REPORT TO:	NHS SOMERSET INTEGRATED CARE BOARD ICB Board Part A	ENCLOSURE: I
DATE OF MEETING:	25 September 2025	
REPORT TITLE:	Winter Resilience Plan	
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EXECUTIVE SPONSOR:	Shelagh Meldrum, Chief Nursing Officer and Director of Operations	
PRESENTED BY:	Emma Dunford, Associate Director of Urgent and Emergency Care Commissioning	

PURPOSE	DESCRIPTION	SELECT
Approve	To formally receive a report and approve its recommendations, (authorising body/committee for the final decision)	☐
Endorse	To support the recommendation (not the authorising body/committee for the final decision)	☐
Discuss	To discuss, in depth, a report noting its implications	☒
Note	To note, without the need for discussion	☒
Assurance	To assure the Board/Committee that systems and processes are in place, or to advise of a gap along with mitigations	☐

LINKS TO STRATEGIC OBJECTIVES
(Please select any which are impacted on / relevant to this paper)

- ☒ Objective 1: Improve the health and wellbeing of the population
- ☐ Objective 2: Reduce inequalities
- ☒ Objective 3: Provide the best care and support to children and adults
- ☒ Objective 4: Strengthen care and support in local communities
- ☐ Objective 5: Respond well to complex needs
- ☐ Objective 6: Enable broader social and economic development
- ☐ Objective 7: Enhance productivity and value for money

PREVIOUS CONSIDERATION / ENGAGEMENT

The winter resilience plan has been developed in collaboration with a wide range of system partners and internal stakeholders. This includes but is not limited to:

- System wide Winter 24/25 Debrief Workshop
- System wide planning workshop in July
- UEC Delivery Group discussions
- Review of EQIA with ICB Quality Team
- Update provided to ICB Directors on 1 September 2025
- Regional and Local Stress test events involving a range of system partners

REPORT TO COMMITTEE / BOARD

The purpose of this report is to provide the Somerset ICB Board with an overview of the Somerset System winter plan including the process that has been followed to develop it.

The Winter Planning process has sought to:

- Understand where we anticipate spikes in activity, pressure and increased demand
- Ensure the system is well prepared to continue to provide high level care during higher levels of demand as well as meet operational and performance targets
- Understand the impact associated with higher levels of demand and the mitigations available
- Identify opportunities to reduce areas of demand, through a combination of proactive care and where appropriate additional capacity.

This plan is the overarching plan describing how the Somerset system is preparing for and will manage the change in demand for our services typically seen during Winter. It has been co-ordinated by Somerset ICB in conjunction with all system partners. The plan is supported by surge and escalation plans that lay out the processes to be followed at times of peak demand. Our Emergency Preparedness, Resilience and Response (EPRR) plans will further complement the winter plan, as will individual provider workforce and business continuity plans. Our response during winter may draw on aspects of all these plans as appropriate.

The following process has been followed in developing our plan:

- A self-assessment against the requirements in the Urgent and Emergency Care Plan 2025/26
- A review of winter 24/25 incorporating learning from not only Somerset but other regions in the South West
- Analysis of A&E and emergency admission data to understand the potential demand for services this winter. This has included the use of various forecasting tools at a range of levels of granularity.
- Systemwide workshops at both local and regional levels, including 2 workshops specifically focused on testing the plans
- Input from a wide range of system partners

Our plan will remain a live document, incorporating learning and changes as we progress into and through the winter period. Examples of changes that may be made include:

- Details of additional schemes stood up not already described,
- Changes made as a result of further preparedness events run locally

Risks to Winter Resilience

The planning process has identified a number of risks, the key ones are outlined in section 14 of the attached plan. Mitigations are in place for these and as a system we will continue to work to further mitigate these for example, by supporting specific schemes over winter. The winter resilience tests held during September have identified further opportunities to strengthen the mitigations which will be actioned in the coming weeks.

Testing the Winter Plan

This year, plans have been tested in two ways: Firstly, a local event held on 4 September using a scenario that followed a very challenging day for the system. The second was a regionally led event on the 10 September, following a range of different scenarios.

Both events provided assurance against our plans as well as some areas of learning. Further changes will be made to all of our response plans in due course. Somerset intend to supplement this learning further with additional scenario tests in the coming weeks designed to test specific elements of our plans, for example, Infection Prevention Control and Ambulance Handovers.

Winter Schemes Funding

£500,000 has been identified to support schemes that will increase resilience through the winter months and address priority areas.

Bids have been invited from all system partners including the voluntary sector against criteria identified through the analysis of A&E attendance and admission data described above. The bids are in the process of being evaluated and schemes funded will be added to this plan at a later date.

Attachments

- Winter Resilience Plan (Appendix 1)

IMPACT ASSESSMENTS – KEY ISSUES IDENTIFIED (please enter 'N/A' where not applicable)	
Reducing Inequalities/Equality & Diversity	An EQIA has been completed on the Winter Plan. A number of positive impacts have been identified through this process. A copy of the EQIA is attached.
Quality	The winter plan seeks to ensure quality and patient experience remain paramount during periods of peak activity by building additional resilience into our system. The forecasting and risk assessment process have identified areas of focus.
Safeguarding	As above
Financial/Resource/ Value for Money	The winter plan includes £500,000 for winter schemes to build resilience into the system between November and March as well as mitigate identified areas of concern.
Sustainability	The winter plan ensures sustainability of services and seeks to mitigate against high increases in demand across all areas of the system, in doing so the plan will contribute towards the sustainability of resources.
Governance/Legal/ Privacy	None identified
Confidentiality	none
Risk Description	A number of risks have been identified and are outlined in section 14 of the winter plan. A brief summary is provided above in the main body of this report.

Somerset Winter Plan 25/26

Purpose of the Plan

Through the winter planning process, we have sought to:

- Understand where we anticipate spikes in activity, pressure and increased demand
- Ensure the system is prepared to continue to provide high level care during higher levels of demand
- Develop specific actions to manage the increased demand and spikes in activity.

Process for developing this years Plan

- Assessed ourselves against the requirements of the Urgent and Emergency Care Plan 2025/26
- Learnt from Winter 25/26 in Somerset and across the region
- Undertaken and analysis of A&E and emergency admissions data to understand the potential demand for services this winter,
- Regional and local planning workshops
- Review and refinement with System Partners
- Winter Preparedness and resilience workshops
- Winter Resilience funding

7 National Priorities for Winter 25/26

Priority Area	Actions Include:
Cat 2 Ambulance Response < 30 minutes	Increasing ambulance capacity through a focus on Hear and Treat, Increasing See and Treat rates (access to alternative pathways/Call B4 Convey), Increasing Emergency Operations Centre Clinical Capacity
Max Handover Time 45 minutes	Reducing demand on ED by reducing conveyances, understanding peaks in conveyance activity, internal focus on flow to wards, Handover processes
78% <4hour Performance	Urgent Treatment Centre growth, Reducing ED Conveyance activity, achieving NCRT Trajectories
< 10% wait over 12 hours for admission	Utilising Care Co from Emergency Departments to directly discharge patients, criteria to admit audits and subsequent action plans
Faster ED Care for Children (within 4 hours)	Paediatric Assessment Unit (PAU) in MPH to continue, Open PAU in YDH in December
Mental Health ED Stays <24hrs	Escalation processes between ED and Mental Health teams, Senior support for out of county patients, Focus on early support to reduce attendances
Reduce over 21 day stays	Review of patients between 0-6 days to expedite discharge, Acute escalation processes to review 7+, 14+ and 21+ LOS, Improving compliance with Discharge Ready Date recording, Eliminate internal discharge delays beyond 48 hours

Additional areas of focus in the UEC Plan

The following areas have been addressed within our winter plan:

- Improving Vaccination Rates
- Planning ahead for those at risk of admission through:
  - Targeted support for <65's who are susceptible to admission
  - All patients at high risk of admission have plans to support their urgent care needs at home or in the community.
- Increase patients receiving care in primary, community and mental health settings
- Set local performance targets by pathway to improve patient discharge times and eliminate internal discharge delays of more than 48 hours in all settings
- Improve flow through hospitals with a particular focus on patients waiting over 12 hours and making progress on corridor care

Learning from Winter 24/25

Based on the learning from last Winter, our plan seeks to:

- Reduce demand on ambulance services by increasing their access to community based urgent care services as an alternative to hospital conveyances. We will achieve this by:
  - Increasing direct referrals from the SWAST Emergency Operations Centre (EOC) to the Care Co-ordination hub. This scheme is due to go live in October.
  - Implementing a call before convey model for ambulance crews
- Increase access for support to common respiratory infections
- Reduce temporary closures in Urgent Treatment Centres
- Improve awareness of the range of services available to support patients this winter
- Provide access for care homes to the Care Co-ordination hub, reducing demand on ambulance and hospital services

Winter Preparedness and Resilience Testing

Two workshops have been held in September, providing an opportunity to test our plans ahead of winter; these provided both assurance and further opportunities. The recommendations from these will be progressed during the autumn.

Further resilience tests will be carried out during Autumn focusing on areas identified during the above tests. These include scenarios relating to Infection Prevention Control and Ambulance handovers

Our plans will remain live during Winter, being monitored, reviewed and updated in line with our learning and experiences.

Surge and Escalation Plans

Somerset System Co-ordination Centre (SCC) has responsibility for ensuring effective oversight and escalation in collaboration with Somerset system partners. The SCC will facilitate collaboration within and across the system through its operational and clinical leadership

Escalation Plan

- The SCC has worked with system partners to develop an ICS escalation framework to ensure national and local OPEL (Operational Pressures Escalation Levels) are followed which in turn would support identifying risks and working on mitigations to reduce harm

Surge plan

- The SCC has worked with partners to understand surge capacity within Somerset and produce clear plans to support escalation when required

- The Surge and Escalation plans will work in conjunction with Somerset Local Health and Care Resilience Plan

Risks to the Plan

Risk	Mitigating actions:
Urgent Treatment Centre Closures/Confidence in availability	• Communications on UTC's to increase confidence in availability (including NHS Quicker), Review of closure processes • Review of staffing and wider workforce
Consistency of response through Care Co Hub	• Review staffing options over evening and weekends • Role of the Specialist Paramedic in the hub
Respiratory capacity to manage peaks in demand	• Respiratory task and finish group in place • Maximise referrals to Hospital at Home Respiratory • Raising awareness of services available e.g. Respiratory at Home, pharmacy
Community Capacity to transfer care out of the acute	• Ensuring correct reporting of capacity • Building confidence in referrals
Not achieving No Criteria to Reside Trajectory	• Revisiting Trajectories to understand impact • Revisiting schemes already in place • Winter schemes funding

NB: Workforce, Industrial Action, Weather all to be mitigated through usual processes with a stronger focus on workforce

Winter Schemes Funding

£500,000 has been made available to system partners to put in place schemes that will build further resilience in our system this winter. Proposals have been requested against a range of criteria, including but not limited to:

- Addresses one of the 7 priorities areas (slide 4)
- Reducing ED attendances, admissions and lengths of stay
- Supporting respiratory related conditions in the community and/or where patients require admissions reducing the length of stay.
- Supporting eye related conditions in the community that would otherwise present to ED departments.
- Supporting Fallers outside of a hospital environment.
- Balancing the proportion of discharges throughout the day/week and in particular increasing weekend discharges

Proposals are currently being reviewed and will be incorporated into our winter plan in due course

APPENDIX 1

SOMERSET WINTER PLAN
2025 - 2026

1. INTRODUCTION

1.1. This Somerset System Winter Plan sets out the arrangements for winter planning and service delivery. In developing this plan, we have considered the likely seasonal variation in demand and the impact this will have on achieving our goals for service delivery. The planning process seeks to ensure a robust range of actions are put in place across Somerset enabling us to continue to provide health and care services that meet the expected levels of demand and at the standard we expect for our patients. The plan has been produced in collaboration with the main stakeholders and is owned by all members of the Somerset Integrated Care System.

1.2. We have arrangements across all Somerset Integrated Care System (ICS) partners to manage patient flow between our services. Working together, we use the *Operational Pressures Escalation Levels* (OPEL) system which identifies the actions we all need to take when we are under increased pressure. This plan should be read in conjunction with our System Escalation Plan and Surge Plan.

1.3. While the 10 Year Health Plan will set a new course for how we deliver Health and Care services in the future there are things we can and must do to ensure our patients receive a better service this coming winter. This plan covers the key areas we will focus on this winter.

1.4. This winter plan describes the over arching intentions for Somerset. Each provider will have its own individual winter plan which will contribute to achieving the ambitions laid out here, in addition our Winter Plan has been aligned with our escalation protocols which include

1.4.1. Acute Escalation Plans
1.4.2. National Acute Escalation Plans
1.4.3. National and Localised Escalation Plans
1.4.4. National and Local Mental Health Action Plans
1.4.5. National and Local 111 escalation plans
1.4.6. SWAST Escalation Plan
1.4.7. Maternity Escalation Plans

2. PROCESS FOR DEVELOPING THE WINTER PLAN

2.1. This plan has been developed through the following process:

- A review of Winter 2024/5, including learning from outside of Somerset (as described in section 3 below).
- Benchmarking our performance against the requirements of the Urgent and Emergency Care Plan 2025/26 and ensuring appropriate actions are in place to achieve the required standards.

- Using forecasting methods and tools, analysis of A&E and UTC attendances as well as SDEC and emergency admissions with a LOS >1 day that have occurred over a period of 4 years to better understand the potential demand for services (alongside the 25/26 operation plan) to identify changes in the of pattern in demand. In addition to evidencing the actions in the plan, this may identify new opportunities to work with Primary Care Networks, proactively managing people at home to avoid emergency admissions.
- System wide winter planning workshop in July 25.

2.2. To support both the development and the delivery of the Winter Plan, the ICB has identified an Executive Lead with responsibility for winter planning.

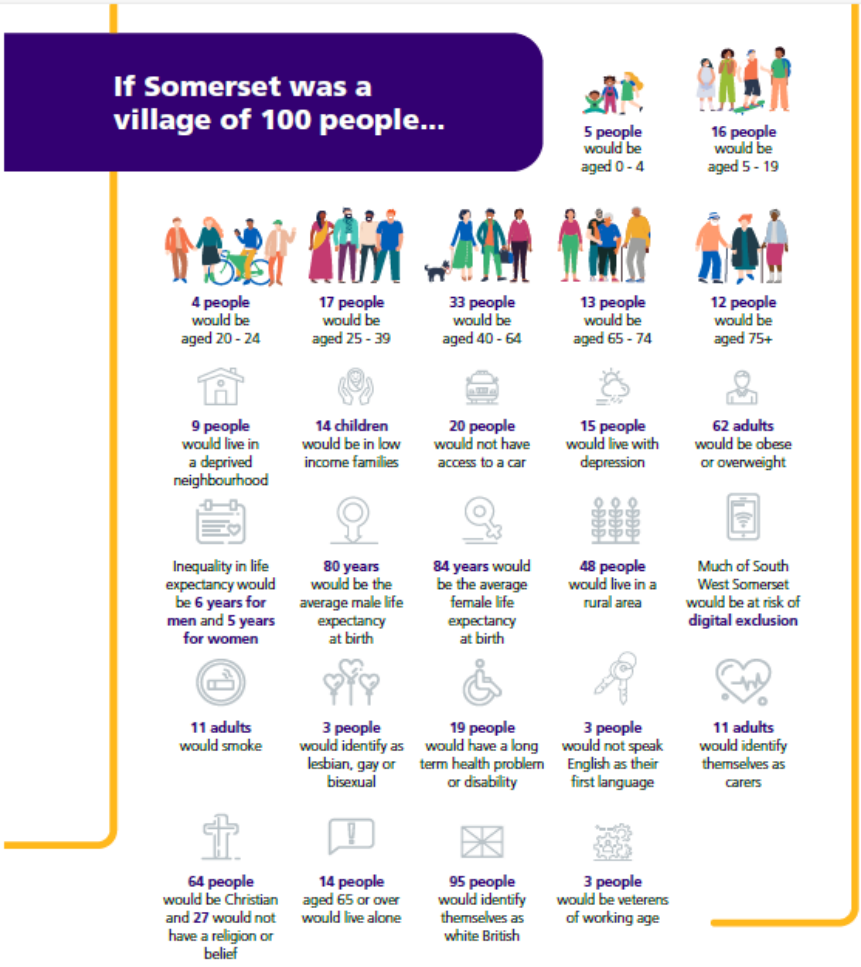
3. DEMOGRAPHICS AND DEPRIVATION

3.1. Our Winter Plan must address the needs of our whole population, with particular attention to our most vulnerable groups. A key part of winter planning is understanding the demographics of our communities and recognising differences in need and service use across population groups and geographical areas.

3.2. Somerset's demographics, relevant to NHS services, include an older population with 25% of residents aged over 65 and approximately half the population residing in rural areas, with the rest in smaller towns and villages.

3.3. Somerset has a significant Armed Forces community, including serving personnel, reservists, veterans, and their families, with dedicated support services like Armed Forces Link Workers.

3.4. While Somerset generally has lower levels of deprivation compared to the national average, there are pockets of deprivation, particularly in West Somerset and coastal areas, with issues like poor transport and access to services.



4. URGENT AND EMERGENCY CARE PLAN 2025/26

4.1. The Urgent and Emergency Care Plan (UEC) 2025/26 (NHS England » Urgent and emergency care plan 2025/26) was released in June 2025 and outlines the actions to be taken to improve urgent and emergency care by strengthening the entire system, from ambulances and A&E to community and digital services.

4.2. The plan places a focus on winter resilience and includes a number of required actions including 7 priorities. The Somerset winter plan incorporates these recommendations as outlined below.

4.3. The 7 priorities identified within the UEC plan as having biggest impact this coming winter are:

- Patients who are categorised as Category 2 (such as those with a stroke, heart attack, sepsis or major trauma) receive an ambulance within 30 minutes.
- Eradicating last winter's lengthy ambulance handover delays to a maximum handover time of 45 minutes.
- A minimum of 78% of patients who attend an A&E to be admitted, transferred or discharged within 4 hours.
- Reducing the number of patients waiting over 12 hours for admission or discharge from an emergency department compared to 2024/25, so that this occurs less than 10% of the time.

- Reducing the number of patients who remain in an emergency department for longer than 24 hours while awaiting a mental health admission. This will provide faster care for thousands of people in crisis every month.
- Tackling the delays in patients waiting once they are ready to be discharged – starting with reducing the 30,000 patients staying 21 days over their discharge-ready-date.
- Seeing more children within 4 hours, resulting in thousands of children receiving more timely care than in 2024/25

4.4. In addition, within the UEC Plan for 2025/26 describes 4 key areas of focus through Winter 2025/26. These are:

- Improve vaccination rates.
- Increase the number of patients receiving care in primary, community, and mental health settings.
- Improve flow through hospitals with a particular focus on patients waiting over 12 hours and making progress on eliminating corridor care.
- Setting local performance targets by pathway to improve patient discharge times and eliminate internal discharge delays of more than 48 hours in all settings.

5. LEARNING FROM WINTER 2024/25

5.1. A key part of winter planning is a review of the previous winter to identify themes and actions that can inform preparedness for the following year. Due to the significant pressures last winter, the Somerset system started the de-brief process in April 2025 and held a winter learning event on 1 May 2025. This provided clear insight into the areas of opportunity for improving the system this year. The group reviewed the impact of the previous plans as well as developed recommendations.

5.2. The review included:

- Understanding the impact of actions outlined in the previous year's plan
- Review of performance data.
- Explore what we did / what was experienced beyond that outlined in the plans.
- Individual conversations with leads.
- Workshop to discuss the above information.

5.3. In addition, Somerset has identified further areas we believe will positively impact on winter by improving the health of our population and creating greater resilience within our system, these have been identified through data analysis. These have been incorporated into the plan outlined below.

6. TESTING OUR PLANS AND READINESS FOR WINTER

6.1. During a regional winter planning workshop led by NHS England, we were provided with an early opportunity to consider our emerging plan against a scenario. The learning from this session has already been incorporated into this plan.

6.2. During September two further workshops took place, on the 4 September Somerset ICB led a system Winter Stress Test where a number of actions were identified e.g. SFT to review on call rotas, Increasing actions on Thursday/Friday to prepare for weekends, reviewing escalation plans for individual teams and Scoping additional “plans” that can be put in place ready for when needed e.g. temporary changes to GP OOH visiting capacity to create short notice appointments.

6.3. The majority of actions relate to managing surge and escalation not specifically Winter.

6.4. The second Winter Stress Test was led by region on the 11 September to check how well the NHS and partner organisations can cope with the extra pressures that typically come during winter and a chance to stress test our own system winter plans, in certain scenarios with an opportunity to take back learning from other systems in the South West, this stress test exercise provided our system with further actions which we will progress alongside the continued development of the winter plan.

7. MONITORING THE PLAN

7.1. This plan will remain a live document. It will continually be developed and adapted as we move closer to and through winter. It will include details of any additional initiatives implemented and changes to those already identified should our experiences and learning suggest this is appropriate.

7.2. Any learning and changes from the preparatory events outlined in section 6 above will also be included.

7.3. Given the critical importance of providing safe and effective services over winter, we will continually monitor the impact and effectiveness of this plan and the schemes outlined with in it. I think under monitoring the plan

7.4. There will be scheduled fortnightly system winter huddles where actions will be monitored which will provide oversight and assurance around actions that are progressing and those that require further support.

7.5. In addition, the Winter Plan will be monitored for its impact and effectiveness via the Urgent and Emergency Care Delivery Group

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8. SOMERSET WINTER PLAN FOR 2025/26

8.1. The sections below outline the actions that Somerset are putting in place to ensure it builds resilience into our system this Winter. They are organised as follows:

- Section 9: Actions against the 7 priority areas outlined in the UEC delivery plan and as described in section 4.2 above
- Section 10: Actions in support of the 4 additional areas of focus outlined in the UEC delivery plan and as described in section 4.3 above.
- Section 11: Actions arising from the winter 24/25 debrief as outlined in section 5

9. ACTIONS IN SUPPORT OF THE REQUIREMENTS IN THE UEC DELIVERY PLAN 2025/26

9.1. The tables below outline the actions that Somerset will put in place to support the 7 priority actions in the UEC delivery plan. It should be noted that whilst actions are articulated against one of performance targets below, many will impact others as well. For ease of reading these have not been duplicated across each relevant area.

7 PRIORITY ACTIONS FOR WINTER	**TIMELINE**
Cat 2 Ambulance Response <30 Mins Increasing the availability of ambulances and crews to respond to Category 2 dispositions through the following actions:	
A continued focus on Hear and Treat throughout South West Ambulance Trust (SWAST).	Ongoing through Winter
Improve SWAST See and Treat rates by working with all system providers to improve access to alternative pathways to avoid conveyance to Emergency Departments wherever possible, for example SDEC	Ongoing through Winter
Introduce direct referrals to the Care Coordination Hub from the Emergency Operations Centre (EOC), helping to free up ambulance capacity.	September 2025
Maintaining EOC clinical numbers to support appropriate pathways of lower acuity patients overnight supporting 999 call handlers and clinicians to provide urgent in-home care for clinically assessed patients, with follow-up services available the next day.	Already Implemented
Ensure the intelligence in the revised Right Care reports are reviewed on a monthly basis and opportunities to improve access to alternative pathways for SWAST crews are understood with system plans developed.	Started August 2025 and continuing through winter and beyond

Maximum Handover Time of 45 Mins	
Ensuring protocols are in place to enable ambulance handovers at a maximum time of 45 minutes	Implemented July
Task and Finish Group meetings have been established to develop and monitor actions focusing on achieving the 15-minute handover standard	Implemented July to December 2025 or as required
An important aspect of reducing handover times is a general reduction in hospital conveyance rates. This will be achieved through a range of initiatives as described throughout this document. This includes the implementation of a Care Coordination Hub.	On going
A system approach to provide sufficient resources to deal with increased A&E attendance at known peak times of day.	Already implemented
Actions to improve ward flow and discharge through onboarding, thereby creating capacity in the Acute Medical Unit and improving patient flow in A&E	Ongoing
78% <4hr Performance The following actions will improve somerset performance against this target to 78%.	
This year's operational plan sets out a series of actions to support delivery of the agreed trajectory. From 21 July, additional measures will be introduced, including daily weekday flow meetings. These are designed to accelerate discharges and provide oversight of targets and progress against trajectories. Additional actions currently under review include: • Exploring the use of EDWIN tool for articulation of ED crowding to support in divert and escalation processes, • Reviewing of blood bundles and 'care sets' in ICE to ensure only necessary bloods • Development of bariatric patient imaging SOP The actions above also support with achievement of the <10% wait over 12 hours for admission target.	Ongoing through winter

<10% wait over 12 hours for admission We will reduce the number of patients waiting over 12 hours for an admission to less than 10% by improving hospital flow. The following actions will be taken.	
The actions we have taken to improve patient flow have enabled us to consistently exceed the standard of fewer than 10% of patients waiting over 12 hours. As of 31 July 2025, 95.4% of patients had been seen within 12 hours year-to-date, with performance rising to 97% in July. We are confident that the measures in place will allow us to sustain and build on this progress. Two further initiatives will help strengthen performance, positively impact other areas of care, and enhance patient experience: • At Musgrove Park Hospital, the Joint Emergency Therapy Team (JETT) is working closely with the Care-Coordination Hub and Discharge to Assess teams to speed up transfers from ED/AMU and enable patients to receive continued support at home. This approach will be expanded to support a wider group of patients and extended to Yeovil District Hospital, drawing on its acute frailty nursing model within the Emergency Department. • In addition, the Emergency Care Improvement Support Team (ECIST) will carry out a 'Criteria to Admit' audit at both hospitals in September, beginning at Musgrove Park Hospital • Plans to Implement point of care testing in ED for flu/covid/RSV for faster and cheaper turnaround than PCR testing.	In progress
Mental Health ED stays <24Hrs The following actions will improve somerset performance against this target to less than 24 hours.	
Actions are underway to support 5% reduction of 12 hour waits for MH presentations in ED in 25/6 – in-line with operational planning trajectories. Escalation processes are being developed between Acute teams (A&E, Site Team) and Mental Health colleagues to ensure clear roles, expectations, and agreed standards. Patients who do not meet the threshold for admission will remain in A&E until Mental Health assessments and actions are completed, or the patient is deemed safe for discharge. For patients from outside Somerset, senior leadership intervention will be sought to support timely decision-making and escalation. As with local patients, those who do not meet admission criteria will remain in A&E Home treatment team and Psychiatric Liaison Team work together to help ensure people are moved from ED within 24 hours. Work is underway to improve communication and escalation processes. MH liaison team aim to see people in ED within 1 hour.	In progress

Alternative crisis options further support this work, including the NHS 111 ‘press 2 for mental health’, the 24/7 MH crisis line, crisis safe spaces, and MH ambulance. Somerset Foundation Trust are reviewing how the home treatment team operates to help better align with urgent care centres reducing the number of people that need to be seen in ED. A plan is in place to ensure operational resilience of all-age urgent mental health helplines accessible via 111, local crisis alternatives, crisis and home treatment teams, and liaison psychiatry services, including senior decision-makers. Somerset Foundation Trust have processes to ensure robust rotas for delivery of these services, which includes use of agency staff (for liaison psychiatry services), where this is needed for resilience. A robust on-call system with operational and tactical levels for senior decision makers is also in place. Furthermore, any patients who frequently access urgent care services and all high-risk patients have a tailored crisis and relapse plan in place ahead of winter. Each locality has an awareness of who these patients are and, where indicated, have worked with the High Intensity Users Group to develop crisis relapse / Trust management plans. The Relational Recovery team hold regular Complex Emotional Needs panels to review patients who are at increased risk of contact with services/admission to hospital.	
Reduce over 21-day stays The following actions will reduce the number of patients with a hospital stay over 21 days.	
Clear and measurable objectives are being developed and agreed to support improvements in discharge performance. This includes establishing an acute escalation process to review patients with a length of stay of 7+, 14+, and 21+ days, with 21+ day delays escalated for executive oversight, (supported by weekly executive level meetings) Work has been undertaken to address issues affecting the accurate reporting of the Discharge Ready Date (DRD) and related discharge events. Although the functionality to record DRD and discharge has been available within the acute system, many colleagues were unaware of the specific requirements for its use. Compliance monitoring has highlighted both gaps in usage and inaccuracies in recording discharge destinations. In response, discharge destination terminology is being updated to make it easier for colleagues to select the correct option, with completion expected within the next two weeks. Current compliance across both sites stands at approximately 55%.	In progress

To increase awareness, performance dashboards are being developed and shared across the Trust, providing visibility of compliance and outcomes. In parallel, system partners are considering the development of a recovery trajectory aligned with these improvement actions, with the aim of restoring performance to previously agreed targets. Monthly performance review meetings have been established to monitor progress and identify any additional mitigations required. Alongside this, work is underway to strengthen knowledge and understanding of DRD to ensure the accuracy of submitted data. Ward Clerks are playing a central role in this project, given their responsibility for data entry within the system.	
Monthly trajectories are currently being explored with acute providers. These trajectories will be pathway-specific and aligned with national expectations, supporting both a reduction in length of stay and the timely discharge of medically fit patients.	In Progress
Internal discharge delays, particularly those exceeding 48 hours post-medical optimisation, are a key area of focus within the System Flow Work Programme. Our aim is to eliminate internal discharge delays beyond 48 hours through a combination of clear trajectory setting, pathway optimisation, and operational improvement.	In Progress
Supporting internal hospital processes which will encompass the review of patients residing between 0-6 days and what actions can be expedited to discharge at an earlier stage in the patient's admission.	
Faster A&E care for Children To achieve the target of more children being seen within 4 hours resulting in thousands of children receiving more timely care than in 2024/25, the following actions will improve ED care for children in Somerset.	
Develop a Paediatric Assessment Unit model with a target opening date in January. Continue with the Paediatric Assessment Unit in Musgrove.	January 2025
Growth of UTC capacity within YDH will increase capacity to support Children and Young People	October
Improving Personalised Care Planning for frequent attenders' so that 50% of frequent attenders will have a Personalised Care plan that is quick and easily accessible across frontlines services in and out of hours. This may help to support the young person's voice during crisis situations and improve continuity of care pathways.	Already Implemented

10. ADDITIONAL RECOMMENDATIONS FROM THE UEC PLAN 2025 / 2026

Recommendation One: Improve Vaccination Rates

10.1. We remain committed to protecting the health and wellbeing of our population and staff throughout the forthcoming Autumn/Winter season. We are confident that our well-developed, system-wide plan we will deliver improved uptake in line with national targets. Somerset's position as one of the top-performing ICB's (ranked sixth nationally for Spring/Summer 2025 delivery) demonstrates the effectiveness of our approach.

10.2. Somerset ICB has developed a comprehensive and integrated vaccination strategy for the Autumn/Winter 2025 campaign. This plan includes Flu, COVID-19, and Respiratory Syncytial Virus (RSV) vaccinations, and is designed to protect our most vulnerable populations. The flu vaccination programme will target adults aged 65 and over, while the COVID-19 campaign will begin with those aged 75 and over. Both programmes will also prioritise individuals who are immunosuppressed with the seasonal campaigns beginning on 1st October 2025 to maximise co-administration for the over 75 years cohort. RSV will continue to form a core part of the winter programme, with an expanded cohort for this season.

Healthcare Workforce

10.3. A priority focus for the seasonal campaign will be to improve the uptake across the healthcare workforce. The Autumn/Winter 2024 figures show national averages of 40% for flu and 21% for COVID-19, while NHS Somerset recorded 44% and 43% respectively. In response to the low national averages and uptake NHS England has set a target to increase flu vaccine uptake among healthcare workers by at least 5%, a benchmark Somerset ICB is also adopting for COVID-19. To meet these targets, we are focusing on leadership engagement across partner organisations, raising awareness among staff of the importance of seasonal vaccination and improving access to vaccination through convenient booking and delivery options across Primary Care, Trust and community settings.

Care Home Residents

10.4. Care Home residents remain a vulnerable group and are a priority for the seasonal campaign. Building on progress made during the Autumn/Winter 2024 campaign, which saw a structured approach to vaccine delivery in these settings, Somerset Foundation Trust will this year be embedding care home discharge protocols to support co-administration of vaccines as part of the Autumn/Winter 2025 strategy. Opted-in Primary Care Networks for COVID-19 and Flu administration will continue with early vaccination in the Care Home setting to achieve 100% offer and >80% uptake for Autumn/Winter 2025.

RSV

10.5. RSV as a key element of the seasonal campaign began successfully in Autumn/Winter 2024 with a catch-up campaign for the 75–79 age group aiming to achieve a 100% offer rate by 31 August 2025. For Autumn/Winter 2025, the programme will be extended in line with NHS England's target of 60% uptake among adults aged 60–74 and this will be delivered with the support of all providers.

Children and Pregnant Women

10.6. Two further areas of focus are the 2–3-year-old flu vaccinations and vaccinations for pregnant women. To support the children's campaign, a proposed regional pilot is being developed through Public Health colleagues and will see Health Visitors supporting flu vaccinations in young children. In addition, we will continue to have the support of the Somerset Foundation Trusts outreach team for maternity services, which contributed to a significant improvement in flu uptake among pregnant women in the 2024 campaign. Both campaigns begin on 1st September 2025.

Addressing Health Inequalities

10.7. Somerset ICB's ongoing work to address health inequalities and improve access to vaccinations remains central to our strategy. Roving vaccination teams, led by Somerset Foundation Trust, will continue to engage with low-uptake communities, building on the success of the 49,000 additional vaccinations delivered in Autumn/Winter 2024 through this approach.

Recommendation Two: Increase the number of patients receiving care in primary, community and mental health settings

Primary Care

10.8. We will collaborate with primary care to review and update patients' respiratory illnesses' action plans and provide rescue packs to manage exacerbations effectively in the community.

10.9. For all long-term conditions, communications will be issued to primary care teams ahead of winter, encouraging them to review QOF registers and use medication reviews or other patient contacts as reminders. Practices will be asked to prioritise high users of services and proactively reach out, for example through Brave AI (where available) or via complex patient MDTs. Patients will also be encouraged to order repeat prescriptions in good time.

10.10. The Community IP Pathfinder project has now gone live, focusing on CVD and hypertension with an emphasis on supporting healthy behaviours through a pharmacy-led approach. The project has since been extended to include lipid management, providing a further opportunity to prepare patients ahead of winter.

10.11. To enable patients to get the right help they need outside of a hospital it is important they are aware of the options available to them. This will help patients access these services without the need to visit a GP or attend a UTC or Emergency Department. We will do this by:

- Supporting to the national choose well campaign
- Promoting the Acute Community Eye Care service for patients, community pharmacy, urgent treatment centres and dental triage via 111 via primary care.
- Covid anti-viral services

10.12. For Paediatrics we will promote the Handiapp, an app which provides straight forward advice and support to parents and carers when a child is unwell.

10.13. A series of videos have also been created to support the messaging around common childhood presentations – Strep A, bronchiolitis and further videos are planned for gastroenteritis, asthma, high temperatures. Comms plan in place to ensure sharing of information through winter.

Community Settings

10.14. Somerset has a range of excellent community services able to support patients with their urgent care needs, including but not limited to Hospital at Home, Urgent Community Response and District Nursing. Ahead of and during winter we will work to maximise the number of patients supported via these services as an alternative to attending or being admitted to hospital.

10.15. Recruitment for the hospital at home nursing team and on-boarding will be complete in September 2025. Merging of Rapid Response and Hospital at Home teams is complete and will add to resilience to cope with peaks in demand. A plan to provide a 6 monthly Hospital at Home in reach service to frailty Acute Medical Unit (AMU) in both acute hospitals is currently in development.

10.16. A communications plan aimed at referrers to urgent care services, including primary care, SWAST and the integrated urgent care service (IUCS) in order to:

- Improve awareness of alternative urgent care pathways, including the Care Coordination Hub.
- Increase utilisation of pharmacy first and the seven clinical pathways.
- Raise awareness of the covid antiviral service

10.17. Patient awareness of community services as a hospital alternative, including specifically the covid antiviral services, reminding patients that if they are vulnerable and have covid, there is a service that can triage and prescribe.

10.18. A task and finish group has been established to consider options for improving access to early support for seasonal respiratory relating conditions over winter. A number of actions have been identified and will be taken forward ahead of winter.

10.19. We will continue to work with the Somerset Ambulance Doctor car team to raise awareness of the service with the relevant services to ensure that the most appropriate patients benefit from the support that can be provided through this service. 85% of the patients seen by the service are able to receive their care at home and avoid conveyances to hospital.

Mental Health

10.20. Mental Health plans are in place to reduce average length of stay by 7% in 2025/26, in-line with operational planning trajectories. There are 7 key actions identified to support length of stay reduction plans. A transformation work plan is in place and monitored by NHS England.

10.21. Embedded processes are in place for monitoring acute and crisis care demand daily with capacity to flex resources as needed. Community caseloads are proactively monitored across all specialties ensuring that teams are supported to deliver care with adequate cover. The Trust has several initiatives in place including:

- Demand modelling tool available (though noting some data issues) and being used to understand areas of forecast future pressure.
- Additional capacity now available via Open Mental Health
- Escalation protocol in place and being used routinely as part of the normal system escalation process and includes specific actions dependent on level of pressure within the mental health system.
- Workforce and recruitment planning is in place, to include annual leave profiling to ensure there is cover over the winter period (and historically this has been managed well). Working with VCSE partners to manage capacity as appropriate.
- Expanding traditional winter pressures services so they are available year-round; this has helped with recruitment and retention and means that additional capacity is available for the winter period. Our crisis safe spaces are well utilised and are used proactively to support sustainable discharge.
- Specific mental health support is part of the ambulance clinical hub which will reduce pressure on other parts of the mental health system as well as emergency care. Introduction of the Mental Health rapid response vehicle has reduced the need for people to go to ED, with an 85% 'see and treat rate'. SWAST are reviewing resourcing and timings of this vehicle ahead of winter to maximise its impact.
- NHS111 "press 2 for mental health" is in place and has resulted in activity increases to the MH crisis line. It is anticipated that this will increase over the winter period and is a significant source of risk related to displaced demand and unmet need.

<u>Dentistry</u>

10.22. An increased provision of urgent dental care has gone live ahead of winter which will reduce presentations in A&E and other areas of the system.

10.23. We are also looking at other ways in which we can enhance urgent dental care in somerset in the approach to winter. This would be achieved through a phased approach and any increased capacity will relieve pressure elsewhere in our urgent care system.

Recommendation Three: Improve flow through hospitals with a particular focus on patients waiting over 12 hours and making progress on eliminating corridor care

10.24. A System Flow Priority Programme is in place with weekly oversight and monitoring of no criteria to reside. This aims to ensure that patients are cared for in the right setting once their acute care needs (both physical and mental health) have been met. A particular focus will be on:

- Reducing hospital process delays
- Building sufficient Pathway 1 capacity
- Optimising the transition from acute to Pathway 2 beds
- Reducing community length of stay
- Providing a dedicated Pathway 3 model.

10.25. The Discharge Fund for 2025/26 is available to support intermediate care transformation, including increased Pathway 1 capacity.

10.26. A Transfer of Care Hub (TOCH) has been established this year to improve access, reduce variation, and streamline processes. It is anticipated that this winter it will:

- Increase the numbers of patients able to return home following acute stay.
- Provide a seamless route to Pathway 1 provision.
- Enable consistent decision making regardless of where the person is referred from.
- Enable community teams to have more control over 'starts' to their services using capacity more effectively and contributing to increasing overall numbers of 'starters'.
- Prevent over-prescription of care on discharge; better decisions made for discharge plans, and increased flow through to Intermediate Care.
- Support more people to return home, moving demand from Pathway 1 to Pathway 0 and Pathway 2 to Pathway 1.
- Improve colleague wellbeing.
- Reduce hospital no criteria to reside (NCTR) delays.

10.27. Working groups have been put in place to improve the support and content provision in the universal referral forms to ensure they are completed pre no criteria to reside or with 24 hours of not meeting the criteria to reside. To ensure more resilience during increased times of pressure/ discharge team shortages.

10.28. Reviewing our hospital processes around no criteria to reside delays. The initial target is to reduce hospital process delays to under 30 across both acute sites. There are three deliverables that will help us achieve the above:

1. Get 'referral to the transfer of care hub (TOCH)' hospital process delays below 20
2. Get 30% of Universal Referral Forms sent to TOCH ahead of the Discharge Ready Date
3. Keep Pathway 0 discharges above 85% on both sites.

<u>Transport to Support Timely Patient Discharge</u>

10.29. Somerset Foundation Trust have a central transport hub for the acute sites; plans are in place to incorporate transport requests/booking forms for our community and intermediate care sites before the winter to provide aligned processes and aid timely support with the aim of preventing aborted and cancelled journeys.

10.30. Working with the transport provider, Somerset will ensure to the appropriate resourcing levels at key times. The aim of these changes is to provide early flow of patients and to prevent transport cancellations.

10.31. Somerset NHS Foundation Trust's transport team have a training programme in place to support the discharge teams and ward teams to ensure as early as possible identification of those patients that require transport ensuring requests and bookings are made in advance.

Recommendation Four: Set local performance targets by pathway to improve patient discharge times, and eliminate internal discharge delays of more than 48 hours in all settings

10.32. We are actively working with system partners to develop and agree on clear, measurable objectives that support improved discharge performance. Monthly trajectories are currently being explored, with ongoing discussions taking place with acute providers. These trajectories will be pathway-specific and aligned with national expectations, supporting both a reduction in length of stay and the timely discharge of medically fit patients.

10.33. Internal discharge delays, particularly those exceeding 48 hours post-medical optimisation, are a key area of focus within the System Flow Work Programme. Our aim is to eliminate internal discharge delays beyond 48 hours through a combination of clear trajectory setting, pathway optimisation, and operational improvement. Performance will be monitored through existing governance routes, including the System Flow Group with escalation processes in place to address areas of underperformance.

10.34. The System Flow Priority Programme has a focus on Intermediate Care transformation and aims to ensure we have the right capacity in the right place, providing better pathways across Somerset, enabling the patient to move to the right place, first time. This includes:

- An increase from 67 to 83 new people into Pathway 1 per week.
- The introduction of 28 spot purchased Pathway 3 beds. Additional care homes will be resourced to allow those people who likely require long-term placement to have their assessments carried out closer to home.
- The reconfiguration of community bed-based intermediate care beds. It is anticipated that additional reablement at home and the supply of additional care home beds will result in more timely access to community hospital beds for people requiring Pathway 2 reablement and shortened length of stay.

10.35. Trajectories currently underway are:

- Discharge by pathway are being produced and agreed by the system with an ambition of Pathway 0: 85%, Pathway 1: 10%, Pathway 2: 4% and Pathway 3: 1%. Discharges will be aligned to the emergency admissions operational plan.
- To reduce variation for Pathway 0 discharges, bringing bring weekend discharges in line with weekdays are in development and will be signed off by the system.
- To eliminate process delays >48 hours are in development and awaiting sign off by system.

Recommendation Five: Improving Discharge and Admission Avoidance

<u>Discharge</u>

10.36. We are actively working with local authorities and system partners to ensure that our BCF capacity plans incorporate appropriate contingencies for winter surges across all care pathways. Where Intermediate Care capacity deficits were shown within the model submitted for 2025/26, these are being mitigated

through the Intermediate Care Transformation as described elsewhere within this plan.

10.37. Pathway 1 capacity is increasing by 10% to support more people to return home and is due to be achieved by July/August 2025. This additional capacity will see an increase in weekly Pathway 1 new starts from 67 to 83, and factors in a forecasted adjustment for double up care visits and cancellations. A positive impact has already been seen with Pathway 1 waits currently at 3 days against a target of 2 days by end of July 2025. This is a reduction from 6 days in March 2025.

10.38. An audit of Pathway 2 discharges has taken place with an aim of understanding the variation in transfer time from acute to Pathway 2 bed. The aim is to reduce this variation and ensure no one waits more than 48 hours to access a Pathway 2 bed. An action plan is being developed to ensure we can meet the outcomes and recommendations provided within the audit.

10.39. Pathway 3 spot purchase model went live in August 2025 prioritising the principle of “right place, first time”. This approach ensures people receive care in the most suitable environment from the outset, supporting better outcomes, continuity of care, and a more dignified experience for individuals and their families.

Admission avoidance

10.40. An extension of the Care Coordination Hub pilot is in place until May 2026, the model is within a development phase, constantly adapting to increase the number of patients it is able to support outside of a hospital setting.

11. ACTIONS FOLLOWING THE WINTER 2025/26 DEBRIEF

11.1. The sections below outline the actions that Somerset will put in place in support of the recommendations made following the winter debrief in April and May.

Direct referrals to the Care Coordination Hub

11.2. We plan to implement a process to increase direct referrals from the SWAST Emergency Operations Centre to the Care Coordination Hub (known as the ITK) this is planned for introduction in September 2025.

Call Before Convey

11.3. For those patients who may be suitable to receive their urgent care in their usual place of residence, we have implemented a Call Before Convey model for ambulance crews on scene to access additional advice and guidance as well as improved access to urgent community services prior to a conveyance. Call Before Convey launched on 19th August. It is anticipated that if just 20% of the assumed cohort could be diverted this will save 3 conveyances to our emergency departments each day.

Respiratory pathways

11.4. A task and finish group has been established to explore opportunities to increase access for common respiratory infections outside of a hospital setting, increasing access to earlier diagnosis and treatment. This group has just been formed and already identified a number of actions, including raising greater

awareness of the services and referral pathways available to both referrers and patients.

11.5. As we go into Winter, we will seek to ensure that our respiratory at home service is well utilised, enabling people with a range of respiratory related conditions to be managed at home instead in hospital. The team support both admission avoidance and early discharge for those patients that require a hospital stay.

11.6. We are looking to increase the number of patients diagnosed with COPD and Asthma by increasing capacity of spirometry services. This will enable people to be effectively managed before winter rather than needing an emergency admission.

Working with Care Homes

Working with Care Co-ordination Hub

11.7. We continue to advocate access to community services as an admission avoidance mechanism and to ensure people receive the right support at the right time in the right place via the Care Coordination Hub. This includes access to community based urgent care services such as Urgent Community Response, Rapid Response and Hospital @ Home. We plan to undertake a communications campaign with care homes and hold a workshop to explore further opportunities to maximise support to care homes via the Care Coordination Hub.

11.8. Through our newly implemented Call before Convey model, crews called to a care home will be encouraged to contact the care co-ordination hub for all patients meeting agreed criteria to review alternative options as outlined above.

Infection Prevention Control (IPC)

11.9. A multi-faceted approach continues to be implemented to enhance infection prevention and control (IPC) across care homes, with a focus on education, proactive support, early intervention, and quality assurance. These initiatives aim to reduce avoidable hospital admissions, particularly from urinary tract infections (UTIs), respiratory infections, and outbreaks of communicable diseases.

11.10. A targeted care home education programme will be implemented, designed for care home staff to improve knowledge and skills in core IPC practices. This includes modules on hand hygiene, PPE, catheter care, hydration, antimicrobial stewardship, and early identification of infection.

11.11. Support visits to care homes will be carried out by IPC specialists to review and support IPC leads with infection prevention management compliance. This includes hands-on support, gap analysis, action planning, and follow-up visits. This approach aims to build long-term IPC resilience within each care setting

11.12. The "Mouth Care Matters" programme has been implemented in selected pilot care homes. This focuses on improving daily oral care practices to reduce

bacterial load and subsequent respiratory infections. The programme aims to reduce hospital admissions due to aspiration pneumonia and related complications.

11.13. Rapid response support is available for care homes experiencing infectious disease outbreaks (e.g. norovirus, influenza, COVID-19). This provides guidance on management, cohorting, testing, communication, etc. It involves liaison with Public Health and NHS partners for coordinated response.

11.14. Monthly virtual IPC support clinics are in place for care home staff to discuss complex cases or IPC queries.

11.15. The Quarterly Care Home IPC Forum is in place. This provides a platform for care homes to share learning, best practices, and updates on IPC policy and guidance. Sessions include guest speakers, Q&A sessions, case studies, and networking opportunities. The forum supports sector-wide consistency and improvement.

11.16. A Somerset Outbreak Dashboard can be accessed to provide visual displays in real time data about a disease outbreak. These dashboards are used to monitor, track and manage the spread of infectious diseases.

11.17. An Outbreak Pathway is currently in development

11.18. An Infection Prevention Control (IPC)IPC folder has been set up on our system drive for all on call directors to access. On call directors will be sent any IPC issues arising every Friday ahead of the weekend.

Winter communications strategy

11.19. We will put in place a winter communications plan aimed at system partners, staff, and the public. It will cover access to services, alternative pathways, flu, RSV and COVID vaccination, and managing seasonal illness. Internal communications should also support consistent use of pathways such as Call Before Convey and Care Coordination Hub referrals. In terms of respiratory our plan will include raising awareness of the range of services available to support to patients.

11.20. Communications can have a key role in supporting delivery of winter performance, using best practice and behavioural insights to help people to take earlier actions to prevent ill health or getting them to the right service for their needs can play a big part in that. At a local level we will support national and regional campaigns including winter vaccinations and choose well.

12. ADDITIONAL ACTIONS AND CAPACITY TO SUPPORT WINTER 2025 / 26

12.1. The sections below outline the additional actions, capacity and services that will be in place within Somerset to build resilience and capacity during the Winter.

High Intensity Users (HIU) Including Under 18s

12.2. The High Intensity Users Service is instrumental to supporting vulnerable patients over winter. Somerset already has a well-structured process in place in supporting patients through Multi-disciplinary Team Meetings (MDTs) which meet monthly across each hospital site to review the top 25 active attenders with 10 or more attendances in the past 3 months.

12.3. Somerset is also the only region in England to be supporting Under 18s. This is a multi-agency meeting once a month across both hospitals, supporting those individuals with 6 or more attendances in a 3-month period.

Voluntary, Community, Faith and Social Enterprise Sector

12.4. The voluntary, community, faith and social enterprise (VCFSE) sector in Somerset support local people in a variety of ways, which sustains community preparedness and support during the winter period.

Targeted schemes

12.5. Our local hospital system is supported by hospital discharge coordinators in various roles, including our High Intensity User team, who support with expediting discharge for people who no longer require hospital care.

12.6. Somerset also draws on additional emergency planning and response where we have risks of flood or snow, such as Wessex 4x4 volunteer drivers or other members of Somerset Emergencies Voluntary Agencies Group (SEVAG).

12.7. Somerset Council has received Household Support Funds again for 25/26 which will enable us to support vulnerable households with energy and water bills, food and wider essentials which will include:

- Support for local warm hubs and spaces using local community hubs to support families and residents in accessing other sources of help.
- Support for food resilience projects.
- Specialist help through winter support to assist with income maximisation and advice, individual grant distribution and practical assistance.
- Administering grants to households, including older people who are experiencing fuel poverty.
- Move-in fund grants to partners supporting individuals who have been homeless

12.8. This works alongside our well-established social prescribing approaches that support individuals with their wellbeing connected to their health. Some examples of this are:

- Community Connectors, Village Agents and other social prescribing roles
- Local physical activity initiatives
- Warm welcome spaces support and food resilience network.
- Somerset Mindline and other groups through Open Mental Health.
- Befriending services which target social isolation and loneliness.
- Debt advice and access to benefits and promoting pension credit uptake.

- Somerset Community Foundation 'surviving winter appeal' and securing funds to support broader activities.

12.9. Integral to the support on offer to people to live happy and healthy lives is help available for vulnerable households around:

- Fuel poverty.
- Food security.
- Loneliness and isolation.
- Community transport.
- Mental health.
- Physical health.

12.10. We acknowledge that there remain enormous untapped benefits to closer collaboration during times of winter pressure, and as we continue to grow our partnership mechanisms this will continue to spread.

Children and Young People

12.11. In addition to the actions outlined elsewhere in this plan Somerset NHS Foundation Trust Services have the following actions in place:

- An escalation pathway integrated model has been developed for supporting a stepped increase to capacity in response to the projected respiratory illness demand, particularly RSV, the preservation of the standard clinical pathway for critically ill children and emergency, general and specialist services.
- Mutual aid: Built into winter workforce planning - Cross cover arrangements dependent upon skillsets of individuals and patients alike.
- Increase the coverage of senior decision-makers at peak times (evenings and weekends)

12.12. To support self-care and management of minor illness we will ensure targeted communication and paediatric advice is available to parents/carers.

12.13. We will ensure collaborative approaches with VCSE partners, embedding preventative approaches to support parents/carers in management of minor illness and navigating NHS services, particularly across areas with high attendances and communities that experience the greatest health inequalities.

12.14. Targeted parenting support is being piloted in two areas identified as having higher levels of deprivation is being delivered through public health nursing

Maternity and Neonatal Services

12.15. YDH Perinatal services closure (neonatal and intrapartum care). The closure of Yeovil District Hospital (YDH) services is being monitored and managed through SFT internal governance and additionally through an ICB led enhanced oversight group supported by the regional NHSE team. At this time, Staff have been re deployed within Somerset and to neighbouring trusts to support a consistent offer of maternity and neonatal services.

12.16. The Trust have undertaken a midwifery review utilising the nationally accredited tool Birthrate + and an associated business case has been agreed

to increase the midwifery establishment. The service has now moved onto the prioritisation of ensuring sustainable obstetric provision is in place during the closure of Yeovil District Hospital.

12.17. The Maternity service is currently being supported through the national team and have onboarded onto an NHSE led Maternity Safety and Support Plan, the Trust are bringing areas of quality improvement and transformation together into one Maternity Improvement Plan. Demand and capacity is being monitored and escalation plans are in place at organisational and system level.

Mental Health

12.18. It is worth noting that typically within Somerset we don't see a significant demand of mental health during our winter period, pressures typically occur during April – September.

12.19. The majority of Mental Health services are provided by Somerset Foundation Trust from several sites across the system, operating both inpatient, crisis and community services. Demand for mental health services has increased significantly from pre COVID-19 levels (however, this is likely a result of both increased need and increased capacity in line with the investment growth over the LTP period).

12.20. It is recognised that patients across both adult and children's services have become more complex. This is evidenced by increasing numbers of patients presenting in crisis, longer length of stays and longer times spent on caseloads.

12.21. Somerset have OPMH beds and an Intensive Dementia Service to alleviate seasonal pressures, support service providers, reduce admissions and bed days lost to delayed transfers of care.

12.22. Inpatient Quality Transformation Plan continues with workstream to improve patient flow, bed occupancy, and local partnership.

12.23. There are bi-weekly ward / community interface meetings running to discuss blockages for patients, clarifying the purpose of admission and what interventions are needed and who will be delivering these. A meeting is being set up with the Local Authority to review and improve social care input and assessments.

Integrated Urgent Care Service

12.24. Somerset continues to promote the use of NHS 111 for people who need urgent care. Members of the public are advised to contact the NHS 111 service, either through the telephone or online, at any time of day or night, to get medical advice and care and especially encourages people to contact 111 before attending A&E. This will help to ensure that people can safely receive the right care, in the most appropriate setting, whilst relieving pressure on hospital emergency departments.

12.25. If needed, experienced clinicians within the Integrated Urgent Care Service, both within its NHS 111 and Clinical Assessment Service (CAS) elements, may make a referral directly to GP surgeries, Emergency Departments (A&E),

Urgent Treatment Centres, Pharmacy First and other urgent care services as well as accessing GP Out of Hours support for a home visit or treatment centre appointment.

12.26. In addition, work within the ICB seeks to complement and support the IUCS patient pathway by:

- Support an improved direct booking process to Urgent Treatment Services (UTCs).
- Ensuring that as many patients as possible receive a booked time slot to attend.
- Maximising the use of Pharmacy First both for emergency medications and treatment for seven common conditions.
- Ongoing review of Directory of Service (DoS) to not only ensure all pathways are reflected in the DoS but also that optimal configuration of services are in place so that the most appropriate service shows, 'top of DoS,' to 111 call handlers.
- Ensuring all referral pathways have been opened up to other services from NHS 111/CAS (such as Urgent Community Response) and booking mechanisms are established where possible
- Regular provider-led 'deep dives' on elements of the IUCS patient pathway to identify improvement opportunities.

12.27. The IUC service has well embedded clinical validation (aka remote clinical intervention). The process is that all patients, be it via 111 telephony or online that have an ED or low acuity 999 disposition after assessment are validated by a non-NHS Pathways clinician. The downgrade rates with non-Pathways clinicians continues to be in the region of 91% and 75% for 999 and ED respectively. This forms part of the core service system contribution and has been an ongoing priority since its inception in December 2020. This process ensures that the numbers of patients that are going to 999 and ED from the IUC service are appropriate. Shift fill for this role is consistently good, with clinicians being able to work remotely making this a popular role within IUCS. Should there be challenges in the rota (due to short-notice absence), clinical resource can be moved from the service's Triage elements, where appropriate, to ensure that this function is maintained even at times of service pressures.

12.28. The service also operates a "PAN HUC" clinical model that can support the IUC during periods of surge and escalation.

12.29. HUC also provide a flu prophylaxis service for Somerset care homes to provide clinical assessment and prescribing of antivirals for those 'at risk' patients who are not ill but have had local contact with a person with influenza-like illness (ILI), and therefore post-exposure prophylaxis with antiviral drugs has been recommended.

12.30. 111 will continue to follow the established Pathways system. All patients who successfully complete Module 0 will undergo a full assessment via NHS Pathways and will be directed to the most appropriate service based on the clinical disposition and the Directory of Services (DOS) allocation.

12.31. HUC will collaborate with the Health Advisors (HAs) to build confidence in the DOS recommendations, encouraging selection of the first service option presented.

12.32. Category 2 ambulance cases will be referred directly to the ambulance service, in line with standard protocol. Category 3 and 4 ambulance dispositions, as well as A&E outcomes, will be reviewed by our internal clinical team for revalidation. Our aim is to revalidate all such cases.

12.33. HUC are currently reviewing their internal processes in preparation for winter, with the goal of achieving 100% revalidation. However, they emphasise that they cannot assume clinical risk beyond their remit, as patient safety remains their top priority.

Primary Care

12.34. In addition to the actions described elsewhere in this document the following sections outline specific actions relating to primary care this winter.

12.35. Practices will have business continuity plans which should cover all areas where there is a risk to the delivery of services including adverse weather conditions, staff sickness, disease outbreaks, loss of premises etc.

12.36. GPAS (General Practice Alert State), a reporting system to collect a sample of data to indicate pressure on general practice is in place. The GPAS data converts the data collected into an OPEL assessment that feeds into the Somerset System Coordination Centre.

12.37. APEX (Business Intelligence Tool) that supports practice and Primary Care Network (PCN) level demand and capacity planning.

12.38. GP collective action is in place and is being monitored along with internal system partner meetings in place to flag and work through any potential mitigations in a proactive way rather than reactive.

12.39. There is also a primary care assurance dashboard used to routinely monitor any provider metrics that start flagging early signs of support/resilience – this in addition, is supported by locality leads, regularly checking in with their respective portfolio practices ensuring support is enabled for practices.

<u>Infection Prevention Control</u>

12.40. As winter approaches, primary care plays a crucial role in keeping people well and easing pressure on hospitals. Here are some key focus areas for this season:

- Ensure space is available to isolate patients with respiratory symptoms. Maintain clear signage, triage, and IPC protocols to minimise transmission of flu, COVID-19, and other infections.
- Review rotas, plan for absences, and build flexibility into schedules. Support staff wellbeing and consider shared cover across practices or PCNs.
- Encourage uptake of flu and COVID-19 vaccines. Promote self-care, staying warm, hydration, and managing long-term conditions. Use messaging and text systems to share advice and signpost appropriate services.
- Consider offering end-of-day respiratory appointments and prioritise urgent access for high-risk patients. Early intervention helps prevent hospital admissions.

- Help patients understand how and when to seek care and not just during times of pressure —use social media and texts to promote pharmacy services, NHS 111, and appropriate use of A&E
- With strong planning and working together, primary care can make a big impact this winter to help keep our patients safe.

Urgent Treatment Centres

12.41. The procedure for temporary short-term closures is currently being reviewed. We are also working with NHSE on the development of a standardised Standard Operation Procedure. We will ensure the Directory of Services always accurately reflects opening hours and any short-term closures.

12.42. In line with the national direction of travel around community UTCs implementing an appointment system following a timely triage. A trial is underway in Bridgwater and an assessment will be made on rolling this out further. It supports capacity and people being seen in the right place closer to home rather than an onward journey to the acute A&E.

12.43. We are looking at ways to promote the NHS Quicker app, to support patients in choosing the most appropriate option to support their needs.

Same Day Emergency Care

12.44. A work programme has been established focused on expanding both SDEC services and access to it. Actions include:

- Increasing opening hours.
- Reviewing opportunities for closer working with ambulatory care sites.
- Increase direct referrals from SWAST to SDEC services as an alternative to ED conveyance.
- Understanding opportunities to increase capacity in SDEC through pathway changes.

12.45. The work will be delivered across three workstreams focusing on SDEC pathways in phase 1. These will be categorised by acute medicine, practitioner led, frailty and other specialities e.g. gastroenterology.

12.46. In phase one, (prior to January 2026), our focuses are on Musgrove Park Hospital medical SDEC, inclusive of Acute Medicine, practitioner led, Frailty and ‘other’ (i.e. sub specialty) pathways. At Yeovil District Hospital our focus will be on frailty pathways predominantly, acknowledging the current higher SDEC activity at Yeovil District Hospital, along with the weekend operating hours in place.

Community Pharmacy

12.47. Community Pharmacy teams across the system will support capacity through the delivery of a range of essential, advanced and locally enhanced services under the Community Pharmacy Contractual Framework. The average community pharmacy will undertake 21.7 informal health advice consultations supporting self-care each day (>69 million per year across England).

12.48. Discharge Medicines Service: Patients are digitally referred to their pharmacy after discharge from hospital. Pharmacists reconcile patient's medicines at discharge to those they were taking before admission to hospital. A check is also made when the first new prescription for the patient is issued in primary care and a consultation with the patient and/or their carer will help to ensure that they understand which medicines the patient should now be using. This service is currently utilised by Yeovil District Hospital and Royal United Hospital Bath. Nationally this service delivers reduction in medicines related re-admissions at 30 days from 16.0% to 5.8%.

12.49. The Pharmacy First model is in place in Somerset. Pharmacists provide advice and NHS-funded treatment, where clinically appropriate, for seven common infections:

- Sinusitis (12 years and over)
- Sore throat (5 years and over)
- Acute otitis media (Children aged 1 to 17 years)
- Infected insect bite (1 year and over)
- Impetigo (1 year and over)
- Shingles (18 years and over)
- Uncomplicated urinary tract infections in women (women, aged 16 to 64)

12.50. Consultations for these seven clinical pathways can be provided to patients presenting to the pharmacy as well as those referred by NHS 111, general practices and others. This service delivered 21,552 consultations in FY2024/25.

12.51. Influenza Vaccination Service - Community pharmacies are integral to the delivery of the system influenza vaccination strategy. Contractors provided approximately 39,000 influenza vaccines to NHS eligible patients in 2024/25, in addition to private services for patient's ineligible for NHS service.

Hospital Pharmacies

12.52. Ward-based pharmacists to support discharge are being explored – A pilot ward is planned to commence in September 2025.

12.53. Pharmacy operational hours at Musgrove to be extended to 6pm from 5.30pm to support operational flow

12.54. Pharmacy clinical provision to AMU to support admissions and discharges - Planned to commence in January 2026, subject to Pharmacist recruitment.

Optometry

12.55. NHS Somerset commission service called Acute Community Eyecare Scheme (ACES) to support Optometry. ACES is a free service available to all patients registered with a Somerset GP. The service provides patients experiencing recently occurring medical eye conditions with appropriate treatment closer to home. The service is provided by local optometrists with the specialist knowledge and skills to carry out this work at a locally approved optician.

12.56. As a result of the consultation patients may be:

- Given appropriate treatment by the optometrist, this may include a follow-up appointment.
- Referred to GP for appropriate treatment if your eye condition is related to general health or requires POM treatment.
- Referred directly to the hospital eye service if eye condition is more serious.

12.57. This service provided 16,411 patient consultations in 2024/25, an 18.4% increase YoY.

Dentistry

12.58. Surges in acute dental conditions are not typical with winter/weather changes. Dental Practices usually see an increase in short notice cancelled appointments due to seasonal illnesses, so increased short notice capacity is possible. Patients are advised to contact their usual dental provider in the first instance of an acute problem (bleeding, swelling and trauma) or contact 111 should they not have a regular dental provider.

12.59. As part of Labour Party manifesto commitment to deliver 700,000 additional urgent care appointments across England in FY25/26, NHS Somerset is expected to deliver 13,500 additional urgent care appointments against a baseline of 19,500.

12.60. Somerset Council have produced materials to support caring for your oral health and a campaign toolkit is in place: Oral health (www.healthysomerset.co.uk)

12.61. A range of actions are also outlined elsewhere in this document that will support patients with their dental needs over the winter period, relieving pressure on other urgent care services.

Safeguarding

12.62. Somerset Domestic Abuse services continue to take telephone referrals from GPs, with patients consent, avoiding the need to complete lengthy written referral forms which GPs may not hold most of the information for.

12.63. Referrals to Adult Social Care can be made by phone or email by GPs. Similarly telephone referrals by GPs to Children's Social Care for acute safeguarding children issues continue, streamlining the referral process and saving valuable clinical time. Somerset Foundation Trust safeguarding professionals attend Multi Agency Safeguarding Hub (MASH) meetings representing the health system, allowing GPs to share information but not attend long meetings.

12.64. GP Lunch and Learn sessions have been scaled back although quarterly Level 3 training continues. GP supervision and the Best Practice Group continues quarterly at the request of GPs; this is seen as a supportive measure during times of greater pressure on services.

12.65. Safeguarding communications to General Practice are rationalised to ensure information is not duplicated. Upcoming training opportunities are now available via an ICB website link, ensuring that additional training emails are no longer necessary.

13. WINTER PLAN FUNDING 2025/26

13.1. £500,000 has been identified support schemes that build resilience during Winter 2025/26. This funding will be used to target key areas of focus, which have been identified through detailed analysis of hospital demand. Bids against the fund have been invited and will be reviewed during September. This document will be updated with details of approved schemes.

14. RISKS ASSOCIATED WITH THE WINTER PLAN

14.1. A number of risks to delivery of this winter plan have been identified by the system. The table below outlines the key ones along with the planned mitigations. Further mitigations may be implemented once we have received proposals to the winter schemes funding. This risk assessment will remain live through winter and updated as appropriate.

Risk	Mitigations in place
Workforce challenges: • High staff absence due to seasonal illness or through special leave utilisation due to increased illness of dependants e.g. flu COVID, RSV	Enable staff flu/COVID vaccination programme, encourage vaccination of dependants and support remote working where possible
• Weather related travel issues	Well established remote working principles to apply in the case of weather related travel
• Staff fatigue & burnout due to increased workload and reduced staffing over winter	Ensure colleagues take appropriate breaks to support their wellbeing, ensure that any overtime worked is recorded (paid or unpaid) to enable an understanding of work pressures. Establish escalation protocols for teams under high pressure.
• Decline in staff mental health due to winter pressures, short daylight hours, reduced physical activity and increased emotional strain	Mental health first aiders, encourage EAP access, support flexible shifts to permit movement within working day, e.g. starting 30 mins earlier to accommodate a 1hr lunch break to take a run in the daylight.
Infection prevention control in Care Homes .	• Improved IPM standards across all care homes in Somerset. • Reduction in avoidable admissions due to UTIs, respiratory infections, and outbreaks. • Greater staff confidence and competence in managing infection risks. • Strengthened collaboration between health protection teams, care providers, and the wider healthcare system.

Demand increases beyond predicted levels and exceeds the available capacity.	• Business continuity processes to be implemented where this is appropriate. • On going monitoring of demand • Mitigate likely increases in demand through the winter planning process, by increasing available capacity, resilience and ensuring the most appropriate services are utilised by patients and referrers (as outlined throughout this document)
Sufficient Patient flow	A range of actions are outlined through this document (in particular in section 9) to mitigate this risk. In addition Somerset Foundation Trust are: • Actively working to improve internal processes by digitalising the current bed management system to support faster and more efficient bed allocation. • SFT escalation plans are being reviewed and refined to ensure alignment with real-time bed availability and demand. • Developing predictive data tools to better anticipate admission and discharge trends. This will allow us to move from a reactive to a more proactive operational model. By digitalising these processes, we aim to increase both productivity and responsiveness during peak periods.
Elective programme delivery is impacted through high winter demand	• Elective surgical cancellations are monitored, and trust has process in place for approval of cancellations • Ring fenced elective capacity in place where possible • Maximise use of day case surgery
Risk of industrial action reducing staffing levels through winter period	• Where any declaration of strike action is determined, contingency staffing arrangements will be considered, for example increased on-call activity. • Where any strikes that impact ICB staffing occur to consider early engagement with unions and communications planning.

Sufficient capacity within the community is available to transfer care out of the acute hospitals	• The pathway 1 service has been expanded to support up to 83 new starts per week. This is up 25% from 63 starts per week. • A dedicated sourcing worker has been employed by Somerset Council to specifically focus on supporting the discharges for pathway 3 patients from acute hospitals. • Ensure capacity reported is correct to maximise usage • Ensure optimal use of the Care Co-ordination hub to ensure co-ordination across teams to maximise the support available to patients. • Ensure consistent resourcing of the care co hub across its full operational hours, including weekends, to optimise the support available through discharge and admission avoidance.
No criteria to reside (NCTR) programme.	• NCTR improvement plan continues to be overseen by an executive SRO and the ICB TMO. Hospital process and capacity delays are the key areas of focus. • Hospital social work team and SFT discharge team are actively working to ensure referrals to TOC do not delay discharge. • Several commissioning incentives are being explored by Somerset Council to ensure that the newly expanded pathway 1 capacity is distributed and available across all geographies in Somerset • The supply of 28 beds specifically for pathway 3 patients started in August with the ambition of reducing acute NCTR duration and community NCTR volumes. • SFT are working internally to reduce the number of cancelled pathway 1 discharges.
Gaps in current data set allowing effective monitoring of the Winter Plan.	• Development of datasets alongside the development of plans and winter schemes, including agreements on the data capture and data flow processes to support monitoring and evaluation.

15. CONCLUSION

15.1. Significant work has been undertaken over recent weeks to finalise a robust winter plan for the system and to put in place the mechanisms necessary to support delivery and respond in an agile way to pressures experienced across our services. As a consequence, we are well placed both to deliver on the requirements set out in the Urgent and Emergency Plan in recent months, and to manage winter as effectively as possible with the resources available to us. The plans set out the mechanisms through which we will remain sighted on the key issues, respond in an agile way to pressures and ensure that the system leadership remains aligned on the kay actions that we take.

15.2. We will continue to develop and adapt this plan as we learn from the local and regional stress tests and as we approach and experience winter.