NHS
Oxfordshire
Clinical Commissioning Group

Oxfordshire Joint Health and Overview Scrutiny Committee

Date of Meeting: 16 November 2016

Title of Paper: Winter Update

Purpose: To provide the Oxfordshire Joint Health and Overview Scrutiny Committee with an update on the Winter Plan including the urgent performance and communications activity to support the plan.

Senior Responsible Officer: Diane Hedges, Chief Operating Officer and Deputy Chief Executive, Oxfordshire Clinical Commissioning Group

1. Introduction

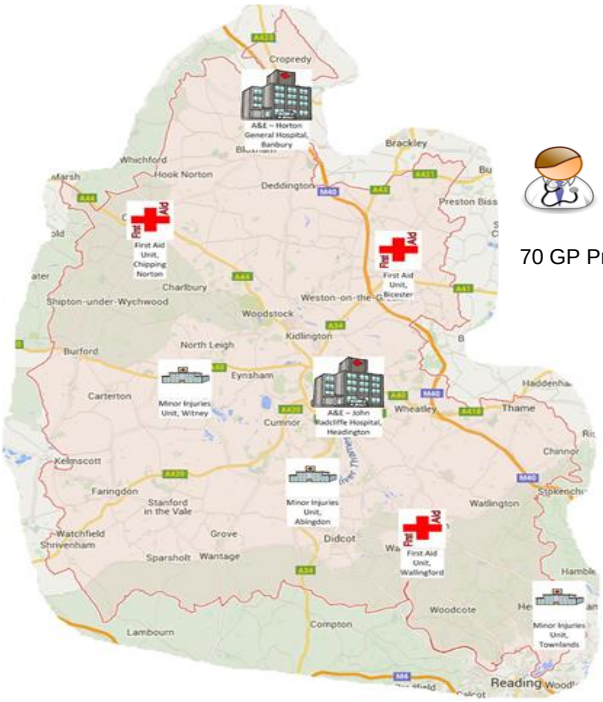
Nationally there is considerable focus on A&E 4-hour performance as we approach the winter period. Demand for urgent care services is rising and financial pressures have grown throughout the year. We are continuing to see rising attendances and emergency admissions compared to previous years and the resources required to meet the needs of all our residents continue to rise.

There is recognition that the 4-hour standard is an indicative measure of how well the urgent care system is performing in delivering care to patients. Both at a national and local level, patient flow through the health and social care system continues to be challenging.

Collaborative system working through our A&E Delivery Board and System Flow Executive continues to focus on key priorities for the system:

- Pathways and flow
- Managing demand
- Achievement of the A&E 4-hour target
- Delayed transfers of care
- Workforce
- Securing value for money
- Primary care capacity and resilience

The Oxfordshire Urgent Care System



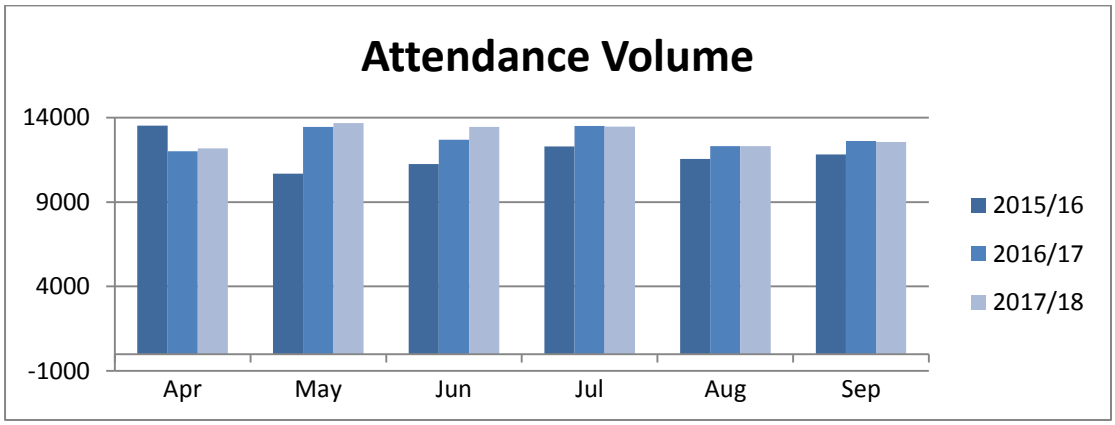
70 GP Practices across Oxfordshire

We are also working in collaboration with colleagues across the Buckinghamshire, Oxfordshire & Berkshire West (BOB) STP footprint to improve access to the most appropriate treatment and care services and to harness the strengths across the three place-based systems. We aim to work together on a number of initiatives to share expertise and work more efficiently. Examples include Primary Care Hubs, Emergency Department streaming, reducing Ambulance Handover delays.

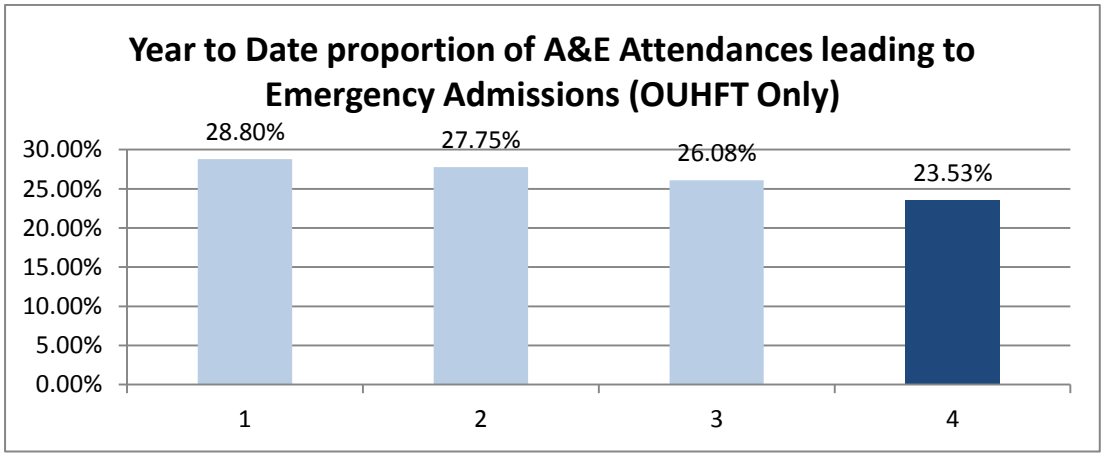
2. Oxfordshire Urgent & Emergency Care

A&E attendances and performance

In Oxfordshire, the number of people using A&E has risen by 1.45% compared with last year or an additional 1108 patients have attended this year to date compared to last year. The proportion of patients admitted when attending ED stands at 23.6% in Year to Date to August 17. The number of people admitted following attendance at ED (conversion rate) for the full year 2016/17 was 26.53%. Year to date performance at the end of September was 84.33% of people transferred out of A&E within 4 hours against the 95% target. Clinicians report increased demand from frail, older people with chronic, long term conditions.



Attendances continued to increase on last year during the early part of the year with a particular spike in demand in June however have remained similar to last year in recent months.



The number of people needing to be admitted from A&E into a hospital bed has decreased slightly over time (vs national trend of increase), with rates tending to be highest in the winter. This lower rate of admission reflects our development of alternative pathways to manage patients in an ambulatory care setting without admitting them to hospital. The ambulatory pathway provides rapid senior review, rapid diagnostics and rapid turnaround for patients without the requirement of staying overnight in hospital bed. This model is supported by national urgent and emergency care priorities and CCG vision and strategy increasing care closer to home and improving outcomes and quality of care for patients. There is enhanced social care support funded through the Better Care Fund which is supporting flow through the system. This includes additional social care staff supporting EDs to identify people who can go home and support these people with any onward arrangements.

Those waiting for admission tend to wait in A&E longer than other people. This is particularly a problem in hospitals when the bed occupancy rate is already high as there is more limited bed availability.

OUH have had five 12 Hour Wait breaches following a 'decision to admit' throughout 2017/18. This compares to no 12 hour breaches in the same period in 2016/17.

Struggling A&E performance has been seen over recent months and priorities have included:

- Ring fencing of staff to prioritise and improve 'minor' performance in ED (i.e. presentations not immediately life threatening). Performance has improved to over 95% in August and September
- Staffing and patient flow issues to ensure alignment for demand and capacity.
- Increased capacity required for discharge flow in reablement and community hospital capacity.

As a system classified by NHS England as Category 3 we are part of the Emergency Care Improvement Programme (ECIP) 3 Programme with support from the ECIP team within the OUH. The national expectation for ECIP3 is that 90% performance by quarter 3 will be achieved and sustained across quarter 4.

A very significant pre-hospital pathway support service has been in operation within the OUH since January 2016. The service is open to primary care clinicians, ambulance clinicians and to clinicians supporting care settings such as care homes and community hospitals and operates for extended hours seven days a week.

Senior clinical decision makers (usually at Consultant or Chief Registrar level) accept calls directly to proactively work with referring clinicians to better determine the appropriate service, timing and venue of care, aiming to avoid reactive, non-patient-centred hospital attendance whenever appropriate.

For example, following discussions and 'co-production' of the optimal clinical pathway between referring and receiving clinician, a patient may be directed to attend one of the Ambulatory Assessment Units (AAUs) on the same or the following day with pre-arranged diagnostics, rather than attend immediately, unscheduled and without prior workup. Such pathway management serves to reduce congestion and over-crowding in the Emergency Department and the Emergency Assessment Unit, improves patient experience, and has the potential to improve other outcomes through matching of need to available resource, and intelligent individualised direction of patients to teams with skills best able to meet their needs.

It is recognised that adoption of good practice in patient flow (the ability of systems to manage patients effectively and with minimal delay as they move through stages of care) is essential.

In line with the National Delivery Plan for Urgent and Emergency Care, Primary Care streaming in ED will also be in place for winter. This will increase GP capacity in ED and will help to improve patient flow through streaming patients to services appropriate to acuity and reducing pressure on emergency pathway.

A&E Performance reporting

Our urgent care system comprises of 2 EDs (JR and Horton) supported by Minor Injury Units (MIUs) and First Aid Units (FAUs) across the county – Three MIUs based at Abingdon, Witney and Henley. Three FAUs based at Wallingford, Bicester and Chipping Norton. This whole system offers same day urgent walk in care.

As we approach winter, there is significant interest in how well the NHS performs in relation to the A&E four hour target. This puts significant focus on our hospital A&Es. At the same time there is a general lack of consistency nationally about how activity is captured (principally within Minor Injury Units / Walk In Centres). The way this activity is collected currently depends on whether the unit is co-located with a hospital A&E department or not, which means that some parts of the country are being held to account for performance that is reported on a different basis to neighbouring areas.

For Oxfordshire, A&E performance and Minor Injury Unit performance are reported to NHS England separately as they are provided in different locations by different organisations. However, in a recent letter from NHS improvement on October 13th systems are asked to review their approach to address this national variation and to consider monitoring performance on a system-wide basis. This brings together NHS providers and Social Care to work together to help patients and residents of Oxfordshire get the right care they need. Performance for each part of the system will continued to be recorded and reported separately by each organisation but will then be collated centrally to report an Oxfordshire system-wide performance.

For Oxfordshire, this would mean continuing to monitor and report publicly performance for each individual A&E and MIU but to report to NHS England a combined performance including:

- A&E at the John Radcliffe, Oxford
- A&E at the Horton General Hospital, Banbury
- Minor Injuries Unit at Witney Community Hospital
- Minor Injuries Unit at Abingdon Community Hospital
- Minor Injuries Unit at Townlands Hospital, Henley

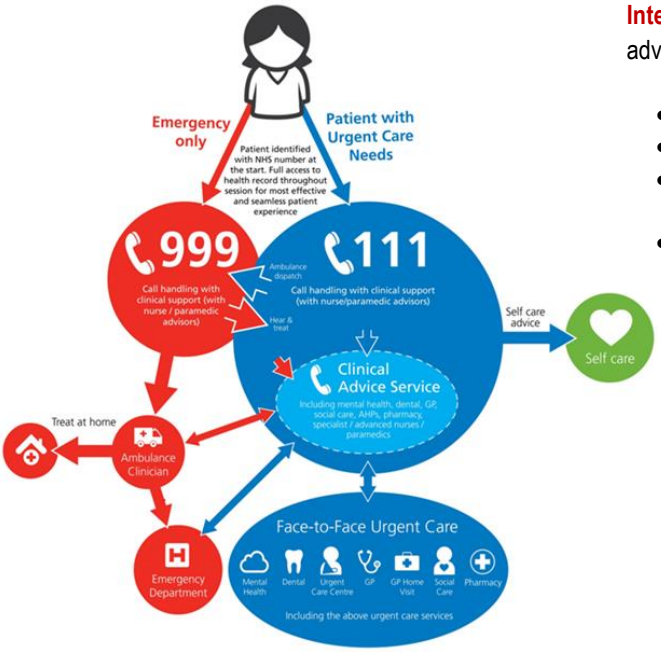
Once we have agreement from all relevant local parties, including our A&E Delivery Board Delivery Board, NHS Improvement will then allocate all A&E and MIU together in line with these local agreements, for performance reporting purposes. The advantage in doing this would be to change the focus of NHS Improvement performance management to recognise the system-wide approach that Oxfordshire takes to managing pressures in urgent care. The A&E Delivery Board supported this approach in their October meeting and we are asking for support in this approach.

Recognition of the role MIUs play in our urgent care system would mean that the system average is around 3% higher than A&E alone. We would be very interested in HOSC views on taking this whole system approach.

NHS 111

The Thames Valley CCGs (including East Berkshire CCGs within the Frimley STP) have collaborated on the procurement of a regional Integrated Urgent Care service, provided by the Thames Valley 111 Partnership- an alliance between South Central Ambulance Service, Berkshire Healthcare NHS Foundation Trust, Buckinghamshire Healthcare NHS Foundation Trust and Oxford Health NHS Foundation Trust. The service was launched on 5th September 2017.

This new service with enhanced multidisciplinary staffing within the service will enable enhanced clinical review of calls to access the right care with information from the call to passed on to clinicians. The Thames Valley Clinical hub is interconnected with providers to transfer calls 24/7 and also enables direct booking to out of hours GPs, some community services and referral to local services including direct to pharmacists.

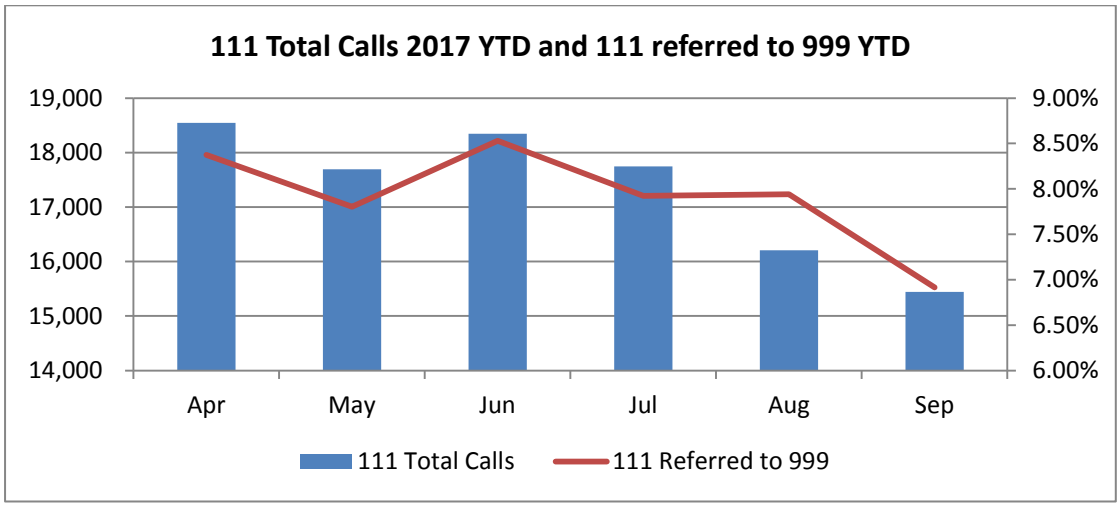


Integrated Urgent Care Service aims for the right advice or treatment first time through:

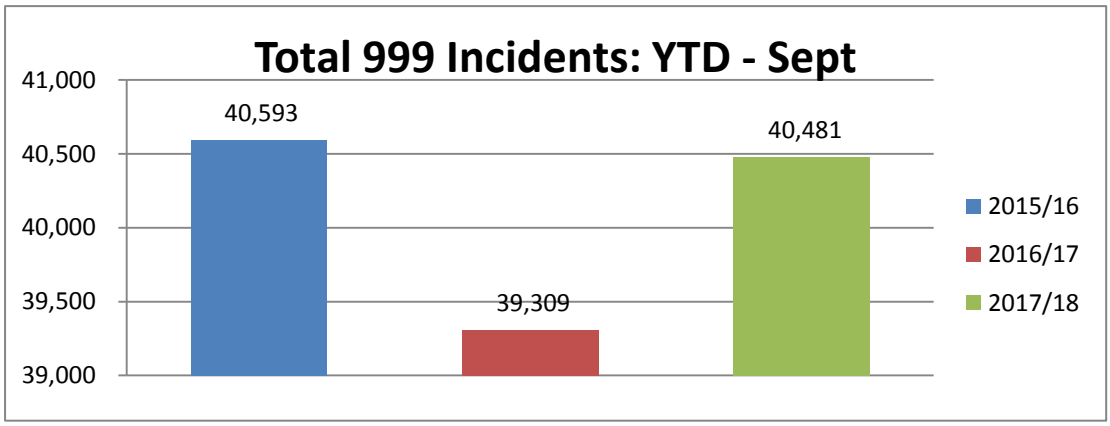
- Improved patient information
- Comprehensive Directory of Services
- Greater levels of clinical input
  E.g. mental health, pharmacist, GP
- Links to booking systems

As represented in the graph below comparative activity is in line with seasonal trend although year to date there has been an overall increase in 111 calls of 11.6% compared to 2016/17.

The graph below also demonstrates reduction in of 111 calls referred to 999 in September.



Ambulance 999 Activity and Performance



Demand for 999 services continues to grow in activity this year. The Year to Date position for Oxfordshire shows an increase of 2.84% in Red 1 and an increase of 8.23% in Red 2 (life-threatening) call demand in Oxfordshire compared to the same periods in 2016/17. This also shows an increase in demand for Red 19 ambulances of 7.92%. Despite this significant increase, SCAS outperformed many other ambulance services across the country. They are working hard to help as many people as they can where they are without conveyance to hospital.

Year to date activity has significantly increased overall with significant increase in Red See, Treat and Convey as compared to the same period last year. This means people who they can offer solutions for on scene and then must bring to hospital.

	YTD to August %Inc/(dec) versus prior year							
	Calls	Hear & Treat	RED See & Treat	RED See, Treat and Convey	GREEN See & Treat	GREEN See, Treat and Convey	HCP's	Subtotal incidents
Oxfordshire	***5.7%***	**20.7%**	**-9.3%**	**17.6%**	**-9.9%**	**-1.7%**	**-4.4%**	**1.6%**
SCAS	**3.8%**	**10.0%**	**-7.5%**	**13.2%**	**-5.3%**	**-3.3%**	**-1.4%**	**1.6%**

Oxfordshire 999 Performance:

	Red 1incidents within 8 minute target – threshold 75%	Red 2 incidents within 8 minute target – threshold 75%	Red 19 incidents within 19 minute target threshold 95%
July 2017	74.4%	70.0%	93.0%
August 2017	70.5%	69.1%	92.4%
September 2017	63.6%	66.8%	92.0%

SCAS continue to fall behind the target for performance due to higher activity and difficulties in resourcing. Actions are underway but are yet to have anticipated full impacts. It is noted however that SCAS remains one of the top performing ambulance trusts across the country.

Name	Red 1	Red 2	Red 19

England	**67.9%**	**60.5%**	**89.7%**

East Midlands Ambulance Service NHS Trust	68.2%	52.8%	82.7%
East of England Ambulance Service NHS Trust	70.4%	57.2%	88.6%
Isle of Wight NHS Trust	54.8%	65.0%	89.5%
London Ambulance Service NHS Trust	72.4%	68.5%	94.1%
North East Ambulance Service NHS Foundation Trust	73.1%	53.5%	85.1%
North West Ambulance Service NHS Trust	64.7%	64.2%	89.8%
South Central Ambulance Service NHS Foundation Trust	75.5%	71.0%	94.8%
South East Coast Ambulance Service NHS Foundation Trust	57.5%	45.7%	86.5%
South Western Ambulance Service NHS Foundation Trust	-	-	-
West Midlands Ambulance Service NHS Foundation Trust	-	-	-
Yorkshire Ambulance Service NHS Trust	-	-	-

Following a successful 18 month trial of the national Ambulance Response Programme at SCAS, all English Ambulance Services have now been mandated by NHS England to adopt the new Ambulance Response Standards. These new standards have been designed to deliver a more clinically appropriate response to 999 calls to drive clinically focused behaviour to ensure the most clinically appropriate response to the patient first time. Key elements of the programme are:

- The use of a new set of pre-triage questions to identify those patients in need of the fastest response at the earliest opportunity.
- Dispatch of the most clinically appropriate vehicle to each patient within a timeframe that meets their clinical need.
- A new evidence-based set of clinical prioritisation codes that better describe the patient's presenting condition and subsequent response/resource requirement.
- A full review of ambulance service measures and quality indicators.

From now on call handlers will be given more time to assess 999 calls that are not immediately life-threatening, which will enable them to identify patients' needs better and send the most appropriate response. There will be four categories of call. Category 1 is for calls about people with life-threatening injuries and illnesses. These will be responded to in an average time of seven minutes. Category 2 is for emergency calls. These will be responded to in an average time of 18 minutes. Stroke patients will get to hospital or a specialist stroke unit quicker because we can send the most appropriate vehicle first time. Category 3 is for urgent calls. These types of calls will be responded to at least 9 out of 10 times before 120 minutes often as a see and treat. Category 4 is non-urgent calls often referred to another service such as a GP. These less urgent calls will be responded to at least 9 out of 10 times before 180 minutes. In these cases the patient will generally be at home.

Evaluation of the pilot provided strong evidence that the introduction of longer call assessment times produces clear benefits for operational efficiency and this is translated in to better response time performance for the most seriously ill patients. SCAS will go live with the Ambulance Response Programme from 31 October.

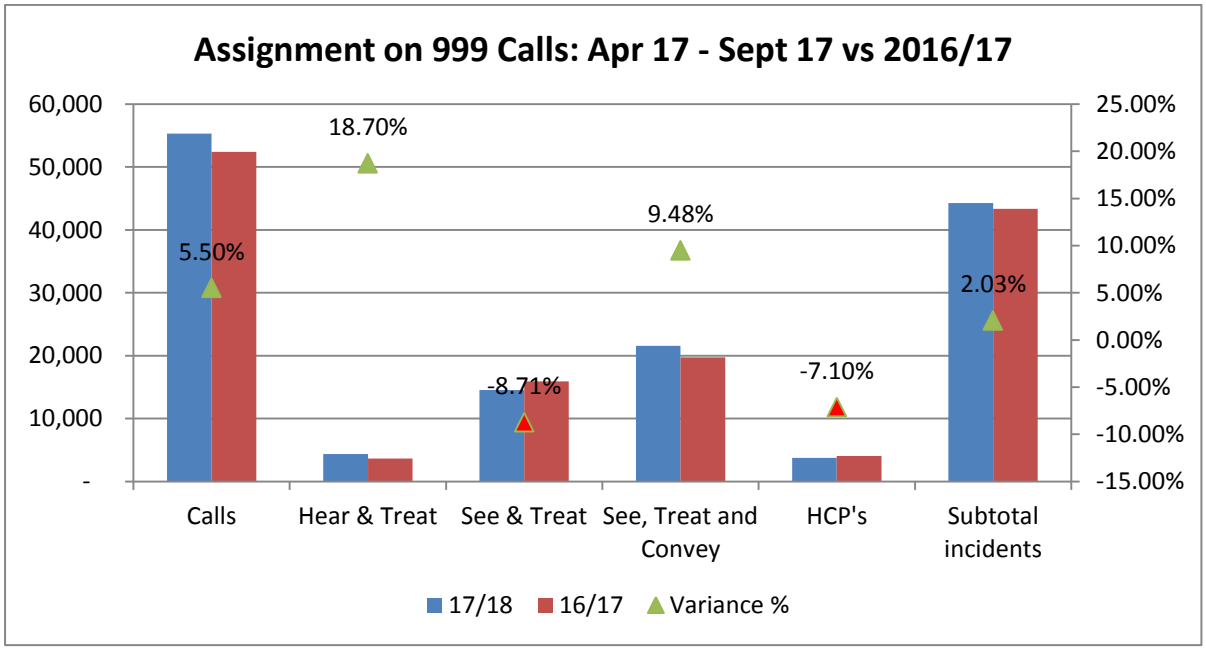
One of the continuing aims within the transformation of the ambulance service into a mobile healthcare provider is to increase the number of patients that the ambulance service can hear and

treat, where advice is provided over the phone with appropriate signposting and see and treat, where the patient is seen by an ambulance clinician and then either treated within their home or referred to the most appropriate care. Oxfordshire's performance during the winter period is shown below:

% of Total Calls:

	Hear and Treat	See and Treat	See, Treat and Convey
July 2017	11.05%	36.47%	52.49%
August 2017	9.80%	35.98%	54.21%
September 2017	10.04%	35.97%	53.99%

As shown within the table above, SCAS continues to only convey approximately half the patients that dial 999 by providing healthcare closer to home.



Patient Transport Services

Since December 2016, SCAS and Oxfordshire CCG, has continued working closely with our partners across the Thames Valley region realigned the service provision to improve the discharge and transfer part of the PTS provision, this has enabled the Oxfordshire system to be able to respond to the higher demand for the hospital beds, improving the experience of patients returning home or transferring from the acute hospital to ongoing care.

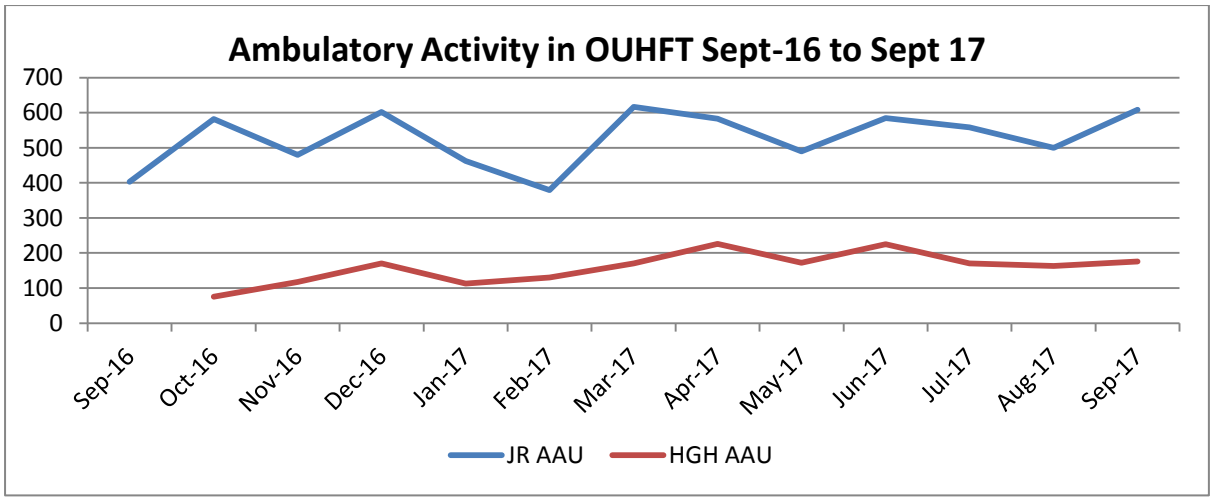
Urgent Treatment Centres

Urgent Treatment Centres are a national initiative aimed at providing a uniform and consistent approach to the delivery of community Urgent Care Services. This includes services such as: Minor Injuries Units, First Aid Units, GP Out of Hours and GP Extended Hours Services. The national drive looks to support patients in making more informed decisions about the use of Urgent Care Services and to simplify the complex "front doors" to existing services. Oxfordshire is looking at the potential efficiencies that can be achieved through the implementation of Urgent Treatment Centres in Oxfordshire. This will be achieved by reviewing existing community services such as Minor Injuries Units and First Aid Units to establish the best model for delivery for patients in Oxfordshire.

Ambulatory Assessment Units

The Ambulatory Assessment units at the John Radcliffe and Horton have developed very substantially since their inception. Their role is vital in streaming patients as early as possible to Urgent Care settings that are not the ED. The unit operates seven days per week with activity volumes increased to an average of 50 patients each day.

The Unit continues to provide assessment and treatment that is timely and tailored with an early focus on de-escalation, enhanced recovery and prompt supported discharge incorporating on-going monitoring arrangements.



Primary Care

There has been much identified nationally about the pressures on General Practice and the sustainability of the current model going forward (The Kings Fund, Understanding pressures in general practice. May 2016). Oxfordshire practices offer about 4 million appointments each year which may be delivered as face-to-face, telephone, or home visit consultations, by GPs, nurses, and other clinical staff. This accounts for about 70% of patient contacts with healthcare in Oxfordshire. This number is currently increasing at the rate of about 4% a year and is likely to increase further as a result of a growing and aging population. The practices are responsible for the majority of urgent appointments, prescribing, long-term condition (such as diabetes or asthma) care, end-of-life care, continuity of care, and co-ordination of care for complex patients. As such, they face challenges common to general practices across the UK, including:

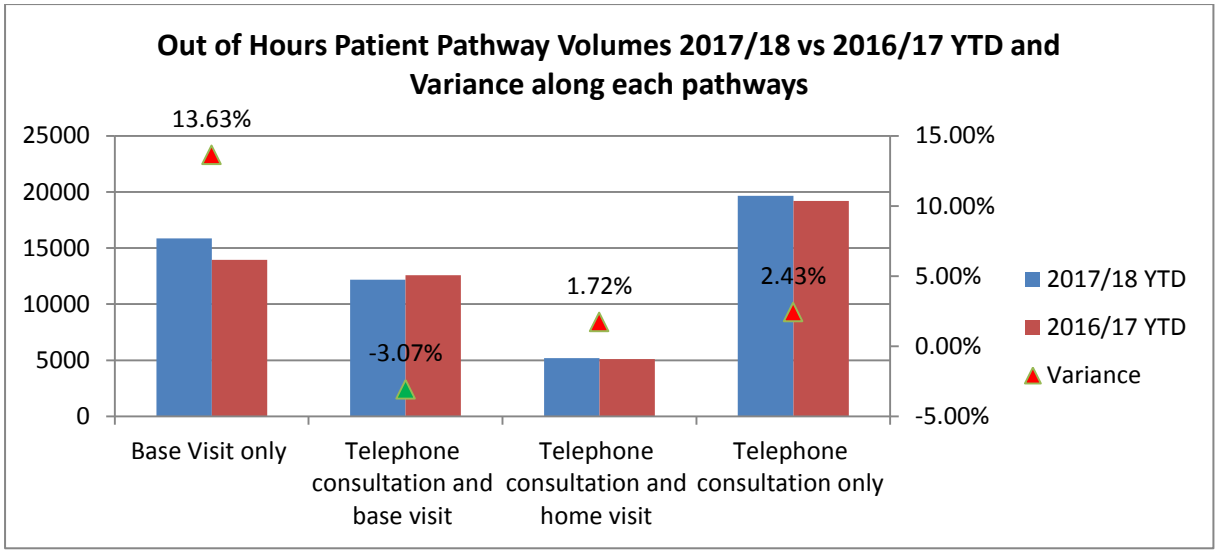
- Increasing need from patients requesting same-day access for urgent care, who are generally low-intensity patients;
- Increasing need from complex, frail, or elderly patients who require continuity and co-ordination of care, who are generally high-intensity patients;
- Worsening practice sustainability due to reduced funding, difficulty in recruiting or retaining staff, need to update premises and other infrastructure, and retirement of older GPs;
- Proliferation of patient contacts and multiple patient records across various organisations (general practice, hospital, mental health services, community health services, social care, and so on), leading to delays and gaps in communication, and greater difficulty in understanding and co-ordinating how care is delivered to the patient.

The Extended Access to GP Services scheme was launched in July this year. The scheme is being delivered by four GP federations in Oxfordshire and includes consultations with GPs, practice nurses and other clinicians such as healthcare assistants.

So far this year the scheme has provided more than 6000 more appointments a month in the county. The additional appointments are provided from locality hubs which serve the patients within that locality. Half of the appointments are provided at times when the practices are usually closed, including weekday evenings or Saturdays and Sundays. This gives patients greater choice about when and where they can access GP services.

Primary Care Out of Hours

Overall activity has increased YTD to date compared to 2016/17 by 3.9% with particular increases in base visits during this period.

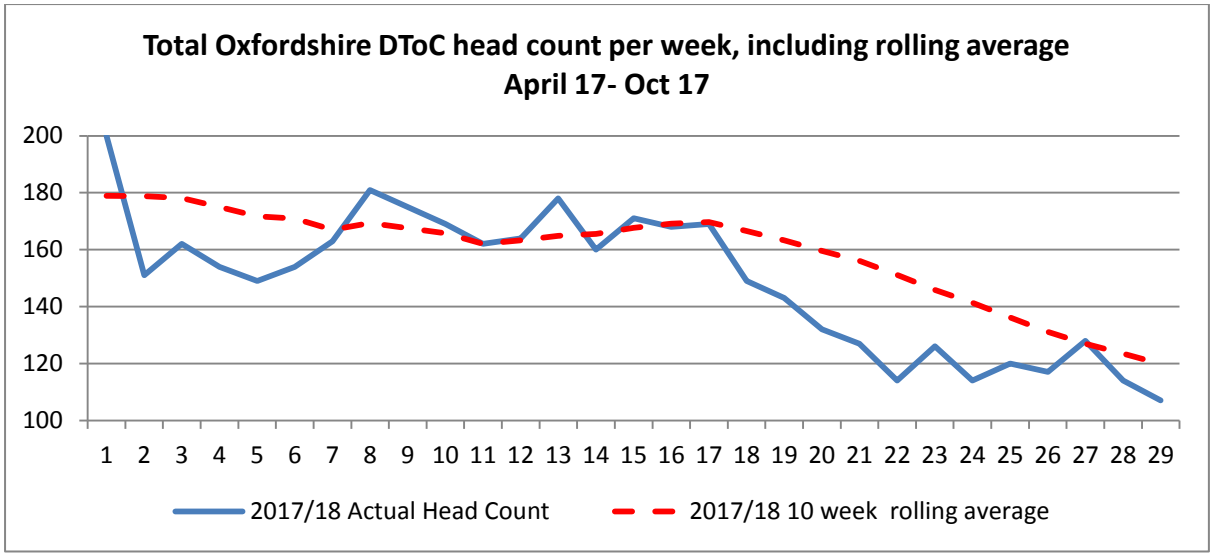


GP workforce remains a challenge within the out of hours service and this remains a risk to the service as we approach the winter period however much work is underway internally to improve this situation and continual focus has resulted in an improving position.
Collaboration with other OOH providers is also being explored to further improve capacity and use of resources.

Delayed Transfers of Care (DTOC)
Delayed transfers of care, occur when a patient is ready to depart from care and is still occupying a bed. Our work on improving delayed transfers of care has a clear interface with the flow people through our beds. According to NHS England, a patient is ready to depart when:

1. A clinical decision has been made that patient is ready for transfer and
2. A multi-disciplinary team decision has been made that patient is ready for transfer and
3. The patient is safe to discharge/transfer.

As we are aware longer stays in hospital can have a negative impact on older patients' health, as they quickly lose mobility and the ability to do everyday tasks. Keeping older people in hospital longer than necessary is also an additional and avoidable pressure on the financial sustainability of the NHS and local government. NHS guidance is that patients are moved out of acute hospital as soon as it is clinically safe to do so. It is important to achieve the correct balance between minimising delays and not discharging a patient from hospital before they are clinically ready.



The total number of delayed patients rose and remained high between January and July 2017. There has been a significant reduction across the Oxfordshire system over recent weeks (from July 2017). This has returned the system wide position to below where it was in the same period in 2016. In the intervening period there has been considerable workforce pressure in the HART reablement service which has impacted on the DTOC. The system has agreed some mitigation activity including purchasing of alternative services. These services are in place and are providing additional capacity to support hospital discharge or admission avoidance.

Based on the trend from the previous years it is expected there would be a rise in the head count in Oxfordshire through the winter period. Our agreed Better Care Fund trajectory is to reduce to a head count of 99 in November then to 83 in March 2018. So far, we are ahead of this target. The target was 137 average daily delays for month at 30 Sep however the actual figure achieved was ahead of plan at 119.

Over recent months significant work has been undertaken in collaboration with all organisations to improve discharge flow. Workshops in August and Sep 2017 identified complex pathways with multiple decision points which may drive poor system performance Other opportunities that were identified include efficiency and LEANing approaches that can make improvements now through operational changes, redesign of existing pathways and reallocation of resources to improve flow and exploring new ways of working (e.g. third sector)

Delays continue to be driven by 4 key areas

- The number of people in both acute and Oxford Health NHS FT community hospital settings waiting for reablement support. Mitigations to improve this include pathway work to reduce duplication and unnecessary referrals and increasing physiotherapy and occupational therapy to support reablement. Also ensuring that a full range of services are available to patients to support discharge including the voluntary and community sector.

  A new community rehabilitation pathway is now in place for patients who require a community hospital setting for part of their rehabilitation once their other nursing or medical needs have been met. These patients could continue their rehabilitation under the care of a clinician in their usual place of residence with 1-2 rehabilitation interventions per day and 1-2 care visits (average LOS on whole pathway 21 days). These are patients who need to remain on a

clinically led rehabilitation pathway which otherwise would be delivered in a community hospital setting. They would continue to be managed by the community hospital team which would support up to 6 patients at any one time in their usual place of residence. The patients would remain under the care of the community hospital until they are discharged from the community rehabilitation pathway. These are patients who are likely to have no ongoing care needs.

- The underlying availability of domiciliary care owing to workforce pressures in Oxfordshire. Workforce challenges are being addressed by OCC, CCG, OUHFT & OHFT collaboratively with a recruitment programme in progress.
- The underlying availability of nursing and care home capacity, especially in relation to people with complex dementias. A tender is underway to source additional care home beds for people with nursing and dementia needs. This is a joint OCC / CCG project.
- Patients self-funding their onward care who are unable to move: this is also related to both the domiciliary care and nursing home issues above. We also need to ensure we are supporting people to make decisions and set expectations from the outset about when they are discharged.

3. Winter Planning

In preparation for winter and in line with Pauline Philip National Urgent & Emergency Care Director NHS England and NHS Improvement July letter gateway 06969, 2017/18 has seen formal winter planning starting in July, with a requirement for final local plans to be submitted in early September. In developing their overarching winter plans the A&E Delivery Boards has prioritised the following: demand and capacity plans, front door processes and primary care streaming, flow through the Urgent and Emergency Care pathway, effective discharge processes, planning for peaks in demand over weekends and bank holidays, ensuring the adoption of best practice as set out in the NHS Improvement guide: Focus on Improving Patient Flow.

The Oxfordshire Winter Plan 2017/18 demonstrates the set of things we are doing and how we will ensure organisational resilience across the Health and Social Care System. The plan describes and provides reassurance on capacity planning, management structures and business continuity and escalation plans within and across the system. It embeds good practice and resilience principles to bring evidenced improvement in achievement in Constitutional Targets and benefits to patient when the system is facing challenges due to increased demand and /or reduced capacity over the winter period.

It also builds upon lessons learnt from winter 16/17 which have informed our planning for this year. These include care home market supply; recognising the value in collective leadership and whole system proactive planning; clinical leadership for improving hospital flow and discharges; workforce planning particularly in the domiciliary care /reablement system.

A systemwide communication plan was agreed in September at the A&E Delivery Board. The activities tie together national initiatives, including the NHS England ‘Stay well this winter’ campaign, which includes information on self-care and sign posting and the national seasonal flu campaign, with

a focus on encouraging targeted groups to maximise uptake of flu immunisation. The CCG is working in partnership with Oxford University Hospitals NHS Foundation Trust, Oxfordshire County Council, and Oxford Health on joint winter communications in support of the work of the A&E Delivery Board and the national winter campaign. The communications strategy will also identify local charities, community groups and schools who can assist us in cascading our messages directly to the target audience using digital, print and face-to-face methods of communication.

There is also significant work underway to maximise uptake of influenza vaccine for our at risk and vulnerable patient groups. Extra provision which has been put in place to ensure less able patients can access this immunisation and we have expanded our programme locally to provide immunisation to key workers in health and social care. We are also working together to increase communications with both health care professionals and patients to raise awareness of the importance of vaccination in these patient groups and the resources available to support this campaign.

Key challenges for the system

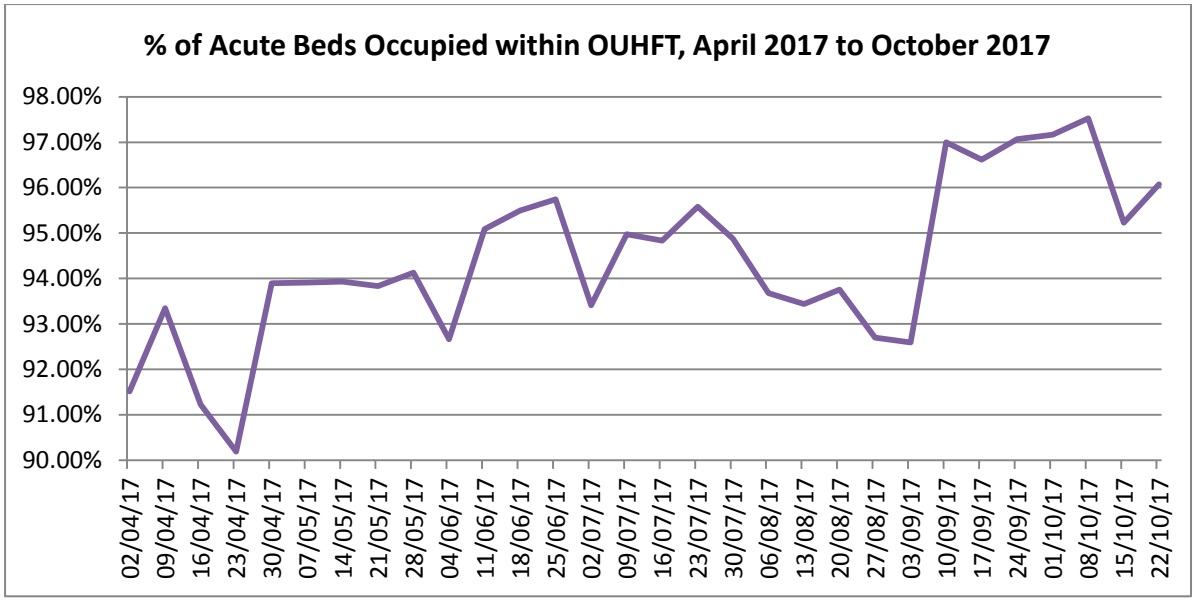
Workforce remains a challenge across the whole system and work is underway to develop a whole system Workforce Strategy however this remains a risk for winter 2017/18.

However there has been investment from the improved Better Care fund to increase rates of pay for home care hours and investment in home care agencies with training on values based recruitment. Collaboration on recruitment into care roles between private sector and various NHS entities is also in development.

The OUHFT Urgent Care Improvement Plan has been refocussed given the and key elements are currently being implemented include additional staffing such as pharmacist and physiotherapist to support the Emergency Department and recruitment of additional consultants to ensure senior medical capacity during the late afternoon / early evening peak period.

Acute bed capacity is another significant challenge as we approach the winter period. As a result of the closer of the Trauma Unit back in August 52 beds were reallocated with the Trust. This resulted in opening of a 22-bedded ward however the remaining 30 beds were allocated from existing bed stock. In addition to this staffing pressures have meant that safety-related bed closures have taken place in recent weeks. These have affected a range of services, including medicine at the John Radcliffe, surgical specialities, children's and other services. As at 3 September 2017, a total of 92 beds were temporarily closed

There is some daily fluctuation in these bed closures depending on staffing and there are plans underway to review/consolidate these workforce/safety related bed closures to maximise efficiency and use of resources.



NHS Improvement published Improving Patient Flow through Urgent and Emergency Care earlier this year which called for health systems to maintain bed occupancy at below 92%. OUH has relaunched its Escalation Framework to support patient flow across its four hospital sites. Despite the pressures described, OUH's length of stay on discharge has been relatively stable since April at around 4 days however bed capacity remains a concern going into the winter period.

The Oxfordshire system winter plan (Appendix1) describes work already underway to improve efficiency and flow through a safe and responsive Urgent Care service, demonstrating an emphasis on value-adding activities, given known workforce and financial constraints.
The plan includes range of new initiatives which will be in place during the winter period.

A summary of these plans is below:

Area	Initiative	Start Date	Lead Organisation	Impact
Pharmacy	Minor Ailment Scheme to provide care and support through community pharmacy	Nov-17	OCCG	Managing Demand, Reduce ED attendances
	Patient Group Direction for UTI Management supplied by pharmacy	Nov-17	OCCG	
	NHS Urgent Medicine Supply Advanced Service (NUMSAS) Repeat prescription supply via community pharmacy to reduce the burden on urgent and emergency care services of handling urgent medication requests, whilst ensuring patients have access to the medicines or appliances they need.	Sep-17	NHS England	
Care Homes	Medication Review – to reduce inappropriate polypharmacy and review patients at risk of admission	Winter 2017/18	OCCG	Admission avoidance, Quality of Care

Area	Initiative	Start Date	Lead Organisation	Impact
	Specialist Continence Prescribing Service – a specialist service to provide increased support to patients	Oct-17	OCCG	
	Improving Nutrition – to improve nutritional support to care home through increased dietician support	Winter 2017/18	OCCG	
	Care Home Support Service – to focus support on discharge and supporting discharge of more complex patients.	Winter 2017/18	OH	
	Proactive GP Support – to provide more support to care homes in proactive management and review of patients.	Winter 2017/18	OCCG	
Attendance Avoidance	SOS Bus – stationed in the centre of Oxford to respond to alcohol related incidents and minor injuries.	Dec 17	SCAS	Improved flow and patient outcomes
Primary Care	Increase in Hours of Provision – to provide additional appointments during the winter period.	Dec-17	OCCG	Reduced demand in ED
Flu	Increasing Flu Vaccinations for at risk groups	Oct-17	OCCG	Reduce admissions, Improve patient outcomes
	Flu Vaccinations for Social care workers – new scheme to provide vaccination to key workers in social care , care homes and domiciliary care	Oct-17	OCC	
Flow	Trusted Assessor – improved liaison and communication to ensure timely discharge.	Oct-17	OUH/OH	Reduce length of stay, Reduce ED Admission, Improve patient outcomes
	Primary Care Streaming in ED – triage of patients to the most appropriate care in ED.	Dec-17	OUH	
Discharges	Complex Discharges – to improve this process for patients and commissioning of additional capacity to support these patients	Aug-17	OH	Reduce length of stay, improve patient outcomes, Reduce admissions
	Hospital at Home – collaborative working to improve patient pathways.	Nov-17	OCCG	
	Third sector Initiative to develop a model to provide alternative support to patients to reduce social admissions.	Winter 2017/18	OCCG	
	Therapy Support to HART – to increase reablement support	Oct-17	OUH	
	200hrs of Contingency care – to provide additional domiciliary care capacity to support the HART team	Oct 17	OCC	
	Procurement of further 200hrs of Contingency care to provide additional domiciliary care capacity	Winter 2017/18	OCC	
	Community Hospital Home Leave- with virtual beds held on each ward to support early supported discharge from community hospitals.	Nov-17	OH	
	Patient Transport Service support to ED – additional support to support discharge and transfer patients home.	Nov-17	SCAS	

Area	Initiative	Start Date	Lead Organisation	Impact
North East Oxfordshire Training Pilot for non-registered staff – increased training provided to support patients and recognising deteriorating patients.		Winter 2017/18	OCCG	Improve patient outcomes

The Oxfordshire system continues to work together to improve patient flow and experience across the urgent and emergency care system. This year NHSE and NHSI have mandated that local systems ensure their winter plans meet specific priorities as well as ensuring preparedness to meet the expected increase in demand on the health and social care system over the winter months. This health and social care winter plan provides our response to these requirements and also describes the programmes of work collectively underway aiming to meet national requirements on A&E performance, delayed transfers of care and reducing variation in best practice. This work will continue to be monitored through the Oxfordshire A&E Delivery Board and System Flow Executive.

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November 2017