

Meeting of Joint Cluster Board

Date: Wednesday 30th September

Time: 11:15 – 13:00

Location: Ground Floor Committee Room, Shire Hall Gloucester

Agenda Number:	9	
Title:	Winter Planning 2026/27 and Board Assurance Statements	
Confidential Papers	Commercially Sensitive	No
	Legally Sensitive	No
	Contains Patient Identifiable data	No
	Financially Sensitive	No
	Time Sensitive – not for public release at this time	No
	Other (Please state)	No
Purpose: For Approval		
Key Points for Discussion:		
This paper presents the 2026/27 place-based Winter Plans and Board Assurance Statements (BAS) for Gloucestershire and BNSSG within a shared cluster approach to oversight, learning and assurance. Both plans respond to NHS England requirements and are informed by system engagement, Winter 2025/26 learning, population need, demand and capacity, prevention and operational resilience. BNSSG and Gloucestershire report a generally strong level of preparedness, with qualifications relating to flow and discharge, corridor-care arrangements and community capacity . Actions will remain under active winter oversight.		
Recommendations:	The Boards are asked to: (1) approve and assure their respective Winter Plans and BAS returns; (2) note outstanding assurance and related actions; and (3) delegate final minor amendments to the respective Executive Winter Leads.	
Previously Considered By and feedback:	Gloucestershire ICS Strategic Executives, August 2026. Cluster FQP September 2026 (Finance, Quality and Performance)	

Management of Declared Interest:	None identified.
Risk and Assurance:	The BAS records local qualifications and actions. Gloucestershire priorities are discharge model maturity and baselining, corridor-care thresholds and community capacity. These will be monitored through place governance, Integrated OPEL and SCC arrangements, with cluster oversight supporting learning and escalation. BNSSG priorities include maximising community capacity, minimising acute corridor care, demand modelling within community pathways,
Patient and Public Involvement:	Plans draw on system partner engagement, population insight and Winter 2025/26 learning. No separate public consultation was undertaken for this assurance submission.
Financial / Resource Implications:	Delivery is expected within agreed financial plans. Unfunded surge requirements will be subject to place-based financial, quality and governance processes.
Legal, Procurement, Policy and Regulatory Requirements:	The plans respond to NHS England Winter Planning Guidance and BAS requirements. Providers retain responsibility for operational plans and statutory duties. No specific legal or procurement decision is requested.
How does this impact on health inequalities, equality and diversity and population health?	Both plans prioritise prevention, vaccination, risk stratification and proactive support for vulnerable groups. Gloucestershire and BNSSG have considered quality, equality and inequalities through its QIA.
Insights from population level data	Population health, activity and demand and capacity intelligence inform risk assessment, forecasting and targeted interventions.
ICS Green Plan and the Carbon Net Zero target?	Care closer to home may reduce avoidable travel and resource use. Material impacts from additional capacity will be managed through organisational Green Plans.
Communications and Engagement:	Each place will deliver targeted winter communications on vaccination, self-care and service access. Cluster coordination will support common messaging where useful.
Author(s):	Keith Robertson BNSSG Head of System Flow Yasmin Bajwa UEC and System Flow Programme Manager Richard Carpenter, Associate Director Commissioning - System Resilience, Gloucestershire ICB
Sponsoring Director:	Caroline Dawe Director Strategic Commissioning – Value and Delivery David Jarrett, Chief Delivery Officer NHS Gloucestershire and NHS Bristol, North Somerset and South Gloucestershire ICBs

BNSSG Winter Plan

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Winter Wrap Up & Lessons 2025/26 Review

A BNSSG system workshop was held 24th March in St. Monicas to assess our approach to Winter 2025-26. Key themes and actions summarised below:

- Need to re-assess our escalation approach for BNSSG - **COMPLETE**
- Increased corridor queuing and management of risk within the acute hospitals - **ACKNOWLEDGED**
- Need to release funding with councils this summer for a system proactive approach – **COMPLETE**
- Community and LA winter plans are required at local (place) level – **ONGOING**
- Flexible interim funding options for complex and out of D2A patient pathways – **COMPLETE**
- Ensure step up pathways (e.g. no pathway from P1 to P3 etc) – **ONGOING**
- Confirm extension / flex to services now to allow for recruitment. E.g. F-ACE, CEMS to be extended now – not during autumn winter - **COMPLETE**
- Exposure to lunch & learn with modelling teams – re: place, housing, planned care, impact on health and social care teams for UEC – **COMPLETE**

Enabling improved Community flow for 26/27

Sirona, AWP, LA feedback

1. Protect & Rebalance Capacity Between Urgent and Planned Care	• Maintain strong grip on UCR 2-hour performance <i>while deliberately releasing limited capacity back into planned pathways</i>, using controlled testing and trajectory-based review. • Identify locality-level capacity gaps and protect planned therapy time, supported by regular monitoring comparing actuals with forecasts.	7. Strengthen System Flow & Escalation Preparedness	• Start pathway-specific planning (e.g., stroke/ICSS, P1/P2) earlier—by September, not mid-winter. (Late winter funding limited recruitment and impact this year.) • Maintain weekly updates to acutes on available capacity in high-pressure pathways to manage expectations and flow.
2. Drive P2 Rehabilitation Flow Improvement	• Strengthen system grip on P2 pathway flow, focusing on reducing avoidable delays in step-down and improving onward care timeliness. • Apply consistent admission criteria and LOS management, as prolonged LOS remains a key constraint on acute flow.	8. Workforce Stability & Contingency	• Earlier surge recruitment for high-impact pathways (e.g., ICSS), avoiding December starts.
3. SPA Telephony & Urgent Access Reliability	• Clarify and update the SPA service specification ahead of winter.	9. Clarify PBUC Funding & Operational Model for 26/27	• Secure recurrent staffing funding to avoid reversion and protect 4-hour/triage performance.
4. Strengthen Data Quality, EMIS Usage & Standardisation	• Complete work of deferral/breach definitions and templates to give a reliable view of unmet need and avoid rework.	10. Enhance Demand Insight & System Coordination	• Continue demand investigations (e.g., PCN variation, MSK FCP impacts) and adopt GIRFT-linked solutions such as Community Appointment Days. • Progress system mutual-aid discussions and FCP expansion scoping.
5. Reduce Planned Nursing & Therapy Deferrals	• BRAG is embedded, and enhanced rostering to reduce deferrals and mitigate wound-care and planned-nursing harm risks. Continue work to embed deferral dashboards and improve accuracy of red/amber/blue scheduling.	11. Address known bottlenecks across the pathways - including bariatric needs, delirium and dementia support, brokerage KPIs, and 'off-pathway' discharges.	• A coordinated, proactive approach is required, If these issues are not resolved outside of winter, the system lacks the necessary elasticity to respond effectively during periods of escalation.
6. Establish D2A Pathway access for MH Patients	• Ensure referral routes in deployed and available to AWP staff for step down purposes.	12. Social care overtime for assessments	• Explore this option across all 3 local authorities for potential deployment across January and December

Thematic Project Findings

Work is progressing for our urgent and emergency care digital strategy. Whilst deliverables may not yet have an impact over this winter, one workstream has identified known challenges to BNSSG.

WHAT WE FOUND

BNSSG has committed services and staff, and pockets of good practice, but the urgent care system often operates in an inefficient and fragmented way that can make it difficult for clinicians to coordinate care, particularly for the frail, vulnerable and complex. Eight interconnected gaps were identified:

1. Fragmented Pathways and Communication Some services are poorly connected, and responsibilities unclear, causing duplication, confusion and frustration.	2. Variable service visibility, accessibility and referability Many community services exist but are patchy and variably accessible, often leading clinicians to default to hospital pathways.
3. Unreliable community alternatives to admission and over-emphasis on hospital discharge UCR, NHS@Home and Reablement are valued but poorly understood and experienced as difficult to access unless from hospital.	4. Lack of timely urgent social care Care Act assessment timescales do not align with urgent care, frequently resulting in avoidable hospital admission.
5. Unclear accountability and risk holding When multiple services are involved, follow-up responsibility can be unclear. Shared risk-holding across organisations is patchy.	6. Late positioning of senior clinical decision-making Senior clinical expertise is unevenly distributed and sometimes arrives too late in the patient journey, increasing escalation to emergency pathways.
7. In-hours and out-of-hours are different Services that function well on a Tuesday morning become inaccessible or unpredictable on a Sunday evening or overnight.	8. Digital and data limitations There is no shared electronic patient record and limited real-time service visibility. Data is aligned to organisational metrics, not patient outcomes.

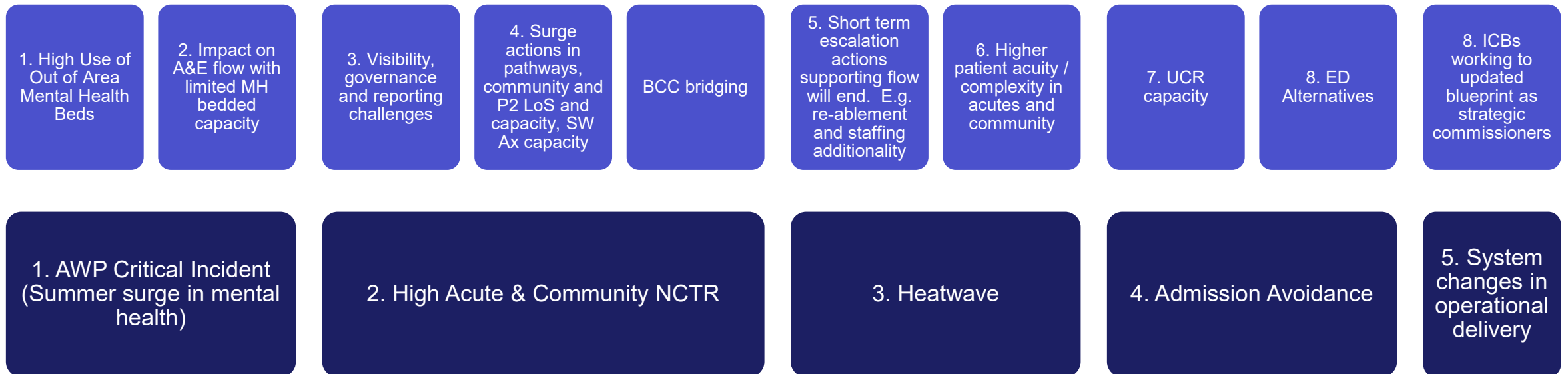
BNSSG Challenges / Themes:

Agreed POM priorities to mitigate

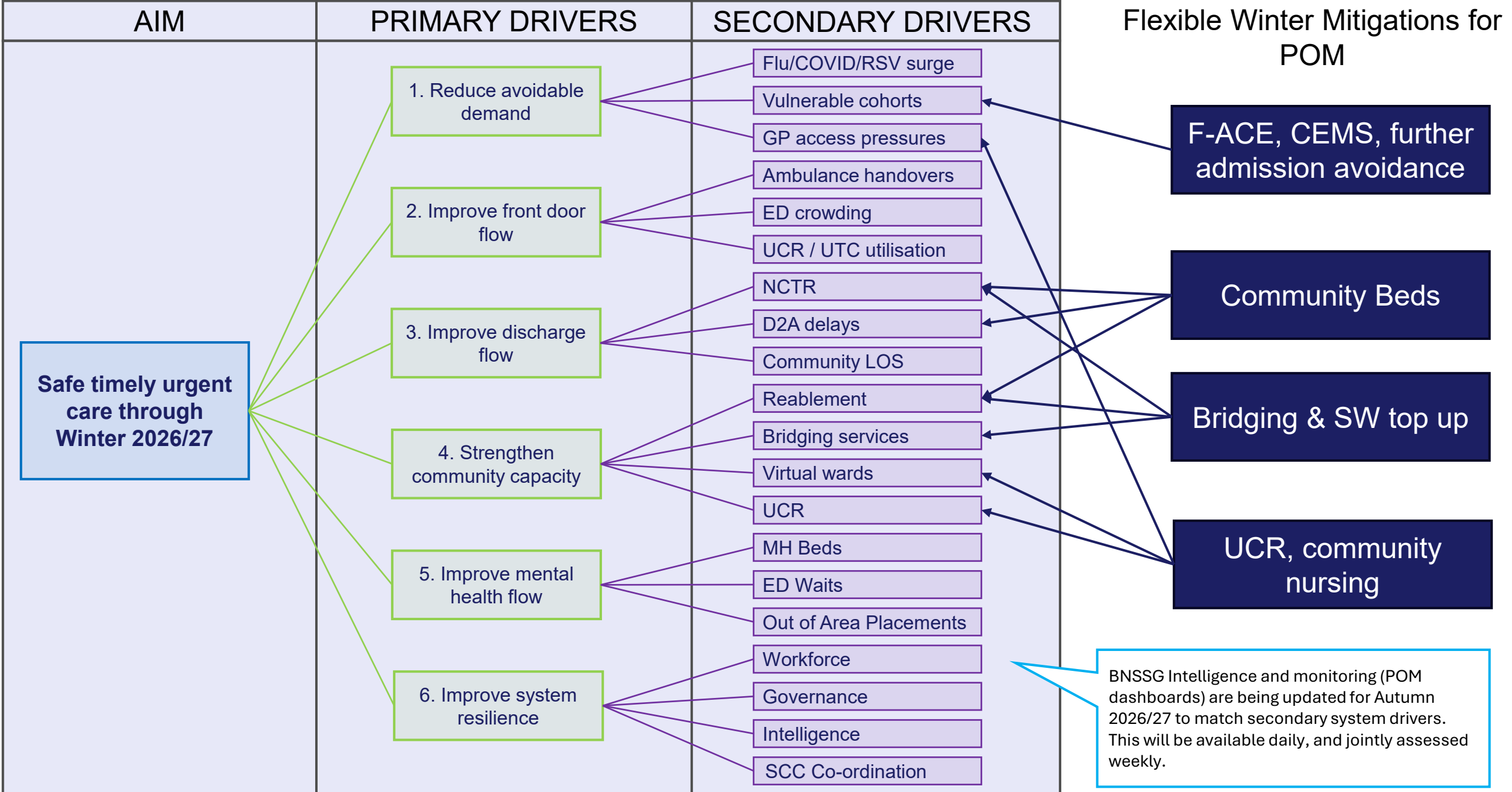
August 2026 and entering Autumn / Winter

Known challenges have emerged in our system through summer 2026, these are captured below and are to be factored into our winter delivery plans, alongside feedback from last year.

Operational agreement is to avoid buying beds in escalation where possible, and an intention to invest in core services to ensure consistent service delivery.



BNSSG UEC Driver Diagram



Board Assurance Statements

BNSSG ICB



Overall Assessment Rating: 5 - Full assurance

			Rating
Section A	Governance	Plan sign off	5 - Full assurance
Section B	Prevention and vulnerable cohorts	- Vaccination program / vaccination campaign - New UEC model of care for those at risk of presenting in crisis	5 - Full assurance
	Flow, occupancy and discharge	- BFT Plans - System mitigations through intermediate care	4 - Substantial assurance
	Demand, capacity, and surge management	- OPEL 4, POM actions - Choose Well Comms	3 - Moderate assurance
	Primary Care, NHS 111 and admission avoidance	Plans reviewed by pharmacy, onecare, primary care, severnside	5 - Full assurance
	Community Health Capacity	Incl. UCR, Virtual wards, community diagnostics, Sirona plan shared.	5 - Full assurance
	Whole System Response	Maximising out of hospital capacity	5 - Full assurance
	Leadership, operational grip and resilience	- On-Call - Resilience: Business Continuity Plans, Severe Weather, Industrial Action - Staff Welfare - Digital systems - Assurance – ICB to NHSE engagement, aligned with escalation	5 - Full assurance

Roadmap & Governance

Key Working Groups (Delivery): POM, Vaccination Working Group, Strategic Communications Group

Key dates and oversight

- PEM: 13th August 2026 09:00 – 10:00 – share approach/progress/engagement
10th September 2026 09:00 – 10:00 – update items for support
- ODG UEC (HCIG): 27th August 2026 11:30 – 13:00 – share approach/progress
24 September 2026 11:30 – 13:00 – for approval prior to board
- FPQ 22nd September 2026 09:30 – 12:10 – DRAfT approach for approval prior to board
- ICB Board: 30th September 2026 (Open Slot) times TBC
joint item with Gloucestershire and BNSSG winter plan
- HOSCs *Bristol (6 Oct), North Somerset (8 Oct), South Gloucestershire (13 Oct)*

Winter Table-Top Exercise (NHSE SW) – 16th September

NHSE South West Winter Workshop – September 16th

Shared Injects:

Inject 1 - IPC/Multi-Pathogen Outbreak and Children and Young People Respiratory Surge

Inject 2 - Workforce Crisis, Sustained System Exhaustion and Industrial Action Escalation

Inject 3 - Hospital IT outage and disruption to digital systems

Inject 4 - System-Wide Discharge and Flow Failure

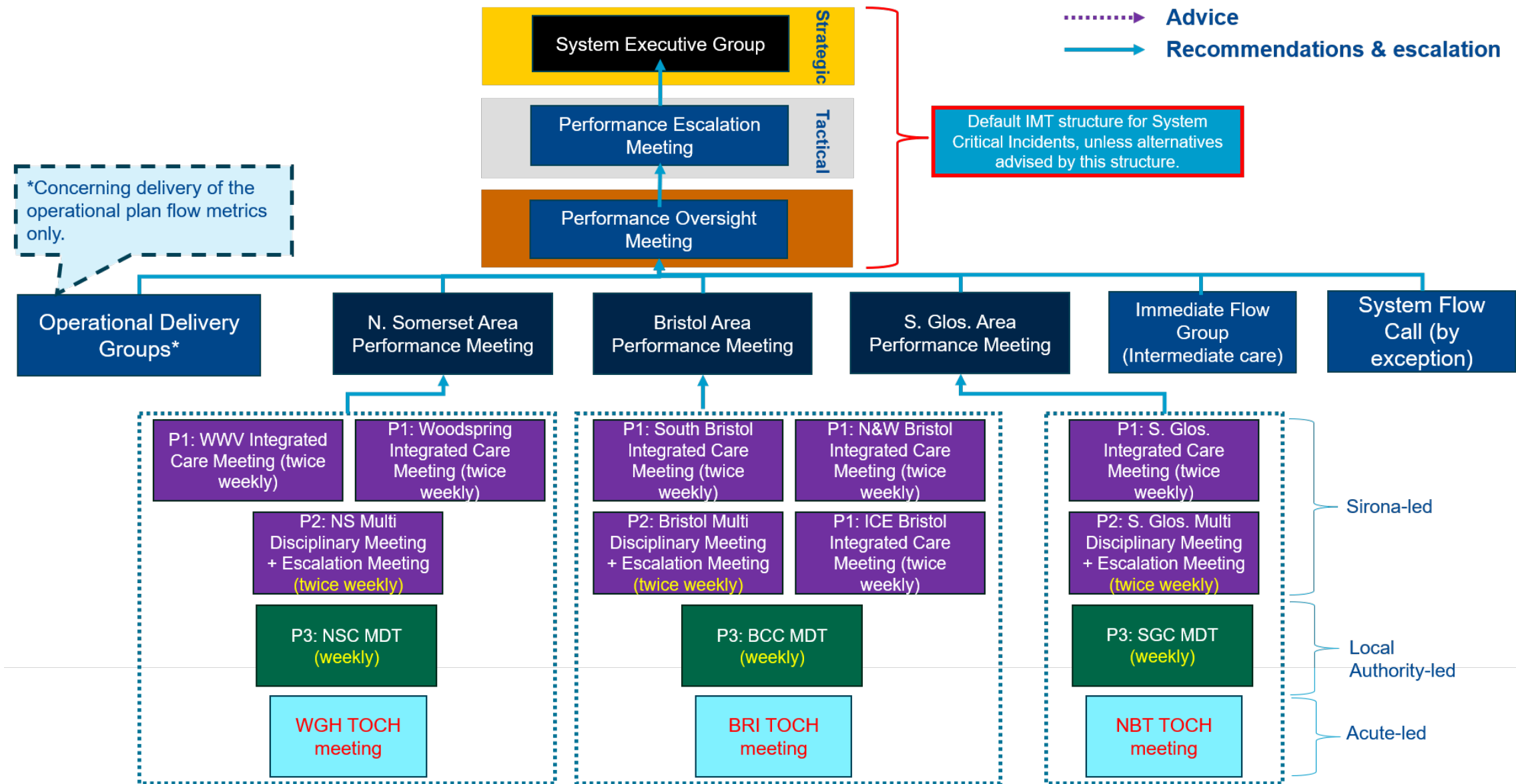
Inject 5 - NHS 111 Capacity and Demand Escalation, Mental Health and Primary Care Surge

Inject 6 - Mass Casualty Incident During Extreme Winter Pressure

Next Steps (September):

- *BNSSG and Gloucestershire dynamic flow model development using agreed system driver diagrams*
- *Gloucestershire in person winter tabletop exercise, local stress testing*
- *BNSSG adoption of triggers for Clinical Reference Group during escalation*
- *Continuing oversight through winter via system executives – scheduling underway for extended UEC oversight beginning first week of January.*

Refreshed Governance



Vaccination Program 2026/2027

Good uptake of the flu vaccine in BNSSG during 2025/26 which showed an increase compared to the previous year, with over 350,900 people vaccinated in the 2025/26 programme.

This was been achieved through a multicomponent approach. This was despite the early start (compared to previous seasons), with significant activity driven by a highly mutated variant of influenza A(H3N2), known as subclade K.

Increases in uptake were seen in all the main cohort areas, however, a slight decrease was noted in the 65 years and over cohort, which was also seen nationally.

Uptake by age/cohort 2025/26 for BNSSG*

- Aged 65 years and older: an uptake of 80.26% at the end of the campaign, which although is slightly lower than last year, is still comparable
- Both primary and secondary school aged children showed increases in uptake, with 58.60% uptake for primary school and 49.47% uptake for secondary aged
- 2- and 3-year-olds: uptake was 52.82% (March 2026), which is an increase from 49.88% the previous year (March 2025)
- Clinical Risk Groups (aged 6 months to 64 years old): uptake was slightly higher during 2025/26 (66.34%) compared to 62.74% in 2024/25
- Frontline Healthcare Workers: uptake was 55.82% during 2025/26 compared to 49.57% in the 2024/25 campaign

Increasing uptake in the children's cohorts will have the biggest impact on reducing the circulation of the flu virus, followed by those aged under 65 years in a clinical at-risk group.

Furthermore, increasing the vaccination rates in Frontline Healthcare Workers may help improve staff absence and protect those they care for from influenza.

Lessons learned from the 2025/26 flu vaccination programme, including local uptake data, outreach team activity, provider feedback, and national and international evidence, are being used to inform planning to increase flu vaccination uptake in 2026/27 and beyond.

The focus will include at least maintaining flu vaccination uptake in the 65 plus years and increasing uptake and vaccination access in:

- Frontline Health and Social Care Workers
- Children – all eligible ages
- Those aged under 65 years in a clinical at-risk group

BNSSG integrated vaccination programme has been prepared through Q1 of 2026/27 with our ICB, acute, local authority and community partners. An additional Flu group has been set up to review and consider the practicalities of the plan.

Q2: Plans submitted, assurances received and roll out of programme. New One Care all aged outreach provider contract to start from 1st September 2026.

Q3/Q4: Ongoing rollout and monitoring.

* Uptake figures are based on data from FDP as per 10/03/26

BNSSG Vaccinations

The BNSSG integrated vaccination programme has been established early with clear priorities summarised below. The BNSSG system wide Immunisation Strategic Oversight Board (ISOB), oversees the vaccination programme work with the Vaccination Clinical Delivery Group (VCDG) forming the operational arm. Vaccines report into the different governance boards within the providers and ICB.

Leadership

Regular CDG Meetings:

Clinical Delivery Group meetings regularly review vaccination plans and coordinate system-wide actions. An additional Flu group has been put in place to support the roll out of this season's programme.

Ongoing Data Review:

- Local vaccination data is continuously analysed using tools like FDP, capacity tracker, and Immform. Fortnightly MSOA data reviews help identify areas where vaccination uptake can be maximised effectively. Relevant data to be proactively discussed with the outreach team.

Vaccine Priorities:

- Data identifies priority groups such as frontline workers and clinical risk groups for vaccination focus in 26/27.

System Coordination:

- System leads and local authorities aim to ensure coordinated flu season planning and are members of the CDG group. Providers have executive support for their plans.

Provider Delivery

Engagement:

- Local trusts are collaborating to promote vaccinations for long-stay patients through clear communication and outpatient signposting. Trust maternity services also support vaccine delivery. GP Practices & pharmacies have plans to encourage uptake, with community pharmacies being able to vaccinate 2 & 3 year olds.

Vaccinating Workers:

- Providers are expected to develop strong strategies for vaccinating frontline healthcare workers to protect staff and patients alike.
- Providers should ensure the vaccine is accessible for all frontline staff, monitor the delivery of their programme whilst aiming to achieve an uptake of 60-65% for FHCWs.

Coordinated Planning:

- Trust vaccination leads collaborate closely to ensure consistent and effective flu vaccination planning during the season.

Monitoring Uptake:

- Use of roving vaccination teams alongside a clinic offer with data monitoring enables proactive review of vaccine uptake across departments.

Communications

Targeted Social Media Engagement:

- Utilising platforms like TikTok and Facebook Live to engage young mothers and address concerns in real time.

Comprehensive Website Hub:

- grabajab.net provides detailed vaccination information, multilingual resources, and Easy Read materials for accessibility.

Video & Audio Case Studies:

- Sharing personal stories through videos and audio to highlight real experiences and care in local hospitals and care homes

Supportive communications to providers

- Highlighting key ambitions and resources

Communities

Community Collaboration:

- Engaging local groups strengthens messaging and supports health initiatives effectively. Activities incl. distributing leaflets, hosting talks, and running pop-up vaccination clinics to promote flu and covid vaccines.

Flu Vaccination Agreement:

- All BNSSG practices have committed to providing flu vaccinations for 26/27, improving access for the population.
- All BNSSG practices have signed up to provide covid vaccination for 26/27. Co-administration will take place where clinically appropriate and practical.

Outreach Support:

- In BNSSG, the new One-Care outreach team will offer support to increase vaccine uptake in lower coverage areas through targeted community/ voluntary sector engagement or in areas where gaps are identified.

Children:

- Data shows most practices have over 20% flu vaccine uptake in young children; support is offered to practices with the lowest uptake. Reminders, tools and vaccine alternatives are all offered. Opportunistic vaccinations offered at all interfaces with health. The school aged immunisation service (SAIS) continue to offer school flu vaccination visits and catch-up clinic vaccinations. Community pharmacy will be able to offer vaccinations to 2 and 3 year olds from Oct-26.

Vulnerable Cohort: New UEC model.

targeted prevention through 1 integrated neighbourhood intervention for rollout through Winter 2026 and beyond

Repeated crisis contact triggers one proactive, whole-person response designed to stabilise people close to home.

01 PROACTIVE ENGAGEMENT TRIADS

Mental health + physical health + LA/VCSE

Cross-provider identification and outreach—bringing support forward rather than waiting for another crisis.

02 CCC SHARED FORMULATION

Comprehend • Cope • Connect

One understanding of the crisis cycle informs one shared crisis plan and portable Passport.

03 NEW INTEGRATED I-IMR

Neighbourhood intervention programme

Recovery, LTC self-management, medicines, behaviour change and social stabilisation around personal goals.

MY TEAM AROUND ME

MENTAL HEALTH • PHYSICAL HEALTH • PRIMARY CARE • LOCAL AUTHORITY • VCSE

Partners contribute their expertise through one formulation, one plan and one integrated programme—not separate parallel responses.

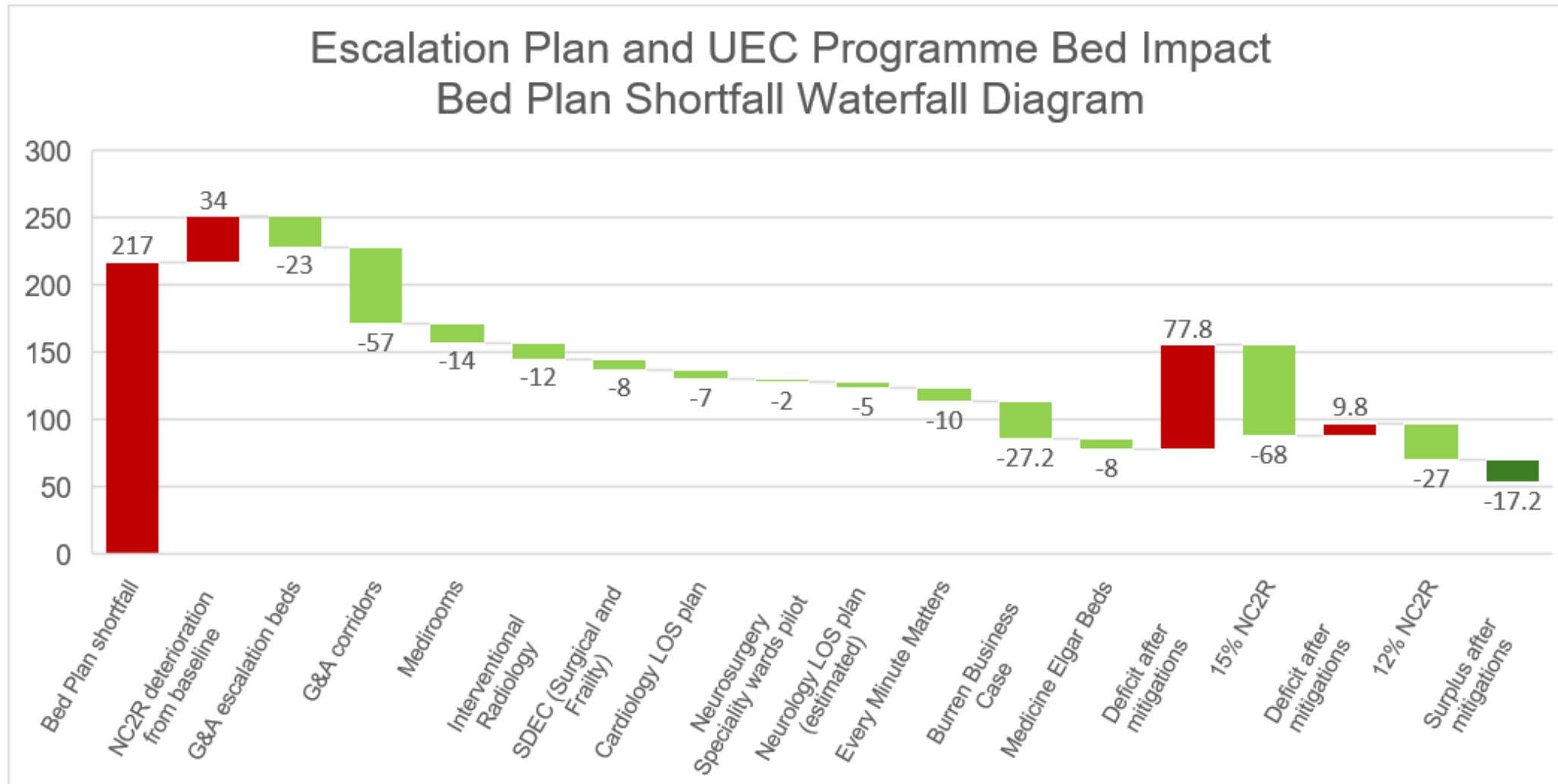
WINTER PURPOSE Targeted prevention for a vulnerable, high-intensity-use cohort

Aim: earlier stabilisation • fewer avoidable escalations • greater use of planned care and alternatives • test impact on UEC, admissions and bed days

BFT Plan: Flow Occupancy Discharge

Area	Planning assumption	Completed Actions
Demand	Emergency demand will remain at or above 2025/26 levels, with seasonal surges from respiratory illness, flu, norovirus, falls and exacerbations of long-term conditions.	Refreshed demand and capacity modelling using latest activity, conversion and admission profiles by site. Sirona working on business case for winter funding to expand Urgent Community Response capacity as an alternative to admission.
Capacity	Non-Elective bed capacity will remain constrained without sustained reductions in length of stay and delayed discharges.	Updated bed models for Southmead, City Centre and Weston at agreed occupancy assumptions. Refreshed Flow, Surge and Escalation policies for all sites
Discharge	No Criteria to Reside and delayed transfers remain material drivers of bed pressure.	BFT commissioning 36 intermediate care beds at The Burren for 12 months. Start date likely to be early November. Intermediate Care Programme working on other actions include a home-based pilot in North Somerset and a business case for emergency admission avoidance beds for end-of-life patients at St Peter's Hospice.
Workforce	Vacancies, sickness, residual industrial action risk and winter illness will affect resilience.	Monitored rota resilience, including additional staffing funded for winter on all sites, bank/agency controls, vaccination plan and wellbeing offer. January to mid-February 2027, workforce availability will be supported through temporary deferral of non-essential training where appropriate. Existing committed UWE course activity will be maintained where reasonably practicable, while study leave will remain subject to operational requirements.
Infection prevention	Flu, Covid, norovirus and other respiratory infections will drive isolation demand and bed closures.	Confirmed testing, cohorting, PPE, fit testing and seven-day IPC cover arrangements.
Finance	Winter schemes must be prioritised against safety, statutory delivery, benefit and affordability.	Allocated winter reserve, recurrent/non-recurrent funding and benefits tracking.

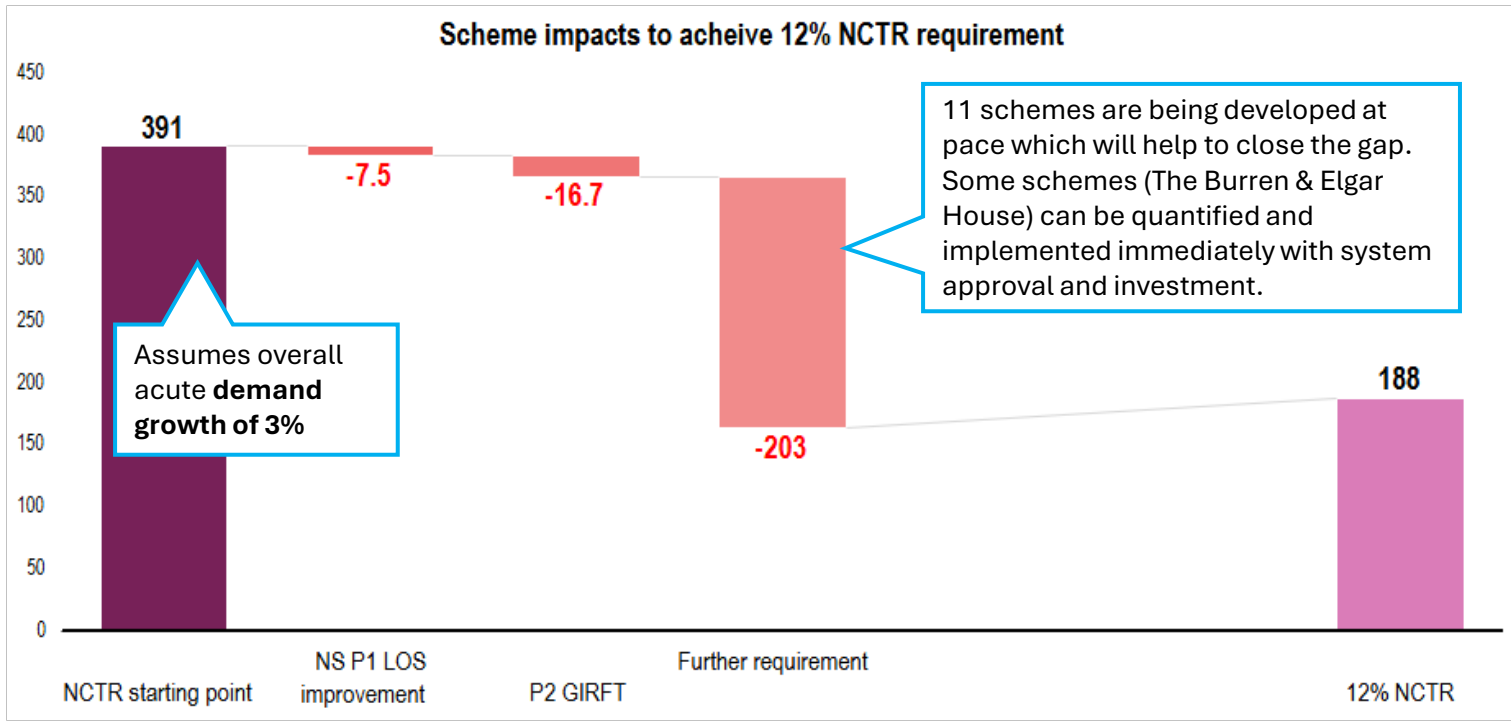
Acute Mitigations



Intermediate Care Programme

System mitigations are chiefly sought through the work of the Intermediate Care & Prevention Programme which is leading on alternatives to admission as well as discharge facilitation schemes.

The program is tracking progress against closing the gap between acute NCTR levels and the system target of 12% by year end. Summer 2026 has seen a deterioration in the acute NCTR position resulting in the starting point for BFT NCTR being c440 (September-2026), and not 391.



Immediate Flow Schemes	Type	Status
North Somerset HBIC test of change (step down)	Step Down – Home	Live on 20 Jul-26
P2 GIRFT	Step Down –Beds	Live
The Burren	Step Down – Beds	Decision needed (investment)
Elgar House	Step Down - Beds	Decision needed (investment)
End of Life admission avoidance	Step Up – Home	In development
GP support for frequent hospital admissions	Step Up – Home	In development
South Glos HBIC test of change (step up)	Step Up - Home	In development
HBIC Menu of Options (P1)	Step Up & Down: Home	In development
North Somerset Sirona ASC Interface (P2/P3)	Step Down - Beds	In development
Bristol P3 delays (self funders, delirium, brokerage)	Step Down - Beds	In development
CHC interfaces and delays	Step Down: Home & Beds	In development
Caafi Health pull model (Southmead)	Step Down – Home	In development
UEC ODG schemes: X-Ray Car, Mental Health ED	Step Up - Home	In development

4 Demand, Capacity, Surge Management

Surge Plans, surge capacity which cannot be managed directly or requires alternative capacity assessment/provision will be mobilised via POM and PEM (scheduled weekly).

The BNSSG OPEL 4 action cards and processes have been refreshed during summer 2026. Our providers and system are practiced in stepping up capacity in the following areas:

- Mental Health OOA (out of area) beds ✓
- Timely Handover Process (THP) – acute A&E corridors ✓
- Other acute escalation space ✓
- 4 beds at Sirona SBCH / dynamic team allocation ✓
- Other system spot purchase beds ✓
- Bridging ✓ (mitigations underway through intermediate care)
- SW capacity ✓ (through PEM)
- Heatwave action cards refined on admission /attendance avoidance, planned for review in preparation for updating cold weather plans
- (CEMS / REACT / F-ACE / P-ACE) ✓

Ref	Actions	Responsible	
1	Complete all actions in previous OPEL declarations	All	✓
2	O4TRI-A: Hospital executive team to consider increasing clinical staff availability through review of non-clinical commitments / redeployment of staff where possible to maintain safe care ratios in the ED and/or expedite patient discharge from in-patient areas and/or ICS Director (or Director on Call) to set a system capacity objective that aims to restore OPEL 3 within 24hrs	Acutes	
3	O4TRI-B: Once +1 protocol has been reviewed, consider initiating reverse boarding protocol1 in the ED to maintain the handover of ambulances to the RAT team. Consider use of areas not usually used for clinical care in the ED or adjacent areas for lowest acuity patients and augment environment to maintain oxygen, suction and other emergency equipment. The initiation of reverse boarding protocol in ED will require the ICS Director (or Director on Call) to set a system objective to immediately reduce both ambulance and walk-in system clinical on-call in these discussions	Acutes	
4	O4TRI-C: Once reverse boarding has been reviewed, consider initiating cohorting protocol 2 of ambulance patients. If no further offloading space, then on-ambulance Rapid Assessment and Treatment plan should be considered. In the event of ambulance cohorting and/or on-ambulance Rapid Assessment and Treatment plan being initiated, the ICS Director (or Director on Call) will review options for further escalation capacity at the affected site and across all community and acute providers within the ICS	Acutes	
5	O4TRI-D: The potential to reschedule planned elective activity and/or cancer treatments reviewed by the Senior Operational team at the hospital provider1. The rescheduling of that ensures the risk of cancellation is fully mitigated through ICS or regional network arrangements, including the option for further independent sector and/or mutual aid support and will require input from the clinical on-call	System Partners	
6	OPEL 4+ agreed with Chief Operating Officers and Directors of Adult Social Services, along with core messages for OPEL 4+ communication plan	ICB & System Partners	
7	Risk based assessment of Infection Prevention and Control requirements and quality to increase surge capacity: - Acutes: - Double Occupancy of single side rooms - Boarding of 5th patient in 4 bed bays - Reverse queuing across ED and Acute Medicine Unit (AMU) corridor - Bedding of extra capacity (IR, SDCU, QDU, cath labs) - UHBW exceptional surge capacity opened (discharge lounge / gym / atrium / surgical day case units / endoscopy) - This should include review of the system dashboard risk scoring and will require input from the clinical on-call and adherence to the system-wide governance of Infection Prevention and Control hierarchy of controls	Acutes	
8	Consider breach of ring-fenced elective wards for non-elective activity at NBT and WGH to release capacity	Chief Operating Officers	
10	Implementation of SWAST EOC58 SOP (Managing Clinical Safety during periods of Escalation)	SWASFT	
11	Consider the use of temporary surge facilities for minor acuity patients.	Deputy COOs/DASSs	
12	Redirection of minors capacity instigated: a) A&E type 1 dept closed to all minors who can be safely treated elsewhere b) SWASFT Category 3 and 4 calls within MIU/UTC opening hours conveyed to MIU/UTCs c) MIU/UTC front door streaming protocol instigated d) 111/Clinical Assessment Service (CAS) call stack triage SOP activated: Navigation Escalation process Clinical on-call to be involved in these decisions	a) Acutes & Directory of Services (DoS) team b) SWAST & Sirona c) Sirona d) Severnside	
13	Acceleration of discharge a) Acutes: rapid reviews of all LOS >7 patients with aim to de-escalate to lower acuity b) Discharge 2 Assess (D2A) pathways c) Promotion of PO and temporary weekend staffing to support discharges d) Post-discharge contact of families to support Packages of Care (POC) or bridging to P1 or suitability for PO e) Cessation of managing expectations choice for patient discharge – move to the first available care home bed that can meet patient needs f) Review and action on use of any spare bedded system capacity	Acutes, IDS, CTCH, ICB	

Winter communications 2026/27

Aim: Support system resilience and improve health outcomes in line with cluster Winter Plan priorities by helping vulnerable groups avoid winter-related illnesses likely to lead to hospital admissions; and helping those who need care to access the right service for their needs.

Objectives



Key audiences



Key messages



	1. Support flu and Covid-19 vaccine uptake	2. Help people access right care	3. Reduce avoidable winter illness	4. Support infection prevention and control	5. Support discharge and flow	6. System readiness and resilience
	Eligible groups. New priority cohorts (homeless). System staff. Care homes.	All 16+, with focus on groups most likely to use ED for minor conditions.	Older adults. People with long-term health conditions and co-morbidities.	All adults. Health and social care staff.	Families and carers of hospital inpatients.	All adults. System stakeholders.
	'Stay Strong Get Vaccinated', protect yourself and others by taking up vaccinations when offered.	'Choosewell', get the right care for your needs (focus on self-care, pharmacy, PBUC, NHS 111)	'Staywell', take simple steps to avoid winter illness (eg stay active, stay warm). Look out for others.	'Beat winter bugs': help stop bugs spreading; handwashing, ventilation, 'catch it/bin it/kill it'.	'When will I go home?': talk to ward staff about how you can help loved ones return home promptly.	'Ready for winter' PR on system readiness. Tiered escalation messaging.

Approach

- **Co-ordinated, cluster-wide approach** overseen by cluster winter comms group, with shared resources and activity
- **Insight-led**, using BI to identify priority audiences and target activity
- **Amplifying national/regional campaigns**, for consistency across cluster and to minimise duplication
- **Prioritising local people and voices**, eg 'Staywell' (right) tailored to local priorities and featuring local people
- **Deliverables/tactics** to include:
 - Media and PR stories aligned to campaign strands
 - Rolling organic social media feat. local voices
 - Digital (system minisites for vaccs, staywell, choosewell)
 - Advertising bursts (targeted social media and outdoor)
 - Partnership, incl. campaign toolkits
 - Stakeholder briefing and updates
 - Staff communications and updates
 - Community engagement, working with local VCSE partners



Creative

Stay Well this winter

Discover ways to
boost your fitness
in the winter
months

Stay active





Kirsty
Wesport

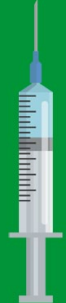


HELP YOUR LUNGS FIGHT FLU



Flu can significantly worsen existing asthma symptoms, triggering severe flare-ups. Flu vaccination can help protect you from the serious effects of flu. Check your eligibility and book now nhs.uk/wintervaccination

**STAY STRONG.
GET VACCINATED.**



give your immune system a hand.

Flu can be a serious illness for some people. Protect yourself by getting your #JabDone.

Search 'flu vaccine' on the NHS website.

#JabDone



Help stop the spread of WINTER BUGS



- Get vaccinated
- Wash hands regularly
- Catch coughs and sneezes in a tissue
- Open windows if you're meeting indoors
- Stay at home if you're feeling unwell



THIS EARACHE IS GETTING WORSE PHARMACY



Think pharmacy first

Subject to age eligibility, including 1-17 years old for earache prescription medicine. Service available at majority of pharmacies.



Get to the help you need



Use 111

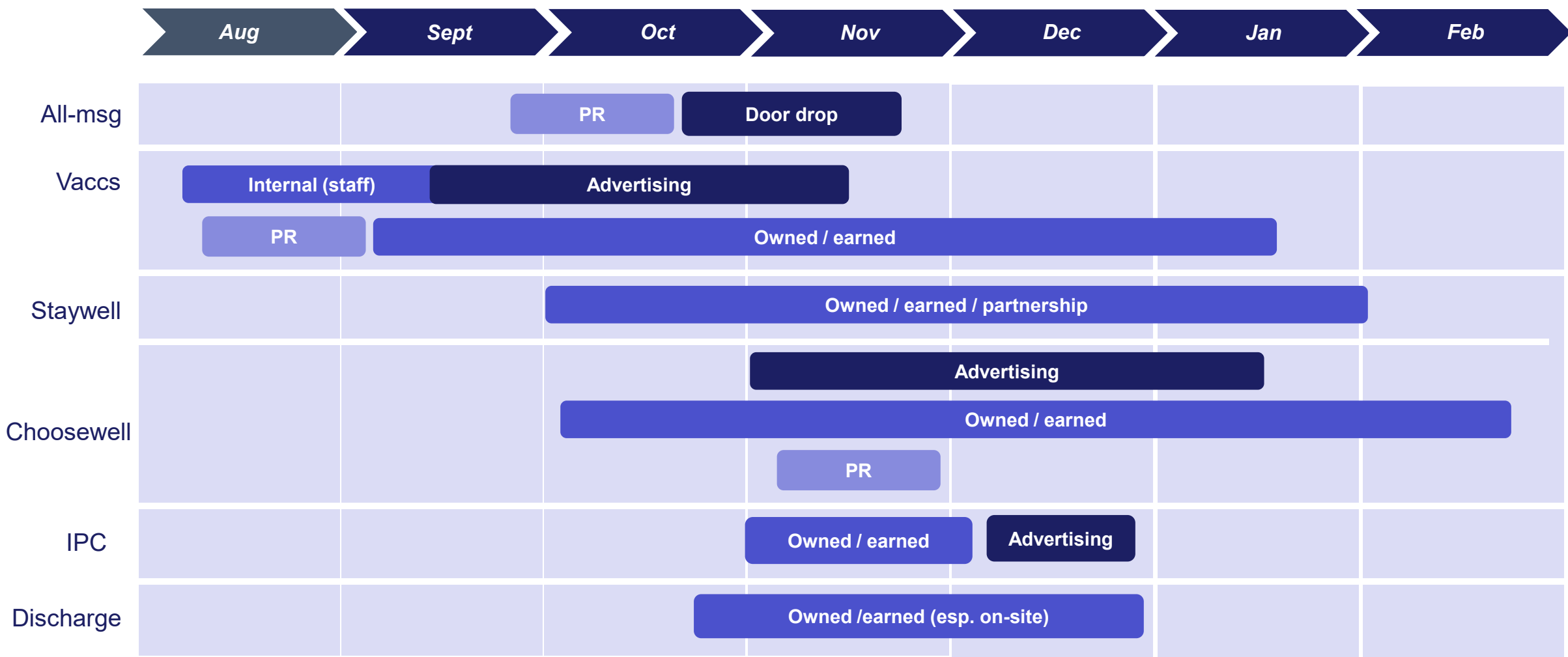
If you need urgent medical help but you're not sure where to go, use 111 to get assessed and directed to the right place for you.

Call, go online or use the NHS App.



111
111.nhs.uk

Winter Communications 2026/27 Indicative Timeline



**Timeline to be aligned to national and regional NHS campaign plans once confirmed.*

5. Primary Care

ARI LES

Acute Respiratory Infection Local Enhance Service. The ARI LES was agreed at the LES steering group including addition of a 'surge' / top up arrangement to this which would be activated during surge in the same way as when One Care managed ARI.

GP OPEL Framework

A new BNSSG GP OPEL framework is in place ready for Winter 26/27. Launch is now pending, as we progress the transition of GP aggregate data into the SCC tool.

Demand & Capacity Primary Care

We are gathering data about the growth of waiting lists for routine appointments, which are understood to be a consequence of some contractual changes last year. There are some winter risks associated as these lists are likely to grow at a faster rate through winter as practices in OPEL 4 manage the balance of routine and urgent slots to prioritise on the day urgent.

Demand & Capacity – Severnside (111)

SevernSide Integrated Urgent Care Services provide our out of hour service including:- 24/7 Clinical Assessment Service-OOH face to face appointments at Treatment Centres across BNSSG-OOH Home Visits when appropriate-24/7 signposting for people to the most appropriate service to meet their needs

Pharmacy

BNSSG remains a leading system nationally in regards to pharmacy first – referrals to community pharmacy for minor illness from 111, GP practices and walk ins for specific conditions.. Demand is regularly assessed; work is ongoing to increase contraception prescribing to free up GP capacity. BNSSG have developed local PGDS (patient group directions for direct prescribing) to further release GP practice capacity. Regular meetings with our out of hours provider (PPG) and the DOS team are undertaken to improve referral from NHS111 telephony to community pharmacy. Independent prescribing forms part of the contract from Autumn 26. DMS (discharge medicine summary) is being looked at in conjunction with our Acute partners.

Admission / Attendance Avoidance Services

Updated the service opening for many of our services which make up our healthcare front door. Service times have been extended where beneficial over winter, and in some cases, now covers 5 days, where before partial weekly cover was previously commissioned.

- **REACT** – The Rapid Emergency Assessment Care Team works in the emergency departments at the Bristol Royal Infirmary (BRI) and Southmead Hospital supporting people over the age of 18, with the aim of preventing unnecessary admissions to hospital and helping people return home sooner. Weekend and evening cover is being assessed over winter.
- **CEMS** – The Community Emergency Medicine Service (CEMS), places a senior Emergency Medicine clinician on a rapid response vehicle alongside a SWAST paramedic. The service focusses on patients who would otherwise be admitted to hospital and enables more people to be treated in the community. This service is now commissioned 5 days / week ahead of winter 2026. This secures the rota and ensures service stability for the EDs and CEMS. Step up weekends can be considered
- **UCR** – The Urgent Community Response offers a same day multi-disciplinary response, incorporating a comprehensive holistic assessment supporting people within the domiciliary setting who are at risk of an unplanned, hospital admission or ED attendance. Funding for extended service provision now confirmed and to be mobilised for Winter.
- **F-ACE & P-ACE** – Frailty-ACE (Assessment and Coordination for Emergency and urgent care) aims to support frail patients who would otherwise be admitted or conveyed to hospital, recognising the balance of risks and benefits associated with admission are often more finely balanced, or even unfavourable, for frail people. This has been expanded to cover bank holidays, evenings and weekends during January and the end of December.
- **NHS@Home** – step up (admission avoidance) activity to be considered, maximising capacity
- **System CAS** – 111 Clinical Assessment Service, Senior clinical advice for patients who have a 999 or ED disposition through the initial health advisors to prevent conveyances or attendance at A&E depts.

6 Community Health Capacity, Sirona Winter Planning Priorities

A thorough community winter plan has detailed service provision, predicted activity and winter mitigations for each service.

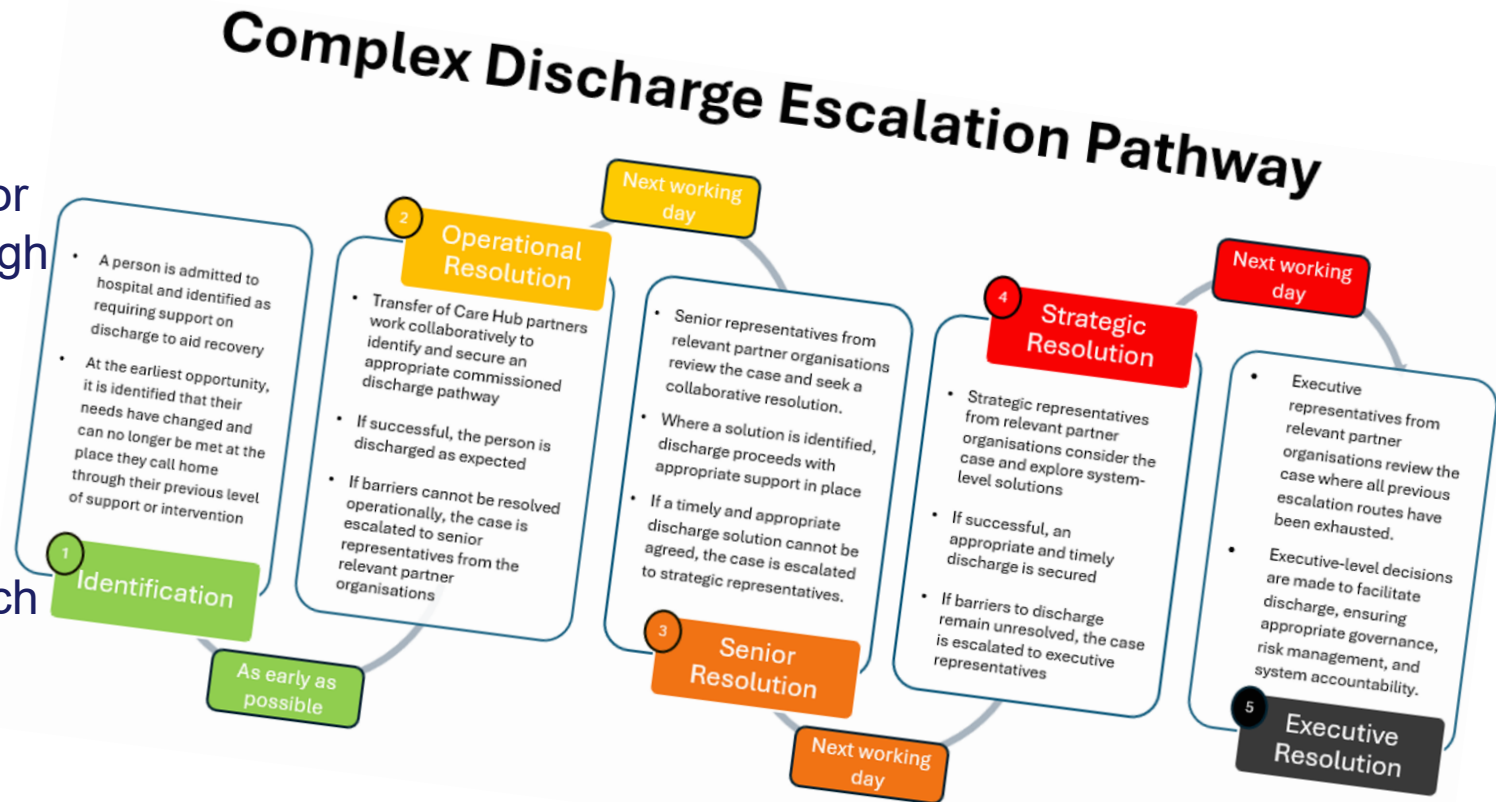
- Maintaining safe and effective delivery of core community services, with explicit prioritisation where demand exceeds available capacity.
- Supporting BNSSG urgent and emergency care flow by strengthening community alternatives to hospital attendance and admission.
- Sustaining Urgent Community Response (UCR) performance, a continued focus on maintaining at least 70% 2-hour response performance.
- Optimising NHS@Home capacity, including the planned capacity expansion from 101 to 117 modelled beds for November 2026, and improved integration with step-up and step-down pathways.
- Supporting discharge and intermediate care flow, including Pathway 1, Pathway 2 and Home Based Intermediate Care improvement work.
- Providing Therapy input for the additional capacity at the Burren Nursing Home
- Strengthening operational grip through daily oversight, escalation, OPEL reporting and clearer action cards.
- Maintaining vaccination, IPC, EPRR and adverse weather readiness as core elements of winter resilience.
- Co-ordinate a system wide perfect fortnight ahead of predicted December / January surge pressures, in line with predicted activity surge

New Escalation Pathway for Complex Discharge

Through summer 2026, a review of the previous P3+ SOP, has enabled a refreshed approach. The revised SOP establishes clear system-wide escalation expectations for all partners when securing discharge solutions for individuals whose needs cannot be met through existing commissioned pathways.

The document is supported by additional appendices setting out each organisation's internal escalation process. This provides clarity on the respective responsibilities of each partner in supporting timely and appropriate discharges for people using our services.

The process is designed to support discharges across the wider system, including community beds and Pathway 1 provision.



7 Leadership, Operational Grip & Resilience

BNSSG UEC governance has been updated ahead of Autumn 2026/27. Our Gold and Silver system meetings (POM and PEM) have had refreshed their terms of reference.

BNSSG and Gloucestershire ICB arrangements now ensures aligned strategic and tactical on-call cover across our cluster footprint. On-call cover has been published till the end of January.

Operational grip for BNSSG has been historically led through daily system calls chaired by the ICB. Summer and Autumn 2026/27 has allowed us to refresh this approach. With improved digital dashboards, giving us increased service visibility, and day to day service flexibility discussed directly between providers. This refreshed approach has released operational leadership time. ICB or partners can stand up a call (by exception) using the following triggers:

- Any organisation declaring Business Continuity Incident (BCI) and requesting a system call
- Any organisation declaring a Critical Incident (CI)
- System Level at OPEL 4 for >48hrs and decision for call confirmed via POM.
- Any exceptional issue requiring a system response such as industrial action, mutual aid requests etc

FDP (SCC) Dashboard – Rollout Sept-26

In conjunction with our BNSSG intelligence centre, a UEC system dashboard replacement has been deployed through Summer 2026. This provides live and near real time visibility of escalation statuses, system flow pressures across all healthcare partners.

BRAG Breakdown: Local Metrics

Ambulance Service

Hospital Handovers

Ambulance Response

IUC-111

IUC-111

Out of Hours

Acute

ED

Discharge Ready

Mental Health

Mental Health

Community

SPA / UCR

D2A Pathway 1

D2A Pathway 2 & 3

Community Nursing

BNSSG OPEL

BNSSG OPEL

NHSE OPEL

OPEL

Community

Acute

Mental Health

Metric Spotlight

2

Mason s136 Beds Available (Capacity 4)

→ Not enough data found (24h)

Key Locations

No locations selected

0%

Calls Abandoned After Threshold Since Midnight that Received (%)

→ Not enough data found (24h)

Key Locations

No locations selected

0

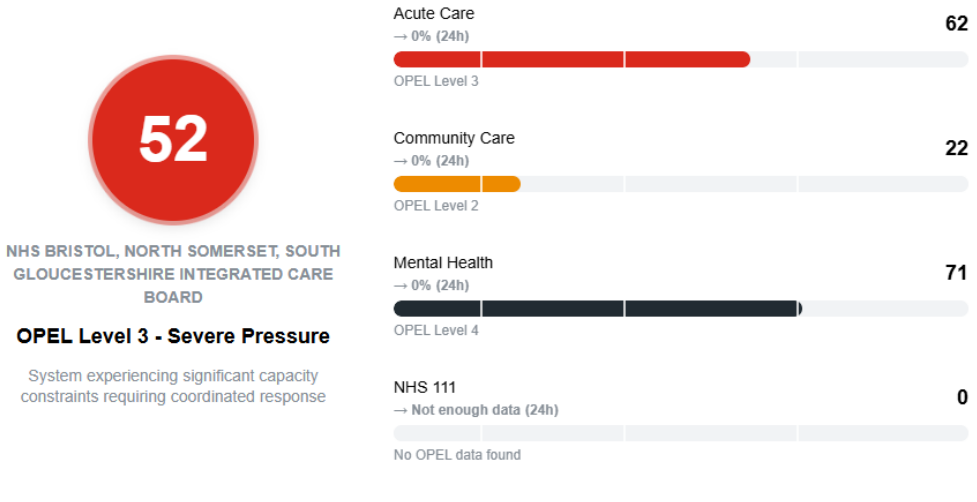
Community Health OPEL Score

→ Not enough data found (24h)

Key Locations

No locations selected

System OPEL Status



ED

BRAG Status Filter

Metric

Patients in A&E

Cohorting & Reverse Queue

No. of DTAs

Ambulance Queue

Resuscitation Capacity

Avg. Time to Triage

Avg. Time to Assessment

A&E Discharges in Last Hour

Total Breaches Since Midnight

(Minors)

(Majors)

No. of DTAs (> 1hrs)

Avg. Breach Performance

New Arrivals in Last Hour

Southmead

94

9

97

1

2

10:00

02:00

10

10.0%

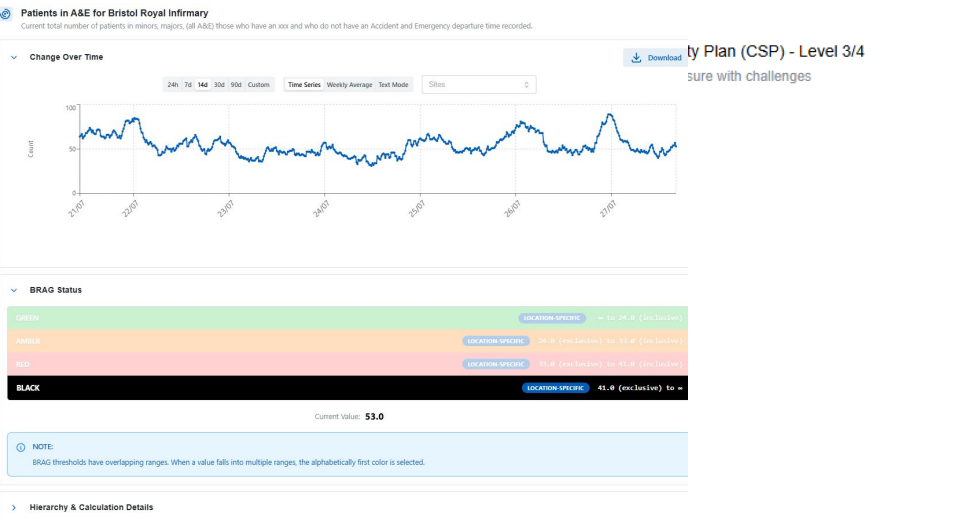
02:00

02:00

1

60.0%

0



8 System Co-ordination Centre (SCC)

The system co-ordination centre (alongside EPRR) will remain the single point of contact for UEC flow resolution through winter 2026. The ICB continues to ensure adherence to the NHSE SCC standards ([here](#)).

Updates to the co-ordination of this ahead of winter will include:

- Streamlining SCC administrative arrangements within the BNSSG and Gloucestershire cluster
- Visibility in our singular UEC dashboards of operational delivery networks impacting our system and partners -
 - Incl. Maternity, Paediatrics, Critical Care – and associated escalation frameworks
- Continuation of our predictive modelling analytics embedded in our operational dashboards
- Scoping digital solutions for deploying system actions

Quality Impact Assessment Policy Brief



Version: 2.1

Date Approved:

Author: Holly Howell - ICB Quality Manager

Approved By:

Review Due: 1 year - 2026

Aim

The purpose of this policy is to set out the overview, responsibilities, process, and format to be followed when undertaking a quality impact assessment (QIA) in line with the NHS England QIA Framework (2025).

Scope

This policy applies to all NHS Gloucestershire ICB staff, commissioned services, and partner organisations when undertaking quality impact assessments for proposed changes to health and care services.

Out of Scope - NHS Gloucestershire ICB maintains separate processes for Equality Impact Assessments to ensure compliance with the Equality Act (2010) and Public Sector Equality Duties. While QIAs and EIAs are closely linked and may inform each other, this policy focuses specifically on quality impact assessment. Staff must ensure appropriate EIA processes are followed in parallel where required.

Policy Overview

This policy details the process and steps to be undertaken to assess the impact of business cases, service changes and other major consultations on the quality of care we offer patients and consider any impact on our staff wellbeing.

QIAs ensure quality of care considerations, and not solely financial considerations, are central to decision-making for the design and delivery of health and care services.

This Policy illustrates the required reporting governance for sign off; providing assurance that all relevant stakeholders have been consulted and enabled to contribute to completing the QIA. That all benefits, risks, hazards and issues have been acknowledged and appropriate controls or actions have been identified to mitigate or remove potential impact.

Quality Impact Assessment Definition

The QIA is the process undertaken to assess the impact of proposed changes on key quality domains (as defined by the NQBs key quality domains (2021) and as per the NHS England QIA Framework (2025)) :

- Safe
- Effective
- Provides Personalised Experience
- Well-lead
- Sustainable

When a QIA should be undertaken?

A QIA is required for any significant change that may impact quality of care, including:

- Commissioning and procurement decisions
- Business Cases and investments
- Service redesign and major service changes
- Decommissioning of existing services
- Workforce redesign and new role implementation
- Pathway redesign or changes to access/eligibility criteria
- Cost improvement plans (CIPs) and efficiency programmes
- Temporary and urgent service changes (including EPRR situations)
- Organisational policy changes affecting staff
- Quality improvement pilots
- Mergers, acquisitions and leadership changes

Note: The list is not exhaustive - any significant change should be evaluated for quality impact.

QIA Process

The QIA form is to be completed as per the format in this QIA document (see tab titled 'QIA') covering:

- Proposal summary with stakeholder identification
- Evidence-based impact assessment against all quality domains
- Risk assessment and scoring (where negative impacts identified)
- SMART mitigations with named leads and deadlines (where negative impacts identified)
- Potential Key Performance Indicators (KPIs) identified for monitoring
- Stakeholder engagement summary

Impact Classification: Each quality domain must be assessed as:

- **Positive** - improves quality
- **Neutral** - no significant impact
- **Negative** - potential harm to quality (requires risk scoring for risk at an ICB level and mitigation)

Risk Scoring: Negative impacts must be risk assessed using the national risk scoring matrix with mitigated risk scores provided.

A checklist is provided to monitor progress and assisting notes provide guidance and suggestions for each section of the QIA.

Governance and Sign-Off Process

Stage 1: Quality Directorate Review

Completed QIAs go to the Quality Directorate for initial review and sign-off or feedback.

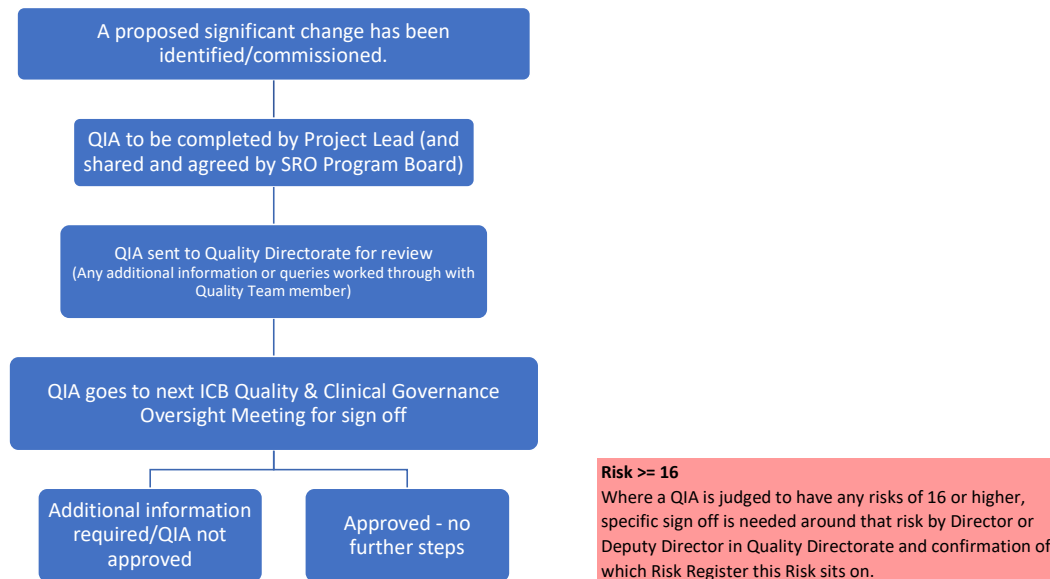
Stage 2: Final Sign-Off

QIAs then proceed to ICB Quality & Clinical Governance Oversight Meeting for final approval.

High Risk Escalation

Risk ≥ 16 : Where any risks are scored 16 or higher, specific sign-off is required from Director or Deputy Director in Quality Directorate, with confirmation of which Risk Register the risk will be recorded on.

QIA Process flow chart



Monitoring and Review

- Approved QIAs will be logged and stored in the central QIA repository (M Drive).
- QIAs reviewed at minimum every 6 months for large-scale changes
- QIAs must be reviewed if the scope of change evolves.
- Best practice would be for QIAs to be an iterative process and updated and reviewed at key milestones (e.g. at project initiation, mid-point and close-down or implementation).
- Outcomes and mitigations must be monitored through existing governance structures.

BNSSG ICB Quality Impact Assessment



Project/Scheme/Change Name: BNSSG ICS Winter Plan

Date: 01/09/2026

Project/Scheme/Change Lead: System Wide Deputy Chief Operating Officers

Project/Scheme Senior Sponsor: Head of System Flow BNSSG, Keith Robertson

Brief Scheme/Change Overview:

As part of planning for additional winter activity, increase in patient demand for access to services and in line with the 26/27 NHSE winter planning asks, BNSSG is required to have a comprehensive system wide delivery plan to manage demand and capacity and to ensure the safety and quality of patient care and treatment through unscheduled care pathways is maintained. The Winter plan encompasses all aspects of system wide urgent/unscheduled care delivery including, SWAST, Acute, community, VCSE, social and primary care patient pathways. The plan has been designed in alignment with the ICB integrated care program with key schemes identified for delivery before or during winter. **NB This QIA should be read in conjunction with the winter plan, vaccination KLOE and System Escalation Policy for detailed evidence of mitigations at provider and service line level against defined risks.**

Are there any specific locations impacted?

Bristol	x	North Somerset	x	South Gloucester	x
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Stakeholders identified as affected by the proposal:	ICB, BFT, Sirona, Primary Care, AWP, SWAST, Severnside, VCSE, patients, carers and the public.	Engagement work completed or planned for the proposal (including engagement with stakeholders):	The winter plan has been developed in collaboration with all partners. Submissions have been received from all provider organisations including SWAST and BFT to form a collaborative plan.
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Risk Matrix

Impact	Catastrophic	5	High	Very High	Very High	Very High	Very High	Very High
	Significant	4	Medium	High	Very High	Very High	Very High	Very High
	Moderate	3	Medium	Medium	High	High	High	High
	Minor	2	Low	Medium	Medium	Medium	Medium	Medium
	Limited	1	Low	Low	Low	Low	Low	Low
			1	2	3	4	5	
			Low	Medium Low	Medium	Medium High	High	
			LIKELIHOOD					

Brief description and evidence of impact		Risk Rating							Quality Indicators/How will you measure this
		Consequence	Likelihood	Risk Score	Mitigation	Mitigated Consequence	Mitigated Likelihood	Mitigated Risk Score	
Describe any potential Patient / Staff / System safety benefits or issues that may arise from the implementation of this overall programme.									
Potential Positive impacts/aims	The completion of a full winter plan that recognises the asks of the NHSE 26/7 UEC plan including detailed completion against all KLOE by all system partners with additional surge actions to improve patient safety during times of demand surge and our 26/27 vaccination uptake plan.								
	The progression of the Integrated Care Programme priority workstreams up to and during winter in order to achieve a revised model for discharge to assess pathway 1, additional community bedded capacity, released through estate and length of stay improvements								
	Fully embedded systemwide learning from the winter 25/26 which will underpin the additional asks of the system in order to maintain patient safety in times of OPEL 4 and CI								

Well-lead	Potential Negative risks/impacts	The risk to staff resilience as a result of increased service demand pressure negatively impacting recruitment and retention in core urgent care services, increased sickness absence, fatigues and burn out					3	5	15	In conjunction with the winter plan National OPEL framework and system escalation policy, predictive staffing capacity against predicted demand will be ascertained from all key services throughout the winter period and reviewed weekly at tactical level with escalation to executive leads as required. Staff wellbeing and resilience to be monitored by leads and direction to well being support resources utilised as part of staff communications. Where required referrals to occupational health can be made to support staff with managing any impact of increased service demand pressure during winter or ensuring annual leave is well spread for breaks to reduce risk of staff burnout. Public communications featuring BNSSG executives regulary acknowledge and support staff, thanking staff and offerieng support.				3	4	12	Daily review of staffing levels at organisational and system levels against predicted and known demand. Weekly review of predicted demand across all core services to enable actions to be put in place to mitigate. Use of Shrewd indicators demonstrating demand and capacity	
		The risk of workforce instability due to potential changes relating to transformation which may require change in role/responsibility/location of work resulting in workforce uncertainty and potential risk to retention.					2	3	6	Workforce and OD requirements have been identified as a key enabler for transformation; the risk to workforce is subject to oversight by providers and will be assessed through each change baord.				2	2	4		
		The risk to leadership capacity as a result of the ICB merger and workforce reduction plan to meet the national mandate for all ICB's					3	5	15	Executive transition committee in place to manage and mitigate risk and ensure identification of emerging risk via the transition period				3	4	12	Oversight of Transition arrangements via core ICB governance structures including strategic executive and ICB board.	
		The risk to leadership capacity and capability as a result of increased demand and operational pressure resulting in compromised resilience, fatigue and burn out					3	5	15	Regular oversight of workforce and leadership resilience via Tactical escalation and aligned to risk registers in place. Proactive on call cover arrangements including buddy systems and shadow on call across providers-where required BCI plans to mitigate.				2	4	8	Regular review and support mechanisms via PEM and POM and via risk registers.	
	Overall Assessment	Positive	x	Negative		Neutral												
	Any Additional Rationale: Progression of the UEC transformation work via integrated care and POM, delivery of the winter plan and the impact of ICB transition is difficult to quantify in terms of risk and workforce impact at present -this risk will need to be reviewed continually as we progress through the remainder of 26/27																	

Sustainable	Potential Negative risks/impacts	The risk of system ability to maintain core urgent care services as per the national emergency care standards as a result of increased demand and reduction in bedded and non bedded capacity					4	3	12	Delivery of the Winter plan surge and KLOE actions adherence to the national OPEL framework and system escalation policy. Progression of surge schemes through POM to support bridging, F-Ace and UCR. Maintaining DRD reduction trajectory via improved pathway 1 offer, and maintaiing length of stay improvements in p2 and P3.	3	3	9	Daily review of system demand and capacity via operational oversight utilising FDP SCC tool, weekly review of interediate care flow via Tactical forums - APMs and POM.	
		The risk of financial impact as a result of additional surge actions instigated that will require either capital or revenue not currently identified in baseline budgets with impact on other system budgets.								Delivery of the Winter plan surge and KLOE actions adherence to the national OPEL framework and system escalation policy. Progression of surge schemes through POM to support bridging, F-Ace and UCR. Maintaining DRD reduction trajectory via improved pathway 1 offer, and maintaiing length of stay improvements in p2 and P3.					Monitoring via Financial governance structure across all partners. Oversight by executives
							4	5	20		3	4	12		
													0		
	Overall Assessment	Positive	x	Negative		Neutral									
		Any Additional Rationale:													

Quality Team sign off				
Name		Title		Date
ICB Quality & Clinical Governance Group sign off				Date
CNO and/or CMO sign off				Date

Recommendation	Approved		Not approved		Further information required	
Additional notes/rationale						

Risk of 16 or higher	Additional / specific sign off name or group		Date	
Additional notes/rationale/confirm which Risk Register this will sit on				



Winter Planning 26/27

Board Assurance Statement (BAS)

Integrated Care Board (ICB)

1. Purpose

The purpose of the Board Assurance Statement is to ensure the ICB's Board has oversight that all key considerations have been met. It should be signed off by both the ICB Accountable Officer and Chair.

2. Guidance on completing the Board Assurance Statement (BAS)

Section A: Board Assurance Statement

Please include the Integrated Care Board's (ICB) name at the top of the tab.

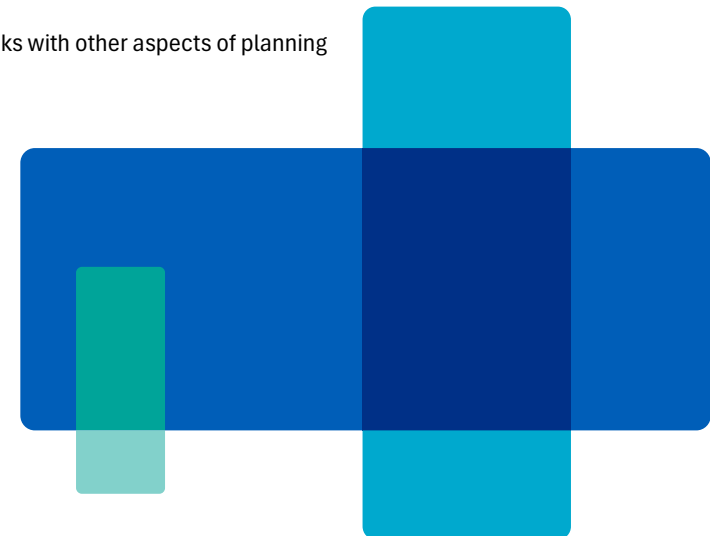
This section gives ICBs the opportunity to describe the approach to creating the winter plan, and demonstrate how links with other aspects of planning have been considered.

Section B: 26/27 Winter Plan checklist

This section provides a checklist of what Boards should ensure is covered in their 2026/27 Winter Plans.

3. Submission process and contacts

Completed Board Assurance Statements should be submitted to the national UEC team via england.eecpmo@nhs.net by **30 September 2026**.



Winter Planning 26/27

Section A: Board Assurance Statement (BAS)

This section gives ICBs the opportunity to describe the approach to creating the winter plan, and demonstrate how links with other aspects of planning have been considered.

Integrated Care Board (ICB):

Bristol, North Somerset And South Gloucestershire

If Other, write ICB Name here:

Contact details (email, phone number):

Richard Carpenter, Associate Director Commissioning – System Resilience,
richardcarpenter@nhs.net 07791 686 366

Date:

15/09/2026

Please complete these sections

Assurance statement			Is this in place? (Y/N)	Additional comments or qualifications (optional)	Blockers/Support requirements (optional)
Governance					
1	1.1	The Board has assured the ICB Winter Plan for 2026/27.	Yes	to be confirmed at ICB Board	
	1.2	The Board is assured that a robust quality and equality impact assessment (QEIA) informed development of the ICB's plan and this has been reviewed by the Board.	Yes	This will accompany the winter plan, and wil be updated throughout winter.	
	1.3	The Board is assured that the ICB's plan was developed with active engagement and input of all system partners, including primary care, 111 providers, Community Health Service Providers (including NHS and non-NHS providers), acute and specialist trusts, mental health, ambulance services, local authorities and social care provider colleagues.	Yes	The BNSSG winter plan has been developeped through the system meeting: Performance Operational Meeting. Executive oversight has been given at nuemrous meetings including FQP, ODG, HCIG, PEM.	
	1.4	The Board has identified a named Executive Winter Sponsor with clear accountability for winter preparedness, delivery, escalation and system oversight.	Yes	This is through Caroline Dawe and David Jarrett	
	1.5	The Board has tested the plan during a regionally-led winter exercise, reviewed the outcome, and incorporated lessons learned.	Yes	BNSSG has run it's own IPC tabletop exercise and incorporaed lesosns learnt into planning for winter 2026. BNSSG has participated in the SW winter planning exercise.	
	1.6	The Board is assured that clear winter governance arrangements, escalation processes and operational leadership arrangements are in place across the system.	Yes	On call rotas have been ppopulated. Bronze silver and gold arrangements have been refreshed in Summer 2026.	
	1.7	The Board is assured that fit testing arrangements, PPE provision and other key infection prevention and control mitigations, as set out in the Health and Social Care Act 2008: code of practice on the prevention and control of infections are in place across the system and are supported by plans to scale rapidly in response to infectious disease surges, ensuring continuity of safe care and workforce protection.	Yes	IPC plans include strengthened core practice, PPE use, environmental cleaning, training and competency checks, outbreak response, vaccination, assurance/audit and workforce resilience. Acute learning includes early isolation and enhanced cleaning approaches.	
	1.8	The Board has received assurance that health protection governance, escalation processes, and provider response arrangements are effective and support timely management of infectious disease incidents and outbreaks, as set out in the ICB Commissioning Guidance - https://www.england.nhs.uk/long-read/clinical-response-outbreaks-of-infectious-disease-commissioning-guidance-icbs/	Yes	Health protection and outbreak response arrangements include clear escalation routes, rapid testing access, coordinated public health/community support, IPC monitoring and escalation through established system governance.	

Winter Planning 26/27

This section provides a checklist on what Boards should assure themselves is covered by 26/27 Winter plans.

			Please complete these sections		
Section B: 26/27 Winter Plan checklist			Confirm (Y/N)	Additional comments or qualifications (optional)	Blockers/Support requirements (optional)
Prevention and vulnerable cohorts					
1	1.1	The Board is assured that those eligible have access to priority vaccination programmes, including childhood vaccinations. This includes 1. RSV vaccination for pregnant women, older adults aged 75 years and over, and older adult care home residents; 2. pneumococcal vaccination for all adults aged 65 years and over and children and adults in a clinical risk group; 3. the annual winter flu and COVID-19 vaccination campaigns.	Yes	1. RSV vaccination is an all tear round offer within our maternity services at trust hospitals/operating units. The RSV for older adults has been expanded, and GP's will deliver to their patients, including those who are housebound and those in older adult care home settings. New all-aged outreach service can support where lowest uptake is identified or any gaps in provision arise. 2. General practice provides a year-round offer to those eligible patients. The school aged immunisation service (SAIS) continues to offer school visits and catch-up clinic vaccinations. New all-aged outreach service can support where lowest uptake is identified or any gaps in provision arise	
	1.2	The Board is assured that a risk-stratified approach is in place to identify individuals at increased risk of winter-related deterioration or admission, including those with co-morbidities that leave them susceptible to hospital admission as a result of winter viruses, younger people with significant co-morbidities, and other vulnerable cohorts. Targeted interventions are in place, including vaccination, pre-winter health checks, personalised care planning, access to antivirals where appropriate, and community-based support to reduce avoidable admissions and support continuing care in the community.	Yes	GP's will use searches to ensure those at risk are contacted and followed up for vaccination where eligible. One Care's new all-aged outreach vaccination service will be in place from 1/9/26. Data will ensure those most at risk and most vulnerable have access to vaccination and vaccination information. One Care will work with general practice, Sirona and other community/voluntary sectors partners to ensure making every contact count is key and link with existing services to ensure health-checks and information is readily available to those communities where uptake may be lowest or communities most at risk and with lower health outcomes. Areas of deprivation and poor engagement will be high priorities. Our GP Federation have developed a risk approach proposal to support practices. All practices have risk stratification processes in place following this being a requirement for Capacity and Access funding. Flu Surge Outreach in place, following learning from 24/25, and GP Federation ability to co-ordinate clinics for additional flu vaccinations, previously at PCN level. Urgent Care Co-ordination Programme in place for improvements to pathways and communication/visibility of these through the system. Population health management, whole-population segmentation and risk stratification are used to identify vulnerable cohorts including older people, frailty, long-term conditions and serious mental illness. Targeted interventions include vaccination, anticipatory care planning, medicines optimisation, falls prevention and proactive community/neighbourhood support. Our providers have a system model for those who have repeated crisis contacts, this will trigger one proactive, whole-person response designed to stabilise people close to home. Targeted prevention through 1 integrated	
Flow, occupancy and discharge					
2	2.1	The Board is assured there are clear operational plans and daily processes to reduce avoidable bed occupancy and improve patient flow seven days a week, including pre-winter review of bed demand and capacity, delivery of model discharge pathway requirements, and executive oversight of required and actual daily discharges, patients with no criteria to reside by pathway, discharge performance and long discharge delays.	Yes	The ICB has earmarked funding to support a significant system wide transformation program, led by BFT called Intermediate Care Program. The program in addition to focussing on in year delivery of flow trajectories, will look at our design of intermediary care services	
	2.2	The Board is assured that system partners have agreed and implemented measures to eliminate corridor care, with defined patient safety thresholds, supported by coordinated patient flow, discharge and escalation arrangements, with system level oversight and mitigation of risk during periods of increased demand.	No	Corridor care remains a risk going into winter 2026. GIRFT corridor-care recommendations are being implemented within our acute partners, with governance and monitoring arrangements in place. Revised escalation policies prioritise use of established bed capacity, safer outlying options and defined escalation areas before corridor care is used. Corridor care is treated as an increased-risk position rather than core capacity and requires senior operational oversight. Community processes are being updated to ensure system OPEL 4 is no longer a trigger for the use of boarding capacity in South Bristol Community Hospital.	
	2.3	The Board is assured that discharge planning is being undertaken jointly with local authorities and social care partners, with effective system discharge coordination arrangements, clear processes to identify, escalate and resolve discharge delays, and real-time visibility of demand and community capacity.	Yes	Revised escalation pathways have been agreed between system partners to mobilise step up (spot purchased) beds. We have refreshed and updated our governance within our Area Performance Meetings, ensuring a direct route to escalate through Silver meetings as required. Pilots continue in NS to support improved community flow, and 'bridging' capacity has been stepped up within Bristol City Council area to support reablement. The intermediate care program is re-assessing real time visibility or pressures.	
	2.4	The Board is assured that providers have baselined current discharge arrangements against the model discharge pathway, identified gaps, and agreed improvement actions across acute, community and social care partners.	Yes	Model Discharge requirements are being implemented through early discharge planning, multidisciplinary decision-making, Transfer of Care Hub arrangements and strengthened working with community and social-care partners. Longer length-of-stay reviews take place across all three acute sites, with executive-led oversight through refreshed performance escalation arrangements.	

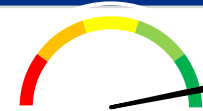
	2.5	The Board is assured that pre-Christmas and holiday-period occupancy reduction plans have been agreed and will be implemented.	Yes	BNSSG system has plans for a system perfect week, this is a collaborative approach led through our community provider to support our occupancy during late December, early January.	
Demand, capacity, and surge management					
3	3.1	The board is assured that whole system demand and capacity modelling has informed winter planning and that tested surge and extreme surge response arrangements are in place to support safe operational delivery during periods of increased demand.	No	The system is finalising demand and capacity modelling, assessing P1 sustainability and activity recovery profiles to meet required trajectories. A revised design of our BNSSG P1 pathway forms part of the intermediate care approach which will be progressing through winter	
	3.2	The Board is assured that workforce, NHS 111 and mutual aid arrangements are sufficient to respond safely to sustained periods of increased demand.	Yes	Workforce capacity, NHS 111/IUCS pressures and mutual aid are included in Severnside winter plans	
	3.3	The Board is assured that bed escalation capacity arrangements have been agreed and tested across system partners.	Yes	Visibility of bed occupancy and bed usage is shared across all partners. Acute, community and mental health beds are embedded into partner escalation SOPs and reviewed collectively where appropriate through PBNSSG governance. Key learning from the Southwest winter exercise will be adopted where relevant.	
Primary Care, NHS 111 and admission avoidance					
4	4.1	The Board is assured that anticipated general practice demand has been assessed, and that: •sufficient capacity has been commissioned, including for surge periods (e.g. ARI hubs) •robust escalation process are in place •through the IUC Clinical Assessment Service (or equivalent), sufficient capacity will be commissioned for out of hours general practice, including weekends and bank holidays.	Yes	The ARI LES was agreed at the LES steering group including addition of a 'surge' / top up arrangement to this which would be activated during surge in the same way as when One Care managed ARI. A new BNSSG GP OPEL framework is in place ready for Winter 26/27. Launch is now pending, as we progress the transition of GP aggregate data in to the SCC tool. Demand & capacity - we are gathering data about the growth of waiting lists for routine appointments, which are understood to be a consequence of some contractual changes last year. There are some winter risks associated as these lists are likely to grow at a faster rate through winter as practices in OPEL 4 manage the balance of routine and urgent slots to prioritise on the day urgent. SevernSide Integrated Urgent Care Services provide our out of hour service including: - 24/7 Clinical Assessment Service - OOH face to face appointments at Treatment Centres across BNSSG - OOH Home Visits when appropriate - 24/7 signposting for people to the most appropriate service to meet their needs	
	4.2	The Board is assured that practices are compliant with contractual requirements, including opening hours, use of online consultation, clinically urgent same day appointments (working towards 90% target) and practices making 1 appointment per 3,000 registered population available to NHS 111 for direct booking.	Yes	All PCNs complete capacity and Access improvement plans on a 6 months basis including confirming all access routes are available to patients. Details of the appointment book set up for 111 direct booking are also included. Mystery shopper exercises are undertaken to confirm access as per the contract. 111 and GPAD access data are monitored on a monthly basis.	
	4.3	The Board is assured that PCN enhanced access appointments are available and that PCNs make available to NHS 111 any unused on the day slots as per DES requirements.	Yes	All PCNs have enhanced access plans in place. Ad hoc mystery shopper checks are carried out to ensure these plans are being carried out and appointments are available.	
	4.4	The Board is assured that unscheduled dental care delivery is monitored as part of the mandated number of urgent dental care appointments.	Yes	We are monitoring this, as part of monthly activity and contract monitoring. Urgent Care activity is reported to dental board and shared at PCOG. Risks: activity not going through dental help line (accessed via 111), disadvantaging those patients without a dental home. ICB is writing out to providers to offer them the opportunity to offer their mandated appointments via the dental help line for BNSSG.	
	4.5	The Board is assured that for community pharmacy, demand, activity and capacity has been assessed, including sufficient out of hours provision across the ICB footprint; and delivery of Pharmacy First and the Discharge Medicines service.	Yes	Community Pharmacy demand, activity and capacity is regularly assessed in conjunction with Community Pharmacy Avon and Wiltshire for Pharmacy First and work is ongoing with community pharmacy PCN leads to increase contraception prescribing to free up GP capacity. BNSSG have developed local PGDs to further free up capacity in GP practices. Regular meetings with our out of hours provider (PPG) and the DOS team are undertaken to improve referral from NHS111 telephony to community pharmacy. Independent prescribing will be part of the contract from Autumn 2026. The Discharge Medicines Service is being looked at in conjunction with the Trust.	
	4.6	The Board is assured that the NHS 111 Directory of Services profiles are accurate, regularly reviewed, and aligned to available capacity across primary care and community services.	Yes	BNSSG employs regional DoS team, and regular reviews are undertaken. Highlight reports are received and actions are taken where required. Project reviews are undertaken regularly, during the summer BNSSG has completed the refresh of UTC and UEC profiles. Dental and DoS profiles have been completed earlier this year. Plans are progressing with PACCS and service finder in SWASFT, to increase see+trear and hear+trear outcomes. Benchmarking has been completed regionally. Dos Profile reviews are scheduled for UCR, Mental Health and SDEC as part of the project plan.	
	4.7	The Board is assured that for all provision, both in and out of hours, there will be communications activity to ensure the public is aware of what services are available.	Yes	This is included in Severnside and ICB communications plans. This has been shared with BNSSG partners for their and is scheduled for delivery as part of the winter communications plan	
Community Health Capacity					
5	5.1	The Board is assured that sufficient urgent community capacity, including UCR, Virtual Wards, Hospital at Home and community diagnostic interventions where applicable, has been commissioned, is monitored and utilised effectively to support admission avoidance and discharge, with appropriate escalation arrangements in place and access to senior clinical decision-making through SPOAs at least 12 hours a day, 7 days a week.	Yes	The system is bolstering capacity to ensure resilience in our urgent care response (UCR) and same day community nursing service. The sirona winter plan is thorough and includes forecast demand vs anticipated shortfall and mitigations. Some mitigations for winter improvements are noted through the intermediate care program - these include, pathwa modeling, additiional community bed options and P1 service design.	

Whole System Response					
6	6.1	The Board is assured that a system wide approach is in place to optimise the use of out-of-hospital capacity and admission avoidance pathways to reduce avoidable admissions and support timely discharge.	Yes	Governance through our POM and PEM meetings would bring exceptional issues to senior attention, where opportunities to maximise capacity have not yet been directly addressed. BNSSG has prioritised services within the admission and attendance avoidance portfolio, including moving Community Emergency Medicine Service (CEMS) to 5 days a week. Ensuring a consistent and regular offer for SWAST. Focus remains on other services, including: UCR, REACT, F-ACE, CAS.	tion, where opportunities to maximise capacity have ensuring consistent service offeres across our
Leadership, operational grip and resilience					
7	7.1	The Board is assured that on-call arrangements are in place and have been tested. Staff on-call have access to medical and nursing leaders for urgent advice if needed.	Yes	Medical and nursing colleagues are available through providers and through the ICB. Experienced Dec & Jan, supported by EPRR and SCC colleagues	on-call staff are allocated to the rota for
	7.2	The Board is assured there will be an appropriately skilled and resourced operating model for system co-ordination over the winter period to enable the sharing of intelligence and risk balance to ensure this is appropriately managed across all partners.	Yes	SCC and UEC structures and model defined for Winter	
	7.3	The Board is assured that tested command, control and escalation arrangements are in place, including OPEL reporting, EPRR arrangements and clearly defined leadership responsibilities.	Yes	Previous experience in system pressures have aligned SCC and EPRR functions. Our on call policies clearly define roles and responsibilities and appropriate escalation routes as required	
	7.4	The Board is assured that mutual aid arrangements, business continuity plans, severe weather preparedness arrangements and industrial action contingencies have been reviewed and tested where appropriate.	Yes	Mutual-aid arrangements across the Trust and wider system have been reviewed, including ambulance-divert arrangements. An internal divert SOP will support winter escalation at BFT, with system mutual aid operating through established OPEL processes.	
	7.5	The Board is assured that plans are in place to support staff welfare through periods of high demand.	Yes	The ICB has a range of tools to support staff welfare, and offer assistance where needed.	
System Co-ordination Centres					
8	8.1	The Board is assured that SCCs will be proactive in resolving operational pressures in hours, and that ICBs will maintain on-call functions for the oversight and resolution of operational pressures and patient flow and safety out of hours.	Yes	BNSSG and Glos will align SCC functions as part of clustering and streamlining. Current SCC operations for BNSSG are visible through our OPEL framework and shared on our live UEC dashboards, on the federated Data Platform SCC tool.	
	8.2	The Board is assured that SCCs will be fully operational 08:00 to 18:00 7 days per week and have the ability to extend hours of operation during periods of extreme pressure.	Yes	The SCC is operated 5 days a week through the performance and resilience team. Weekends the SCC function is covered through tactical on call.	
	8.3	The Board is assured that ICB SCCs will maintain proactive engagement and communication with NHSE Regional teams.	Yes	The SCC continues to liaise daily/weekly with the ROC, addressing issues and openly communicating required support and emerging pressures.	

BAS Self-Assessment Dashboard

BNSSG ICB

Overall Assessment Rating: 5 - Full assurance



Section A

Governance

Rating

5 - Full assurance

Section B

Prevention and vulnerable cohorts

5 - Full assurance

Flow, occupancy and discharge

4 - Substantial assurance

Demand, capacity, and surge management

3 - Moderate assurance

Primary Care, NHS 111 and admission avoidance

5 - Full assurance

Community Health Capacity

5 - Full assurance

Whole System Response

5 - Full assurance

Leadership, operational grip and resilience

5 - Full assurance

Executive Approval

The purpose of the Board Assurance Statement is to ensure the Trust's Board has oversight that all key considerations have been met. It should be signed off by both the ICB Accountable Officer and Chair.

Integrated Care Board (ICB) name: BNSSG ICB

ICB CEO/AO name: Shane Devlin

Date reviewed: 30/09/2026

ICB Chair name: Jeff Farrar

Date reviewed: 30/09/2026

Please update following completion of the BAS template

Please provide name and contact details of designated Senior Responsible Officer (Executive Level)

David Jarrett

Please provide confirmation that the SRO has reviewed and approved the responses within this document, confirming they are correct and complete.

Caroline Dawe

Please confirm date reviewed

30/09/2026

One Gloucestershire's Urgent and Emergency Care 26/27 Winter Plan



Version	1
Author	Yasmin Bajwa – UEC and System Flow Programme Manager
Sponsor	Caroline Dawe, Director Strategic Commissioning – Value and Delivery
Approved By	ICS Strategic Executives
Approval Date	September 2026
Review Date	As required

Version Control

Version Number	Summary of Change	Date
1	Final Draft	07.09.2026

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1. Introduction

Purpose

The Gloucestershire Winter Plan 2026/27 sets out a place-based response, working in partnership with health and social care organisations across Gloucestershire, to provide strategic leadership, commissioning oversight and whole-system assurance to support safe, effective and resilient health and care services throughout the winter period as part of the wider Gloucestershire, Bristol, North Somerset and South Gloucestershire ICB cluster.

Developed in response to NHS England's Winter Planning Guidance 2026/27 and the associated Integrated Care Board, Board Assurance Statement (BAS), this plan provides assurance regards how the ICB will work with partners to understand population need, assess winter risk, commission sufficient capacity, strengthen prevention and proactive care, and coordinate a whole-system response to seasonal pressures. It demonstrates how Gloucestershire will meet national expectations while responding to the needs of its local population.

Scope

This is an ICB-led system plan rather than a detailed provider operational plan. Individual NHS trusts, primary care providers, community services, mental health services, ambulance services, local authority partners and commissioned providers remain responsible for developing and delivering their own organisational winter plans.

The role of the ICB is to commission a whole-system approach. This includes assessing population health need, understanding demand and capacity across the system, identifying strategic risks and dependencies, commissioning additional capacity where required, coordinating whole-system resilience arrangements and providing assurance to the ICB Board and NHS England.

National and Local Context

Winter planning for 2026/27 takes place within a significantly evolving national policy landscape. The NHS 10 Year Health Plan establishes three long-term shifts for health and care services: from hospital to community, from analogue to digital, and from sickness to prevention. These ambitions are supported by the Neighbourhood Health Framework, which promotes integrated, proactive care delivered closer to home through stronger neighbourhood services, improved care coordination and greater use of digital technology.

Alongside these strategic reforms, NHS England's Winter Planning Guidance requires every Integrated Care Board to develop a clinically led, evidence-based and deliverable winter plan that demonstrates whole-system preparedness. Plans must be developed collaboratively across acute, community, mental health, ambulance, primary care, social care and voluntary sector partners and provide assurance that systems have assessed demand, commissioned sufficient capacity, planned for escalation and established effective governance arrangements.

Gloucestershire's place-based approach to winter planning is informed by the Population Health and Strategic Commissioning Plan 2026–2031 and the wider One Gloucestershire Integrated Care Strategy. Together, these set out a shared vision of improving health outcomes, reducing inequalities and delivering sustainable health and care services through integrated commissioning and partnership working.

Strategic Commissioning Approach and Objectives

The plan adopts a strategic commissioning approach based upon population health intelligence, demand and capacity planning, commissioning intentions, service transformation and system operational assurance as outlined in the Gloucestershire System Escalation Policy.

The plan aligns winter preparedness with Gloucestershire's wider strategic priorities, including strengthening prevention, expanding neighbourhood health services, improving access to urgent and emergency care, enhancing community-based alternatives to hospital admission, supporting timely discharge and embedding digitally enabled system coordination.

The objectives of this plan are aligned to the eight assurance domains contained within the NHS England Integrated Care Board Winter Board Assurance Statement.

The strategic objectives of the Winter Plan are to:

Strategic Objective	Intended Outcome
Protect people most vulnerable to winter pressures	Identify high-risk individuals early and strengthen prevention through vaccination, anticipatory care, proactive neighbourhood support and targeted interventions that reduce avoidable deterioration and health inequalities.
Maintain safe patient flow and timely discharge	Work with partners to improve patient flow across acute, community, mental health and social care services, enabling people to receive the right care in the right place and return home as soon as clinically appropriate.
Commission sufficient demand, capacity and surge arrangements	Ensure demand modelling, workforce planning, commissioned capacity and escalation arrangements provide a resilient response to anticipated and unforeseen winter pressures.
Strengthen primary care, urgent care and admission avoidance	Maximise access to primary care, NHS 111, community pharmacy and urgent community services to reduce avoidable emergency department attendances and hospital admissions.
Expand community-based care and neighbourhood services	Increase the availability and utilisation of community health services, urgent community response, virtual wards, Hospital at Home and integrated neighbourhood services to support care closer to home.
Deliver a coordinated whole-system response	Enable providers, commissioners, local authorities and voluntary sector partners to work as a single integrated system, supported by shared decision-making, common priorities and effective escalation arrangements.
Maintain effective leadership, operational grip and resilience	Ensure robust governance, risk management, command arrangements and operational oversight enable timely decision-making and proportionate responses to system pressures.
Provide effective system coordination and assurance	Maintain a coordinated system response through the Gloucestershire System Co-ordination Centre, supported by real-time intelligence, Integrated OPEL, SHREWD and clear governance arrangements that provide assurance to the ICB Board and NHS England.

2. Governance, Assurance and Winter Planning Approach

Governance and Leadership

Winter planning is a whole-system responsibility requiring collective leadership, shared ownership and coordinated decision-making across Gloucestershire

Overall accountability for delivery of this Winter Plan sits with Integrated Care Board, supported by a designated Executive Winter Lead who will oversee implementation, provide strategic leadership and report progress through established governance arrangements to the ICB Board.

Operational oversight throughout the winter period will be provided through Gloucestershire's Urgent and Emergency Care governance structure in accordance with the 26/27 Gloucestershire System Escalation Policy and Integrated OPEL Framework. This provides clear routes for decision-making, escalation, risk management and whole-system coordination throughout the winter period.

The Gloucestershire System Co-ordination Centre (SCC) will provide the operational coordination function for the system, maintaining a shared operational picture, monitoring emerging risks, coordinating escalation activity and supporting collective decision-making across partner organisations.

Partnership Working and Planning Methodology

This Winter Plan has been developed collaboratively with partners across Gloucestershire, including acute, community, mental health, ambulance, primary care, adult social care, public health and voluntary, community and social enterprise (VCSE) organisations.

Development of the Gloucestershire Winter Plan has been informed through a structured planning process incorporating:

- NHS England Winter Planning Guidance and the Integrated Care Board, Board Assurance Statement.
- The Gloucestershire Population Health and Strategic Commissioning Plan 2026–2031.
- Learning from Winter 2025/26, including recommendations arising from local winter debriefs and system evaluation.
- Population health intelligence, activity and demand forecasting, demographic analysis and service utilisation data.
- Engagement with system partners across health, care and the voluntary sector.
- Existing transformation programmes and commissioning priorities.
- Local and regional winter stress-testing exercises.

This approach ensures that winter planning is evidence-based, population-focused and aligned with Gloucestershire's wider strategic priorities.

Learning, Continuous Improvement and Stress Testing

Gloucestershire views winter planning as a continuous cycle of planning, delivery, evaluation and improvement, rather than a standalone annual exercise. The development of the Winter Plan 2026/27 has been informed by the formal multi-agency debrief following Winter 2025/26.

The 2025/26 debrief identified recommendations that have shaped this year's approach, including the need for earlier winter planning, strengthened whole-system stress testing, clearer escalation arrangements, improved understanding of Integrated OPEL actions, enhanced communications planning, greater workforce resilience and wellbeing, and stronger commissioning of surge capacity.

The review also recognised areas of good practice, including improved ambulance handover performance, stronger infection prevention and control arrangements, effective partnership working and more rapid system recovery compared with previous winters.

To further strengthen preparedness, Gloucestershire will undertake a programme of assurance and testing ahead of winter, including participation in the NHS England regional winter stress-testing exercise and locally led scenario-based exercises. These exercises will test governance arrangements, escalation processes, command and control, communications, surge capacity and organisational interdependencies, ensuring lessons can be incorporated before periods of peak demand.

Following Winter 2026/27, the ICB will undertake a further structured multi-agency debrief to evaluate delivery against this plan, review system performance and capture learning to inform future commissioning decisions. This approach supports continuous improvement and reinforces the ICB's commitment to strengthening system resilience year on year.

Quality, Risk Assessment and Equality

The development of this plan has been supported by consideration of quality, equality and health inequalities to ensure that winter arrangements improve outcomes for all sections of the Gloucestershire population.

The plan has also been developed in partnership with system stakeholders to ensure that commissioning decisions reflect local population need and support equitable access to services throughout the winter period.

Progress against this Winter Plan will be monitored through established governance arrangements and regular reporting to the ICB Board. Delivery will be reviewed throughout the winter period, with formal post-winter evaluation informing future commissioning, service development and continuous improvement.

3. Urgent and Emergency Care Transformation Programme

Gloucestershire's winter planning is underpinned by the Working as One Urgent Care and Flow Transformation Portfolio. This commissioned portfolio brings together the system priorities required to improve access, flow and outcomes across the urgent and emergency care pathway. It aligns immediate operational delivery with longer-term service redesign, ensuring winter resilience is supported by sustainable transformation rather than short-term additional capacity.

The programme is commissioned to systematically reduce the risk of delay-related harm; improve outcomes and support people to maintain or regain independence; reduce duplication for patients and staff; improve value for money; and deliver the ambitions within Gloucestershire's Joint Forward, Operational and Financial Plans.

Our Transformation Priorities

The programme is structured around three interconnected priorities spanning the UEC pathway:

Priority 1 – Managing demand and providing care in the most appropriate setting.

This focuses on reducing avoidable reliance on acute hospital services by strengthening alternatives and improving coordination of urgent care. Key workstreams include the continued development of a Single Point of Access (SPOA) for healthcare professionals and development of the Urgent Community Response offer. The SPOA model is being developed iteratively following phased implementation, with the intention of reducing fragmentation and unnecessary hand-offs, strengthening senior clinical decision-making and increasing access to community and virtual alternatives to hospital attendance or admission.

Priority 2 – Improving hospital flow and discharge.

The second priority focuses on ensuring that people leave hospital at the earliest clinically appropriate point and that downstream capacity is used effectively. This includes sustainable delivery of Pathway 1 and Pathway 2, reducing delays for people who no longer meet the criteria to reside, and improving coordination of discharge through development of the Transfer of Care Hub model as per the national framework

Priority 3 – Developing the long-term model for urgent and intermediate care.

Alongside immediate improvement, the programme is developing the longer-term model required to meet Gloucestershire's future population needs. This includes development of a home-by-default intermediate care model, informed by Pathway 1 and 2 redesign and learning from Community Hospital tests of change, together with consideration of the future Urgent Treatment Centre and Minor Injury and Illness Unit offer, including the opportunity for a co-located UTC at Gloucestershire Royal Hospital.

It is expected that these programmes will continue to be delivered against agreed milestones within the UEC Portfolio Board. Wherever possible, winter interventions will reinforce the future model of care: strengthening community alternatives to admission, improving access and navigation through SPOA, supporting timely discharge, maximising Pathway 1 and 2 effectiveness and progressing the longer-term intermediate and urgent care models.

4. Winter Planning and Delivery

Prevention and Protecting Vulnerable People

(BAS Domain 1)

Preventing avoidable deterioration and reducing demand on urgent and emergency care services remains a cornerstone of Gloucestershire's winter approach. The ICB will continue to commission and assure preventative services that identify those at greatest risk of deterioration, enable earlier intervention and support people to remain independent within their own homes wherever possible. Through population health management, risk stratification and neighbourhood working, the system will target support towards vulnerable cohorts, including older people, those living with frailty or long-term conditions, and residents of care homes.

A coordinated programme of preventative interventions will be delivered across the system, including seasonal vaccination, anticipatory care planning, medicines optimisation, falls prevention and proactive community support. These interventions will be complemented by robust infection prevention and management arrangements, helping to reduce avoidable winter-related illness and hospital admission, protect vulnerable populations and minimise the operational impact of seasonal infection.

The ICB has led a whole-population health segmentation programme, which has strengthened the system's understanding of how different population groups access and use health and care services across Gloucestershire. The intelligence generated through this work is being used to identify opportunities for earlier intervention and to inform targeted commissioning and transformation with system providers, including through the Gloucestershire Provider Partnership. Initial areas of focus include frailty, complex long-term conditions and serious mental illness, supporting the development of more proactive and personalised models of care for cohorts at greatest risk of deterioration and unplanned service use.

Seasonal vaccination will form a key part of this preventative approach. Working in partnership with Primary Care, Community Pharmacy, Gloucestershire Health and Care NHS Foundation Trust (GHC), Gloucestershire Hospitals NHS Foundation Trust (GHFT), Public Health and the Voluntary, Community and Social Enterprise (VCSE) sector, the ICB will oversee delivery of targeted vaccination programmes for eligible cohorts. Building on learning from previous campaigns, targeted communications, outreach activity and population health intelligence will be used to support uptake amongst underserved communities, care home residents and housebound patients. Performance will be monitored throughout the campaign to maximise protection ahead of peak winter demand and reduce avoidable respiratory illness and admission.

Infection Prevention and Control (IPC):

Learning from Winter 2025/26 within the acute trust demonstrated the benefits of closer collaboration between IPC and operational site teams, including daily touchpoints, earlier action in response to symptoms ahead of confirmed results and the "Don't wait, isolate" approach, particularly in response to Norovirus. Enhanced cleaning processes also supported efforts to minimise nosocomial spread and recolonisation of organisms. Collectively, these measures contributed to fewer acute beds being closed due to infection control than in previous years, despite infection rates being higher or comparable, alongside greater consistency in available bed capacity.

In terms of community and care home oversight plans are in place to:

- Strengthen core IPC practice across all providers Ensuring consistent adherence to hand hygiene, PPE use, environmental cleaning, and safe clinical practice, supported by regular training and competency checks.

- Embed robust outbreak prevention and response Clear escalation routes, rapid testing access, and coordinated support from public health and community teams will minimise transmission and reduce disruption to resident care.
- Improve vaccination uptake for residents and staff Continued focus on seasonal vaccination programmes to reduce risk from respiratory infections and maintain resilience during winter.
- Enhance assurance and monitoring Routine IPC audits, data reporting, and targeted support for homes requiring improvement will strengthen system oversight and quality.
- Support workforce resilience Ensuring staff have access to training, guidance, and wellbeing support to maintain safe practice and reduce sickness-related staffing pressures.

Flow, Occupancy and Safe Discharge

(BAS Domain 2)

The system's priority ahead of and throughout winter 2026/27 is to reduce acute bed occupancy and delayed discharge through a coordinated programme of operational, clinical and commissioning actions. This includes mobilisation of the new Home First and Community Reablement models, optimisation of existing intermediate care capacity, redesign of Pathway 2 provision and continued development of the Care Transfer Hub. Together, these actions are intended to increase the number of people supported to return home, improve utilisation and flow through intermediate care, and reduce avoidable delays across acute and community pathways.

In autumn 2026/27, Gloucestershire commenced mobilisation of its newly commissioned Pathway 1 Home First service, delivered by Gloucestershire Health and Care NHS Foundation Trust (GHC), alongside the new Community Reablement Service delivered by Gloucestershire County Council (GCC).

The new Home First service, led by Gloucestershire Health & Care (GHC), is a major redesign of how the system supports people to return home safely, quickly, and with the right level of short-term support after a hospital stay. It consolidates multiple discharge and community functions into a single, clinically led, home-based service that strengthens flow, improves independence, and reduces avoidable long-term care. The model supports discharge from GHFT, out-of-county hospitals and community beds, with approximately 85% of referrals expected to originate from acute hospitals.

Core Ambitions:

- A single, unified Pathway 1 service; One coordinated model delivered through shared leadership, common processes, and a single front door for referrals. This removes variation, reduces duplication, and ensures equitable access across the county.
- Trusted assessment at the heart of the model A standardised, multidisciplinary approach to assessing needs in hospital and at home, enabling quicker decisions, fewer handoffs, and improved patient experience.
- Rapid, same-day response to support discharge; the model aims for <24-hour decision-making and timely commencement of care at home, reducing unnecessary hospital days and improving flow.

The new Community Reablement Service, led by Gloucestershire County Council (GCC), is a cornerstone of the county's shift toward a home-first, independence-focused model of care. It will deliver a single, strengthened, outcomes-driven service designed to reduce reliance on long-term care, improve patient experience, and support system flow.

Core Ambitions:

- A single, countywide reablement offer with consistent standards GCC will lead a unified service with one operating model, one workforce, and one set of quality expectations—ensuring equitable access and reducing variation across districts.
- Independence as the primary outcome; the service is designed to maximise recovery and independence, reducing long-term care packages and supporting people to remain safely at home.
- Stronger integration with health partners and Pathway 1 The reablement service becomes a core component of the wider discharge and intermediate care system, enabling smoother transitions from hospital and reducing delayed discharge days.
- Rapid, responsive support at home; the model aims for timely commencement of reablement—typically within 24–48 hours—helping people leave hospital sooner and preventing avoidable readmissions.
- A skilled, multidisciplinary workforce Investment in training, recruitment, and professional development will create a stable, capable workforce able to deliver high-quality reablement and trusted assessments.

Alongside Pathway 1 redesign, the system will continue to optimise existing bed-based intermediate care capacity. GHC currently operates Community Hospital Pathway 2 beds, including rehabilitation, complex, stroke and CATU capacity, with additional P2/P3 beds commissioned by GCC on behalf of the system. A temporary test of change to the Community Hospital bed model is underway and is expected to continue until at least April 2027, subject to system governance review.

Improving flow through this capacity is a key winter priority. A Community Hospitals DRD Task and Finish Group has been established with system partners, alongside arrangements to monitor delays and escalate long waits. September performance indicates significant opportunity to release additional effective capacity through reducing discharge delays and length of stay, supporting increased admissions into intermediate care and improved flow from the acute sector.

The new independent sector pathway 2 commissioning model, due to be finalised in November 2026 ahead of winter, delivers a clearer, more accountable and outcomes-driven approach to bed-based rehabilitation. It establishes a single, consistent countywide offer, strengthens clinical governance, and improves patient flow from acute hospitals. By commissioning P2 as one unified service with shared standards, defined KPIs, and coordinated bed management, the model supports faster access to rehabilitation, better recovery outcomes, and reduced long-term care demand. It aligns directly with commissioning intentions to create a coherent intermediate care system, improve independence, optimise resources, and ensure best value for Gloucestershire.

In addition to discharge pathway redesign, the Care Transfer Hub (CTH) will form the central coordination point for all discharge and intermediate care activity across Gloucestershire. Over the next 18 months, the focus is on completing the transition to a fully mature, single-team model with unified leadership, digital infrastructure, and consistent operational standards.

Core Ambitions Phase 1 (2026–27):

- Complete the transition to a single integrated team, bringing together ICB, GHFT, GHC and GCC functions into one coordinated operating model.
- Embed trusted assessment and centralised capacity allocation across all Pathway 1–3 activity.
- Strengthen MDT case management to ensure consistent discharge planning from admission and improved flow.
- Align CTH development with wider Intermediate Care and SPOA transformation, ensuring seamless pathways and shared governance.

Discharge escalation intelligence is reviewed through the System Co-ordination Centre (SCC)

Daily Position Call and System Flow Tactical Escalation Group (SF-TEG), providing a clear route from identification of pressure to coordinated system action. Used alongside Integrated OPEL and IUCS OPEL arrangements, the framework provides a broader view of flow across the patient's pathway and enables targeted escalation where capacity or performance is deteriorating. This will be particularly important during winter, supporting earlier intervention, system-wide mitigation and more effective use of available health and social care capacity.

Demand, Capacity and Surge Planning

(BAS Domain 3)

Gloucestershire's approach is underpinned by whole-system demand and capacity modelling, enabling commissioning and planning decisions to be informed by population need, activity forecasts and emerging operational intelligence.

Demand and capacity modelling undertaken through the Working as One programme, has informed the development of Gloucestershire's three priority transformation workstreams: management of demand, discharge efficiency and intermediate care redesign. This evidence base continues to inform commissioning decisions and capacity assumptions, supporting alignment between anticipated demand and available resource across acute, community, ambulance and primary care services.

Alongside longer-term modelling, Gloucestershire has developed a robust predictive approach to system oversight. Integrated predictive intelligence is routinely reviewed through the Tactical Escalation meetings, reviewing admission forecasts, bed occupancy, workforce capacity, historical demand trends and relevant public health intelligence, including seasonal flu forecasts and COVID-19 prevalence. This provides an early indication of where and when pressures are likely to emerge and supports a shared system understanding of risk before operational escalation occurs and enables effective surge planning

Learning from Winter 2025/26 reinforced the importance of testing assumptions and system resilience before periods of peak demand. Gloucestershire will participate in the NHS England regional winter stress-testing programme, complemented by locally led scenario exercises to test demand and capacity assumptions, governance and command arrangements, workforce resilience, mutual aid, escalation processes and organisational interdependencies. Findings will be used to refine winter plans and mitigations, providing additional assurance of whole-system readiness ahead of winter.

Primary Care, NHS 111 and Admission Avoidance

(BAS Domain 4)

Primary care, NHS 111 and Community Pharmacy provide the initial front doors to urgent care and are central to preventing avoidable Emergency Department attendance and hospital admission. During Winter 2026/27, the ICB will continue to commission and assure an integrated urgent care offer spanning General Practice, NHS 111 and out-of-hours services, Community Pharmacy, Minor Injury and Illness Units (MIIUs), urgent treatment services and acute assessment pathways. The aim is to maximise same-day access, strengthen navigation between services and ensure people receive timely care in the most appropriate setting.

Primary care winter assurance will combine commissioned additional capacity with contractual oversight and improved integration across urgent care pathways. Additional General Practice appointments will be targeted around known periods of increased pressure, including Christmas and New Year, alongside continued assurance of contractual access requirements, including same-day access for clinically urgent need, online access and NHS 111 direct-bookable capacity. PCN Enhanced Access arrangements will also support the wider urgent care offer, with further work continuing to strengthen direct booking from NHS 111 and address digital or hub constraints where these remain.

Winter planning will include specific assurance of service availability across peak periods, particularly Christmas, New Year and bank holidays. This will include maintaining accurate Directory of Services (DoS) information and referral routes, assuring appropriate NHS 111 and out-of-hours capacity and coordinating public communications to promote alternatives to Emergency Departments. Gloucestershire's out-of-hours provision is delivered by GHC, with an IC24 element, and regular engagement between providers and DoS teams supports continued improvement in referral pathways and patient navigation.

Community Pharmacy forms an increasingly important component of this integrated offer. Capacity is routinely monitored through local intelligence and the South West Community Pharmacy Dashboard, providing oversight of core, supplementary and out-of-hours opening hours. Bank holiday pharmacy provision is coordinated through the Collaborative Commissioning Hub across the seven ICB areas, providing additional assurance of access during periods when other services may operate reduced hours. Alongside this, the ICB maintains oversight of unscheduled dental care through contract-level and routine performance monitoring, supporting a broader view of primary care access and resilience.

Gloucestershire will continue to maximise the contribution of Pharmacy First and the Discharge Medicines Service (DMS) to winter resilience. Pharmacy First provides an alternative route to assessment, advice and treatment for appropriate conditions, while DMS supports continuity and optimisation of medicines following discharge from hospital. Gloucestershire's locally commissioned Patient Group Direction (PGD) service further broadens access to assessment and treatment where appropriate without requiring a General Practice appointment. Together, these services increase the range of alternatives available to patients, protect General Practice capacity and reduce avoidable demand elsewhere in the urgent and emergency care pathway.

Throughout winter, the ICB will maintain a whole-pathway view of access, demand and capacity across General Practice, NHS 111, out-of-hours provision, Community Pharmacy and associated urgent care services. Oversight of service performance, DoS accuracy, direct-bookable capacity, Pharmacy First and DMS activity, and holiday-period provision will support early identification of emerging gaps and enable targeted action where additional capacity or system intervention is required.

Community Health Capacity

(BAS Domain 5)

The Working as One UEC portfolio programme continues to redesign community urgent care through the development of the Single Point of Access (SPOA), Urgent Community Response (UCR), Hospital at Home and Virtual Wards. Together, these services will provide a more coordinated front door into community care, enabling healthcare professionals to access rapid assessment and intervention through simplified referral routes and reducing unnecessary duplication and hand-offs between services.

During Winter 2026/27, development of the SPOA/SPCA model will continue through a phased approach, supported by strengthened senior clinical decision-making and improved coordination and visibility of community capacity. Winter plans include proposed increased SPCA clinical capacity from 08:00–20:00 during periods of increased demand, supporting referrals from SWAST, streaming from the Clinical Assessment Service and improved coordination of community and step-up capacity, subject to clinical sign-off across provider partners. Alongside continued development of UCR, Virtual Wards, Hospital at Home and intermediate care, this supports Gloucestershire's longer-term ambition to provide more urgent care outside hospital and reduce avoidable admissions.

Core Ambitions:

- Continue to develop the SPOA to support a single point of access for community-based professionals to access multiple urgent care services, embed senior clinical decision

making, and introduce real time digital visibility of community capacity. Strengthen links with the Care Transfer Hub to ensure seamless flow between admission avoidance and discharge pathways.

- Develop and expand the full offering of an Urgent Care Response (UCR) across multiple pillars of conditions and presentations with a focus on performance monitoring to meet national 2 hour standards consistently but also the development of the clinical workforce particularly the ACP role. Strengthen integration with Home First/Reablement and Virtual Wards to support safe alternatives to admission.
- Grow Virtual Ward capacity across priority pathways over a 7 day period (frailty, respiratory, heart failure), enhance remote monitoring capability, and embed shared MDT oversight. Improve step up access from SPOA to reduce acute pathways and support home-based recovery models.

Additional urgent care GP slots will be commissioned via the Gloucester Health Access Centre (GHAC) to bolster the GP out of ours and clinical assessment services during periods of surge, capacity can be flexed in response to anticipated system pressure. Building on the success of the approach used during Winter 2025/26, the ICB and GHAC Integrated Urgent Care Service are developing a planned annual utilisation plan for additional GHAC capacity, informed by forecasting of demand across weekends, bank holidays and known seasonal pressure periods. The proposed model identifies additional 08:00–20:00 clinic capacity during key winter weekends and the Christmas and New Year period, with the ability to deploy further capacity in exceptional circumstances where additional support is required to relieve pressure on IUCS or the wider UEC front door.

For 2026/27, the intention is to move further from reactive deployment of additional capacity towards a planned, intelligence-led approach, with utilisation reviewed throughout the year and clear arrangements for approval of additional winter surge capacity. The longer-term role of GHAC is also being considered alongside the development of Gloucestershire's Single Point of Clinical Access model, ensuring that short-term winter investment supports, rather than operates separately from, the wider transformation of urgent and community care.

Whole-System Response

Gloucestershire County Council's Winter Response 2026/27 sets out a coordinated, multi-agency plan to protect vulnerable residents, maintain essential services, and support health and care system flow during periods of severe weather and seasonal pressure. The approach focuses on proactive outreach, targeted welfare checks, warm spaces and wellbeing hubs, enhanced crisis support, and strengthened homelessness and housing measures, alongside robust emergency planning for flooding, gritting, and major incidents. Workforce surge arrangements and joint operational cells with NHS partners ensure rapid decision-making and continuity of care, helping reduce avoidable admissions, improve discharge flow, and build community resilience throughout the winter period.

The Neighbourhoods Approach for Winter 2026/27 provides a place-based, integrated model designed to strengthen community resilience, support vulnerable residents, and reduce pressure on statutory health and care services during periods of heightened winter demand. Operating across defined neighbourhood footprints, multi-agency teams (including health, social care, district councils, VCSE partners and community organisations) coordinate daily activity through local huddles, enabling proactive identification of risk, targeted outreach, and rapid deployment of practical and emotional support. The model enhances system flow by offering light-touch stabilisation for individuals at risk of deterioration or readmission, ensuring timely access to community-based support such as warm spaces, wellbeing hubs, crisis prevention pathways, and voluntary-sector offers. By mobilising local assets and improving shared intelligence, the approach aims to reduce avoidable escalation, maintain independence, and improve outcomes for residents while contributing to overall system resilience and performance during the winter period.

In addition to core services Gloucestershire also works closely with the voluntary care sector alliance with direct support for discharge provided by the British Red Cross –First Call Offer, which offers a short-term, preventative support service that stabilises people at home after crisis or discharge, reducing avoidable demand on health and care.

This service provides:

- Proactive wellbeing calls to check safety and identify emerging risks.
- Light-touch practical help (medication collection, food access, transport).
- Emotional reassurance to reduce loneliness, anxiety, and repeat contacts.
- Rapid signposting into community or statutory pathways when needed.

The service supports people with low-level needs who are vulnerable, isolated, or recently discharged but do not meet criteria for formal services. Resulting in, reduced unnecessary GP/999 activity by addressing non-clinical issues early, supporting discharge flow by providing a safe “soft landing” at home and Improving patient experience and strengthened community resilience.

Leadership, Operational Grip and Resilience

(BAS Domain 7)

Strong leadership, clear accountability and proportionate escalation are central to maintaining operational grip throughout winter. Gloucestershire's System Escalation Policy provides the overarching framework for recognising, communicating and responding to operational pressure, translating national Integrated OPEL requirements and South West regional escalation arrangements into a single local approach.

Learning from Winter 2025/26 has informed a comprehensive review of the policy and associated OPEL Action Cards for 2026/27. Actions have been revised to improve clarity, proportionality and whole-system accountability, with strengthened arrangements for Primary Care, Maternity and UEC Mental Health. The policy also clarifies the interface between business-as-usual OPEL escalation and formal Emergency Preparedness, Resilience and Response (EPRR) arrangements, ensuring there is a clear transition where the nature or severity of an incident requires emergency response structures to take precedence.

The updated 26/27 escalation policy incorporates the Gloucestershire Primary Care OPEL Framework, the South West Regional Maternity Escalation Framework and locally developed UEC Mental Health Action Cards, alongside the existing national Acute, Community Health Services, Mental Health and NHS 111 OPEL pillars.

The locally developed UEC Mental Health Action Cards translate regional expectations into clear actions at each escalation level and strengthen the interface between mental health and the wider UEC pathway. This will be complemented by continued development of the paediatric mental health Memorandum of Understanding, supporting clearer responsibilities and coordinated responses for children and young people requiring urgent mental health support.

System partners are expected to maintain aligned internal escalation arrangements, provide timely operational intelligence and senior representation when required, and implement agreed actions within their own organisations. Shared intelligence, including Integrated OPEL and SHREWD data, supports this process and enables system leaders to identify deteriorating positions early, assess cross-system consequences and deploy proportionate mitigations before pressures become critical.

Operational grip is maintained through a tiered governance structure proportionate to the level of system pressure. The daily operational call provides routine operational oversight and real-time coordination, with emerging or persistent cross-organisational risks escalated through the System Tactical Escalation structure and, where required, the System Flow Directors Group. At OPEL 3 and 4, the cadence and seniority of oversight increases, including additional

escalation calls, enhanced tactical oversight and, at OPEL 4, escalation to System Flow CEOs where required. This provides a clear route from operational identification of risk through tactical management to executive intervention.

The governance model itself will continue to evolve during 2026/27. Work is underway through the Gloucestershire Provider Partnership to determine the future leadership and coordination model for system flow and escalation, including ownership, chairing, meeting cadence and escalation routes.

System Coordination Centre

(BAS Domain 8)

The Gloucestershire System Co-ordination Centre (SCC) will continue to provide the operational coordination function for the Integrated Care System throughout Winter 2026/27, maintaining whole-system situational awareness and supporting timely, evidence-based decision making during periods of increased pressure.

Building upon the successful use of provider predictor data during previous winters, Gloucestershire will further enhance its operational intelligence through investment in SHREWD reporting and predictive analytics. The introduction of real-time dashboards and Integrated OPEL forecasting will strengthen visibility of demand, capacity, patient flow and emerging risks across the system, enabling earlier intervention and supporting Tactical Escalation Group (TEG) decision-making.

In line with the South West cluster approach to winter planning, Gloucestershire will continue to work collaboratively with neighbouring ICBs to share intelligence, align assurance processes and adopt best practice, whilst maintaining a place-based approach to operational leadership through the Gloucestershire SCC. Together, SHREWD, Integrated OPEL, system intelligence and coordinated governance will provide the ICB with a comprehensive oversight framework to assure delivery throughout Winter 2026/27.

5. Communications Plan

The Gloucestershire winter communications programme will support delivery of the Gloucestershire Winter Plan by helping people stay well, promoting uptake of priority vaccination programmes, reducing avoidable demand on health and care services and supporting effective access to care throughout the winter period. Communications activity will be informed by audience insight, business intelligence and learning from previous campaigns, with channels and tactics selected to best reach priority audiences and communities. The programme will make use of national and regional campaign assets where appropriate, supplemented by locally developed communications to reflect Gloucestershire services, priorities and population needs.

Communications activity will be developed collaboratively with BNSSG colleagues to maximise efficiency, reduce duplication and support greater consistency of messaging across the wider system. This will include sharing insight, campaign assets, learning and evaluation approaches, while retaining flexibility to reflect local service models, operational priorities and audience needs.

In addition to vaccination, prevention and urgent care campaigns, the wider winter communications programme will support infection prevention and control, timely discharge and recovery at home, and system readiness during periods of heightened operational pressure. This includes public-facing infection prevention messaging, support for trust-led discharge communications and coordinated stakeholder, public and media communications throughout the winter period.

Access to priority vaccination programmes incl. annual flu and C-19 campaigns

The ICB will deliver a multi-channel vaccination communications programme to support uptake of flu, Covid-19 and other priority vaccination programmes among eligible groups and priority cohorts identified through vaccination programme intelligence.

Campaign activity will be developed in partnership with system vaccination leads and delivery partners and will seek to align with BNSSG activity where appropriate, enabling shared use of insight, messaging and campaign assets. Communications will be informed by uptake data and audience insight, with targeted activity focused on communities and groups where uptake is lower. Delivery will utilise a combination of NHS-owned channels, partner networks, stakeholder communications, media activity and targeted advertising where appropriate.

Reduction of avoidable admissions among vulnerable groups

The ICB will build on the established Stay Well This Winter campaign, supporting people most at risk of winter-related illness to take practical steps to stay healthy and seek support early.

The campaign will focus particularly on older adults, people with long-term health conditions and those at greater risk of serious illness from winter viruses. Communications will promote preventative actions such as staying warm, staying active, eating well, maintaining wellbeing and seeking advice promptly when unwell. Activity will be developed with local authority public health teams, NHS organisations and VCSE partners and, where appropriate, aligned with BNSSG winter wellbeing activity to support a consistent prevention-focused approach across the wider system. Audiences, messaging and channels will be informed by business intelligence, audience insight and learning from previous winter campaigns.

Primary care, NHS 111 and admission avoidance

The ICB will support delivery of the Choose Well campaign, helping people access the right care in the right place and reducing avoidable pressure on urgent and emergency services.

The campaign will promote self-care, community pharmacy, general practice, urgent treatment services and NHS 111, encouraging people to choose the most appropriate service for their needs. Activity will align with national and regional priorities while reflecting local services and pathways across Gloucestershire and BNSSG. Delivery will be supported through NHS and partner channels, with messaging informed by audience insight, business intelligence and evaluation.

6. Appendices

Gloucestershire ICB Quality Impact Assessment



GICB QIA Winter
plan 2026 - Copy.xls

Board Assurance Statements – Self Assessment Templates due 30 Sept 2026



BAS Self
ICB: Assessment Templat



BAS Self
Trust: Assessment Templat



BAS Self
Amb: Assessment Templat

Vaccination Assurance



20260623 ICB Flu
Vaccination Assuran

7. Glossary of Acronyms and Definitions

A&E	Accident & Emergency Department. The hospital department providing urgent and emergency treatment for serious injuries or illnesses.
AI	Artificial Intelligence. Used for predictive modelling, demand forecasting, or operational decision-support tools.
AMU	Acute Medical Unit. a hospital ward where patients with acute medical conditions receive rapid assessment and treatment.
AOT	Assertive Outreach Team. mental health service supporting people with severe and enduring mental illness in the community.
ARI	Acute Respiratory Illness. sudden onset respiratory conditions requiring urgent medical attention.
ASC	Adult Social Care. Local authority services that provide support for adults with care and support needs, including home care, residential care, and reablement.
BAU	Business as Usual. Standard operational activity outside of escalation or surge measures.
BCF	Better Care Fund. programme to join up health and social care services.
BCI	Business Continuity Incident. an event disrupting normal service delivery requiring contingency measures.
BCP	Business Continuity Plan. documented plan for maintaining services during disruption.
BCP	Business Continuity Plan. documented plan for maintaining services during disruption.
CAMHS	Child and Adolescent Mental Health Services. Specialist services for children and young people experiencing mental health difficulties.
CAS	Clinical Assessment Service. A team of clinicians providing telephone triage and advice to support NHS 111 and urgent care pathways.
CATU	Community Assessment & Treatment Unit. Provides rapid assessment and treatment in a community setting to avoid unnecessary hospital admissions.
CGH	Cheltenham General Hospital. one of the acute hospital sites in Gloucestershire.
CI	Continuous Improvement. A structured approach to improving services through iterative changes, measurement, and review.
Cinapsis	Digital advice and guidance platform connecting clinicians for rapid consultation and decision-making.
COPD	Chronic Obstructive Pulmonary Disease. A long-term lung condition causing breathing difficulties, often managed in both primary and secondary care settings.
COTE	Care of the Elderly. hospital wards or services specialising in older adult care.
COVID	Coronavirus Disease. An infectious disease caused by the SARS-CoV-2 virus.
CRHTT	Crisis Resolution and Home Treatment Team. mental health team providing intensive home-based support as an alternative to admission.
CYP	Children and Young People. Refers to the 0–25 age group in planning and service delivery.
DRD	Discharge Ready Date. The date on which a patient is deemed medically optimised for discharge from hospital, meaning their acute care is complete and they no longer require an inpatient bed.
ED	Emergency Department. A hospital-based service providing assessment and treatment for urgent and emergency conditions (also referred to as A&E).
EDD	Expected Discharge Date. The planned date a patient is expected to leave hospital, agreed early in their admission to support discharge planning.
EFI	Electronic Frailty Index. digital tool for identifying patients living with frailty.

EOC	Emergency Operations Centre. Coordinates ambulance dispatch and other emergency responses.
EPRR	Emergency Preparedness, Resilience and Response. NHS and partner organisations' arrangements for responding to major incidents and emergencies.
ESR	Electronic Staff Record. NHS HR and payroll system.
FAS	Frailty Assessment Service. specialist service assessing older or frail patients to avoid unnecessary admission.
FDP	Full Delivery Plan. A comprehensive plan detailing actions, timelines, and resources required for delivery.
GCC	Gloucestershire County Council. local authority providing social care and public health services.
GHC	Gloucestershire Health and Care NHS Foundation Trust. Provides community health, mental health, and learning disability services in Gloucestershire.
GHFT	Gloucestershire Hospitals NHS Foundation Trust. Provides acute hospital services in Gloucestershire.
GP	General Practitioner. A doctor who provides primary care services.
GRH	Gloucestershire Royal Hospital. main acute hospital in the county.
HALO	Hospital Ambulance Liaison Officer. Coordinates ambulance arrivals and handovers at hospital sites.
HDU	High Dependency Unit. Provides a higher level of care than a general ward, for patients who need close monitoring.
HIU	High Intensity User. Patients who frequently access urgent and emergency care services.
ICB	Integrated Care Board. The statutory NHS organisation responsible for planning and funding health services in an Integrated Care System area.
ICS	Integrated Care System. Partnerships of health and care organisations working together to plan and deliver joined-up services.
ICU	Intensive Care Unit. A specialist hospital ward providing continuous, intensive monitoring and life support for critically ill patients.
IFH	Integrated Flow Hub. A central coordination function managing patient flow across acute, community, and social care.
IMT	Incident Management Team. group coordinating response during incidents.
IPC	Infection Prevention and Control. Measures to prevent the spread of infections in healthcare settings.
IUCS	Integrated Urgent Care Service. Combines NHS 111 and GP out-of-hours services into a single urgent care offer.
JCVI	Joint Committee on Vaccination and Immunisation. UK advisory body on vaccination.
KLOE	Key Lines of Enquiry. A framework used for assessing and assuring service delivery, often used in NHS operational reviews and winter planning.
LOS	Length of Stay. The duration of a patient's admission in hospital.
MDT	Multi-Disciplinary Team. A group of professionals from different specialities working together to plan and deliver care.
MECC	Making Every Contact Count. An approach where health and care professionals use routine interactions to promote healthy lifestyle choices.
MIU	Minor Injuries and Illness Unit. Provides urgent care for minor injuries and illnesses, avoiding the need for ED attendance.
MOPEL	Mental Health OPEL. escalation framework for mental health capacity pressures.
NHSE	NHS England. The national body responsible for overseeing the NHS in England.
OAP	Out-of-Area Placement. When a patient is placed in a hospital or care setting outside their home area due to capacity or specialist need.

OOH	Out of Hours. Health services provided outside normal working hours, including GP services, urgent care, and community nursing.
OPEL	Operational Pressures Escalation Levels. A national framework to describe and manage pressure in urgent and emergency care systems.
OPTICA	Optimising Patient Transfers, Improving Care and Access. A local operational programme aimed at improving hospital discharge and patient flow.
PAU	Paediatric Assessment Unit. Provides rapid assessment and short-term care for children.
PCN	Primary Care Network. group of GP practices working together with community partners.
PICU	Paediatric Intensive Care Unit. specialist unit providing critical care for children.
RSV	Respiratory Syncytial Virus. A common respiratory virus that can cause serious illness in infants and older adults.
SAIS	School Aged Immunisation Service. Provides vaccinations to children and young people within school or community settings.
SDEC	Same Day Emergency Care. Clinical pathways that allow patients to be assessed, diagnosed, and treated without being admitted overnight.
SEG	System Escalation Group. Oversees escalation decisions across the ICS during periods of pressure.
SHREWD	Single Health Resilience Early Warning Database. A system for real-time monitoring of healthcare system status.
SOP	Standard Operating Procedure. A set of step-by-step instructions for routine or emergency processes.
SPCA	Single Point of Clinical Access. A central hub for clinical referrals and triage into urgent and community services.
SPOA	Single Point of Access. Central contact point for coordinating referrals and patient access to services.
SWAST	South Western Ambulance Service NHS Foundation Trust. Provides emergency and urgent ambulance services across the South West.
TEG	Tactical Executive Group. Oversees the tactical-level coordination of health and care services during incidents or high-pressure periods.
THP	Timely Handover Process. A national programme focused on improving ambulance handover times and returning vehicles to operational readiness.
UCR	Urgent Community Response. A service providing rapid crisis care in the community within two hours.
UEC	Urgent and Emergency Care. NHS services that respond to people with serious or life-threatening health needs.
UKHSA	UK Health Security Agency. A government agency responsible for public health protection and infectious disease response.
UTC	Urgent Treatment Centre. walk-in facility for urgent but non-life-threatening conditions.
VW	Virtual Ward. technology-enabled remote monitoring allowing patients to be cared for at home.
XCAD	eXpected Capacity and Demand system. A tool used for real-time monitoring of hospital capacity and demand.

Gloucestershire ICB Quality Impact Assessment



Project/Scheme/Change Name: Gloucestershire ICS Winter Plan Date: 17/08/2026

Project/Scheme/Change Lead: System Wide Deputy Chief Operating Officers
Project/Scheme Senior Sponsor: Eve Olivant -Director of System Flow

Brief Scheme/Change Overview:

As part of planning for additional winter activity, increase in patient demand for access to services and in line with the 26/27 NHSE winter planning asks, Gloucestershire is required to have a comprehensive system wide delivery plan to manage demand and capacity and to ensure the safety and quality of patient care and treatment through unscheduled care pathways is maintained. The Winter plan encompasses all aspects of system wide urgent/unscheduled care delivery including, SWAST, Acute, community, VCSE, social and primary care patient pathways. The plan has been designed in alignment with the ICB UEC transformation portfolio with key schemes identified for delivery before or during winter. **NB This QIA should be read in conjunction with the winter plan, vaccination KLOE and System Escalation Policy for detailed evidence of mitigations at provider and service line level against defined risks.**

Are there any specific locations impacted?

Cheltenham	x	Cotswolds	x	Forest of Dean	x	Gloucester	x	Stroud & Berkeley	x	Tewkesbury	x
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Stakeholders identified as affected by the proposal:

ICB, GHFT, GHC, Primary Care, GCC, SWAST, VCSE, patients, carers and the public.

Engagement work completed or planned for the proposal (including engagement with stakeholders):

The winter plan has been developed in collaboration with all partners. Submissions have been received from all provider organisations including SWAST and GCC to form a collaborative plan. The plan has been reviewed at ICB Strategic Execs prior to onward progression to ICB board in September

Risk Matrix

Impact	Catastrophic	5	High	Very High	Very High	Very High	Very High	Very High
	Significant	4	Medium	High	Very High	Very High	Very High	Very High
	Moderate	3	Medium	Medium	High	High	High	High
	Minor	2	Low	Medium	Medium	Medium	Medium	Medium
	Limited	1	Low	Low	Low	Low	Low	Low
			1	2	3	4	5	
			Low	Medium Low	Medium	Medium High	High	
			LIKELIHOOD					

		Risk Rating							Quality Indicators/How will you measure this
Brief description and evidence of impact		Consequence	Likelihood	Risk Score	Mitigation	Mitigated Consequence	Mitigated Likelihood	Mitigated Risk Score	
Describe any potential Patient / Staff / System safety benefits or issues that may arise from the implementation of this overall programme.									
Potential Positive impacts/aims	The completion of a full winter plan that recognises the asks of the NHSE 26/7 UEC plan including detailed completion against all KLOE by all system partners with additional surge actions to improve patient safety during times of demand surge and our 26/27 vaccination uptake plan.								
	The progression of the UEC transformation portfolio priority workstreams up to and during winter in order to achieve at minimum- a minimal viable product for a SPOA, improving patient access to the right care, at the right time by the right service and the first phase of our system transition to a care transfer hub model which will ensure discharge planning and admission avoidance from ED attendance will improve the optimisation of home based discharge reduction in pathway 2 utilisation and greater return to independence.								
	Fully embedded systemwide learning from the winter 25/26 which will underpin the additional asks of the system in order to maintain patient safety in times of OPEL 4 and CI								

Patient Experience (Provides personalised patient experience)		We will continue to respond to patient complaints and concerns, key operational KPI and service KPI throughout the winter period to provide evidence based feedback to staff and the public regards our service offers.															
		Winter schemes are all aligned to delivery of national objectives within the NHSE Winter planning asks for 26/27 and the National OPEL escalation framework to ensure that safety, quality and experience remain our system priority through out winter.															
	Potential Negative risks/impacts	The risk to patient experience caused by increased demand for services resulting in potential delay to diagnosis and treatment					3	4	12	Completion of surge and escalation actions as per the winter plan, national 24/25 OPEL framework and system escalation policy, escalation to CAG as indicated. Revised System Escalation Policy and Tactical Escalation Group, Strategic Escalation Group for governance to monitor and respond to performance and impact dynamically.			2	3	6	Daily review of the emergency care access standards, review of compliments complaints and user feedback via partner and ICB forums.	
		The risk to patient experience caused by receiving care in a temporary escalation space resulting in the inability to suitably provide privacy and dignity and optimal care and treatment					2	4	8	Completion of surge and escalation actions as per the winter plan, national 24/26 OPEL framework and system escalation policy, escalation to CAG as indicated. Revised System Escalation Policy and Tactical Escalation Group for governance to monitor and respond to performance and impact dynamically.			2	3	6		Daily review of occupancy and service capacity across all components of the patient pathway utilising shrewd. Review of FFT, complaints and user feedback. Use of predictive demand modelling via holiday assurance Daily review of staffing levels at organisational and system levels against predicted and known demand. Weekly review of predicted demand across all core services to enable actions to be put in place to mitigate via TEG. Use of Shrewd indicators demonstrating demand and capacity enabling response as per the OPEL framework.
		The risk to patient experience as a result of dilution of workforce and excessive workforce demand resulting in delay to treatment and reduced time to administer care.					3	3	9	Completion of surge and escalation actions as per the winter plan, national OPEL framework and system escalation policy, escalation to CAG as indicated. Revised System Escalation Policy including changes to provider and ICB governance post transition, to monitor and respond to performance and impact dynamically.			2	2	4		
	Overall Assessment	Positive	x	Negative		Neutral											
Any Additional Rationale:																	

Brief description and evidence of impact		Consequence	Likelihood	Risk Score	Mitigation	Mitigated Consequence	Mitigated Likelihood	Mitigated Risk Score	Quality Indicators/How will you measure this
How will the service development impact on staffing?, What are the leadership and governance structures that support the change?									
Potential Positive impacts/aims	System ICB winter director identified, organisational leads identified at deputy executive level to ensure a joined up approach to risk mitigation across the system and further inform provider and partner winter plan continuous development-weekly oversight via TEG								
	The completion of the additional holiday period demand an capacity assurance (see Winter plan appendices) will provide the system with workforce and resilience plans in advance of known pressure periods to ensure key services can meet demand and maintain patient safety								
	UEC meeting cadence including daily system calls, weekly tactical (silver level) review meetings with escalation to strategic level as required will be stepped up/down in accordance with the Winter plan, System escalation policy and OPEL framework to ensure a clear governance architecture, with early thresholds for action and risk mitigation clearly identified and enacted								
	The completion of the winter plan in adherence to the NHSE 26/27 Winter planning asks, plan ensuring board sign off in September will enable wider stakeholder engagement across provider organisations, social care and primary care-commitment in place to share the Winter plan with the LMC, provider partnership and HOSC.								
	Oversight and delivery of the UEC transformation portfolio requirements for winter will offer staff the opportunity to innovate and develop services in line with national best practice.								
	Opportunity via Portfolio based schemes to test new ways of working, improve staff development and service delivery								

Well-lead	Potential Negative risks/impacts	The risk to staff resilience as a result of increased service demand pressure negatively impacting recruitment and retention in core urgent care services, increased sickness absence, fatigues and burn out				3	5	15	In conjunction with the winter plan National OPEL framework and system escalation policy, predictive staffing capacity against predicted demand will be ascertained from all key services throughout the winter period and reviewed weekly at tactical level with escalation to executive leads as required. Staff wellbeing and resilience to be monitored by leads and direction to well being support resources utilised as part of staff communications. Where required referrals to occupational health can be made to support staff with managing any impact of increased service demand pressure during winter or ensuring annual leave is well spread for breaks to reduce risk of staff burnout.	3	4	12	Daily review of staffing levels at organisational and system levels against predicted and known demand. Weekly review of predicted demand across all core services to enable actions to be put in place to mitigate. Use of Shrewd indicators demonstrating demand and capacity
		The risk of workforce instability due to potential changes relating to portfolio scheme progression which may require change in role/responsibility/location of work resulting in workforce uncertainty and potential risk to retention.				2	3	6	Workforce and OD requirements have been identified as a key enabler for the UEC transformation portfolio; the risk to workforce is subject to oversight by portfolio oversight board with the ICB executive director for people and OD as SRO	2	2	4	Weekly joint SRO meetings with all workstream SRO - escalation and oversight via Portfolio oversight board-feedback form staff -vacancy and staff sickness reporting.
		The risk to leadership capacity as a result of the ICB merger and workforce reduction plan to meet the national mandate for all ICB's				3	5	15	Executive transition committee in place to manage and mitigate risk and ensure identification of emerging risk via the transition period	3	4	12	Oversight of Transition arrangements via core ICB governance structures including strategic executive and ICB board.
		The risk to leadership capacity and capability as a result of increased demand and operational pressure resulting in compromised resilience, fatigue and burn out				3	5	15	Regular oversight of workforce and leadership resilience via Tactical escalation and aligned to UEC portfolio oversight board-risk register in place. Proactive on call cover arrangements including buddy systems and shadow on call across providers-where required BCI plans to mitigate eg IUCS.	2	4	8	Regular review and support mechanisms via TEG and portfolio oversight board risk register.
	Overall Assessment	Positive	x	Negative		Neutral		Any Additional Rationale: Progression of the UEC transformation portfolio work, delivery of the winter plan and the impact of ICB transition is difficult to quantify in terms of risk and workforce impact at present -this risk will need to be reviewed continually as we progress through the remainder of 26/27					

Brief description and evidence of impact		Consequence	Likelihood	Risk Score	Mitigation	Mitigated Consequence	Mitigated Likelihood	Mitigated Risk Score	Quality Indicators/How will you measure this
How will the service impact on public health and the environment? Long-term viability of services, including workforce, financial, and environmental sustainability.									
Potential Positive impacts/aims	Delivery of the GHFT Tower capacity changes will enable essential maintenance works to be carried out improving the safety of the acute hospital estate								
	Our targeted communications and vaccination campaign will aim to prevent illness and improve public awareness of service availability and self care encouraging the public to remain well over winter.								
	The development of a whole system approach to winter planning, utilising national frameworks for best practice will ensure that all urgent and unscheduled care services are able to maintain sustainable levels of service capacity to ensure that the population receives safe and timely care with minimal impact on elective recovery.								
	All partners have been asked to provide high level costings for any additional surge plans, activity or capacity not funded in baseline budgets to enable a clear understanding of potential financial impact and mitigation against non delivery of the 26/27 financial plan to be managed.								
	Proposed capacity changes within the community and independent sector bedded setting will improve the quality of reablement offer to our frail and elderly population with more complex needs.								

Sustainable	Potential Negative risks/impacts	The risk of system ability to maintain core urgent care services as per the national emergency care standards as a result of increased demand and reduction in bedded and non bedded capacity					4	3	12	Delivery of the Winter plan surge and KLOE actions adherence to the national OPEL framework and system escalation policy. Progression of the UEC transformation programme delivery of a minimal viable product for SPOA and care transfer hub for winter, maintaining DRD reduction trajectory via increased pathway 1 utilisation and reduction in P2 utilisation.			3	3	9	Daily review of system demand and capacity via operational oversight utilising SHREWD, weekly review of Emergency care standards via Tactical forums
		The risk of financial impact as a result of additional surge actions instigated that will require either capital or revenue not currently identified in baseline budgets and the inability to deliver the UEC transformation portfolio savings target					4	5	20	Delivery of the Winter plan, adherence to the national OPEL framework and system escalation policy. Progression of the UEC transformation programme delivery of a minimal viable product for SPOA and care transfer hubs for winter, maintaining DRD reduction trajectory via increased pathway 1 utilisation and reduction in P2 utilisation.			3	4	12	
															0	
	Overall Assessment	Positive	x	Negative		Neutral										
Any Additional Rationale:																

Quality Team sign off			
Name		Title	Date
ICB Quality & Clinical Governance Group sign off			Date
CNO and/or CMO sign off			Date

Recommendation	Approved		Not approved		Further information required	
Additional notes/rationale						

Risk of 16 or higher	Additional / specific sign off name or group		Date	
Additional notes/rationale/confirm which Risk Register this will sit on				



Winter Planning 26/27

Board Assurance Statement (BAS)

Integrated Care Board (ICB)

1. Purpose

The purpose of the Board Assurance Statement is to ensure the ICB's Board has oversight that all key considerations have been met. It should be signed off by both the ICB Accountable Officer and Chair.

2. Guidance on completing the Board Assurance Statement (BAS)

Section A: Board Assurance Statement

Please include the Integrated Care Board's (ICB) name at the top of the tab.

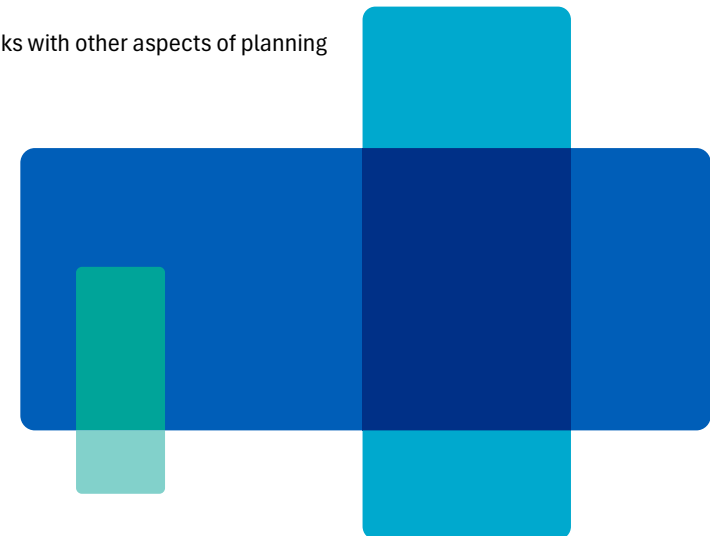
This section gives ICBs the opportunity to describe the approach to creating the winter plan, and demonstrate how links with other aspects of planning have been considered.

Section B: 26/27 Winter Plan checklist

This section provides a checklist of what Boards should ensure is covered in their 2026/27 Winter Plans.

3. Submission process and contacts

Completed Board Assurance Statements should be submitted to the national UEC team via england.eecpmo@nhs.net by **30 September 2026**.



Winter Planning 26/27

Section A: Board Assurance Statement (BAS)

This section gives ICBs the opportunity to describe the approach to creating the winter plan, and demonstrate how links with other aspects of planning have been considered.

Integrated Care Board (ICB):

Gloucestershire

If Other, write ICB Name here:

Contact details (email, phone number):

Richard Carpenter, Associate Director Commissioning – System Resilience,
richardcarpenter@nhs.net 07791 686 366

Date:

07/09/2026

Please complete these sections

Assurance statement			Is this in place? (Y/N)	Additional comments or qualifications (optional)	Blockers/Support requirements (optional)
Governance					
1	1.1	The Board has assured the ICB Winter Plan for 2026/27.	Yes	The Winter Plan is now Version 1 and has been approved by ICS Strategic Executives in August 2026. Onward progression to ICB Board is scheduled for September	Evidence Board review in Sept.
	1.2	The Board is assured that a robust quality and equality impact assessment (QEIA) informed development of the ICB's plan and this has been reviewed by the Board.	Yes	Quality, equality and health inequalities have informed development of the plan and a Gloucestershire ICB Quality Impact Assessment is identified in the appendices; however, the completed QEIA has yet been reviewed by the Board.	Complete/finalise QEIA and evidence Board review.
	1.3	The Board is assured that the ICB's plan was developed with active engagement and input of all system partners, including primary care, 111 providers, Community Health Service Providers (including NHS and non-NHS providers), acute and specialist trusts, mental health, ambulance services, local authorities and social care provider colleagues.	Yes	The Winter Plan was developed collaboratively across acute, community, mental health, ambulance, primary care, adult social care, public health and VCSE partners, using system engagement, population intelligence and learning from Winter 2025/26.	
	1.4	The Board has identified a named Executive Winter Sponsor with clear accountability for winter preparedness, delivery, escalation and system oversight.	Yes	A designated Executive Winter Lead is identified with accountability for implementation, strategic leadership and reporting through ICB governance. The Winter Plan names Caroline Dawe, Director Strategic Commissioning – Value and Delivery, as sponsor.	
	1.5	The Board has tested the plan during a regionally-led winter exercise, reviewed the outcome, and incorporated lessons learned.	Yes	Participation in the NHS England regional winter stress-testing exercise and locally led scenario exercises is planned on Wednesday 16th September. Following the exercise, intelligence and lessons learned will be incorporated locally.	
	1.6	The Board is assured that clear winter governance arrangements, escalation processes and operational leadership arrangements are in place across the system.	Yes	Clear winter governance and escalation arrangements are set out through the Gloucestershire System Escalation Policy, Integrated OPEL, SCC operational coordination and tiered Operational/Tactical/Strategic escalation, with enhanced senior oversight at OPEL 3–4.	
	1.7	The Board is assured that fit testing arrangements, PPE provision and other key infection prevention and control mitigations, as set out in the Health and Social Care Act 2008: code of practice on the prevention and control of infections are in place across the system and are supported by plans to scale rapidly in response to infectious disease surges, ensuring continuity of safe care and workforce protection.	Yes	IPC plans include strengthened core practice, PPE use, environmental cleaning, training and competency checks, outbreak response, vaccination, assurance/audit and workforce resilience. Acute learning includes early isolation and enhanced cleaning approaches.	
	1.8	The Board has received assurance that health protection governance, escalation processes, and provider response arrangements are effective and support timely management of infectious disease incidents and outbreaks, as set out in the ICB Commissioning Guidance - https://www.england.nhs.uk/long-read/clinical-response-outbreaks-of-infectious-disease-commissioning-guidance-icbs/	Yes	Health protection and outbreak response arrangements include clear escalation routes, rapid testing access, coordinated public health/community support, IPC monitoring and escalation through established system governance.	

Winter Planning 26/27			This section provides a checklist on what Boards should assure themselves is covered by 26/27 Winter plans.		
			Please complete these sections		
Section B: 26/27 Winter Plan checklist			Confirm (Y/N)	Additional comments or qualifications (optional)	Blockers/Support requirements (optional)
Prevention and vulnerable cohorts					
1	1.1	The Board is assured that those eligible have access to priority vaccination programmes, including childhood vaccinations. This includes 1. RSV vaccination for pregnant women, older adults aged 75 years and over, and older adult care home residents; 2. pneumococcal vaccination for all adults aged 65 years and over and children and adults in a clinical risk group; 3. the annual winter flu and COVID-19 vaccination campaigns.	Yes	Seasonal vaccination is a core prevention priority, delivered with Primary Care, Community Pharmacy, GHC, GHFT, Public Health and VCSE partners. Targeted communications/outreach and population intelligence will support eligible and underserved cohorts, including care home residents and housebound patients. Full details can be found in the Vaccination Return provided to NHSE on 28/08/2026.	
	1.2	The Board is assured that a risk-stratified approach is in place to identify individuals at increased risk of winter-related deterioration or admission, including those with co-morbidities that leave them susceptible to hospital admission as a result of winter viruses, younger people with significant co-morbidities, and other vulnerable cohorts. Targeted interventions are in place, including vaccination, pre-winter health checks, personalised care planning, access to antivirals where appropriate, and community-based support to reduce avoidable admissions and support continuing care in the community.	Yes	Population health management, whole-population segmentation and risk stratification are used to identify vulnerable cohorts including older people, frailty, long-term conditions and serious mental illness. Targeted interventions include vaccination, anticipatory care planning, medicines optimisation, falls prevention and proactive community/neighbourhood support.	
Flow, occupancy and discharge					
2	2.1	The Board is assured there are clear operational plans and daily processes to reduce avoidable bed occupancy and improve patient flow seven days a week, including pre-winter review of bed demand and capacity, delivery of model discharge pathway requirements, and executive oversight of required and actual daily discharges, patients with no criteria to reside by pathway, discharge performance and long discharge delays.	No	Flow plans are in place and continue to develop, including the new Pathway 1 Home First service, countywide reablement, Pathway 2 commissioning redesign and development of the Care Transfer Hub as the central coordination point for discharge and intermediate care. Elements of the Care Transfer Hub model are already in place, with further development and implementation actively progressing through Winter 2026/27. As the full model will not be in place ahead of winter, the ICB cannot yet provide full assurance against this statement. Discharge pressures will continue to be reviewed through the SCC Daily Position Call and tactical escalation, supported by pathway escalation intelligence and Integrated OPEL.	Continued implementation and maturation of the Care Transfer Hub model during Winter 2026/27, with progress monitored through established UEC and system flow governance.
	2.2	The Board is assured that system partners have agreed and implemented measures to eliminate corridor care, with defined patient safety thresholds, supported by coordinated patient flow, discharge and escalation arrangements, with system level oversight and mitigation of risk during periods of increased demand.	No	Internal arrangements and thresholds are in place within provider organisations to identify and respond to risks associated with corridor care. However, these are not currently reflected within a system-wide escalation framework or agreed system thresholds. Further work is required to develop and embed a consistent system-wide approach, and therefore the ICB cannot currently provide full assurance against this statement.	Develop and agree system-wide corridor care thresholds and escalation arrangements
	2.3	The Board is assured that discharge planning is being undertaken jointly with local authorities and social care partners, with effective system discharge coordination arrangements, clear processes to identify, escalate and resolve discharge delays, and real-time visibility of demand and community capacity.	Yes	Discharge planning is system-wide across ICB, GHFT, GHC and Gloucestershire County Council. The Care Transfer Hub is being developed as a single integrated team with trusted assessment, centralised capacity allocation and MDT case management; discharge escalation provides a route to resolve pathway delays.	
	2.4	The Board is assured that providers have baselined current discharge arrangements against the model discharge pathway, identified gaps, and agreed improvement actions across acute, community and social care partners.	No	Discharge pathway modelling and improvement work is taking place within individual organisations; however, refreshed modelling and baseline assessment are required at ICB/system level to provide a consistent whole-system view against the model discharge pathway. As this system-level work has not yet been completed, the ICB cannot currently provide full assurance against this statement.	Complete refreshed system-level baseline assessment against the model discharge pathway
	2.5	The Board is assured that pre-Christmas and holiday-period occupancy reduction plans have been agreed and will be implemented.	Yes	The acute trust is actively developing its pre-Christmas and holiday-period occupancy reduction plan ahead of the winter peak. There is confidence that the approach will build on the successful arrangements implemented during Winter 2025/26; however, as the 2026/27 plan is still being finalised, the ICB cannot yet provide full assurance against this statement.	Finalise and assure the Trust pre-Christmas and holiday-period occupancy reduction plan
Demand, capacity, and surge management					
3	3.1	The board is assured that whole system demand and capacity modelling has informed winter planning and that tested surge and extreme surge response arrangements are in place to support safe operational delivery during periods of increased demand.	Yes	Whole-system demand and capacity modelling informs commissioning and the Working as One transformation priorities. Predictive intelligence reviews admissions, occupancy, workforce, historical demand and public-health forecasts. Regional and local stress testing is planned to test surge/extreme-surge assumptions.	Complete planned stress-testing and incorporate learning/mitigations.
	3.2	The Board is assured that workforce, NHS 111 and mutual aid arrangements are sufficient to respond safely to sustained periods of increased demand.	Yes	Workforce capacity, NHS 111/IUCS pressures and mutual aid are included in predictive oversight and OPEL action cards.	Complete planned stress-testing and incorporate learning/mitigations.
	3.3	The Board is assured that bed escalation capacity arrangements have been agreed and tested across system partners.	Yes	Demand/capacity and surge planning are established through the Winter Plan and OPEL Action cards.	Complete planned stress-testing and incorporate learning/mitigations.
Primary Care, NHS 111 and admission avoidance					

4	4.1	The Board is assured that anticipated general practice demand has been assessed, and that: •sufficient capacity has been commissioned, including for surge periods (e.g. ARI hubs) •robust escalation process are in place •through the IUC Clinical Assessment Service (or equivalent), sufficient capacity will be commissioned for out of hours general practice, including weekends and bank holidays.	Yes	Anticipated primary care demand has been assessed. Additional GP appointments are funded around known pressure periods, with planned/flexible GHAC urgent GP capacity for weekends, bank holidays and Christmas/New Year. Gloucestershire has a General Practice OPEL framework and GHC/IC24 provide OOH/IUCS capacity.	
	4.2	The Board is assured that practices are compliant with contractual requirements, including opening hours, use of online consultation, clinically urgent same day appointments (working towards 90% target) and practices making 1 appointment per 3,000 registered population available to NHS 111 for direct booking.	Yes	Practices are contractually compliant. The ICB continues to review GPAD mapping anomalies and has reminded practices of requirements for online access, clinically urgent same-day access and NHS 111 direct-bookable appointments. The ICB digital & PC team are working with practices where they have identified anomalies in GPAD mapping. The ICB have reminded all practice of the contractual requirement to provide NHS 111 direct booking appointments.	Continue targeted work with practices where GPAD mapping or direct-booking configuration issues are identified.
	4.3	The Board is assured that PCN enhanced access appointments are available and that PCNs make available to NHS 111 any unused on the day slots as per DES requirements.	Yes	PCN Enhanced Access is in place. 10 of 16 PCNs reported that NHS 111 can directly book into available EA appointments; 6 of 16 reported technology/hub constraints and use an alternative route via the practice. The ICB is working to improve access and direct booking.	Resolve technology/hub constraints affecting direct booking in 6 of 16 PCNs.
	4.4	The Board is assured that unscheduled dental care delivery is monitored as part of the mandated number of urgent dental care appointments.	Yes	Please see text box at the bottom of the page	
	4.5	The Board is assured that for community pharmacy, demand, activity and capacity has been assessed, including sufficient out of hours provision across the ICB footprint; and delivery of Pharmacy First and the Discharge Medicines service.	Yes	Our Community Pharmacy PCN Engagement Leads continue to monitor capacity via capacity grid and our Collaborative Commissioning Hub colleagues keep a South West Community Pharmacy Dashboard up to date that includes core, supplementary and OOH hours. The CCH team also administer the 'Bank Holiday ROTA' on behalf of the 7 ICB's. Glos ICB launched a parallel local PGD service same as BNSSG to offer patient greater access to assessment and treatments as appropriate without the need for GP appointment. G ICB OOH provider is Glos Health and Care (with IC24 element) and regular meetings together with DoS team drive referral improvement opportunities	
	4.6	The Board is assured that the NHS 111 Directory of Services profiles are accurate, regularly reviewed, and aligned to available capacity across primary care and community services.	Yes	Winter assurance includes maintaining accurate NHS 111 Directory of Services information and referral routes. Regular engagement between GHC/IC24 and DoS teams supports review and improvement of pathways and alignment with available capacity.	
	4.7	The Board is assured that for all provision, both in and out of hours, there will be communications activity to ensure the public is aware of what services are available.	Yes	The ICB has a coordinated winter communications programme in place to ensure the public are aware of services available both in and out of hours. The Choose Well campaign will promote self-care, Community Pharmacy, General Practice, urgent treatment services and NHS 111, supporting people to access the right care in the right place. This will be complemented by Stay Well. This Winter and vaccination communications, with activity targeted around periods of increased winter pressure and informed by audience insight and business intelligence.	
Community Health Capacity					
5	5.1	The Board is assured that sufficient urgent community capacity, including UCR, Virtual Wards, Hospital at Home and community diagnostic interventions where applicable, has been commissioned, is monitored and utilised effectively to support admission avoidance and discharge, with appropriate escalation arrangements in place and access to senior clinical decision-making through SPOAs at least 12 hours a day, 7 days a week.	Yes	Community capacity includes UCR/Rapid Response, Virtual Wards, Hospital at Home, Home First, intermediate care and Single Point Clinical Access (SPCA). Home First is commissioned to deliver an average of 63 starts per week, with variable capacity up to 80 starts per week, and is currently in mobilisation with trajectories being developed to achieve commissioned and surge capacity. UCR/Rapid Response development will strengthen resilience and 2-hour response performance, with additional winter surge capacity planned across North and South teams, operating 08:00–20:00, seven days a week, to support admission avoidance, SWAST and Hospital at Home pathways. SPCA plans include increased clinical capacity from 08:00–20:00 to manage increased referral volumes, improve streaming and coordination of community and step-up capacity, subject to clinical sign-off across provider partners. Intermediate care capacity includes 167 Community Hospital P2 beds, alongside additional P2/P3 capacity commissioned by GCC. System work is focused on improving DRD performance and reducing length of stay to release further effective capacity, supported by joint system governance and escalation of long waits. The commissioning intentions and SPOA plans (subject to business case approval) align with having the full model and SCDM in place by April.	
Whole System Response					
6	6.1	The Board is assured that a system wide approach is in place to optimise the use of out-of-hospital capacity and admission avoidance pathways to reduce avoidable admissions and support timely discharge.	Yes	A whole-system admission avoidance and out-of-hospital model is in place through SPOA/UCR/Virtual Wards/Hospital at Home, GHAC surge capacity, neighbourhood working, GCC winter response and VCSE support including British Red Cross First Call. These offers support both admission avoidance and discharge.	
Leadership, operational grip and resilience					
7	7.1	The Board is assured that on-call arrangements are in place and have been tested. Staff on-call have access to medical and nursing leaders for urgent advice if needed.	Yes	The System Escalation Policy sets defined operational, tactical and strategic leadership arrangements, including enhanced senior oversight at OPEL 3–4 and escalation to System CEOs at OPEL 4. Existing ICB escalation arrangements provide access to senior clinical/leadership support across the system.	
	7.2	The Board is assured there will be an appropriately skilled and resourced operating model for system co-ordination over the winter period to enable the sharing of intelligence and risk balance to ensure this is appropriately managed across all partners.	Yes	The SCC provides the system operational coordination function, maintaining situational awareness and coordinating escalation using SHREWD, Integrated OPEL, partner intelligence and tiered governance. The operating model is being further developed through the Provider Partnership / Cluster arrangements with BNSSG.	Finalise the future provider/cluster leadership and coordination model, including ownership, chairing, cadence and escalation routes.
	7.3	The Board is assured that tested command, control and escalation arrangements are in place, including OPEL reporting, EPRR arrangements and clearly defined leadership responsibilities.	Yes	Tested/established command and escalation structures are set out through Integrated Operational, Tactical, Strategic and CEO responsibilities and defined transition into formal incident response	

	7.4	The Board is assured that mutual aid arrangements, business continuity plans, severe weather preparedness arrangements and industrial action contingencies have been reviewed and tested where appropriate.	Yes	Business continuity, mutual aid, severe-weather and incident arrangements are embedded in system planning and are included in the planned regional/local winter stress-testing programme.	Complete planned winter resilience testing and document assurance for mutual aid, BCP, severe weather and industrial action contingencies locally.
	7.5	The Board is assured thatplans are in place to support staff welfare through periods of high demand.	Yes	Workforce resilience and wellbeing were identified through the 2025/26 debrief as a priority for 2026/27. IPC/community plans include access to training, guidance and wellbeing support to maintain safe practice and reduce sickness-related staffing pressure.	
System Co-ordination Centres					
8	8.1	The Board is assured that SCCs will be proactive in resolving operational pressures in hours, and that ICBs will maintain on-call functions for the oversight and resolution of operational pressures and patient flow and safety out of hours.	Yes	The SCC is the system coordination/SPOC function for operational pressures and supports proactive resolution through daily operational oversight, Integrated OPEL, SHREWD and escalation governance. The escalation policy provides system visibility and escalation arrangements across operational periods.	
	8.2	The Board is assured that SCCs will be fully operational 08:00 to 18:00 7 days per week and have the ability to extend hours of operation during periods of extreme pressure.	Yes	SCC will operate throughout Winter 2026/27.	
	8.3	The Board is assured that ICB SCCs will maintain proactive engagement and communication with NHSE Regional teams.	Yes	The System Escalation Policy includes regular liaison with NHS England South West/ROC, regional Red Flag reporting and alignment with regional escalation frameworks.	

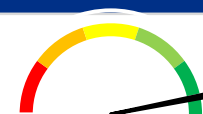
4.4

Unscheduled dental care is monitored at contract level by the South West Collaborative Commissioning Hub using NHSBSA activity/payment data, monthly performance monitoring, provider-level review and year-end reconciliation against the mandated urgent-care requirement.The Board is assured that unscheduled dental delivery is rigorously monitored and reconciled against mandated urgent care targets. Following the 2026/27 contract reforms, high street providers must allocate 8.2% of their total contract value to unscheduled care. This provides NHS Gloucestershire ICB with a predictable, legally binding baseline of urgent appointments.Key monitoring and assurance arrangements include:Contract level monitoring: The South West Collaborative Commissioning Hub, acting on behalf of NHS Gloucestershire ICB, monitors delivery against each eligible contractor's agreed urgent care requirement. Required activity is established at contract level and monitored against actual delivery.
Monthly performance monitoring: Urgent care delivery is reviewed through routine contract performance monitoring, using activity and payment data submitted through the NHS Business Services Authority (NHSBSA) systems. This enables the Hub and ICB to identify delivery trends, emerging underperformance and variations in urgent care activity throughout the year.
Year-end reconciliation: Actual urgent Courses of Treatment are reconciled against each contractor's required number at year end. This provides assurance that delivery is assessed against the nationally determined requirement rather than solely against local activity forecasts.
Financial and contractual accountability: The required number of urgent treatments represents a minimum contractual delivery requirement. Where delivery is below the required level, the position is subject to contractual review and the applicable financial reconciliation arrangements. This provides a clear mechanism for identifying and addressing under-delivery.
No double-counting: The Hub maintains a clear distinction between the nationally mandated urgent care requirement delivered through eligible core dental contracts and additional urgent care capacity commissioned separately by the ICB. Separate commissioned unscheduled care contracts are not included within the 8.2% requirement.
Provider level assurance: Monitoring is undertaken at individual contract level, allowing the Hub to identify providers that are below, meeting or exceeding their required urgent care activity and to target appropriate follow-up where required.
Escalation and intervention: Where monitoring identifies potential under-delivery or material variation from the required activity, this can be raised through routine contract management arrangements with the provider, enabling corrective action to be considered during the financial year rather than relying solely on year-end reconciliation.
Governance oversight: Performance and any significant contractual or financial risks arising from urgent care delivery are escalated through the established commissioning and governance arrangements to ensure that the ICB has appropriate oversight of delivery, access and financial implications.
The combination of a nationally defined contract-level requirement, monthly activity monitoring, NHSBSA data, provider-level review, year-end reconciliation and established contractual escalation arrangements provides the Board with assurance that unscheduled dental care delivery is being actively monitored throughout 2026/27 and that under-delivery can be identified and addressed.

BAS Self-Assessment Dashboard

ICB

Overall Assessment Rating: 5 - Full assurance



		Rating
Section A	Governance	5 - Full assurance
Section B	Prevention and vulnerable cohorts	5 - Full assurance
	Flow, occupancy and discharge	3 - Moderate assurance
	Demand, capacity, and surge management	5 - Full assurance
	Primary Care, NHS 111 and admission avoidance	5 - Full assurance
	Community Health Capacity	5 - Full assurance
	Whole System Response	5 - Full assurance
	Leadership, operational grip and resilience	5 - Full assurance

Executive Approval

The purpose of the Board Assurance Statement is to ensure the Trust's Board has oversight that all key considerations have been met. It should be signed off by both the ICB Accountable Officer and Chair.

Integrated Care Board (ICB) name: BNSSG and Gloucestershire ICB

ICB CEO/AO name: Shane Devlin

Date reviewed: 30/09/2026

ICB Chair name: Jeff Farrar

Date reviewed: 30/09/2026

Please update following completion of the BAS template

Please provide name and contact details of designated Senior Responsible Officer (Executive Level)

David Jarrett (david.jarrett2@nhs.net)

Please provide confirmation that the SRO has reviewed and approved the responses within this document, confirming they are correct and complete.

Yes

Please confirm date reviewed

30/09/2026