Oxford University Hospitals
NHS Foundation Trust

Cover Sheet

Trust Board in Public: Wednesday 30 September 2026

TB2026.83

Title:	**OUH Winter Preparedness Plan 2026/27**

Status:	**For Information**
History:	**Reviewed by Trust Management Executive on 10 September 2026**

Board Lead:	**Chief Operating Officer**
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Confidential:	**No**
Strategic Pillar:	**Patients, People, Partnerships, Performance.**

Executive Summary

1. Oxford University Hospitals faces a challenging winter in 2026/27, with sustained urgent and emergency care demand, seasonal respiratory illness, severe weather, workforce pressures and constrained acute, community and social care capacity. This clinically led, Trust-wide plan sets out how OUH and system partners will maintain patient safety, flow and operational resilience across all sites.
2. **Flow first:** Maintain SDEC for at least 12 hours a day, seven days a week; strengthen front-door frailty and earlier senior decision-making; improve inpatient flow, length of stay and bed productivity and apply Home First principles through board rounds, long-stay review, MADE, outlier oversight and extended discharge support.
3. **Safe surge capacity:** Use an agreed phased, trigger-based response aligned to OPEL, the Full Capacity Protocol and Gold, Silver and Bronze command. Divisions must confirm safe core, surge and extreme-surge capacity, taking account of the expanded JR Level 1 EAU, SEC1 activity, limited JR surge space, paediatric and critical care requirements and options across all sites.
4. **System collaboration and service protection:** Reduce avoidable conveyance and admission and accelerate discharge through Call Before Convey, alternative pathways, SPA, Urgent Community Response, community SDEC, virtual wards, expanded Hospital at Home, mental health crisis alternatives and commissioned social care and intermediate care capacity. Protect ambulance handovers and elective, cancer, outpatient and diagnostic delivery as far as clinically possible.
5. **Workforce and assurance:** Require each Division to provide a quantified staffing plan for core and surge services, including robust rostering, seven-day senior cover, managed leave, recruitment, temporary staffing, competency assurance, sickness management, vaccination and staff wellbeing. Delivery will be stress-tested and monitored through the Winter Planning Programme Board, UEC Delivery Board, Trust command structure, Delivery Committee and Board Assurance Statement.

Recommendations

6. The Trust Board is asked to:

   - Note the national requirements for Winter Planning 2026/27
   - Approve the Winter Preparedness Plan 2026/27 and supporting Board Assurance Statement for submission by 30 September 2026, subject to incorporation of outputs from the regional and Place level winter stress-testing exercise* *post board paper deadline, verbal update by COO to be provided*
   - Note the key risks and dependencies, including Level 1 capacity, Ward 5B, Surgical Elective Centre activity, discharge performance, workforce resilience, vaccination uptake and Launch Point implementation

- Support completion of surge and extreme-surge stress testing and recognise financial risk to EDF, if additional capacity requirements are enabled through the correct governance channels
- Support escalation unresolved system dependencies to the ICB, including community alternatives, social care, intermediate care, cross-border discharge, urgent transport and plans to reduce occupancy before Christmas
- Require ongoing monitoring of surge-capacity utilisation and associated workforce and financial impacts throughout winter 2026/27, in line with previous winter periods

Contents

1. Purpose

This paper amalgamates the multiple moving parts that bring the OUH Winter Plan 2026/27 to life, utilising specific national guidance and thematics, cross Divisional plans and ICB level plan to ensure that the organisation has a robust, safe and adaptable winter plan that delivers safe care for patients.

2. Background

The NHS England winter planning letter, published on 17 July 2026, sets a clear expectation that every local area must produce a robust, clinically led and deliverable winter plan for 2026/27. It requires draft plans by the end of August 2026, regional stress testing in mid-September 2026 and board sign-off through the Board Assurance Statement process by 30 September 2026.

2.1. The proposed approach builds upon lessons from Winter 2025/26 together with emerging UEC recovery planning and focuses on:

2.1.1. Reducing demand and avoidable admissions

2.1.2. Improving patient flow through the Trust

2.1.3. Maximising discharge and reducing hospital occupancy

2.1.4. Protecting elective and cancer capacity

2.1.5. Strengthening workforce resilience

2.1.6. Delivering system-wide actions with partners

2.2. The plan recognises that the Trust enters Winter 2026/27 without any significant additional permanent bed stock and, therefore, success will depend on flow, discharge performance, utilisation of community alternatives and whole-system ownership of emergency care demand.

2.3. The national letter reinforces the operating model that ICBs commission, providers deliver and regions oversee with winter plans underpinned by demand and capacity analysis, surge and extreme surge testing and clear executive accountability.

2.4. For providers, including OUH, the immediate requirements are to complete an organisational winter plan by the end of August 2026, have staff flu vaccination programmes ready to launch, implement the Model ED, Model acute pathway and Model discharge pathway requirements ahead of winter, treat elimination of corridor care as a patient safety priority, maintain elective capacity and assure escalation, IPC, on-call leadership, staff welfare and deliver trajectories.

2.5. The letter places particular emphasis on the ICB role in prevention and alternative capacity: vaccination uptake, support for people most at risk from winter viruses and cold weather, same-day primary care, NHS 111 direct booking, community pharmacy, urgent community response, virtual wards, Hospital at Home, mental health crisis provision, social care and intermediate care capacity and agreed plans to reduce hospital occupancy ahead of Christmas to 80% target 24 December 2026 (Regional COO target August 2026).

3. Proposed OUH Winter Surge plan 2026/2027

3.1. The Winter 2026/27 model distinguishes clearly between routine pressure managed locally and sustained or exceptional pressure requiring potential ICB intervention. The ICB role is reframed around oversight, situational awareness and escalation rather than operational ownership. Unique challenges face OUH this winter with the proposed opening of an expanded JRH L1 EAU planned in mid-January 2027, but more importantly the opening of SEC1 and the potential tension caused by additional bed requirements for day case conversions, that are not currently in the OUH bed base.

3.2. OUH will manage winter 2026/27 through a *flow-first* strategy focused on admission avoidance, discharge acceleration, flexible surge capacity, workforce resilience and system-wide escalation arrangements, with clear trigger-based deployment of additional capacity with Executive oversight throughout the winter period. We hope to escalate through a person specific plan rather than being reliant on bed base expansion. This will require Senior Decision Makers being made available to front line services flexibly, in line with the Trust UEC Standards. Additional beds should be opened only as a last resort, recognising the associated workforce and financial pressures

3.3. We aim to maintain safe, timely and effective care throughout periods of sustained winter demand by:

3.3.1. Maximising admission avoidance

3.3.2. Accelerating discharge and reducing stranded patients

3.3.3. Protecting elective and cancer delivery where clinically possible

3.3.4. Expanding operational capacity through a structured escalation framework

3.3.5. Working with system partners to manage whole-system flow

3.4. Surge will be managed with a phased approach against bed deficit; bed deficit is defined as the number of unplaced DTA in ED against the number

of available/predicted beds. We will ring fence and protect Trust wide SDECs and ensure that all funded capacity is open consistently

3.5. The Strategic objectives will be to:

Reduce demand on acute beds:

3.5.1. Expand Call Before Convey arrangements with SCAS

3.5.2. Increase utilisation of same-day and alternative pathways

3.5.3. Strengthen frailty assessment at front door

3.5.4. Develop alternatives via primary care, Oxford Health and community services

3.5.5. Pilot earlier senior assessment of elderly and ambulance-conveyed patients

3.6. ICB promotion of RSV vaccine alongside flu vaccine given the association with an 82% reduction in hospitalisation with RSV in older adults with RSV Vaccine effectiveness of a bivalent respiratory syncytial virus (RSV) pre-F vaccine against RSV-associated hospitalisation among adults aged 75-79 years in England | medRxiv.

3.7. Maintain all SDECs operating hours at a minimum of 12 hours a day, seven days a week, including holiday periods and increase direct referrals from primary care and ambulance services.

3.8. Maintain 24/7 community mental health crisis provision and develop further diversion from Emergency Departments through advice lines, safe alternatives and rapid escalation for patients requiring specialist assessment. The new SCAS Mental Health pathway will be in place for winter and offers Oxfordshire Adult Crisis Resolution and Home Treatment Team (CRHTT) who can provide clinical advice and respond to urgent requests for mental health 24 hours a day across Oxfordshire. Oxfordshire.

Improve admission-to-discharge flow:

3.8.1. System wide Executive led MADE events

3.8.2. 7/7-day; 12-hour Discharge lounge extended opening JRH and HH (as per Model discharge pathway)

3.8.3. Discharge lounge at the Churchill

3.8.4. 7-day therapies enactment

3.8.5. Switch IV to oral antibiotics to facilitate earlier discharge.

3.8.6. Pharmacy discharge process maximisation

3.8.7. Enhanced scrutiny >14/>21d LoS reviews

3.8.8. Earlier identification of patients likely to require admission by Senior Decision maker

3.8.9. Expansion of 72-hour turnaround pathways

3.8.10. Optimised utilisation of EAU - early allocation and movement to ward

3.8.11. Use flexible community bed admission criteria against agreed OPEL triggers and ensure weekend and bank holiday medical cover supports both admission and discharge

3.8.12. Maintain seven-day Transfer of Care Hub arrangements, weekend and bank holiday discharge support and weekly MADE activity for adult services. Increased frequency and oversight of Children's delayed discharges escalation meeting, with paediatric discharge improvement embedded through Children's pathways

3.8.13. Review Horton medical workforce configuration post 1600

3.8.14. Maintain outlier team arrangements

3.8.15. Commitment to eliminating corridor care with Full Capacity Protocol and local ownership

3.9. Board Round roll out extended to include adult assessment areas

3.10. *Cohorting Plan* as per detailed by Operational Team with Director of Infection Prevention and Control- 4.7/4.8

Create flexible surge capacity aligned to OPEL triggers:

3.11. Level 1 – Normal winter pressure

- Use existing escalation beds
- Extended ward opening hours
- Increased staffing flexibility

3.12. Level 2 – Sustained pressure

- Open identified surge beds across sites
- Increase ambulatory capacity
- Redeploy workforce according to agreed divisional plans
- Daily command-centre oversight

3.13. Level 3 – Severe pressure

- Full escalation bed stock enabled
- Cancellation thresholds applied to selected elective activity
- Command structure moves to twice-daily review
- System-wide discharge and transfer actions activated

3.14. Level 4 – Critical incident risk

- Trust Gold command
- Suspension of non-essential activity
- Regional escalation procedures enacted

These arrangements should align with the existing Trust surge and escalation planning framework.

4. Board Assurance

The required Winter Preparedness checklist covers the following headlines, with explicit details behind them. Self-assessment templates are available for Trusts, ICBs and Ambulance providers. Assurance priorities requiring completion and stress testing:

Acute Trust

4.1. Demand-and-capacity model, including surge and extreme-surge scenarios, by site, specialty and critical dependency.

4.2. Safe staffing, vaccination, workforce availability, leave and temporary staffing arrangements across seven days.

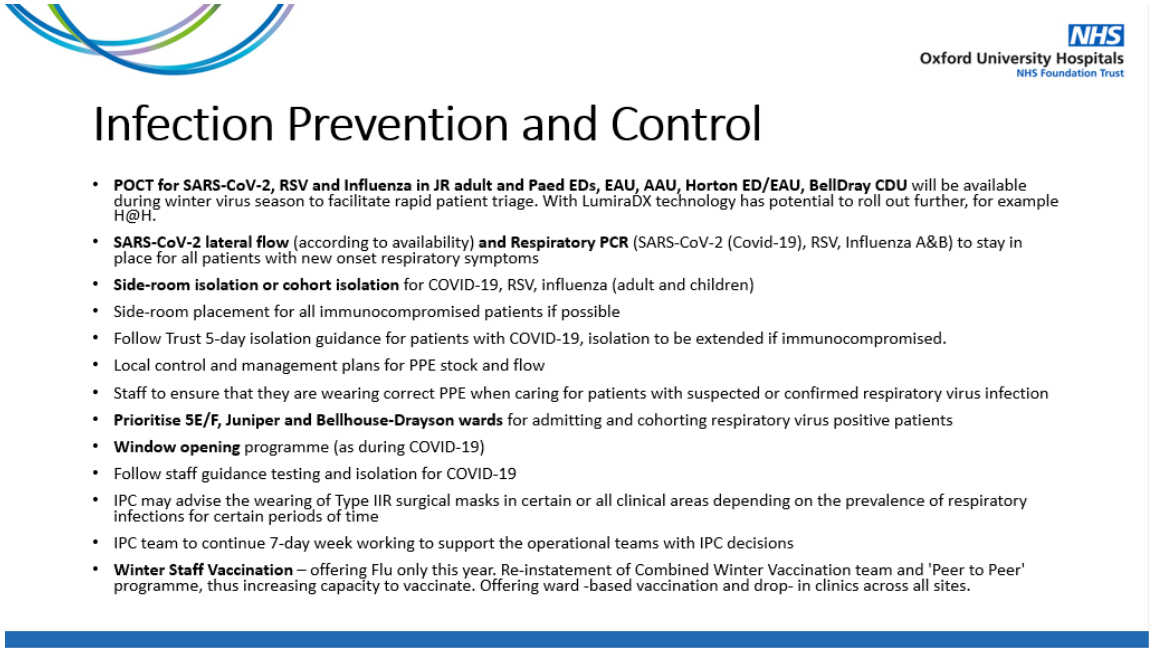
4.3. Implementation and audit of Model ED, acute pathway, discharge pathway and Full Capacity Protocol standards.

4.4. Corridor care elimination plan, ambulance handover improvement and readiness of all temporary escalation spaces. Weekly Medical Optimised For Discharge (MOFD) Assurance and Accountability review meetings, led by the CNO to validate MOFD, deliver cross Divisional accountability and escalate to System appropriately.

4.5. Elective and cancer protection, including thresholds, executive approval and recovery arrangements.

4.6. IPC led advice regarding capacity for patients' placements and cohorting, severe weather, oxygen, supplies, digital resilience and business-continuity assurance.

4.7. *Cohorting plan* - replicates the 25/26 plan given the superior ventilation on 5E/F, Juniper and Bellhouse-Drayson wards.



4.8.

Integrated Care Board

4.9. Vaccination (influenza, shingles, pneumococcal, RSV) as guided by age cohorts, same-day primary care, NHS 111 direct booking, pharmacy, urgent community response, virtual wards and Hospital at Home capacity.

4.10. Commissioned social care, intermediate care and mental health crisis capacity, with clear access criteria and operating hours.

4.11. A jointly owned plan to reduce medically optimised patients and occupancy pre and post-Christmas, including weekend and bank holiday arrangements.

4.12. System surge governance, mutual aid, cross-border discharge and rapid resolution of provider constraints.

Ambulance Provider

4.13. Call Before Convey, alternative destination and clinical validation arrangements.

4.14. Ambulance handover trajectories, escalation thresholds, cohorting safety and senior operational contacts.

4.15. Alignment of vehicle and patient-transport capacity with discharge lounges, inter-site transfer and out-of-hours demand.

5. Oxfordshire Winter plan 2026/27 areas of focus:

5.1. **Neighbourhood development:** Focus on early intervention and prevention-based approaches e.g. frailty support to prevent falls to gradually reduce risks in the community that can lead to unplanned admission and

improve integrated urgent care access across community, social care and primary care services when same day care needs arise.

Reducing ED attendances

5.2. **Community services:** Maximising on the day triage/assessment in the person's own home accessing Single Point of Access, Urgent Community Response and Hospital at Home teams.

5.3. **Reducing emergency admissions** by 10% by 2029.

5.4. **Mental Health:** SCAS MH Crisis pathway/guidelines and avoiding people with no physical health needs but have a mental health need attending an Emergency Department.

5.5. **Ambulance Services:** Reducing Cat 2 response times, maximising hear and treat, reducing conveyances to ED and achieving ambulance handovers under 45 minutes.

5.6. **Intermediate Care:** Reducing length of stay for those who require support to return home and bed occupancy within frailty cohort bed bases. Learning from planned system wide 'Perfect Week' to promote Model Discharge pathway delivery.

Performance against system trajectories – May 26/7

Oxfordshire's system trajectories for 26/7 consist of core BCF and locally-determined metrics. The underlying principle is to build on progress in 25/6 through existing and newly commissioned schemes, improve processes, develop baselines and continue delivery against longer term national trajectories.
Note – UEC sit rep and BCF metric data included as appendix 1

Priority area	Performance metric	Agreed system targets	Actual performance	May RAG | vs plan/target
1. Non-elective admissions (NELs)	a) All non-elective admissions aged 65+ (BCF core)	Zero growth compared with 2025/26	1649	GREEN 7% below plan
	b) General Medicine & Geriatric Medicine admissions at OUH (local frailty subset aligned with national target)	2% reduction on 2025/26 levels • 4 fewer admissions per week (progression towards 10% reduction by 2029)	905	GREEN 0.3% below plan
	c) Conveyances to ED (local stretch)	3% reduction on 2025/26 levels • (3 fewer conveyances per day)	96	AMBER 1.1% above plan
2. Discharge delays and flow	a) Average delay per discharge (BCF core)	0.6 days	0.8 days	RED | 29% above
	b) % discharged on Discharge Ready Date (BCF core)	88%	86.6%	AMBER | 1.6% below
	c) Average delay for those not discharged on DRD (BCF core)	5 days	6 days	RED | 18% above
	d) Length of stay MOFD	Pathway 1: 4.4 days Pathway 2: 3 days Pathway 3: 14.7 days (zero growth)	P1 R | 4.9 days P2 R | 4.5 days P3 G | 12.4 days	P1 R | +11% P2 R | +40% P3 G | −17%
	e) MOFD patients per day (OUH) f) MOFD patients per day (OH)	80 per day 15 per day	OUH R | 110 OH R | 19	OUH R | +32% OH R | +24%
3. Outcomes after discharge	a) % of people in the community 12 weeks after reablement (new BCF metric) - End of life cohort outcomes (national target)	Indicative baseline - 72% • 8% died within 12 weeks – audit ongoing	N/A – TV ICB data workstream	N/A
4. Long-term care home admissions	a) Admissions to residential and nursing care aged 65+ (BCF core)	Zero growth on 2025/26 • (~800 admissions per year)	567	AMBER 7.1%

6. Risks to Delivery

Principal Risks and Mitigations

Risk	Impact	Mitigation and assurance	
Emergency demand exceeds modelled capacity	ED crowding, corridor care, ambulance delays and patient harm	Daily demand review; Call Before Convey; SDEC, frailty and ambulatory pathways; assessment-area surge; pre-agreed trigger-based capacity.	
Delayed discharge and insufficient pathway 1–3 capacity	High occupancy, stranded patients and reduced admission capacity	Seven-day discharge standards; Transfer of Care Hub; MADE and/weekly CNO led MOFD meetings; long-stay reviews; system escalation; pre-Christmas occupancy plan; cross-border escalation.	
Workforce gaps, sickness and fatigue	Unsafe staffing, restricted surge capacity and staff burnout	Winter bank and recruitment plan; robust rostering and leave controls; occupational health and wellbeing support; vaccination; divisional redeployment plans; safe staffing sign-off.	
Estates and programme dependencies	Loss or late availability of clinical capacity	Integrated readiness plan for Level 1 EAU and SEC1; estates contingencies; QIA of all temporary escalation areas; clear go/no-go decisions.	
Elective and cancer displacement	Longer waits, financial loss and poorer outcomes	Protected site and specialty capacity; explicit cancellation thresholds; weekly impact monitoring; recovery plan for any displaced activity.	
Infection outbreaks or severe weather	Bed closures, staff absence and operational disruption	IPC cohorting and escalation plans; vaccination; PPE and supply assurance; severe-weather and business-continuity plans.	
Transport, pharmacy or diagnostics constraints	Delayed clinical decisions and discharge	Extended-hours plans, escalation contacts, discharge medicines standards, transport tracking and mutual-aid arrangements.	
Surge space opened without safe staffing or support services	Quality, safety and reputational risk	No area opens without approved staffing, equipment, medical cover, pharmacy, therapies, housekeeping, catering, portering, oxygen and infection-control assurance.	
Financial risk in opening additional bedded capacity	Deviation from break even financial position	Utilisation of surge capacity and associated financial risks should remain visible and be monitored throughout winter. Ring fenced portion (c£350k) from EDF funds to delegate to governance approved schemes; costed surge plan to reflect available finances	
System wide clinical responsibility lost	Siloed organisational working, with intervention from	Place level collaborative stress tests- September, reliance on Place level escalation at Executive level, with system wide sitreps setting ‘battle rhythm’ with action plans	

Risk	Impact	Mitigation and assurance	
through ICB restructuring	ICB only at system wide OPEL 4 for 72 hours		
Launch Point digital initiative- Major redesign of how ED staff interact with FirstNet	Distraction and inefficiency if not implemented well	Ensure sufficient clinical and operational leadership capacity to deliver and sustain change through SRO/ Business Change Managers and project team overview	

7. Learning from Winter 2025/26

What worked well:

7.1. Gold command and escalation arrangements: daily Divisional representation and Executive visibility improved responsiveness and operational grip.

7.2. Weekend multidisciplinary outlier ward rounds: these improved discharge performance and reduced Monday bed pressures.

7.3. Medical outlier model: the service-maintained oversight of dispersed medical patients and supported flow.

7.4. Discharge lounge arrangements: Horton discharge lounge capacity supported earlier discharge and improved evening flow.

7.5. Therapy support: enhanced cross-site therapy support helped mitigate increasing outlier demand.

7.6. POCT in place for respiratory viruses in ED areas to support patient placement. 7 day working by IPC team to support patient placement and working with Ops team. Cohort ward/areas were identified.

Priority themes from winter learning event (presented to IAC in April 2026)

Updates following this work have been requested to inform the developing plan.

7.7. Children's SDEC and emergency assessment arrangements, including Level 1 PORU and CHOX CDU.

7.8. Capacity and activity dashboards, agile bed capacity and reduction of 12-hour ED length-of-stay breaches.

7.9. Improved planning for agile beds, non-clinical services and action-focused escalation calls.

7.10. Review of the response when moving to OPEL 3.

7.11. Refinement of Gold, Silver and Bronze command arrangements.

7.12. Vaccination programme coordination through the Chief Medical Officer's office.

7.13. Registered nurse-led transfer and discharge.

7.14. Transport reliability.

7.15. Workforce sickness, rotation between clinical environments, training outside peak winter months and improved cross-team working.

Supporting our Workforce:

7.16. Aim to fully recruit to all maternity leave and vacancies to increase resilience in staffing levels and minimise temporary workforce usage.

7.17. Corporate nursing team assistance to support patient flow and /or surge support.

7.18. Ensure all staff have access to health and wellbeing conversations and encourage them to access support to address their needs and concerns.

7.19. Use team huddles to check in with each other

7.20. Managers should support staff to take flu vaccination.

7.21. Robust rostering and planning for annual leave to maintain senior cover across seven days over winter, including Christmas, New Year and bank holiday periods.

7.22. e-Roster KPIs will be monitored weekly and maintained to target.

7.23. Temporary staffing and NHSP pay rates will be managed against plan.

8. Recommendations

8.1. The Trust Board is asked to:

- Note the national requirements for Winter Planning 2026/27
- Approve the Winter Preparedness Plan 2026/27 and supporting Board Assurance Statement for submission by 30 September 2026, subject to incorporation of outputs from the regional and Place level winter stress-testing exercise
- Note the key risks and dependencies, including Level 1 capacity, Ward 5B, Surgical Elective Centre activity, discharge performance, workforce resilience, vaccination uptake and Launch Point implementation
- Support completion of surge and extreme-surge stress testing and consideration of associated funding through the appropriate governance route
- Support escalation of unresolved system dependencies to the ICB, including community alternatives, social care, intermediate care, cross-

border discharge, urgent transport and plans to reduce occupancy before Christmas

- Require ongoing monitoring of surge-capacity utilisation and associated workforce and financial impacts throughout winter 2026/27

Appendices – In Reading Room

1.	NHS England winter planning letter, 17 July 2026
2.	BAS Self- Assessment Template
3.	Model ED self-assessment
4.	Self- assessment- Corridor care
5.	Model Discharge self-assessment
6.	Oxfordshire Winter programme and winter plan 2026/27
7.	Divisional Winter Plans
8.	Learning from Winter 25/26 and action plan
9.	Surge Capacity Plan
10.	Equality Impact Assessment