One Gloucestershire
Transforming Care, Transforming Communities

NHS

One Gloucestershire
Winter Pledge

One Gloucestershire
Integrated Care System (ICS)

WINTER PLAN

2022/23

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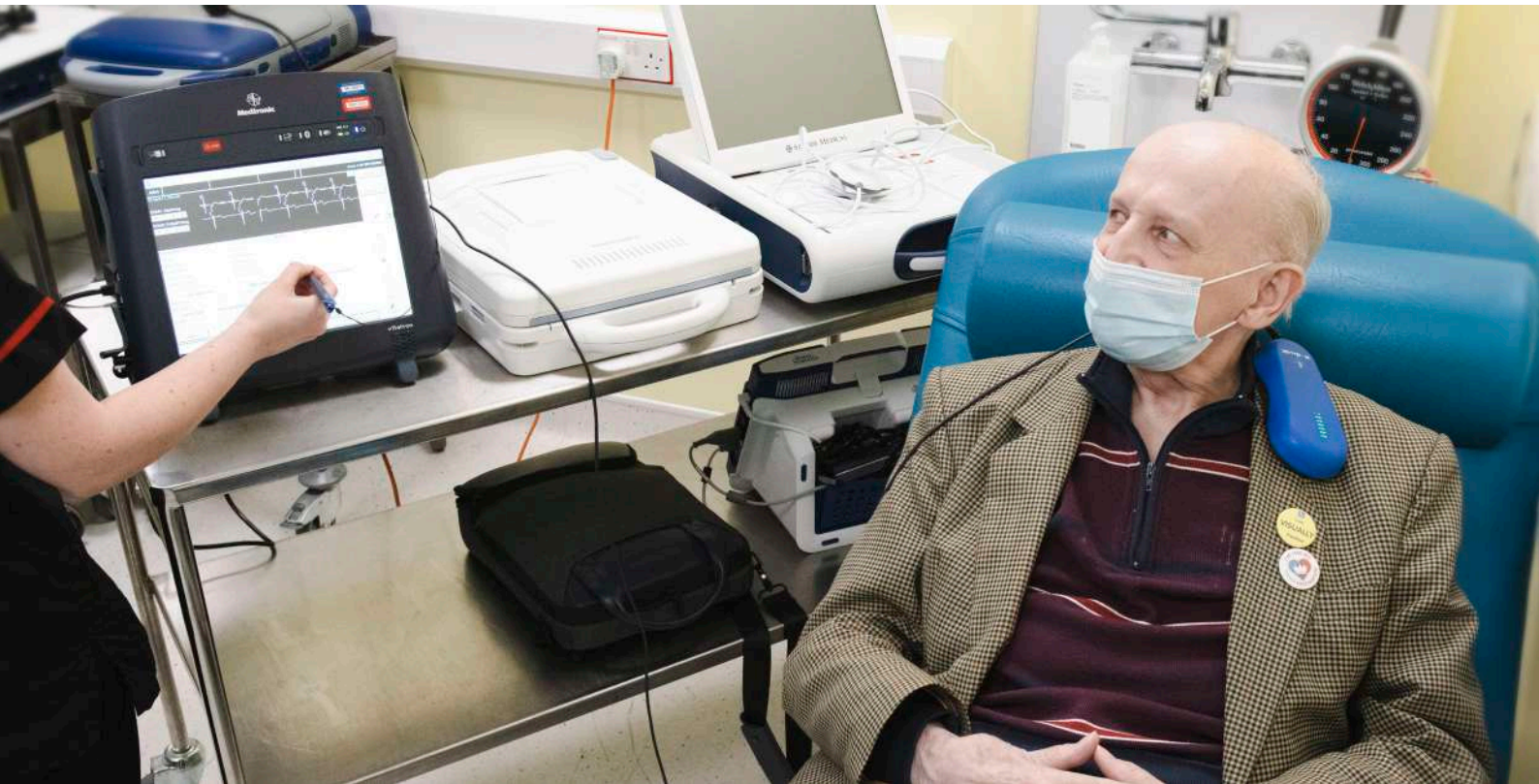

Forewords

Albert Weager
Chair of the Urgent and Emergency Care Patient and Public Involvement Network

It is my privilege, as your long serving community representative, to pen this introduction to One Gloucestershire's Winter Plan 2022-23.

Born out of the principles underpinning 'Your Health, Your Care', designed and co-produced by a collaboration of partnerships across the new Integrated Care System (ICS), it offers pledge-based opportunities for the provision of our winter care.

These offer a framework for the provision of our care in a seamless, timely, effective and appropriate way, from a point of need along pathways to a point and place of delivery.

This plan is very much about what 'the system' will do for us, the people of Gloucestershire. What can we do, as a thoughtful population, to give it every chance of success?

Can we make our own pledges, in caring communities, to best care for ourselves, our families and neighbours, to reduce or avoid a need for care, locally or more distant?

A significant challenge to all of us! Can we rise to it?

Faye Noble
Urgent and Emergency Care Clinical Lead for One Gloucestershire ICS

As a consultant doctor in Gloucestershire's Accident and Emergency (A&E) department, I know first-hand that winter is a time that represents great challenge for the NHS and social care, and particularly for urgent and emergency care services.

More recently, seasonal variation has become far less pronounced, with most services working at capacity throughout the year, not just peaking in the winter months.

Our plan to deliver the best care we can through winter aims to be responsive to you, the people and communities of Gloucestershire. It aims to be realistic for our staff who work in our busy health and social care services, who have already worked so tirelessly throughout this year and following the peaks of COVID-19 over the last two winters.

Earlier this year the health and social care organisations that provide all these services came together as an Integrated Care System. This change gives us a real opportunity to create a shared plan for winter that truly represents our joint priorities. In this regard the sum is far greater than the parts, and we pledge to do our very best to rise to the challenge that Albert describes above, with you and for you.

Our 2022/23 Winter Plan is clear and simple. We will work together to deliver joined up urgent and emergency services, focussing on our goals of ensuring care is safe, timely and person-centred. I am confident that this plan offers us a real opportunity to address the challenges that face urgent and emergency care as we go into next year.

This winter in context

Our plan to handle the pressures we know come at this time of year is more important than ever, and reflect the priorities faced by the whole country. Our main priorities will be to:

- Prepare for new COVID-19 variants and other respiratory challenges; central to this is our integrated COVID-19 and flu vaccination programme
- Increase how much care we can provide outside our two acute hospitals, including expanding additional roles in primary care and releasing annual funding to support mental health through the winter
- Increase the resilience of NHS 111 and 999 services by expanding the number of call handlers, ensuring the fastest possible responses
- Improve the speed in which 999 Category 2 (i.e. urgent, but not emergency) responses happen and reduce how long it takes for ambulance colleagues to be able to transfer their patients into hospital care. This is both better for the patient and ensures our ambulances can get to the next priority call sooner
- Improve patient experience by expanding the availability of alternative services which means more people who need urgent (not emergency care) will be able to be seen without going to an acute hospital. This will also improve the patient experience of people who do need emergency care in our A&E departments by reducing crowding and wait times
- Reduce how busy our acute and community hospital wards are, through a mix of new physical beds, 'virtual wards' where patients receive excellent care in their own home, and by making sure moving through our services is as smooth and timely as possible

- Ensure people can be discharged safely and quickly from our acute, mental health, and community settings, by working ever more closely with social care and implementing nationally recognised improvement action plans
- Provide better support for people at home, including expanding our existing 'virtual wards', and giving support to those people who have complex care needs or access our hospital services frequently.

"Our plan to handle the pressures we know come at this time of year is more important than ever."

In July 2022, the new One Gloucestershire Integrated Care System (ICS) was legally established as one of the 42 ICSs across England, bringing together all parts of health and social care – with voluntary and community organisations too – in greater collaboration than ever before. Supporting all the organisations that provide care and treatment is the new Integrated Care Board (ICB), which drives forward and coordinates wide-ranging improvement projects, and helps overcome hurdles that can crop up. This winter presents a real opportunity to demonstrate how these new ways of working can make a real difference to the people and communities of Gloucestershire. A key example is the strengthening partnership between health organisations and Gloucestershire County Council as we work together to address the impact of the pressures faced by social care, which can contribute to patients staying in hospital longer than necessary.

In Gloucestershire we feel that we have the right level of autonomy to make decisions that best support our communities and citizens, to hold each other to account as critical friends, and solve our own issues and challenges together.
We work closely in partnership with our NHS England Regional and National colleagues and can call upon their support and input as required. They will also help monitor how winter is impacting us through a new national 'Assurance Framework', a mechanism that demonstrates how our investments and efforts are making a difference to tackling the pressures of winter which will be reported on regularly through our Integrated Care Board.

Finally, and most importantly, our communities and you, the residents of Gloucestershire, are key to how well we manage this winter, and so we present this plan and our pledges to you and ask for your help and support to use the right services at the right time for your needs.

Our System Plan

This plan sets out how we will ensure services provided by each of the partners that make up our system will be resilient through this winter.

We have arrangements across all One Gloucestershire 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.

We learned much from the pandemic and from our responses. Perhaps most importantly it showed us that, on a day-to-day basis, all our partner organisations in Gloucestershire are stronger and better when we work more closely together. We have a shared commitment and determination to ensure people are cared for in the right place at the right time, so that they can achieve the best health outcomes.

At a system level we will work together to drive delivery of the plans set out in this document, managing risk and daily patient flow between all our partners through the establishment of a *System Control Centre*. This Control Centre will be clinically and managerially led, ensuring a continuous focus on this plan to ensure we are delivering the safest, most appropriate care we can over the winter months.

In this Winter Plan we set out some examples of how each organisation makes a difference every day, and some of the specific actions we are taking in each area that support our pledges.

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Primary Care

Building resilience across our GP Surgeries

There are recognised national workforce pressures in primary care, including a longer-term concern regarding the numbers of GPs retiring and leaving the profession. Our GP practices increasingly work in *Primary Care Networks* or PCNs, groups of practices serving broadly the same community, to provide support and help to each other. These PCNs also work together in six wider geographical collaboratives called *Integrated Locality Partnerships* (ILPs), with representatives from all of our county's health and social care organisations.

The ICB is supporting PCNs to conduct longer-term workforce planning to understand where our local gaps are and will be. In the short-term to help this winter, we have used additional NHS funding to recruit more part-time GPs to ensure our practices work as flexibly as possible, and we regularly welcome new groups of GP Assistants in training.

Integrated Community Teams in PCNs

Case Study

- Improved joint working provides around 100,000 extra GP surgery appointments, including evenings and weekends. Social prescribing in these teams looks at people's non-medical needs and wellbeing. One patient we spoke to really struggled while on benefits, feeling isolated and unable to go out anywhere. Working with social prescribing helped him to start applying for jobs and move forward more positively
- Similarly, Advanced Physiotherapy Practitioners provide around 180 appointments each month, helping people to help themselves, and referring them to the right specialist service if needed
- This multi-expert approach looks at the whole person, including those with complex needs like dementia, frailty and other long-term conditions, and help them regain and maintain their independence at home
- The most important person in the care journey is the patient themself – we listen to them, hear what their goals are, and then work on ways to achieve that.

We are also taking innovative approaches such as our *Primary Care Flexible Staffing Pool*. All 70 Gloucestershire GP Surgeries practices are signed up to this service, which has provided over 4,000 hours of valuable locum GP time since April 2022. Our *Primary Care Training Hub* actively works with all practices to ensure training and support offers are tailored to needs.

We recognise how important it is to ensure the wellbeing of our colleagues in primary care – building resilience across the county through these and other initiatives will help us retain staff, show what a great place Gloucestershire is to work, and provide the best possible access to care for patients.

Working together, and improving access to your local primary care services

Our GP Surgeries have been putting into place some exciting initiatives that enable staff to get patients into the right services as quickly as possible, for example the Rosebank Hub *Clinical Assessment Service* (CAS) and *Church Street Care Navigation*.

In Gloucestershire we develop our clinical services by bringing together the people who deliver those services – from Primary Care to our large acute hospitals, to community-based services and social care. This is our *Clinical Programme Approach* which links closely with PCNs, including an information 'dashboard' showing the quality and patient level impact of investments on the care they provide.

PCNs have *Enhanced Access Plans* to meet the needs of local communities and the differences in people's daily lives. Our PCNs are keen to include blood tests and health checks as part of these Saturday Enhanced Access Clinics, and we are discussing the possibility of a Saturday morning phlebotomy service to take blood samples.

Primary Care recognises the importance and growing awareness of Mental Health, including for people with learning disabilities and severe mental health illness. Our GP practices now have access to a Learning Disabilities Liaison Nurse to support annual health checks, and we have recruited ten mental health practitioners to work within our GP practices, including three in inner-city Gloucester to provide one-to-one support in the early stages of need.

GP practices, by working together and with every other part of the health and social care system in Gloucestershire, are working every day to provide services that meet the real needs of their local communities. Our PCNs and GP practices conduct a range of quality improvement projects; many of these focus on Frailty, one of Gloucestershire's key healthcare priorities.

We work in partnership with the charitable *Independence Trust* to help with booking and attending appointments for serious mental Illness health checks.

Mental health practitioners in primary care

Case Study

Winter can be a hard time for mental health, and especially this year with cost-of-living pressures. One patient told us he was at a real crisis point, having anxiety attacks daily. He saw the mental health practitioner at his practice by calling and making an appointment, just as with a GP. They provided longer consultation times and worked closely with him to make joint decisions. From his first appointment he felt improvement – joining up our different services to care for the 'whole person' is our vision for the future, and that starts this winter.

Case Study

In the winter, bad weather and shorter days can lead to accidents that can leave more people frail. Our services together helped one of our patients to regain normality back in her life after being knocked down by a bicycle, living independently and enjoying the outdoors again.

Our GP practices in Tewkesbury, Newent, Staunton, North and South Cotswolds and Berkeley will offer and support innovative services through winter, including 'anticipatory care' frailty nurse services, frailty assessments to identify and support patients, strength and balance classes (which 100% of current attendees recommend), and a frailty 'virtual ward' providing hospital-level care and support in people's own homes.

Based on the COVID-19 virtual ward model we developed during the pandemic, patients are given the simple technology at home such as pulse oximeters similar to those used in our hospitals. so they can monitor their own oxygen saturation and pulse readings. Clinical staff can then access those readings and contact the patient if they spot deterioration.

Patients tell us they have greater confidence living independently, and that our virtual ward approach helped them feel they weren't alone and were making progress, without needed to be in a hospital bed.

The Primary Care winter pledges

One Gloucestershire Winter Pledge

- We will make GP practice appointments available for NHS 111 to book directly into
- We will make more GP services available on Saturday afternoons across the county
- We will continue to expand the numbers and kinds of roles in primary care such as social prescribing link workers, first contact physiotherapists, paramedics, pharmacists, and mental health practitioners, to respond to people's various needs more quickly
- We will continue to improve GP practice telephone systems to ensure we answer your call as soon as possible
- We will support and help provide COVID-19 booster and flu vaccination programmes
- We will continue to provide, and further develop, our 'anticipatory care' services to do everything we can to support people to stay at home, reducing the need for hospital based care where this is appropriate for them.

First Response Services

NHS 111

NHS 111 helps people get the right advice and treatment when they urgently need it, be that for their physical or mental health, 24 hours a day, 7 days a week. Nearly half of all calls to NHS 111 are resolved by the initial call handler who can help people with self-care advice or to find the service they need.

To get help from NHS 111, you can:

- **Go online to 111.nhs.uk (for assessment of people aged 5 years and over only)**
- **Call 111 for free from a landline or mobile phone.**

For Gloucestershire, NHS 111 is provided by an organisation called Practice Plus Group (PPG). Increasingly, NHS 111 can book people directly into appointment slots in A&E and our Minor Injuries and Illness Units (MIIUs), helping to ensure patients are cared for and treated as quickly as possible and in the most appropriate place. The features of the website are a focus for continuous improvement, and we continue to make NHS 111 a priority and the first port of call for as many people as possible.

There are workforce challenges for NHS 111, as in many other parts of health and social care. We are supporting our NHS 111 provider with recruitment and staff retention efforts, learning from some of the best practice ideas across the country and coordinating with other areas in the South West region. Nationally, NHS England are supporting our local efforts by making it easier for NHS 111 providers to move to a regional 'network' approach to handling calls.

The NHS 111 winter pledges

One Gloucestershire Winter Pledge

- We will improve our availability and speed of response to calls from patients
- We will increase the number of clinical staff in NHS 111 to help patients sooner
- We will improve the resilience of the service to answer and deal with calls, especially in times of adverse weather when it could be challenging for our staff to travel into work
- We will reduce the number of people sent to A&E, instead directing them to appropriate alternative services where it is possible to do so, directly booking them appointments in the alternative services to make it as easy as possible to access care.

Out-of-hours (OOH)

Our Out of Hours Services are also provided by PPG, this service provides a General Practitioner (GP) service outside normal GP practice hours:

- **18:30-08:00 Monday to Friday, and all-day Saturday, Sunday and Bank Holidays.**

In Gloucestershire we have out of hours colleagues based in both of our main hospital sites, and two mobile GPs to be able to provide services to patients who are unable to leave their home. Out-Of-Hours services includes:

- GPs and other healthcare professionals working alongside A&E departments and MIIUs
- Healthcare professionals (not just doctors) making home visits after detailed clinical assessments.

The Out Of Hours winter pledges

- Local GP practices will provide additional capacity to the Out of Hours services
- We will make as much use as possible of technology that has become more familiar during the pandemic, such as video consultations, to contact patients more quickly and provide a better experience.

South West Regional Directory of Service (DoS) Team

The *Directory of Services* (DoS) is a system used primarily by NHS 111, 999 call centres, ambulance crews and other front-line professionals to access information about the range of services available. It is accessed by these service providers to instantly find out about availability, capacity information, referral routes, opening hours, contact details, and other service information. It allows front-line professionals access to the right service, first time, and to make the best use of community services such as pharmacies, primary care and MIIUs.

In Gloucestershire, the MiDoS platform has been designed in collaboration with local professionals from the health, social and voluntary sectors MiDoS gives local health and care professionals a fast way to access accurate, real-time information to help signpost patients to available services, including by-pass telephone numbers and instructions about who is eligible for services and how to refer a patient. The public can also access the same MiDoS information using MiServiceFinder (https://miservicefinder.co.uk) which is fast, free and does not ask for personal data.

The team that manages this for the six million people in the South West is based in Gloucestershire, giving us immediate insight and improvement to the system for our local services.

The Directory of Services winter pledges

- We will ensure the DoS is updated in real time to reflect local services, helping NHS 111 to direct patients to the most suitable service
- We will make the MiDoS tool available through Ambulance systems and software, ensuring ambulances are used appropriately for the most unwell or injured patients
- We will make the MiDoS tool more widely available to front line colleagues who see and treat patients in our urgent and emergency care departments, supporting them to redirect patients to appropriate alternatives where possible
- We will ensure MiServiceFinder is promoted and used as much as possible and ensure the information it uses is as accurate as possible to help people care for themselves.

South West Ambulance Service NHS Foundation Trust (SWAST)

Since February 2022 the South West Ambulance Service NHS Foundation Trust (SWAST) 999 hub has had a dedicated Mental Health station from 8am to 10pm every day. This has proved to be so successful that we are proposing to extend the service to 24 hours a day, as soon as possible.

Within our acute hospitals we have established a Hospital Ambulance Liaison Officer (HALO). HALO assists with quicker flow into hospital to reduce ambulance handover delays and improve patient experience, for example by identifying which patients could be cared for by Same Day Emergency Care (SDEC) alternatives once at A&E.

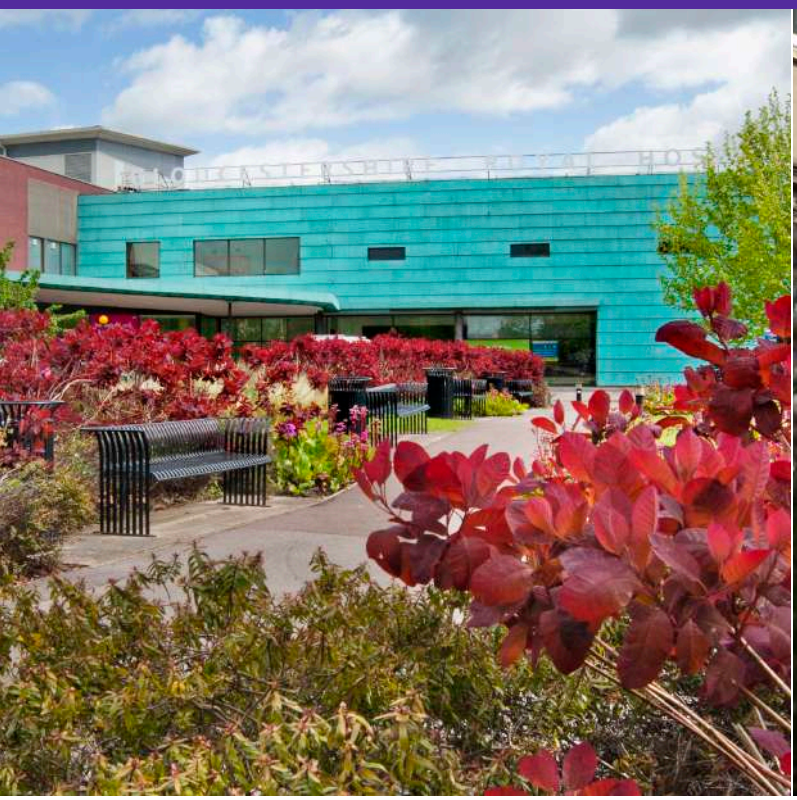
We have also improved the ambulance handover *Standard Operating Procedure* (SOP) to ensure the transfer of patients' care between ambulance and hospital clinicians is as quick and safe as possible – we improved this key process in collaboration with our hospital colleagues. When we do have delays transferring patients from our ambulances to the hospital, Gloucestershire Hospitals operate an 'Assess and Return' model. The enables us to take patients for diagnostic blood tests as soon as possible, then return them to the ambulance until they can be transferred into the hospital.

We are identifying digital solutions to connect ambulance software to our partners' systems, both to improve our shared view of information and to be able to identify sooner if someone can be cared for by an alternative service. This will be enabled further by the use of specialised tablet computers designed to be used by our mobile crews wherever they are to access up to date patient information, and the Directory of Services to ensure we find the most appropriate service for the individual. We work closely with the Directory of Services team to update the information in the system, and improve how it is presented to our ambulance crews.

The Ambulance service winter pledges

- We will make use of the DoS tool in our Ambulance systems and software, ensuring ambulances are used appropriately for only the most unwell or injured patients
- We will treat as many people as possible in their own home when we are called out, avoiding taking them to hospital unless our paramedics make that clinical decision. This is known as 'See and Treat'; similarly, we will do as much 'Hear and Treat' as possible, guiding and directing appropriate patients to care for themselves and use alternative services
- We will make our call 'stack' available to partner organisations for them to identify appropriate patients they can care for and treat directly, allowing us to focus on those people who truly need ambulance services
- We will redirect and direct people into assessment units to ensure they are in the best place for their care
- We will do everything we can to ensure patients are transferred as quickly and safely as possible from our ambulances to hospital care and move to the next priority call as soon as possible.

One Gloucestershire Winter Pledge



Gloucestershire Hospitals NHS Foundation Trust

Our two acute hospitals – Cheltenham General Hospital (CGH) and Gloucestershire Royal Hospital (GRH) – provide specialist diagnostics, treatment and care. This falls into two broad categories:

- Planned or 'Elective' care – including outpatient appointments, surgical operations, therapies and treatments including cancer
- Urgent and Emergency Care or 'Unscheduled' care – Accidents and Emergencies (A&E), one at each hospital, and Same Day Emergency Care (SDEC) units.

The pressures on A&E departments usually increase during the winter months. We have some important standards that we always strive to achieve in A&E, notably how long people wait to be seen and triaged, how long it takes for them to get the care and treatment they need and, if necessary, how long it takes them to be admitted to one of our inpatient wards for overnight or long-term care.

This winter sees our major building works at the hospitals reach their final stages; this will create more space and efficiency as we move services to the best physical space for their needs. We will also do our best to make these moves as quickly and quietly as possible while still caring for patients 24/7

Urgent and Emergency Care happens at various stages through our hospitals, and all prioritise safety, quality of care, and compassion.

Arriving at hospital

We will work with SWAST to ensure patients are transferred from their care to ours as safely and quickly as possible. This allows us to ensure patients receive the diagnostics and treatment they need while the Ambulance crew can focus on the next priority call. To help with this we are creating more seated spaces in the hospitals for those patents who don't need to lie down on trolleys or beds to be observed and monitored appropriately.

Care in our Accident and Emergency departments

This winter we will do all we can to ensure only the people who really need Accident and Emergency services are in the department. To help with this, we are rolling out the use of the Directory of Services (DoS) system widely, to help our clinicians determine the best possible place for each person's care if not A&E. We will also use the Cinapsis system to advise and guide colleagues in other parts of health and social care to direct people to the right service, first time.

We will do everything possible to keep the length of time people spend waiting in A&E as short as possible, and will also reduce the chance that someone will be admitted for an overnight stay when they don't need to.

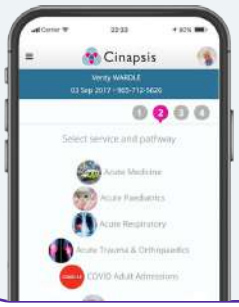
To take as much pressure off A&E as possible, we will make as much use as possible of our assessment areas to 'stream' patients, quickly identifying their needs and guiding as many as possible to the best place in the hospital for their care, such as:

- Same Day Emergency Care (SDEC) services
- Paediatric Assessment Unit
- Surgical Assessment Unit
- Trauma Assessment and Treatment Unit
- Frailty Assessment Unit (see Case Study)

Expert advice across health and care

Our acute hospital specialists are available through a system called Cinapsis, which makes it easier and quicker for other professionals to get expert advice and guidance on the best care and place for people and hopefully direct them to non-hospital services.

Through autumn we saw use of Cinapsis increase from around 3 to over 25 per week; over half of these come from SWAST, helping to ensure as many people as possible avoid a hospital visit where it wasn't needed. We will continue to expand the use of this throughout winter.



Case Study

Reaching out

This winter our acute hospitals are working closer than ever with the range of services across all of health and social care, both to ensure people are cared for in the best place for them to appropriately avoid an unnecessary stay in one of our wards, and to ensure we can care for the most unwell people who need to use A&E as quickly as possible.

As well as ensuring the work that happens in the hospitals is as effectively and timely as possible, our front-line staff are increasingly informed about alternative services through the Directory of Services, and by true partnership working. Some key examples are the collaboration with SWAST on their ambulance handover process, the Hospital Ambulance Liaison Officer (HALO) function, and the Assess and Return model that starts diagnostic tests for patients before they transfer into hospital care.

We are also encouraging more use of a dedicated 'Admission Avoidance Line' service provided by our Social Care colleagues, where A&E staff can get immediate advice on existing care being given to patients in their own homes that could affect clinical decisions, and any other community services that be more appropriate for an individual.

Case Study

Frailty

Frailty is a theme throughout Gloucestershire's plan for winter, from community based Rapid Response and assessment units to ongoing care and monitoring including in 'Virtual Wards'. In our acute hospitals we will increase the use of our Frailty Assessment Unit.

During Autumn over 120 people used this service, over a third referred after advice through Cinapsis and nearly two-thirds directed from A&E. Three quarters of patients using the Frailty Assessment Unit go home the same day instead of being admitted to a ward bed. Half of those patients who are admitted are discharged within three days.

Over winter we will continue to identify as many appropriate patients as possible who will benefit from the Unit.

Similarly, we are completing projects that improve 'flow' through the hospitals by identifying patients as early as possible who will be admitted to wards. This allows us to plan our ward bed allocations and ensure those wards are expecting them at an agreed time.

Over winter we will provide more dedicated clinics for those patients who use A&E very frequently or have very complex needs. These clinics help people remain as independent as possible and have the best quality of life, reducing the need to use A&E as much.

We want as many people to be treated and sent home safely on the same day to avoid a hospital stay. Where people do need to stay in one of our wards for one or more nights, we do all we can to ensure the right person is safely making a timely decision about what each patient needs, and where, and arrange their transfer to keep A&E running smoothly for the next patient.

Case Study

A person not just a patient

A number of our patients have very complex needs and use our A&E services frequently. This winter we are working closely with these people, and with colleagues across all parts of the health and social care system, to provide dedicated clinics to understand their 'whole person' needs.

These clinics allow the creation of 'personalised support plans' to help clinical decision making, and to understand the needs of our patient better so that we can provide alternatives to A&E, including engaging with a social prescriber and signposting to mental health, voluntary and charitable organisations.

Care in our hospitals

This winter we are enhancing care over weekends, conduct additional consultant-led 'ward rounds' to improve care to the same level every day of the week. These ward rounds, the same as those conducted weekdays, review patient conditions and care with a range of specialist staff including medical, nursing, therapies, dietician and pharmacy. This also helps us to identify patients who are well enough to be cared for somewhere more appropriate, for example a community hospital or care home), or be discharged without waiting until Monday.

To support this across the whole week, we will ensure that at least 80% of diagnostic tests (e.g. scans, blood tests) are requested at morning ward rounds. This will improve how early in the day we

have up-to-date information on patients' progress and status and can make decisions about their care and discharge sooner. This is better for the person, and also ensures our hospital beds are being used as effectively as possible.

Capacity and space in our hospitals in critical to overall patient 'flow' through their pathway of care, and to making sure we have space for the next patient to start being cared for as soon as possible. Later in the 'System Resources Plan' section of this document you will see some details about the major investments being made in the hospitals this winter, notably the expanded Discharge Waiting Area and our Prescott Ward 'escalation' space. These kinds of projects give us both more space and flow and allow us to flex our capacity to meet patients' needs as they change over winter. They will also help us make best use of the two additional, temporary operating theatres we will use this winter to increase the number of operations we can do each day.

One of the additional pressures in winter healthcare is seasonal illnesses. We learned during the COVID-19 pandemic that, occasionally, we have to make difficult decisions in the best interests of our patients and staff. This winter, if unavoidable, we will restrict visits to wards if there are risks of infection, notably from COVID-19, flu or norovirus (vomiting bug). These infectious illnesses can make patients more ill, and also impact our staff numbers, potentially leading us to close entire wards and placing a lot of pressure on the rest of the hospital.

Leaving our hospitals

Our acute hospitals are really designed for the most unwell people. When our patients begin to recover, they need different care and support arrangements be comfortable, and regain as much independence as possible, as soon as possible, to avoid having to be readmitted to hospital. This winter we will work hand-in-hand with our colleagues in the community and social care to ensure people can go home, or to a more appropriate place than the acute hospitals to finish their recovery.

To help with this approach to 'hospital discharge' over winter we are introducing more accurate methods and systems across the hospitals to estimate when patients should be well enough to leave hospital. This enables us to plan their time with us, and work with our system colleagues, to plan and arrange their next steps and avoid unnecessary time in our wards.

We know it can take some time to get everything ready to safely discharge patients, for example medication, social care, and transport. Earlier this year we conducted 'improvement weeks' to test how we focus our people and processes on patient discharges happening as early as possible each day and are building what we learned from those into our usual working practice for winter.

For example, we will increasingly prioritise as much care and treatment as possible for patients in our wards in the morning. This will improve our chances of discharging people that day and avoid unnecessary additional overnight stays. This includes having medications for patients to take home ready by lunchtime.

The Acute hospitals winter pledges

- We are building lessons learned from our response to the COVID-19 pandemic, and our improvement projects this year, into our everyday working over winter to ensure patients are assessed, treated and cared for as safely and quickly as possible
- We will increase actual hospital capacity through up to 35 new 'escalation' beds in the refurbished Prescott Ward, our temporary operating theatres, and our building projects
- We will also increase our capacity by the equivalent of 22 beds by providing more 'virtual wards' - hospital-level monitoring and care for people at home
- We will be diligent in keeping avoidable infections out of our departments and wards, avoiding unnecessary delays in peoples' care and doing all we can to make sure they can be visited by loved ones.

Gloucestershire Health and Care NHS Foundation Trust

Gloucestershire Health and Care NHS Foundation Trust (GHC) provides mental health, physical health, and learning disability services to people of all ages across Gloucestershire. We do this in community hospitals and other buildings and, primarily, in people's own homes. We employ over 5,000 staff who work at around 200 sites all over the county, offering over 100 different clinical and support services.

The focus of our community services winter plan is on how we will manage the expected seasonal increase in respiratory diseases, such as influenza and COVID-19. We play a crucial role in caring for people in the most suitable place possible – in their own home with our district nursing teams, in our range of clinic facilities, or in our local community hospitals.

Physical Health services

Our six Minor Injuries and Illness Units (MIIUs), based in our community hospitals, are all open from 8am to 8pm for walk-in patients and appointments booked through the NHS 111 service, GPs and by calling directly.

Our six MIIUs:

- Lydney and District Hospital
- Tewkesbury Community Hospital
- Stroud District Hospital
- Vale Community Hospital
- Cirencester Hospital
- North Cotswolds Hospital.

What our MIIUs can treat:	What our community hospitals cannot treat:
Sprains	Head injuries with loss of consciousness
Simple fractures needing x-rays and plasters	Persistent, severe chest pains
Simple wounds that may need suturing (stitches)	Pain that is not relieved by simple pain killers
Minor burns	Sudden confused state of mind
Emergency contraception	Breathing difficulties
Minor head injuries with no loss of consciousness	Stroke or suspected stroke
Minor illness, earache, sore throat, etc	Alcohol-related problems
Skin problems such as rashes, bites, stings and infections	Overdoses
Eye conditions including foreign bodies and conjunctivitis	Complicated or serious injuries
	Major or long-standing illnesses

As well as our MIIUs that treat patients with urgent, but not critical, health issues, our community hospitals provide inpatient wards and a range of other services. A key function of these wards is to provide rehabilitation and 'step-down' inpatient beds, so that when someone is well enough to not need an acute hospital bed but not quite well enough to go home, we can care for them closer to home in a community hospital. This provides a better experience for those patients and ensures acute hospital beds are rightly used for the most unwell people in Gloucestershire.

We have also invested in setting up our *Community Assessment and Treatment Unit* (CATU). This short-stay unit in Tewkesbury Hospital provides an additional ten beds in time for winter, and helps appropriate patients get the care and treatment they need but avoid going to an acute hospital.

Like our county's acute hospitals, we continually strive to find ways to ensure our community hospitals work as effectively and smoothly as possible. This helps to reduce our patients' average *Length of Stay* the earlier they can be back in their own home, the better their recovery and long-term quality of life.

We do other important work across Gloucestershire's communities to support people

to remain independent at home, whilst also helping to keep A&E and the Ambulance service available for those who really need it, including:

- Providing a 'falls response' service in partnership with Gloucestershire Fire and Rescue Service – this helps avoid ambulance call-outs and prevent people from having to go to hospital
- Identifying 999 calls that can be dealt with by our Rapid Response Team, avoiding a call for an ambulance
- Providing assessment and treatment beds at community hospitals that GPs can refer patients to rather than sending patients to the acute hospitals
- Increasing our 'Home First' service that can get people out of hospital and back into their own home with appropriate care as soon as possible.

Case Study

Specialist Stroke services

Every second counts with stroke - our dedicated service makes sure people are assessed and treated as soon as possible, giving the best chance for the best recovery.

A team of different experts who work at the acute hospital will start treating the patient as soon as they come through the door – doctors, specialist nurses, therapists, psychologists, all trying to reverse the stroke as soon as it happens. We then provide more intensive help to recover quickly in dedicated stroke unit outside the acute hospitals at Vale Community Hospital – 80% of the patients treated there are helped to return home within just a few weeks with improved mobility and speech.

It doesn't end there – our specialists visit patients in their own homes to see their everyday lives and challenges, working on those things that are specific to them. Through this winter we will provide the specialist care people need to support them following a stroke, across both our acute hospitals and community services.

Mental Health services

We provide a broad set of Mental Health services and facilities similarly to our community physical health services – in people's own homes, dedicated clinics and residential facilities, and our inpatient mental health hospitals.

Winter can be a hard time for people's mental health as well as physical health, and the need for our services will be higher than in the summer months. We are using a number of initiatives to ensure we can help and support people in the most timely way over winter, including:

- Focusing on our Crisis Response service
- Continuing our liaison service in the acute hospitals to ensure mental health is cared for along with physical health
- 'Street triage' – providing mental health care on our high streets

- Care and treatment in people's homes
- Outreach services such as the Crisis Resolution Home Treatment, supporting earlier discharge from hospitals
- A *Mental Health Discharge Hub*, focusing on the earliest and safest possible discharges from our Mental Health facilities to give people the best possible levels of independent living
- Focusing on how effective our inpatient facilities work and expand the space we have to care for more people with serious mental health issues.

Young Minds Matter

Case Study

We know that mental health issues affect our young people more and more. Young Minds Matter provide specialist mental health support to over 70 schools across the county. This not only helps our young people, but also their families, and mental health is no longer the taboo subject it once was.

It's another place where social prescribing helps, working alongside children and young people based on their interests to be creative through film or music, for example. These services are especially important in the darker winter months when it can be harder to get out and see people.

Where to go for help:

- www.bewellglos.org.uk
- Samaritans, if someone is experiencing feelings of distress or despair – 116 123 (free)
- The Stay Alive App, packed full of useful information and tools to help you stay safe in crisis
- Gloucestershire Self Harm helpline - 0808 801 0606 or text 07537 410 022
- Shout – 24/7 text service for anyone in crisis – text 85258 (free on all major mobile networks)
- Childline – 0800 11 11 (free)
- The Silver Line (supporting older people – 0800 4 70 89 90 (free)
- GP practices now have access to ten dedicated primary care Mental Health workers.

The Community and Mental Health services winter pledges

One Gloucestershire Winter Pledge

- We will focus on improving patients discharge and flow from our community and mental health hospitals to ensure people can return home, or a more suitable place for their care, as soon as possible
- We will have access to the SWAST 'stack' of patient calls and will identify and direct appropriate patients to our services to care for them sooner, and ensure ambulances are sent to the most unwell or injured people
- We will increase the number of 'Home First' cases we start each week to 50, then 70, to help the flow in our acute hospitals and help patients recuperate in the most comfortable place possible
- We will provide a 2-hour 'crisis response at home' service operating 8am-8pm, 7 days a week
- Our Crisis Resolution Mental Health Helpline for children, young people, and adults will be available 24/7
- Our Community Assessment and Treatment Unit (CATU) will provide 10 additional beds for non-acute care.

Social Care

Gloucestershire County Council is an active partner in the One Gloucestershire ICS. We support the flow of people through health and social care services with two teams: the adult social care *Hospital Discharge and Assessment Team* (HDAT) and the *Gloucestershire Integrated Brokerage* (GIB) team. Our mantra is "your own bed is the best bed".

Adult Social Care: Hospital Discharge and Assessment Team (HDAT)

HDAT are a countywide team working in and around a number of partner sites in the county, notably:

- Gloucestershire Royal Hospital – A&E and in daily ward-based patient reviews ('board rounds')
- Cheltenham General Hospital – based at nearby Cheltenham Fire Station
- Charlton Lane Mental Health Hospital
- Assessment Bed Units across Gloucestershire
- Continuing Health Care (CHC) South West Hub.

The team uses 'Care Navigators' an innovative new role that supports both acute hospitals on referral and provides support and information using early notifications when people are admitted to hospital wards. They also work alongside the *Complex Care at Home* teams, the North Cotswold Frailty Team, and Community Hospitals across Gloucestershire. The team also includes colleagues from Housing services, providing two short-term step-down flats to aid timely discharges for those awaiting a non-statutory service.

HDAT also operates an *Admission Avoidance* advice telephone line, 7 days a week, offering support to the hospitals' A&E Departments by advising health colleagues about alternatives to hospital admissions, and signposting people to other prevention options.

Key priorities:

- To provide informed, quality advice and guidance to prevent avoidable admissions and to support timely hospital discharges over a 7-day period
- To support and advise Multidisciplinary team board rounds within the Acute hospital, in order to inform decision making, alongside sharing our Social Care knowledge around complex dynamics and situations
- To support and where appropriate assess the needs of those entering short term assessment beds, ensuring good partnership working to aid timely discharges

- To support the reduction of bed-based care on discharge, and to support partners with social care information to achieve the 'home first' ethos
- To connect people with their local community services to promote as much prevention as possible
- Support, information and care for Carers.

Case Study

Housing and social care working together

One of our residents was admitted to a care home in September 2021 following a stay in the acute hospital. The Adult Social Care worker first met him in October, where he expressed a wish to return home where he had been living independently on the first floor of a block of flats. His mobility had decreased so he was no longer able to manage the steps to get to his patient transport three times a week for dialysis.

The Adult Social Care worker liased with housing support and found a more suitable flat, which the resident's daughters were closely involved in agreeing. A support plan was completed for a small domiciliary (home) care package. Our worker stayed in regular touch with him and his family to review his situation and progress.

The resident's daughter told us he settled in well and was really happy. He even managed to return to his social club after a gap of more than a year; all his friends were thrilled to see him back living in the community. He has also met with another person in his block of flats, who he knew many years ago and they have struck up friendship again and see each other most days.

We will continue providing this joined-up, compassionate care for the 'whole person' needs of our citizens throughout winter, especially as we all face cost-of-living pressures.

Gloucestershire Integrated Brokerage (GIB)

Based in the County Council's headquarters at Shire Hall in Gloucester, GIB are part of a *Joint Commissioning* function of the new NHS Gloucestershire Integrated Care Board (ICB), a truly partnership approach to providing services across health and social care. GIB purchase residential and nursing placements and 'packages' of care for the people of Gloucestershire who need them. The team also manage the purchase of out-of-hospital intermediate care bed and facilities from the independent care sector.

This winter we are strengthening our home care market by purchasing 'blocks' of service in advance from our domiciliary care providers in local communities. This will enable those providers to offer competitive and attractive salaries, employment terms and training to the staff providing front-line care, which ultimately supports staff retention at such a critical time.

This will also support flow through the *Enhanced Independence Offer's* Home First service, supporting the aim to keep people independent and at home for longer.

Purchasing block home care in this way will improve local employment, connecting our workforce with the communities they are working within and in turn linking the people we serve with their communities. This will also reduce the time some of our staff spend travelling, increasing the time available for delivering care to more people and enable:

- Rapid and safe discharges from hospital
- An option for hospital avoidance in emergency situations
- Flexibility for providers to step-up or step-down care when the individual's needs fluctuate.

We have been piloting some blocks within Gloucestershire over the last couple of months and so far, have seen some positive outcomes for those being supported.

Case Study

1. Urgent response

We sent a referral to a 'block' provider for an urgent case. The individual lived alone with multiple ailments. Our provider visited the individual within the hour. There was no answer and neighbours had not seen them for three days. Emergency services were contacted to gain entry. Fortunately, the resident was found to be safe, and was happy with the response as previously when they had had a fall they had been unable to get help.

2. Trust and confidence

We supported an urgent package of care for an individual with dual sensory loss who had no support in place. Their assessed need was for three calls a day and required two carers. We arranged a provider who stepped in to support that evening. They have managed to work with the resident to gain enough confidence to reduce support to just one carer, as the block agreement we put in place gave greater continuity – the resident built up trust and confidence in the provider and reduced their anxiety.

The Social Care winter pledges

One Gloucestershire Winter Pledge

- We will work as closely as possible with our health and independent sector colleagues to ensure we look after the 'whole person', not just their physical health needs
- We will work on a 'Home First' approach to discharges – this means that we try to ensure as many people as possible go home, to finish recuperating with the right level of support, when they have used health services
- We will provide a range of suitable option depending on people's needs, whether in their own homes or short-term stays in one of our non-hospital bedded environments for recovery and independence.

Voluntary, Community and Social Enterprise Sector

The cumulative impact of health inequalities, the impact of COVID-19 on health and livelihoods, and the risks to health and wellbeing arising from the cost-of-living crisis have focussed our attention on the strength of communities and the nature of our partnership with the VCSE.

Health inequalities have a significant bearing on whether a person needs to access urgent or emergency care – on average, 34 emergency admissions to hospital per day come from the three areas of the county that tend to have the most significant health inequalities. With fuel poverty anticipated to affect a greater number of households this winter - including a proportion of the people who make up our workforce - we expect to see these needs increase.

Our shared focus this winter is to work alongside VCSE providers to support and strengthen communities to reduce where possible peoples' need for health and social services. Our VCSE partners are the real front line in response to the cost-of-living crisis, as they were during the pandemic. We will continue to work with them this winter to identify and handle risks to safe and secure communities that help keep people well, and at home where it is possible to do so.

"Our VCSE partners are the real front line in response to the cost-of-living crisis, as they were during the pandemic."

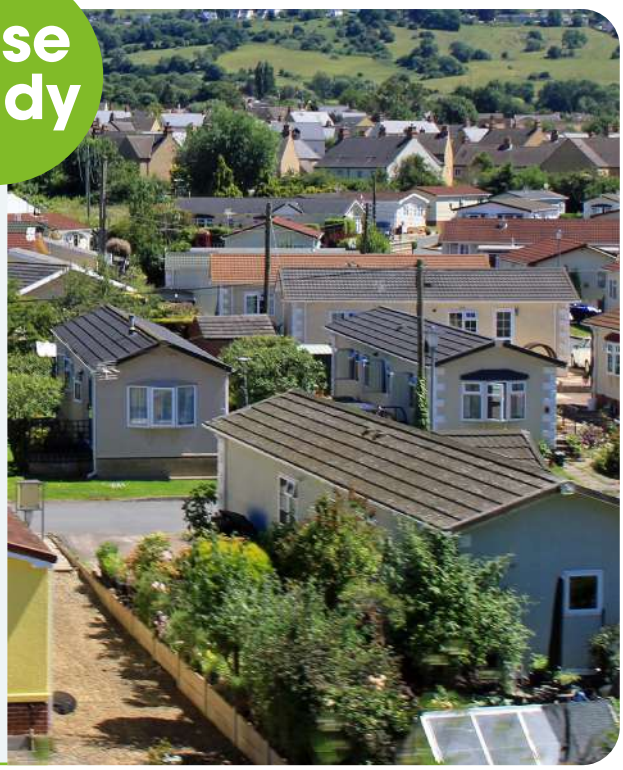
Case Study

Insulating park homes

So many factors impact our health and wellbeing; we look at the bigger picture, teaming up at county, district and neighbourhood levels to make an impact on some of our most vulnerable citizens.

Working with voluntary, community and social enterprise organisations that are rooted firmly in local places, we can tackle the avoidable and unfair differences between people in different parts of our county.

With the Severn Wye Energy Agency we have insulated over 170 park homes, creating healthier homes for people in fuel poverty and reducing heating costs at this difficult time going into winter.



The One Gloucestershire ICS and VCSE winter pledges

- We will bring together decision-makers from county and district local government, health and VCSE organisations to assess and act upon risks across the whole county - a *'Community Resilience Forum'*
- We will work with our six *Integrated Locality Partnerships* to improve information sharing via existing routes such as Know Your Patch Networks, Your Circle, organisational websites and social media commonly accessed by members of the public
- Our workforce specialists will provide information to and support VCSE staff in their daily work and wellbeing through winter
- We will develop our existing initiatives that support capacity of community-based services, both those that help prevent hospital attendance, and those who support people after being discharged from health services, e.g. social prescribing link workers in A&E, warm homes grants in partnership with local housing associations, respiratory clinical teams. This will be aided by our new volunteering web portal *Go Volunteer Glos* (www.govolunteerglos.org) and in partnership with the countywide Volunteering Collaborative
- We will identify more key 'community anchor' organisations who play a coordinating role as safe havens for citizens this winter.

System Resource Plan

Many of the challenges and pledges outlined in this winter plan will be met by our continuous focus on delivery across all of our services, but in some cases will involve changes to how we currently do things.

Most of these changes are based on learning from our experience in previous years or adopting new ways of working from best practise and new ideas to improve how smoothly our services run.

Some of these changes, however, will require investment, either by changing the buildings or facilities people are treated and cared for in, adapting the number and type of staff providing that care, or using technology in a different way, to meet the pressures that arise at this time of year.

This year we have six clear investment and spend priorities, which will create the equivalent of over 100 bed spaces across Gloucestershire:

Where?	What?	Why?	How much?	When?
In people's own homes	Provide high quality ***care for people where they live through the use of Virtual Wards*** *(sometimes called Hospital at Home)* *Equivalent to 22 beds*	Many people can receive the excellent medical care they require in the comfort of their home, which can in turn make hospital beds available for those who must be in hospital. Often referred to as 'virtual wards'	£2,077,000 staffing and running costs	September 2022 to March 2023
In our community	**Re-open Kingham Unit** to provide more rehabilitation space *Equivalent to 14 beds*	More patients can be supported outside of acute hospitals before they safely go home, known as 'discharge to assess'	£838,000 staffing and running costs	September 2022
	Community Assessment and Treatment Unit (CATU) *Equivalent to 10 beds*	A short-stay unit in Tewkesbury Hospital to help appropriate patients avoid going to an acute hospital	£570,000 staffing and running costs	November 2022
In our acute hospitals	Increasing space and staffing for our ***discharge waiting area*** *Equivalent to 27 beds*	Waiting to go home in a comfortable, dedicated area can make hospital beds available sooner, improving flow all the way back to ambulances	£1,500,000 building and refurbishment £1,980,000 staffing and running costs	December 2022
	More ***social care workers in our hospitals*** every day Equivalent to 14 beds	Avoiding unnecessary admissions, and earlier planning for post-hospital care, ensures patients are cared for in the best place as soon as possible	£505,000 staffing and running costs	December 2022
	Use the ***Prescott Ward*** in Cheltenham as an area to handle surges and peaks in activity ('escalation') 35 beds	Increasing the number of acute hospital beds will reduce unnecessary waiting in the emergency department	£1,600,000 refurbishment £3,000,000 staffing and running costs	October 2022

We will monitor the improvements these investments will make in a number of ways, including:

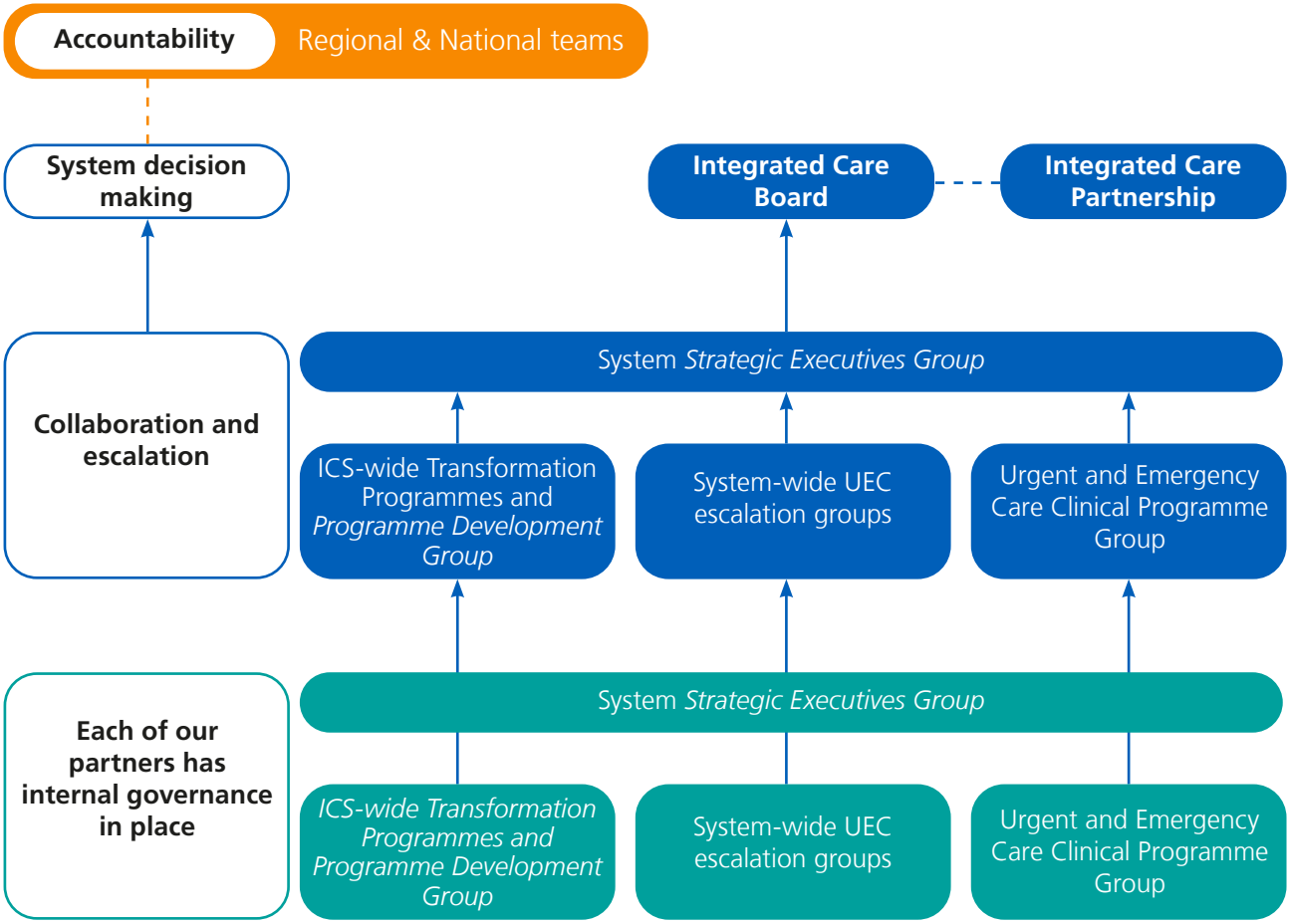
- Guiding people to the right place for their care, using new facilities such as virtual wards and CATU, and monitoring peoples' outcomes
- The average time ambulance crews spend waiting to transfer people into emergency departments
- The time people spend waiting in our emergency departments
- How long people spend in our acute and community hospital beds, and beds within community facilities, to ensure we are caring for people in the right place for the care they need.

Governance and Oversight

Our plan for winter is exactly that – our shared plan for all the organisations and people who provide health and care services in Gloucestershire. The formation of the One Gloucestershire Integrated Care System (ICS) has brought all of these organisations together in true collaboration, with the people we care for as our shared focus. We challenge each other as 'critical friends' and recognise that while we have our own jobs to do, together we are greater than the sum of our parts.

This is reflected in our governance, those structures and groups within and across all our organisations to ensure care and treatment is the highest possible quality whilst being value for public money.

The diagram below describes how these structures work both independently and collaboratively:



All our partners, and the ICB itself, have a **Board Assurance Framework**. This is a report on strategic risks that could affect the delivery of the objectives and aims of this plan. Strategic risks that are classed as Red (score 15+ out of a maximum 25) are recorded onto the Board Assurance Framework with the actions we have agreed need to be taken to improve them. This allows Boards to quickly determine the right decisions to improve our health and care services by putting resources into the highest priority and most impactful areas.

What can you do to help?

- Follow local social media and our websites for updates on our services (see the next page)
- Get flu and COVID-19 vaccinations in good time for winter
- If you are feeling unwell but have no specific symptoms, use your local pharmacy for advice on self-help, or contact your GP practice for a telephone or face-to-face appointment
- If you're not sure, always contact NHS 111 first to get advice and guidance
- Use MiServiceFinder online, which can also be saved as an App Tile on smartphone home screens. https://miservicefinder.co.uk or scan the QR code with your smart phone camera
- If you feel very unwell, or you think it might be urgent, use NHS 111 online or by telephone. Please do not use the A&E department at your nearest hospital as a first option for treatment unless it is a serious or life-threatening emergency
- If NHS 111 direct you to one of our MIIUs, please use virtual or telephone services where able (0300 421 7777); the clinicians are trained to decide if you need to be seen face to face
- If asked to do so by one of our colleagues, please wear a Type II mask to help protect each other
- Don't come in to visit patients in our acute or community hospitals if you feel unwell and/or have symptoms of COVID-19, flu or vomiting and diarrhoea. We will try to support you in contacting loved ones in hospital in other ways
- Order your medication ahead, don't risk running out – if you have a smartphone, try the NHS App, which gives you access to order repeat prescriptions, make GP appointments, and see parts of your medical history
- Have simple medicines you can buy over the counter in your cupboard to treat minor illness e.g. paracetamol and ibuprofen
- Stay hydrated (8 glasses of water per day for an adult) and try to regularly eat the most balanced, healthy diet possible
- Keep warm; have warm drinks, layers of clothing, blankets ready for use, hot water bottles and reliable heating sources
- Get to know local support services from your local voluntary and charitable networks e.g. Carers Gloucestershire, AgeUK, to benefit from their support
- Stay in touch with friends, family and neighbours – we are all stronger, together.

Glossary

The organisations that provide your health and social care and support:

Organisation	What they provide	Where they provide it
GP practices	Broad diagnosis, treatment and care of non-urgent illness Support and decisions to refer patients to specialist services in other organisations Long-Term Care and supporting self-care	Through 70 GP practices across the county, and their branch sites Via the Out of Hours service
Gloucestershire Health and Care Foundation NHS Foundation Trust (GHC) www.ghc.nhs.uk	District nursing Health services, clinics and therapies Inpatient care, rehabilitation and Minor Injury and Illness Units Mental Health assessment, treatment and care services	In people's homes At NHS clinic sites around the county At community hospitals At mental health specialist centres and hospitals
Gloucestershire Hospitals NHS Foundation Trust (GHT) www.gloshospitals.nhs.uk	Specialist medical treatment and care, and diagnostics A&E departments for the most urgent and serious accidents and illness	At Cheltenham General Hospital and Gloucestershire Royal Hospital
Gloucestershire County Council (GCC) www.gloucestershire.gov.uk/health-and-social-care/	Social care services Domiciliary care visits Carer assessments	In people's homes At social care units around the county Via independent sector units
South West Ambulance NHS Foundation Trust (SWAST) www.swast.nhs.uk	999 call handling Ambulance and paramedic prioritisation and despatch Transfer of patient care appropriate for other services	Ambulance main hub, local ambulance stations, a range of ambulance vehicles and in people's homes
Voluntary, Community and Social Enterprise (VCSE) organisations www.glosvcsalliance.org.uk/	Ranges from small community-based groups/schemes through to larger registered Charities that operate locally, regionally & nationally	Within communities and peoples' homes and health and social care facilities
Practice Plus Group (PPG) www.gloucesteroutofhours.nhs.uk/	NHS 111 call centres, advice, clinical review and booking into urgent care services. Out of Hours GP services	Online and via telephone Primary Care centres
E-zec e-zec.co.uk/our-services/	Non-emergency patient transport services	Non-emergency ambulance vehicles
Gloucestershire Integrated Care Board (ICB) www.glosnhs.nhs.uk	Oversight and commissioning (purchasing) of all health and care services for Gloucestershire. Gloucestershire Integrated Brokerage	

Terms and acronyms

Not all of these terms appear in this plan; however you may see or hear them referenced if you use our urgent and emergency care services:

A&E	Accident & Emergency, operated from two acute hospital Emergency Departments (ED)
ARRS	Additional Roles Reimbursement Scheme, expanding kinds of roles in primary care
ASC	Adult Social Care, a function of Gloucestershire County Council
CATU	Community Assessment & Treatment Unit (Older Person)
CGH	Cheltenham General Hospital, one of our two acute hospitals
CPG	Clinical Programme Group
CYP	Children & Young People
D2A	Discharge to Assess
DoS	Directory of Services
EAC-I	Enabling Active Communities and Individuals – promoting healthy lifestyles
ED	Emergency Department, dealing with the most serious injuries and illness
EPR	Electronic Patient Record
FAU	Frailty Assessment Unit – a dedicated unit to assess underlying frailty
G-care	Online point of clinical reference for Gloucestershire clinicians
GP	General Practitioner
GRH	Gloucestershire Royal Hospital, one of our two acute hospitals
HALO	Hospital Ambulance Liaison Officer – a dedicated function to enable flow
HAT	Homeward Assessment Team
HIU	High Intensity User – patients who have complex and frequent health issues
HOSC	Health Overview & Scrutiny Committee (GCC) holding organisations to account
IAPT	Adult Improving Access to Psychological Therapies, a key mental health service
ICS	Integrated Care System, now enshrined in law
IPC	Infection Prevention and Control
LA	Local Authority (Gloucestershire County Council)
LoS	Length of Stay, a key measure in hospital-based care
MDT	Multi-Disciplinary Team, an approach to care that looks after all a patient's needs
MH	Mental Health
MiDOS	MiDOS – My Directory of Service, electronic signposting to the most appropriate care
MIIU	Minor Injury & Illness Unit, based on community hospitals
NEPTS	NHS funded Non-Emergency Patient Transport Service
NHS 111	Free telephone and online service for patients to access urgent health care advice
NHSE	National Health Service England, the national body that oversees delivery of services
OOH	Out Of Hours (usually in reference to primary care services at night and weekends
OPEL	Operational Pressures Escalation Levels (1,2,3 & 4)
POC	Package of Care
ReSPECT	Recommended Summary Plan for Emergency Care and Treatment
SDEC	Same Day Emergency Care
SHREWD	Single Health Resilience Early Warning Database
ToCB	Transfer of Care Bureau
UEC	Urgent & Emergency Care
VCSE	Voluntary, Community and Social Enterprise

Appendix

Actions: Further details on increasing capacity and operational resilience in urgent and emergency care ahead of winter:

National Planning requirement:	System Response:
1. New variants of COVID-19 and respiratory challenges SPI-M scenarios for COVID-19, combined with scenarios for flu, suggest that even in optimistic scenarios, high numbers of beds may be needed for respiratory patients during winter. Resulting IPC requirements will make bed management complex, especially if bed occupancy remains high. We will do further work with you in the coming months on stress-testing planning for the operational response to realistic worst-case scenarios. We are working with local areas to: ▸ Deliver an integrated COVID-19 booster and flu vaccination programme to minimise hospital admissions from both viruses ▸ Implement UKHSA's IPC guidance in a proportionate way and develop strategies to minimise the impact of 'void' beds.	Gloucestershire ICB has been planning an integrated approach to COVID-19 and Flu vaccination for many months. The alignment of supply chains and establishment of a delivery network (Community Pharmacies, GP surgeries, Local Vaccination Centres and workplace centred locations) against a changing backdrop of new vaccines, emerging JCVI guidance on cohort eligibility and uncertain contractual arrangements has been challenging. The Autumn Booster programme for COVID-19 and the seasonal Flu programme for 2022 in Gloucestershire will maximise the opportunities to co-administer these vaccines. Once the majority of Flu deliveries have been completed to GP practices (estimated mid-October) then most vaccination sites will be able to co-administer. The new Bivalent COVID vaccines are effective against both Delta and Omicron variants of the virus and the Booster programme (expected to reach c200,000 Gloucestershire residents) will help minimise hospital admissions over the Winter period.
2. Demand and capacity A lack of capacity across the NHS has an impact on all areas of the system. It is essential that ambulance and NHS 111 services have the necessary capacity in place and that access to primary care, community health services and mental health services for urgent patients is sufficient to ensure patients do not need to present to emergency services. We are working with local areas to: ▸ Open additional beds across England, to match the additional capacity identified by ICSs to be able to deliver against expected winter demand. This should create the equivalent of 7,000 additional general and acute beds, through a mix of new physical beds, scaling up virtual wards, and improvements in discharge and flow ▸ Increase the number of NHS 111 call handlers to 4,800 and the number of NHS 999 call handlers to 2,500 ▸ Increase provision of High Intensity User services	The National direction is to implement the Single Virtual Call Centre to optimise economies of scale. Reflecting on Gloucestershire's position, since the first week of April 2022, Gloucestershire have reported an actual reduction in workforce in this area of -7.3% (-3.2) for call handling resource and is not achieving the national target. However, learning from SVCC currently operating in London, has provided evidence that there are increased efficiencies in call handling and reduced abandonment rates. Therefore, Gloucestershire are actively working towards this with regional and national colleagues. ▸ **Improving and streamlining flow of patients from the back of the ambulance into A&E** through triage and onwards, with a key focus on direct liaison between A&E, Acute Medical Units and Same Day Emergency Care. Includes increasing the GHT discharge waiting area to 30 spaces (beds and chairs) - December 2022 ▸ **Creating additional Discharge To Assess capacity within the community** by reopening Kingham Unit and increasing rehabilitation support to existing D2A capacity – September 2022 ▸ Embed a step-up short-stay **Community Assessment and Treatment Unit (CATU)** in Tewkesbury Community Hospital to avoid acute admissions – November 2022

National Planning requirement:	System Response:
▸ Support good working relationships with the independent sector, building on the success so far, and facilitating patient choice. **In community care:** ▸ Increase two-hour Urgent Community Response provision by maximising referrals from the ambulance service and other providers, aiming to maintain and improve the current standard of responding to 70% of call outs within two hours ▸ Increase the number of virtual wards to create an additional 2,500 virtual beds. **In primary care:** ▸ We will maximise recruitment of new staff in primary care across the winter, including care co-ordinators and social prescribing link workers ▸ ICBs to actively support and engage with PCNs to work with each other and other providers to develop collaborative models to manage seasonal preparedness and specific winter pressures (such as oximetry monitoring for COVID-19 patients) alongside the digital development of primary care. **In mental health, cancer, and elective care:** ▸ Share mental health best practice between systems and work with the VCS and LA sector to alleviate capacity constraints ▸ Releasing £10m of annual funding to support Mental Health through the winter, in addition to continued planned growth in community and crisis provision ▸ Maintain and increase elective capacity to eliminate waits of over 18 months, as per the Elective Recovery Plan, except for patients who choose to wait longer or require alternative plans due to clinical complexity ▸ Reduce the number of people waiting more than 62 days from an urgent cancer referral back to pre-pandemic levels by March 2023 ▸ Ensure the preservation of the standard clinical pathway for CYP elective surgery, critically ill children, and emergency, general and specialist services.	▸ **Increase the social worker presence across GHT** to deliver a 7-day service that supports admission avoidance and facilitates patient flow – December 2022 ▸ **Reopening the decommissioned Prescott Ward** to provide additional General and Acute beds – October 2022 ▸ **Virtual Wards** will come online at different points as the models of care are developed: (bed equivalency shown in the main Winter Plan document): **1. Trauma virtual ward** — September 2022 **2. Frailty virtual ward** — September 2022 **3. Respiratory virtual ward** — December 2022 **4. Condition agnostic virtual ward** — March 2023 ▸ Delivering **IV Therapy** at home, including via Virtual Wards, instead of through a hospital ward admission ▸ **Two-hour Urgent Community Response** • Performance for August 2022 was 78.9% (Jul 73.2%, Jun 74.5%). Supporting Ambulance service, with 31% of referrals in 22/23 March-August being from SWAST (compared to 24% in 2021/22, and 18% in 2020/21). 86% increase in referrals from A&E in 22/23 compared to 20/21 • Referrals for two-hour Urgent Community Response are also now being accepted by 111, and further work is underway to support care and nursing homes. ▸ **Enabling quicker access to our Rapid Response team** by using the DoS system for HCPs and NHS 111 clinicians to contact. In October we gained agreement for SWAST to convey patients directly to the Rapid Response Service ▸ **Falls training** – will be delivered by all system partners this winter to better support care home and domiciliary care staff to manage individuals who are at risk or have fallen within care homes and their own homes. Our 'Pick-Up' project is aligned to the national Ageing Well Programme and specifically to the Urgent Community Response workstream which aims to '…deliver universal coverage of a 2-hour crisis response at home service operating 8am-8pm, 7 days a week'. ▸ **Primary Care** • Making more **GP practice appointments available for NHS 111 to book patients** into directly • Making more **GP services available on Saturday afternoons** across the county • Continuing to **expand the numbers and kinds of staff roles in primary care** such as social prescribing link workers, first contact physiotherapists, paramedics, pharmacists, and mental health practitioners, to respond to people's various needs more quickly

National Planning requirement:	System Response:
	• Continuing to **improve GP practice telephone systems** to answer patients calls more quickly • Continuing to provide, and further develop, our **'anticipatory care' services** to do everything we can to support people to stay at home when that is more appropriate than a hospital stay. ▸ **Mental Health** • **Earlier identification of patients who need our MH services** by developing our access to the SWAST 'stack' of patient calls to direct appropriate patients to our services to care for them sooner, and freeing up ambulances to attend the most unwell or injured people • **Improving patients discharge** from our community and mental health hospitals to ensure people can return home, or a more suitable place for their care, as soon as possible, and help the flow through our acute hospitals • **Increasing the number of 'Home First' cases** we start each week to 50, then 70, and help patients recuperate in the most comfortable and appropriate place possible.
3. Discharge While challenges are often seen at the 'front door', we know that their root cause is often in the ability to discharge patients from, and flow through, hospitals. There is a significant number of patients spending longer in hospital than they need to, often due to a lack of availability of social care. While the provision of social care falls outside of the NHS's remit, the health service must ensure patients not requiring onwards care are discharged as soon as they are ready and can access services they may need following a hospital stay. We are working with local areas to: ▸ Implement the 10 best practice interventions through the 100-day challenge ▸ Encourage a shift towards home models of rehab for patients with less severe injuries or conditions ▸ Maximise support available from the Seasonal Surge Support Programme, provided by VCS partners.	Gloucestershire recognises issues which are affecting discharges and is taking a holistic system approach working with health and social care partners. Gloucestershire ICB is fully engaged in the '100-day challenge' process having developed a system risk mitigation plan reporting weekly progress to tactical escalation group (TEG), strategic escalation group (SEG) and NHSE. This plan reflects the system approach to discharging patients in line with the 'home first' principles which includes optimising models of rehabilitation, VCSE support and Personal Health Budgets. Initiatives include: ▸ Implement the 21-day Length of Stay Predictor Tool (Polygeist) with a result to improve 72-hour short stay model ▸ Discharges before 5pm ▸ Reduction in A&E Length of Stay. Improved ward and board round including weekend planning and criteria led discharge ▸ Improved presence of senior decision makers at weekends to improve the weekend rhythm ▸ Adopt and implement criteria to admit to all patients attending A&E by reducing admissions ▸ Front Door presence of Adult Social Care to operate a joined-up Multi-Disciplinary Team to support clear decision making ▸ Home First recruitment campaign launched with social media adverts, leaflets, and posters to support increase capacity ▸ Voluntary sector service supporting hospital discharge of pathway 0 patients, supporting the discharge and post discharge process to increase pathway 0.

National Planning requirement:	System Response:
4. Ambulance service performance While ensuring there is enough capacity for ambulances to respond to the most urgent calls and take patients to hospital is essential, it is also important to focus on what can be done to reduce avoidable ambulance activity, through treating patients at the scene. We are working with local areas to: ▸ Implement a digital intelligent routing platform and live analysis of 999 calls ▸ Agree and implement good practice principles for the rapid release of queuing ambulances in response to unmet category two demand ▸ Work with the most challenged trusts on ambulance handover delays to develop solutions, including expanding post-A&E capacity ▸ Increase the utilisation of rapid response vehicles, supported by non-paramedic staff, to respond to lower acuity calls ▸ Model optimal fleet requirements and implement in line with identified need ▸ Implement the ambulance auxiliary service which creates national surge capacity to enhance the response and support for ambulance trusts ▸ Deploy mental health professionals in 999 operation centres and clinical assessment services and deliver education and training to the workforce ▸ Increase the use of specialist vehicles to support mental health patients.	The ICB continues to work with system partners at a local and regional level to manage demand for ambulance services and preventing avoidable admissions this winter. Building on learning from a number of system and NHSE initiatives, including the 30-day challenge, Gloucestershire recognises the need to implement continuous improvement: ▸ Hospital Ambulance Liaison Officer (HALO) - SWAST currently provide a 24/7 HALO which has meant an operational resource is taken from the deployment plan - this is not funded but in current contract negotiations. Assist with quicker flow into Hospital to reduce ambulance handover delays and improve patient experience. Signpost Same Day Emergency Care (SDEC) pathway alternatives once at A&E ▸ Handover Standard Operating Procedure (SOP) - Handover of patients between an ambulance clinician and a hospital clinician ▸ Management of handover delays - Optimise the number of patients who can be handed over and therefore not be held or queued due to the restrictions on access to the Emergency Department. We also identify new opportunities such as: ▸ Interoperability Toolkit Connectivity – We are looking at digital options for connectivity between systems, to operationalise an intelligent routing platform to be able to push/pull calls from SWAST call stack to UCR services ▸ Tough Books – SWAST user will be using Tough Books only to search, and the algorithms in the background will return the relevant information from MiDoS or Service Finder, dependant on location and postcode. For SWAST, there will be a single system for the SW Region to redirect patients to alternative services ▸ SWAST Red Release Standard Operating Procedure - following the success at GRH, expand to CGH through winter ▸ Assess and Return - Introduced to offload patients from Ambulance crews rapidly. Initial diagnostics blood tests completed to reduce delay and return to the Ambulance. **Mental Health** Since February 2022 the Mental Health desk in the 999 hub has been operational on an 8am to 10pm basis 7 days per week. Overall performance since commencement has resulted in 64% Ambulance stands downs. Winter planning proposal is to extend this overnight 10pm to 8am. Mental Health Ambulances capital bid has been placed (SWAST led) to secure 1 vehicle for Gloucestershire. This will take a year to procure. Task and finish group to be set up to establish funding sources and pathways these are to be joint worked with Police, SWAST, ICB and community Mental Health teams.

National Planning requirement:	System Response:
5. NHS 111 performance The NHS 111 service can only work if it has sufficient clinical capacity to provide consultations if required and patients are able to be directed to the right service for their needs. We are working with local areas to: ▸ Improve call handling performance through the implementation of regional call management which will enable better integration between providers and ensure the entire NHS 111 capacity is used effectively ▸ Continue pilot of national Paediatric Clinical Assessment Service and build on what we are learning ▸ ICBs to update details of the 24/7 urgent mental health helplines for patients experiencing a mental health crisis, and ensure these services are promoted.	**Regional Call Management (RCM)** RCM aims to introduce a regional NHS 111 call handling model in which providers in a region combine forces to achieve economies of scale and improve the quality and performance of the service. Whereas previously calls would be answered by the provider covering the geographical boundaries of that contractual footprint, going forward calls could be answered by any provider in the region. In Gloucestershire, Phase 1 of the programme is in progress, with PPG ready to 'switch on' the digital platform. From a DoS perspective we have continued to work on the following aspects that are essential for a successful RCM: ▸ DoS driven validation: – Gloucestershire has DoS driven validation in place ▸ Direct Booking via a National Solution: - Care Connect is the preferred method to deliver this, albeit there are limitations when using this system. Gloucestershire are working towards completing this work as soon as possible. DoS Leads are working to a completion by Nov 2022 ▸ Other aspects of the DoS plan such as ranking, profile review, use of restrictions, Mental health provision etc are all expected to make DoS service selection easier and consistent across the South West Region. These tasks are due to be completed by the end of September 2022. **Paediatrics** Gloucestershire is not currently part of any of the national Paediatric Clinical Assessment Service Pilot; we will learn from the outputs of these pilots. **Mental Health** The National direction of travel is that all calls will be handled by the Single Virtual Call Centre (SVCC) with functionality for calls to be redirected at a National level and is reliant on the SVCC digital platform. The National team working deadline is March 2023, and we are actively working with them to meet this deadline. Currently, NHS Mental Health Helpline is profiled on the DoS for Gloucestershire. Whilst the name on DoS does not reference 'Mental Health Helpline' (the service in question is Crisis Resolution and home Treatment Team), it is fully profiled in accordance with the NHSE requirement for children, young people, and adults over a 24/7 timeframe. There is no crossover into other services, meaning only this service will return, and is ranked sufficiently high on the DoS to ensure any other service will come below it. For patients currently known to Mental Health services, they already have access to a direct dial helpline which operates 24/7. Patients requiring Mental Health services via NHS 111 will be furnished with the same helpline number for them to contact directly.

National Planning requirement:	System Response:
6. Preventing avoidable admissions A full range of urgent care services should be available to ensure patients can access the right care in the right place. The Directory of Services should be used by staff to direct patients to the most appropriate place, while same-day emergency care, frailty and 'hot' outpatient services should also be available for patients requiring urgent specialist treatment but not necessarily via an A&E. We are working with local areas to: ▸ Increase number and breadth of services profiled on the Directory of Services to ensure only patients with an emergency need are directed to A&E ▸ Develop and protect capacity for same-day emergency care services so that operational hours are profiled against demand and surgical availability ▸ Review non-emergency patient transport services so that patients not requiring an overnight hospital stay can be taken home when ready ▸ Improve the provision of the Acute Frailty service, including the delivery of thorough assessments from multidisciplinary teams ▸ Implement out of hospital home-based pathways, including virtual wards, to improve flow by reducing hospital attendances. Reduce unnecessary attendances for patients with mild illness through revised NHS @home pathways that incorporate broader acute respiratory infections.	GHC services are profiled on the Directory of Services (DoS) as alternatives to A&E. In addition, Gloucestershire has removed A&E outcomes from A&E profiles during the operational hours of our MIIUs to ensure patients are directed into other, more suitable settings. Furthermore, Gloucestershire has validation services sitting above A&E service types on DoS, meaning that clinically appropriate alternative services will appear ahead of A&E, and wherever possible, we have suppressed A&E where more suitable alternatives exist when available. However, much of the selection sits with 111 providers and the call handlers selecting the correct service, therefore, Gloucestershire now have a monthly meeting with our local 111 provider to facilitate top of the DoS selection and understanding why A&E gets selected when other services exist. We have had a commitment from 111 to work towards reducing the number sent to A&E when alternatives exist and to increase their top of the DoS selection rate. Finally, through up to date and meaningful DoS data reporting we are enabled to see trends and to react quickly to identified opportunities for improvement. **Non-emergency Patient Transport Services** for on-the-day discharges from hospital currently run as follows: Monday – Friday 08.00 – 22.00 Saturday – Sunday 10.00 – 20.00 We are aware of the overnight need for transport for those people who have more complex discharge support. We have plans in development, led by GHNHSFT to gain additional funding to expand transport through to midnight, improve flow and lengths of stay, and the experience of our patients. Discharge vehicles are managed by the acute hospital and can be used for discharges from A&E. Eligibility is assessed by Healthcare Professionals. GHT is currently scoping and sourcing data to support earlier discharge planning, to be taken through governance process by December. Our **frailty strategy** focuses on four priorities: Prevent, Identify and Manage Frailty, and develop our Workforce. These will create an 'anticipatory model of care', a proactive approach which, with greater collaboration between primary, community, acute, social care and VCSE, will support frail and older people to live independently for longer and receive treatment more quickly in the most appropriate location and by the most appropriate professional. Our Frailty Virtual Ward and CATU, for example, will be key methods to bring the frailty strategy to life. This winter all system partners will deliver **Falls** training to better support care home and domiciliary care staff to manage individuals who are at risk or have fallen within care homes and their own homes. Our 'Pick-Up' project is aligned to the national Ageing Well Programme and specifically to the Urgent Community Response workstream which aims to '…deliver universal coverage of a 2-hour crisis response at home service operating 8am-8pm, 7 days a week.' There is an appetite to use one system (Cinapsis) as the primary referral route to simplify the process or referral for community and primary care service providers and to further develop the

National Planning requirement:	System Response:
	business intelligence for SDEC in order to establish capacity more accurately to develop in line with local need. In our A&E department there are 'huddles' every two hours to review current state and prioritise. Our teams work to internal professional standards and are focussed on improving the consistency of response times across our acute specialties, 16 of which provide Same Day Emergency Care (SDEC) services, with opportunities to add further speciality services to the offer. Population-level communication campaigns - how to access help, how to give help Inform staff on support available and share information from partners (e.g. through ILPs, Community Safety Partnerships, Know Your Patch networks, Link Workers, Your Circle, MiDoS) To support VCSE partners we are easing transfer of information to and from the other elements (e.g. digitise social prescribing) Identifying and mitigating strategic risks (e.g. financial viability of community groups/infrastructure).
7. Workforce NHS staff have worked incredibly hard throughout the pandemic and both current and future pressures on the health services mean teams will remain stretched. The health and wellbeing of the workforce is crucial and interventions targeting recruitment and retention will be important in managing additional demand this winter. We are working with local areas to: ▸ Implement your recruitment and retention plans including staff sharing and bank arrangements ▸ Utilise international support for Urgent and Emergency Care recovery, identifying shortages of key roles and skills and targeting recruitment as such ▸ Implement the Wellbeing Practitioners' Pack ▸ Develop roles for volunteers that reduce pressure on services and improve patient experience, such as community first responders and support in discharge.	Our main provider organisations have well-developed recruitment and retention plans. These include targeted recruitment initiatives, extensive international recruitment efforts and an incentive package starting in October for improving Home First and Reablement Staffing. The ICS is taking a collaborative approach to the recruitment of Health and Care Support Workers (HCSW) with a joint and targeted event supported by Indeed at the end of September. There is an ambitious aim is to recruit up to 350 HSCWs across the system using an alternative and one stop recruitment process. Work is continuing on the implementation of a reservist programme hosted by GHC. In June 2022 the system launched Go Volunteer Glos, an initiative aimed at recruiting further volunteers into the system generally. Funding has been approved for continuation of specialist consultant capacity through the period September to December 2022 to support key priorities within the Gloucestershire Volunteering Programme. The future programme of work will focus on development of a high-level strategy/approach for volunteering in ICB settings, including seeking ways to use Employer Supported Volunteering more effectively to source volunteers (e.g. trustees) for local VCSE organisations; Focus on developing an approach to increase volunteering input across ICB areas specifically including: ▸ Investigate potential opportunities for the expansion of volunteering to help enable people to gain skills required for employed roles. Then agree a prioritised action plan ▸ Working with local VCSE organisations to maximise the use of volunteers to support timely discharge from hospital settings ▸ Linking into, and supporting as required, Primary Care Network Quality Improvement volunteer-related projects. The Well Being Line is a system wide service supporting staff and teams health and wellbeing. The service provides individual support for any member of staff contacting the service with bespoke and targeted support, outreach support and management consultations to support team development with an approach of using compassion-based therapy.

National Planning requirement:	System Response:
8. Data and performance management Making the full use of data at a local, regional, and national level will help inform operational decision-making and improve the delivery of services. We are working with local areas to: ▸ Ensure timely and accurate submission to the Emergency Care Data Set ▸ Encourage use of the A&E Forecasting Tool.	**We make full use of local, regional and national level data including:** ▸ Weekly and monthly performance view of 6 key winter metrics to Gold/Silver. This also forms the exception reporting for the Sloman Plan shared and discussed with regional and national colleagues ▸ Performance is routinely reviewed at all key system groups (including Urgent and Emergency Care and System Flow Clinical Programme Group), as well as executive level assurance (ICS Strategic Executive and ICB Board) ▸ Focussed use of system data across organisations is used to support operational plans and recovery action plans. This includes demand forecast via operational planning, refreshed for winter plan as a system – including the impact of winter schemes and use of the A&E forecasting tool ▸ GHC and GHT submit data to the Emergency Care Data Set at NHS Digital, in line with national specification as urgent care providers in the Gloucestershire system ▸ GHT have also developed their own A&E predictor and bed modelling tool.
9. Communications We are undertaking the following actions to enable strong communications: ▸ Implement your winter communications strategy to support the public to minimise pressures on urgent and emergency services ▸ Deliver the NHS 111 and GP Access strands of the Help Us Help You campaigns.	Our comprehensive approach to communications and campaigns is set out in our Winter Communications Plan, which is based on national guidance and underpinned by the '3 Ps' - Preparation, Prevention and Performance. **Preparation** - Production of a stakeholder briefing pack and associated case studies to support: ▸ Communication with community partners ahead of the winter season - setting out our approach to preparedness ▸ Campaign launch activities - highlighting action to support prevention, service resilience and access ▸ Media broadcast features. **Prevention** - Planned campaigns to support service users, the public and health and care services: ▸ Boost your Immunity - ensuring Gloucestershire continues to be a system with one of the highest vaccination uptakes in the country ▸ Click or Call First (aligned to the national 111 campaign) -mainstream campaign to ensure people are signposted to the right advice and services to meet their needs. Also targeted campaign interventions based on prevalent conditions (avoidable attendances), age groups, geography and ethnicity ▸ Stay Well This Winter - based around 6 core themes - helping people and communities to plan ahead for Winter and highlighting examples of community action ▸ No Place Like Home - supporting family members and carers through the hospital discharge process and highlighting the health benefits to the individual of recovery at home. **Performance** - Working together to ensure an effective communication response to seasonal pressures: ▸ Escalation arrangements - to support services and citizens at times of peak pressure. Includes communication with LRF partners ▸ Media protocol - to support timely response to enquiries.

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