OXFORDSHIRE COUNTY COUNCIL

REPORT OF: THE JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE (HOSC):

Winter Planning

REPORT BY: HEALTH SCRUTINY OFFICER, OXFORDSHIRE COUNTY COUNCIL, DR OMID NOURI

INTRODUCTION AND OVERVIEW

1. At its meeting on 12 September 2024, the Oxfordshire Joint Health and Overview Scrutiny Committee (HOSC) received a report providing an update on the plans developed by system partners to manage demand for health and care services during the ensuing winter months.

2. The Committee felt it crucial to examine the preparations for the winter months, particularly given the anticipated increases in pressures and demands on Urgent and Emergency Care services.

3. This item was scrutinised by HOSC given that it has a constitutional remit over all aspects health as a whole; and this includes initiatives by the NHS and the County Council to ensure that adequate measures and preparations are in place to cope with potential increases in demand and pressures during the Winter. When commissioning this report on Winter Planning, some of the insights that the Committee sought to receive were as follows:

    - Emergency department capacity and waiting times.
    - The degree to which there is a sufficient amount of workforce, and how recruitment and retention will be optimised.
    - The extent to which plans are in place to support staff wellbeing, both in terms of the physical and mental wellbeing of staff.
    - Whether there are any vaccination programmes for Flu and Covid-19, and how these will meet demand.
    - The extent to which Primary Care access can be optimised, including through the use of out of hours services.
    - The discharge processes that are in place and whether there is sufficient resource for efficient discharging; including in the context of discharge-to-assess.
    - The extent to which there is effective coordination overall amongst the various actors in the system, and what the channels of coordination between these actors will be.

SUMMARY

4. The Committee would like to express thanks to Lily O'Connor (Programme Director Urgent and Emergency Care for Oxfordshire), Ed Capo-Bianco (Urgent Care, Palliative and End of Life Care, Cardiovascular Disease Clinical Lead for Oxfordshire Place in BOB ICB), Ben Riley (Executive Managing Director for Community, Primary and Dental Care, Oxford Health NHS Foundation Trust), Sally Steele (Service Manager Hospitals, Adult Social Services), Tamsin Cater (Head of Transfer of Care Hub, OUH), Karen Fuller (Director of Adult Social Care OCC), Ansaf Azhar (Director of Public Health OCC), and Dan Leveson (BOB ICB Director of Place) for attending this item and answering questions from the Committee in relation to Winter Planning.

5. The Committee noted that whilst there was a helpful discussion about the winter risk assessment at the scrutiny session, information on the acuities in the paper for the Committee could have been elaborated on, and that the fullest transparency on acuities was important for public confidence and scrutiny.

6. The first question from the Committee focused on workforce and funding challenges for the upcoming winter. The Committee asked what measures were being taken to address these challenges in the short term. The BOB Integrated Care Board (ICB) Director of Place highlighted that the winter plan was essentially an urgent emergency care plan, with workforce being a significant challenge. The Director of Adult Social Care explained that across the Oxfordshire system, efforts were being made to maximise the workforce, ensuring the right people were in the right place at the right time. She mentioned an ambitious recruitment campaign that had yielded positive results, particularly in recruiting qualified social workers and occupational therapists. Additionally, work was being done with care providers to support hospital discharges and ensure a buoyant home care market.

7. The Committee raised concerns about A&E and ambulance handover times. The BOB ICB Director of Place indicated that while the four-hour standard in A&E had been challenging, improvements had been made through partnerships and the establishment of urgent care centres. The performance had improved, with the target for the year being 78%. He also touched on the challenges faced by different trusts and the importance of system-wide collaboration to manage discharges and patient flow.

8. The Committee inquired about the confidence in reducing ambulance handover times. The Head of Transfer of Care Hub reiterated that Oxfordshire was performing well in this area, with excellent relationships with the South Central Ambulance Service. She noted that it was rare for ambulance handover delays to exceed 60 minutes, and efforts were being made to further reduce this time.

9. The Committee asked about the maturity of community services. The Executive Managing Director for Community, Primary and Dental Care reflected on the challenges faced due to stagnant funding despite increasing demands from a growing and ageing population. To address these challenges, he discussed efforts to streamline and consolidate services, such as implementing a single

point of access for planned, urgent, and emergency care. This approach aimed to free up clinical time and improve efficiency, with some success already seen in the planned care sector.

10. Additionally, the Director mentioned ongoing staffing changes to make services more sustainable, moving away from short-term staffing solutions to long-term employment plans. This shift was expected to reduce costs associated with agency fees and provide more reliable staffing. He also discussed the development of hubs to bring together services from multiple locations, aiming to deliver more care closer to home.

11. The Committee raised concerns about primary care capacity during the winter. The Cardiovascular Disease Clinical Lead for Oxfordshire Place in BOB ICB acknowledged that GP capacity was stretched, but efforts were being made to manage demand through triage models and the involvement of multidisciplinary teams. Investments in community pharmacies and same-day emergency care units were also supporting primary care capacity.

12. The Committee asked about the availability of vaccines and the challenges faced in certain areas. The Cardiovascular Disease Clinical Lead for Oxfordshire Place in BOB ICB indicated that the vaccine programme had been commissioned to ensure better alignment and availability, with efforts to address any gaps in provision. The Director for Public Health reported no significant issues with vaccine availability this year, though prioritisation remained necessary. Compared to previous years, there was no notable increase in respiratory illnesses, but they would not be complacent.

13. The Committee inquired about the capacity for reablement services and the balance between patient flow and personalised care. The Service Manager for Hospitals in Adult Social Services explained that the discharge to assess model had been implemented to ensure decisions were made in patients' homes, allowing for better reablement opportunities. She acknowledged the challenges but emphasised the importance of system-wide collaboration to maximise resources and support patients effectively.

KEY POINTS OF OBSERVATION & RECOMMENDATIONS

14. Below are four key points/themes of observation that the Committee has in relation to Winter Planning. These four key points of observation relate to some of the themes of discussion during the meeting on 12 September, and have also been used to shape the recommendations made by the Committee. Beneath each observation point is a specific recommendation being made by the Committee.

    Reducing time spent in emergency departments: As winter approaches, healthcare systems, in the United Kingdom as well as worldwide, brace for the inevitable surge in patients seeking emergency care. The colder months bring a variety of seasonal illnesses and injuries, from influenza and respiratory infections to slips and falls, that

significantly increase the pressure on emergency departments (EDs). In this context, the implementation of clear plans and processes is crucial to manage patient flow, reduce waiting times, and ensure that patients receive timely and effective care.

Winter is synonymous with a spike in health-related issues. Influenza, and other respiratory ailments become more prevalent, particularly amongst vulnerable populations such as the elderly, young children, and those with pre-existing conditions. Additionally, the winter season sees an increase in accidents related to adverse weather conditions. These factors collectively contribute to a higher volume of patients in EDs, often applying pressure on healthcare providers and leading to longer waiting times and, potentially, poorer health outcomes.

The Committee believes that effective triage is the cornerstone of managing patient flow in emergency departments. Clear and well-defined triage protocols ensure that patients are assessed quickly and accurately based on the severity of their conditions. By prioritising cases that require immediate attention, healthcare providers can allocate resources more efficiently, and ensuring that all patients receive appropriate care in a timely manner. This would not only improve patient outcomes but also enhances overall ED efficiency.

Furthermore, clear plans and processes facilitate better communication and coordination among healthcare teams. During peak times, the ability to quickly and accurately share information about patient status, resource availability, and treatment plans is essential. Standardised communication protocols and regular briefings can help ensure that all team members are on the same page, reducing errors and delays in patient care. Additionally, coordination with other departments and external healthcare providers can potentially help manage patient overflow and improve continuity of care.

Moreover, there is also a point about potentially utilising data analytics to effectively predict and forecast the levels and type of demand that will rise during the winter months. This could also help to inform the level of preparedness of Eds in terms of their resource allocation/capacity.

Recommendation 1: *To continue to ensure that clear plans and processes are in place to help reduce time spent in emergency departments by patients during the winter months when pressures are likely to be higher.*

Balancing patient flow with efficacy of care: In the modern healthcare environment, achieving a balance between efficient patient flow and personalised care is paramount. This delicate balance ensures that patients receive tailored treatment while healthcare facilities operate smoothly and effectively. The Committee understands the challenge of optimising patient flow. This involves reducing lengths of stay in hospital as well as in step-down units. Nonetheless, it is vital that achieving greater patient flow does not compromise the quality of individualised

care each patient requires. Accomplishing this balance demands good strategic planning, resource management, and a deep commitment to patient-centred care.

Many patients who were initially admitted into hospital, or who were placed in step-down beds, often suffer from challenging conditions that would involve ongoing care and support. It is also the case that such patients will remain vulnerable and that they would therefore require ongoing/routine monitoring. It is therefore crucial that if vulnerable patients are discharged, three things are considered:

1. Their process of discharging should not be based purely on the need to maintain efficient patient flow.

2. Any risk of the emergency being repeated is assessed, discussed with a letter sent to primary care who can action any recommendation in a timely way.

3. That if it is deemed appropriate for them to not be in a hospital or step-down setting, that they receive the utmost care and support at home that they may require. Careful consideration should be given to the amount of resource available for this.

Hence, while optimising patient flow, it is imperative to maintain the individualised care that patients need. Whilst health settings are likely under pressure, it is critical to prevention and patient safety that patients are kept at the centre. Firstly, care plans should be as comprehensive as possible; and should be detailed and personalised in a manner that they address the unique needs of each patient. Secondly, there should be clear and effective communication with patients. Engaging in open and empathetic dialogue with patients and their families to understand their preferences and concerns is necessary. Thirdly, continuity of care is also paramount, and it should be ensured that patients experience seamless transitions between different care settings through careful coordination and follow-up.

Balancing patient flow with personalised care is a complex yet achievable goal. By implementing strategic measures and fostering a culture of patient-centeredness, services can ensure that they provide high-quality care efficiently and support future prevention of emergency. This balance not only enhances patient outcomes but also optimises the operational effectiveness of healthcare institutions.

Recommendation 2: *To continue to ensure a careful balance between providing patient flow on the one hand (including through reducing lengths of stay across step down beds), whilst continuing to provide the personalised care that each patient needs.*

Maximising primary care capacity: As winter approaches, primary care services, especially General Practitioner (GP) services, face increased pressure due to seasonal illnesses and a general increase in healthcare

needs. Maximising the capacity of primary care to handle this surge is essential to maintain the quality of care and ensure that patients receive timely and effective treatment.

Maximising staff capacity is a vital aspect of maximising overall primary care capacity. There are a couple of steps that could be taken to achieve this:

1. Recruitment and Training: To meet the heightened demand, recruiting additional healthcare professionals, including locum GPs, nurse practitioners, and allied professionals whose role and competencies are appropriate and clear and well communicated to patients is crucial. Providing targeted training for existing staff on managing common winter ailments can further enhance the workforce's preparedness.

2. Flexible Scheduling: Adopting flexible scheduling practices, such as extended hours and weekend clinics, can alleviate pressure during peak times. Rotating shifts and offering overtime can also help distribute the workload more evenly among staff.

Furthermore, effective triage systems can be efficient and help prioritise patients based on the severity of their conditions. This can help ensure that those with urgent needs are seen promptly, while less critical cases can be managed through alternative means such as phone consultations or advice services. However, the Committee urges that GP practices are consistent and as careful as possible in applying this logic. Some patients may genuinely require a prompt and an in-person appointment, and careful judgement should be used to ensure that such patients do not lose the opportunity of being offered this. People with long-term conditions are more likely to be experts in their lived experience and know if a risk is urgent. The elderly and other vulnerable groups on patient lists who may be likely less able to use new systems well or to advocate need to be carefully considered. Patients with mental health issues or other sensitive issues may be less likely to share information except with a trusted professional. Evidence-based training for triage and inclusive of lived experience should be used.

In addition, strengthening the link between primary and secondary care is important. Strengthening these links can facilitate smoother patient transitions and reduce hospital admissions. Regular communication and potentially shared care protocols/procedures can enhance coordination between different levels of care. This can also help ensure that patients are seen and followed up in ways that would prevent them being lost or unnecessarily held in-between primary and secondary care services. Systems that help identify patients and particular populations of patients that have repeat emergencies can help prevention through improved risk management during an emergency and communication of risk and management plan from acute to primary care.

Moreover, utilising data analytics to monitor patient demand and service performance can also help to inform resource allocation and identify areas for improvement. Primary care services can be in a more ideal position to forecast the levels and types of demand that could arise during the winter, and can plan accordingly. Regular feedback from patients and staff can also offer valuable insights.

Recommendation 3: *To maximise capacity within primary care (particularly with GP services) to cater for any increased pressure during the winter.*

Preparations for increased infection rates: As we continue to grapple with the challenges posed by infectious diseases both locally and nationally, it is imperative that we proactively prepare for potential surges in infection rates. Healthcare facilities must be prepared to handle a sudden influx of patients. This involves increasing the capacity of hospitals, emergency rooms, and intensive care units. Additionally, establishing temporary healthcare facilities and isolation centers can help manage overflow situations.

It is important that healthcare facilities are prepared to handle a sudden influx of patients. This involves increasing the capacity of hospitals, emergency rooms, and intensive care units. Additionally, ensuring the availability of essential medical supplies and equipment, such as personal protective equipment (PPE), ventilators, and testing kits, is crucial. Providers should maintain stockpiles of these supplies and avert the prospects of shortages.

Furthermore, establishing a robust vaccination infrastructure is critical for efficient vaccine administration. Consideration should also be given to setting up vaccination centers and mobile units that would increase capacity. Engaging communities in preparedness efforts is a key learning from the pandemic. Community-based organisations, local leaders, and volunteers can play a significant role in being aware in advance of emergency planning and part of that plan. Roles such as disseminating information, identifying vulnerable populations, and supporting vaccination campaigns should be given consideration. This relates to a broader point that the Committee is recommending around communicating with residents to help them understand the importance of vaccines and in helping them to understand how to go about getting vaccinated.

Recommendation 4: *To ensure that adequate preparations are in place for a potential surge in infection rates, and to secure the availability of vaccinations. It Is recommended that relevant system partners clearly communicate with the public in relation to both viral infection patterns as well as how residents can reduce the likelihood of spreading/contracting diseases.*

Legal Implications

15. Health Scrutiny powers set out in the Health and Social Care Act 2012 and the Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013 provide:
     - Power to scrutinise health bodies and authorities in the local area
     - Power to require members or officers of local health bodies to provide information and to attend health scrutiny meetings to answer questions
     - Duty of NHS to consult scrutiny on major service changes and provide feedback on consultations.

16. Under s. 22 (1) Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013 'A local authority may make reports and recommendations to a responsible person on any matter it has reviewed or scrutinised'.

17. The Health and Social Care Act 2012 and the Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013 provide that the committee may require a response from the responsible person to whom it has made the report or recommendation and that person must respond in writing within 28 days of the request.

Annex 1 – Scrutiny Response Pro Forma

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