected or confirmed COVID-19 will be cared for in dedicated COVID-19 wards or in side rooms within a speciality (if the patients main reason for admission is not related to COVID but the speciality in which they need to be cared for). • As with the COVID-19 initial Peak Plan, a detailed escalation plan is being developed to set out the thresholds for moving through the plan and onto different wards.

Organisation of JR2 stack:	• Following a reorganisation of the John Radcliffe Hospital stack (JR2 stack), services are broadly be organised as follows:
	  • **JR2 Level 1:** Emergency Assessment Unit **-** 31 beds
	  • **JR2 Level 4:** Ambulatory Care – AAU; COVID-19 care on John Waring Ward (JWW= 15 beds but can escalate to 19)
	  • **JR2 Level 5:** Flexible respiratory capacity, with side rooms for COVID-19 - 24 respiratory and 38 medical short stay beds)
	  • **JR2 Level 6:** General Surgical, Trauma, Gastroenterology and Vascular capacity = 112 beds
	  • **JR2 Level 7:** Complex Medicine, incl. stroke care; PPE training facility – 94 beds

Providing safe and effective COVID-19 critical care:	• Any patient requiring level 3 care who have suspected or confirmed COVID-19, will be admitted to Adult Intensive Care Unit (AICU) on the JR site. On AICU, two side rooms and adjacent beds are being kept empty for any COVID-19 positive patients requiring critical care. • Each of the bays within the unit (A, B and C) have been adapted to ensure that they can now function as self-contained units, enabling each of them to become a safe COVID-19 unit if required. The escalation route within AICU will be Unit A > Unit B > Unit C. • Following reaching capacity within AICU, it is expected that the escalation approach will follow the strategy of the peak plan

Infection and Prevention and Control Plan (setting specific)

Acute settings	• *As per national guidance*
	• *Further detail:*
	  • Continue universal level 1 PPE for all patient contacts, unless level 2 indicated, in line with government guidelines.
	  • Continue to triage all acute patients according to symptoms of possible COVID-19, with correct patient placement. Include the possibility of atypical presentations in the elderly.
	  • Establish social distancing wherever feasible for all patients (in-patients, day cases, out-patients).
	  • All visitors and out-patients to be given a face mask if they arrive on site without a face covering
	  • Re-invigorate training and safety huddles focused on PPE. Introduce PPE safety team (PPEST) – complete.
	  • Await Government recommendations regarding BAME staff working in acute settings – Ensure risk assessments have been completed and appropriate actions taken for all vulnerable staff including BAME staff.
	  • Reinforce the requirement for social distancing between staff at all times – Implement universal mask wearing as per Government guidelines, in order to reduce staff to staff transmission; Establish 'COVID-secure' areas for all staff in order to allow periods of rest, and the ability to eat and drink. Reinforce the importance of social distancing between staff and their contacts outside the workplace; Contact trace and require to self-isolate all contacts of newly identified COVID-19 positive staff; In line with Government advice, promote home working
	  • Distribute hand sanitiser and Clinell wipes to all office areas if hand washing facilities not accessible within the office.
	  • Maximise the use of rapid diagnostics and lab capacity – Continue to offer the asymptomatic staff testing programme; Continue admission and weekly patient COVID-19 screening in all areas
	  • Review cleaning procedures - frequency and areas cleaning (focus on high touch points etc.)

Social Care settings	• Continue universal level 1 PPE for all patient contacts, in line with government guidelines. • Continue to cohort/isolate all COVID-19, within care home settings. • Establish social distancing wherever feasible • All visitors to be given a face mask if they arrive without a face covering
Community settings	• Continue universal level 1 PPE for all patient contacts, in line with government guidelines. • Continue to triage all patients requiring assessment according to symptoms of possible COVID-19, • Establish social distancing wherever feasible for all patients . • All visitors to be given a face mask if they arrive on site without a face covering

Primary care

- Aim- reducing crowding in clinical areas through better management of resources throughout the day reduces the risk of infection.
  - Total Triage - Remote clinical triage and a booked face to face appointment slot only where clinically indicated.
  - Improve patient experience by minimising time spent waiting in healthcare settings.
  - Additional capacity through COVID-19 clinics at 3 sites in North Oxfordshire, South Oxfordshire and City (October 2020 – March 2021 inc) supported by a visiting service for those unable to travel.
  - PPE – supplies available through normal supplies, national PPE portal and National Supply Disruption Response for both primary care and care homes.
  - Testing Capacity in Oxfordshire:
  - The testing services in Oxfordshire is comprised of a combination of local and national services. National testing is accessible through:
    - Regional testing centres in Oxford and Milton Keynes.
    - Mobile testing units (MTU) which are deployed in various locations in the County for a few days at a time.
    - Postal/ courier swab sampling kits
  - There are 2 reserve MTUs in Thames Valley which can be deployed in >12 hours' notice in the event of an outbreak and a testing site being identified by the relevant local authority.
  - MTUs can be at a site between 1-3 days before they're deployed elsewhere to meet demand. Local Testing Sites are fixed locations.
  - Routes into testing are;
    - Acute hospital and community and mental health patients (including those who are asymptomatic, where indicated by clinical need) can be tested in a hospital setting.
    - Outbreak testing- at the point of notification, PHE will request testing of symptomatic individuals where appropriate, in order to inform an outbreak management in various settings including care homes, prisons and hostels.
    - Care home and NHS staff can access testing for asymptomatic and symptomatic staff and residents via the gov.uk site.
    - Essential workers can be access tests directly via gov.uk site
    - Symptomatic residents can apply via the NHS website or by telephoning 119, to be tested at either a regional testing site, mobile testing unit or receive a home swab kit.

Care homes

- Continuation of Care Home Cell throughout Winter: weekly review of trends, emerging issues and solutions. Focus on continuing communication with care homes and partners.

- Monitoring of key indicators and identification of services requiring support. This includes daily review of the national capacity tracker and outbreak reports.

- Ongoing monitoring of staffing trends and challenges, with system response to support safe staffing levels in the sector.

- Additional training and support regarding Infection Control, including ongoing support to maintain excellence in standards and bespoke support in response to outbreaks. Recruitment underway for additional Infection Control staffing capacity, to be in place before winter.

- Link with flu vaccinations program to deliver high levels of vaccination amongst staff and residents.

- PPE stocks are in place. Supply chains continue to be monitored and communication routes for providers to request support with PPE remain in place, with capacity for urgent response and support.

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