

SHSCT Winter Plan 2026/27

Working Together to Provide Safe, Timely Care This Winter

Executive Summary

Winter presents predictable but significant pressures across health and social care services arising from increased respiratory illness, higher demand for urgent and emergency care, increased frailty, workforce challenges and pressure on patient flow across acute and community services. The Southern Health and Social Care Trust (SHSCT) Winter Plan 2026/27 outlines a comprehensive whole-system approach to managing these pressures whilst maintaining safe, effective and high-quality services throughout the winter period.

This plan aligns with regional Winter Surge Planning Guidance and reflects the Trust's commitment to prevention, early intervention, admission avoidance, timely discharge, workforce resilience and collaborative working across health and social care partners. It brings together a portfolio of initiatives designed to improve patient flow, reduce avoidable hospital attendance and admission, support care closer to home, protect elective services and ensure effective operational resilience throughout periods of peak demand

The Trust will work in partnership with Primary Care, Northern Ireland Ambulance Service (NIAS), Public Health Agency (PHA), Strategic Planning and Performance Group (SPPG), Community Pharmacy, Independent Sector Providers, Care Homes, Voluntary and Community Sector organisations and Integrated Neighbourhood Teams to deliver coordinated interventions that improve outcomes for patients and maximise system capacity. In addition, independent care home and home care providers are important partners in maintaining patient flow and supporting people to remain safely in the community. The Trust will continue to work closely with statutory and independent providers throughout winter, with particular focus on capacity, timely discharge, continuity of service and preparedness over weekends and holiday periods.

The Trust will also engage with regional arrangements established to strengthen communication with independent-sector providers, share key winter messages and identify and resolve emerging system pressures.

Strategic Objectives

The Trust's Winter Plan is built around five strategic objectives:

1. Prevention and early intervention.
2. Avoidance of unnecessary attendance and admission.
3. Timely assessment, treatment and discharge.
4. Whole-system coordination and patient flow.
5. Workforce resilience and operational readiness.

Success will be measured through improvements in patient flow, reduced length of stay, reductions in delayed discharge, improved Emergency Department performance, reduced avoidable admissions, enhanced patient experience and strengthened workforce resilience.

System Context and Anticipated Winter Challenges

The Trust anticipates increased demand associated with:

- Seasonal respiratory illness.
- Influenza and COVID activity.
- Increased frailty among older people.
- Rising urgent and emergency care attendance.
- Delays in patient discharge.
- Workforce shortages and sickness absence.
- Increased demand for social care support.
- Ongoing pressure on elective recovery programmes.

The Winter Plan seeks to address these pressures through proactive service enhancement, greater utilisation of community-based alternatives and strengthened operational management arrangements.

Strategic Priorities

1.Prevention and Public Health	
Prevention remains the most effective intervention for reducing winter demand and improving population health outcomes. The Trust will work closely with the Public Health Agency and partner organisations to support vaccination uptake, encourage self-care and reduce avoidable illness	
Key Action	Key measure
• Support seasonal influenza vaccination programmes. • Support COVID-19 booster programmes. • Increase staff vaccination uptake. • Deliver winter wellbeing and prevention campaigns. • Promote self-care and appropriate use of services. • Increase awareness of Community Pharmacy services. • Promote infection prevention and control measures. • Deliver targeted communications to vulnerable population	• Staff flu vaccination uptake. • Population vaccination uptake. • Respiratory related attendances. • Community Pharmacy utilisation. • Avoidable admission rates.
2: Inclusion Health and Reducing Inequalities	
The Trust recognises that winter pressures disproportionately affect vulnerable populations and those experiencing health inequalities. Specific measures will be implemented to ensure equitable access to services and support	
Focus Groups	Key Actions
• People experiencing homelessness. • Individuals with disabilities. • Older people living alone. • Individuals with learning disabilities. • Individuals with severe mental illness. • Carers.	• Engagement with the Trust Inclusion Health Lead. • Enhanced discharge support for vulnerable groups. • Targeted public health communications. • Improved access to vaccination programmes. • Partnership arrangements with statutory and voluntary organisations.

• Rural communities. • Socially isolated individuals. • Populations experiencing deprivation	• Improved identification of vulnerable patients through multidisciplinary review
3: Primary Care and Integrated Neighbourhood Working Integrated neighbourhood working will play a critical role in reducing hospital demand and supporting people to remain safely at home.	
Key Components	Planned Actions
• General Practice. • GP Out-of-Hours. • Community Pharmacy. • Community Nursing. • District Nursing. • Integrated Neighbourhood Teams. • Hospital at Home. • NIAS. • Voluntary and Community Sector partner Community-based interventions including Hospital at Home, Frailty at the Front Door, Discharge to Assess (D2A) and Rapid Access Clinics are expected to increase same-day care, reduce avoidable admissions, shorten length of stay and support more patients to remain safely at home.	• Expansion of Community-based alternatives to admission. • Enhanced anticipatory care planning. • Medicines optimisation. • Care home support initiatives. • Enhanced rapid response services. • Increased use of Hospital at Home pathways
4: Protecting Elective Services The Trust remains committed to minimising disruption to elective care throughout the winter period.	
Key Actions	Outcomes
• Protect cancer pathways. • Maintain day-case capacity where possible.	• Reduced elective cancellations. • Protection of cancer services.

• Prioritise urgent and time-critical procedures. • Monitor cancellations through winter governance arrangements. • Utilise ambulatory pathways to minimise demand on inpatient beds. • Implement escalation measures only where clinically necessary	• Improved patient experience. • Maintenance of elective recovery trajectories
5: Workforce Resilience and Wellbeing Workforce availability remains fundamental to winter resilience. The Trust will implement measures to strengthen staffing capacity, support staff wellbeing and minimise operational disruption. Workforce planning will take a multiprofessional approach, recognising the contribution of medical, nursing, Allied Health Professions, pharmacy, social work, diagnostics, community services, support services and operational decision-makers to maintaining safe care and patient flow.	
Key Actions	Measures
• Enhanced Christmas and New Year medical staffing. • Recruitment and retention initiatives. • Flexible deployment arrangements. • Staff wellbeing programmes. • Staff vaccination campaigns. • Active sickness absence management. • Daily workforce monitoring.	• Vacancy rates. • Sickness absence. • Agency utilisation. • Staff vaccination uptake. • Staffing escalation incidents.

Digital Intelligence and Operational Management

The Trust will utilise digital systems including Encompass, SAPPHIRE and local operational dashboards to support effective winter management. Digital intelligence will be used to:

- Forecast demand.
- Monitor capacity.
- Track patient flow.
- Identify vulnerable patient groups.
- Support escalation decisions.
- Evaluate intervention effectiveness.

Governance and Performance Monitoring

Delivery of the Winter Plan will be overseen through established Trust governance arrangements with regular reporting to Timely Care Steering Group Executive Management Team and Trust Board.

The following indicators will be monitored:

- ED attendances.
- ED 12-hour waits.
- Ambulance handover performance.
- Bed occupancy.
- Delayed discharges.
- Length of stay.
- Readmissions.
- Respiratory admissions.
- Vaccination uptake.
- Workforce indicators.
- Elective cancellations

Regional Coordination, Surveillance and Commissioner Oversight

The Trust will work as part of the wider regional health and social care system throughout Winter 2026/27. This will include participation in regional coordination and escalation arrangements, including the Regional Control Centre (RCC) where activated, and engagement with SPPG and PHA arrangements for surveillance, information sharing, performance oversight and escalation.

Regional intelligence on respiratory illness, vaccination uptake, demand, capacity and system pressures will inform the Trust response. The Trust will use this information alongside local operational intelligence to support early, proportionate and coordinated action across acute, community and social care services.

Escalation Framework

Escalation Framework	
The Trust will maintain a structured escalation framework throughout Winter 2026/27. Escalation status will be reviewed daily through established operational management arrangements. Escalation decisions will also be informed by PHA surveillance intelligence, including respiratory infection activity and vaccination uptake, together with regional and local operational information. This will support earlier identification of emerging pressures and timely activation of proportionate responses.	
Escalation Indicators	Potential Escalation Responses
• Emergency Department attendances. • ED waiting times. • Ambulance handover delays. • Bed occupancy levels. • Delayed discharge numbers. • Workforce pressures. • Community capacity pressures. • Respiratory infection activity.	• Additional staffing deployment. • Opening of surge capacity. • Enhanced executive oversight. • Increased system coordination. • Review of elective activity. • Activation of mutual aid arrangements where appropriate

Timely Care Programme

Our Winter Plan builds on the Trust's Timely Care Programme, a year-round programme bringing hospital, community and social care teams together to improve how people move through urgent and emergency care. The programme focuses on earlier assessment, alternatives to hospital admission, faster access to tests, better coordination within hospitals and helping people leave hospital safely when they are ready. The benefits being achieved by these initiatives are being monitored through the performance metrics of the Timely Care Programme.

During winter, these established services provide an important foundation for the additional winter measures described in this plan.

Timely Care Initiative	What are we doing?	How will it help?
Hospital coordination and ambulance handover	Hospital site coordination will support communication between Emergency Departments, wards and operational teams, with a continued focus on patient flow and timely ambulance handover.	Better coordination can reduce avoidable delays, help beds become available sooner and support ambulance crews to return to the community more quickly.
Specialist frailty care	The Frailty Integrated Team provides early specialist and multidisciplinary assessment for older people living with frailty, working alongside Emergency Department and Hospital at Home services.	Suitable patients can receive specialist assessment earlier and, where safe, return home the same day or as soon as possible with appropriate support.
Cardiology ambulatory care	Specialist cardiology pathways provide assessment, treatment and follow-up for suitable patients without the need for an inpatient stay, including direct referrals from hospital and primary care pathways.	Patients can receive specialist heart care sooner and may be able to avoid admission or leave hospital earlier with planned follow-up.
Respiratory ambulatory care	Respiratory teams provide same-day assessment and treatment and can identify suitable patients in Emergency Departments and wards who can be managed through ambulatory or community pathways.	More patients with respiratory conditions can receive timely specialist care without an unnecessary admission or prolonged hospital stay.

Timely Care Initiative	What are we doing?	How will it help?
Faster access to diagnostic tests	Timely Care supports faster access to diagnostic imaging and blood tests for Emergency Department, ambulatory and inpatient services.	Faster test results can help clinical teams make earlier decisions about treatment, admission or discharge.
Single Discharge Team and weekend discharge support	The Single Discharge Team coordinates hospital discharge for people who need additional services, with enhanced weekend support to maintain discharge activity throughout the week.	Patients can have care and support arrangements coordinated earlier, reducing unnecessary delays once they are ready to leave hospital.
Extended Discharge Lounge	Extended evening and overnight discharge lounge arrangements provide a dedicated area for suitable patients who are ready to leave hospital but are waiting for final arrangements such as medicines, transport or collection.	Patients can complete the final steps of discharge in an appropriate area while hospital beds are released earlier for people who need admission.
Early Review of care at home	The Early Review Team reviews new or increased domiciliary care packages after discharge and adjusts support as a person's needs change.	People receive care that better reflects their current needs, while available home-care capacity can be used to support others who need it.
Vestibular rehabilitation	Specialist physiotherapy provides assessment and treatment for suitable adults attending Emergency Departments with dizziness, balance problems or falls.	Earlier specialist assessment can help suitable patients return home safely and may reduce unnecessary admission, investigations or repeat visits.
Making best use of day and ambulatory care	The Day Clinical Centre will support suitable follow-up and review appointments, helping free ambulatory services to focus on new and urgent patients.	Patients can access follow-up in the most appropriate setting while urgent ambulatory capacity remains available for people who need it most.

Our Approach to Winter Planning

Building on the year-round improvements delivered through the Timely Care Programme, the Trust will implement a series of additional targeted initiatives that will receive particular focus during the winter months. These initiatives have been identified in response to anticipated winter demand, learning from previous years and the need to further strengthen capacity and patient flow across urgent and emergency care, acute hospitals and community services

The initiatives are focused on the key points in the patient pathway where additional intervention can have the greatest impact: preventing avoidable attendance and admission; improving flow through Emergency Departments and acute care; reducing length of stay and delays in discharge; and maintaining operational resilience during periods of peak pressure.

A number represent significant developments for Winter 2026/27, with particular emphasis on senior medical triage and Rapid Assessment and Treatment at the Emergency Department front door, Grand Multidisciplinary Ward Rounds for longer-stay patients, and strengthening the Discharge to Assess (D2A) model. Together, these initiatives are intended to support earlier senior clinical decision-making, reduce unnecessary waits and admissions, identify and resolve barriers to discharge sooner, and enable more patients to leave hospital safely once they are medically fit.

These priority actions support the objectives reflected in winter and urgent and emergency care guidance and are consistent with the principles of Getting It Right First Time (GIRFT), particularly improving clinical decision-making, hospital flow and discharge. They also support the wider objective of reducing Emergency Department crowding and the risk of patients receiving care in inappropriate environments, including corridor care.

Key Winter 2026/27 Focus

Earlier Decisions: ED Front Door Medical Triage and Rapid Assessment and Treatment

Better Flow: Grand Multidisciplinary Ward Rounds focused on longer-stay patients

Earlier Discharge: Strengthened Discharge to Assess (D2A) model

Additional Winter Targeted Initiatives

1. Preventing Avoidable Attendances and Admissions		
Objective	Key measure	Expected outcome
NIAS – Direct referral pathway – Mental Health Development of alternative pathways to avoid Emergency Department (ED) attendance where appropriate. Test of concept whereby the Home Treatment and Crisis Response (HTCR) team will provide “in-reach” into the Northern Ireland Ambulance (NIAS) control room to provide a Response services, providing rapid mental health assessment and intervention in the community and reducing avoidable Emergency Department presentations by 15%	• Mental health related ED attendances via NIAS that have no identified medical need – divert by 15% • Average HTCR response time ◦ from referral – reduce by 2hrs • Patient experience score	• Preventing avoidable attendances and admissions: • Reduce unnecessary ED attendances • Improved Patient Experience and Safety • Faster access to mental health crisis support • Better patient outcomes • Improved patient experience and satisfaction • providing additional assessment, ambulatory and discharge capacity across acute and community settings, releasing inpatient bed capacity, supporting patient flow and reducing Emergency Department congestion during peak winter pressures

NIAS – Direct referral pathway – Hospital @ Home A direct referral pathway between the Northern Ireland Ambulance Service (NIAS) and Hospital @ Home (H@H) to enable care home residents to be assessed for community-based management before conveyance to the Emergency Department (ED), where clinically appropriate. Operational referral hours: 8am - 6pm Mon-Fri; 9am - 5pm weekends and Bank Holidays	- Number of patients managed through H@H following NIAS referral - Care home residents referred by NIAS to H@H prior to ED conveyance	- Improved patient flow - Reduce avoidable hospital admissions - Reduce avoidable ED attendances - Support patient flow - Improve access to care
GP Out-of-Hours – Enhanced Cover for Winter Surge To sustain current demand and ensure patients are managed efficiently and effectively during peak winter pressures. Increase GP Out-of-Hours Cover: - Weekdays: Monday–Friday, 18:00–21:00 - Weekends: Saturday–Sunday, 09:00–18:00	- Additional sessions to absorb surge demand. - Direct booking via Phone First and ED diversion pathways to reduce unnecessary ED congestion.	- Maintain timely access to primary care - Improved patient access to urgent GP care during peak hours. - Reduction in ED attendances for primary care conditions. - Enhanced patient experience through timely and appropriate care settings.

Diabetes & Endocrine Ambulatory To provide an early intervention pathway for patients presenting to the Emergency Department (ED) with acute diabetes-related conditions, including Diabetic Ketoacidosis (DKA) and hypoglycaemia, enabling rapid specialist review, timely treatment, and expedited discharge where clinically appropriate. This will reduce ED pressures, minimise inpatient admissions and length of stay, and improve patient flow and patient experience.	• Reduction in inpatient admissions for diabetes-related conditions. • Reduction in average length of stay for diabetes patients. • Percentage of patients discharged on the same day or within 24 hours.	• Earlier specialist assessment and treatment for patients presenting with DKA, hypoglycaemia, and other acute diabetes complications. • Reduced delays in care and faster clinical stabilisation. • Increased same-day emergency care and earlier discharge from ED. • Reduction in avoidable hospital admissions and inpatient bed utilisation. • Improved patient flow through ED and reduced pressure on acute services. • Improved patient experience through timely access to specialist diabetes support. • Safer transitions of care with reduced risk of re-attendance and readmission.
Enhanced Paediatric Ambulatory Access To strengthen paediatric support within the Emergency Department (ED) during periods of increased demand by enhancing medical, nursing, and pharmacy resources and ensuring sufficient bed availability within the Paediatric Ambulatory service.	• Enhance medical cover across both paediatric units for timely clinical assessment and intervention. • Provide adequate nursing staff to maintain safe ratios, including full night duty coverage. • Ensure paediatric specialist pharmacist availability to support medication safety, timely dispensing, and clinical decision-making. • Maintain sufficient paediatric beds overnight to accommodate	• Reduction in ED boarding times for paediatric patients. • Faster transfer from ED to paediatric wards, improving throughput. • Timely access to paediatric medical and nursing expertise for urgent cases. • Improved medication safety and reduced delays in prescribing and dispensing. • Increased availability of paediatric beds during peak demand periods. • Reduced risk of cancelled or delayed admissions due to bed shortages. • Shorter waiting times for assessment and treatment.

	admissions and prevent delays in patient flow.	• Improved continuity of care and reduced stress for families during high-pressure periods.
Enhancement of the Frailty at the Front Door Service (DHH) Proactive oversight and coordination of care for older people presenting to the Emergency Department and Same Day Emergency Care/Short Stay Unit pathways. Through early comprehensive frailty assessment, timely multidisciplinary intervention, and rapid discharge planning, the service will identify suitable patients for alternative pathways, reduce avoidable admissions, and ensure patients receive care in the most appropriate setting.	• Increase the number of patients pulled to the Frailty at the front door service • Reduce the number of admissions over 65's. • Increase number of ED patients	• Increased identification and management of frail older people at the earliest point of contact. • Reduction in avoidable hospital admissions for patients aged 65 years and over. • Increased same-day discharge rates from ED and SSU. • Improved patient flow through ED and reduced departmental pressures. • Reduced length of stay and inpatient bed occupancy. • Earlier access to specialist frailty assessment and multidisciplinary support. • Improved patient experience through timely assessment and care closer to home. • Enhanced coordination between acute, community, and social care services. • Improved functional outcomes for older people through prevention of deconditioning associated with hospital admission. • Increased availability of acute beds for patients requiring inpatient care.
Establish a Respiratory Ambulatory Service (DHH) Provide a 2-day rapid same-day assessment, diagnosis, treatment, and follow-up for patients presenting with respiratory-related	• The service will manage an estimated 5 respiratory patients per day who may otherwise require ED attendance or admission, providing approximately 900 ambulatory	• Increased access to rapid specialist respiratory assessment and treatment. • Reduction in avoidable ED attendances and hospital admissions. • Improved patient flow and reduced pressure on ED and inpatient respiratory beds.

conditions, enabling care to be delivered without the need for hospital admission where clinically appropriate. The service will support early specialist intervention, improve patient flow through the Emergency Department, and provide an alternative pathway for patients who require urgent respiratory care but can be safely managed on an ambulatory basis. This will reduce pressure on both ED and inpatient beds while improving patient experience and outcomes.	episodes over the winter period. Benefits include reduced respiratory admissions, improved patient flow, reduced pressure on inpatient beds, earlier specialist intervention and improved patient outcomes through care delivered closer to home.	• Increased numbers of patients receiving treatment and returning home on the same day. • Reduced length of stay for patients requiring hospital-based respiratory care. • Improved patient experience through timely, coordinated care closer to home. • Enhanced management of chronic respiratory conditions, reducing the risk of deterioration and future hospital presentations. • Improved utilisation of acute hospital capacity, allowing inpatient beds to be reserved for patients with the most complex clinical needs.
Day Clinical Centre (DCC) Provide additional nursing workforce to enable full utilisation of DCC accommodation which will provide two additional treatment rooms and will increase capacity to accommodate 8 additional patients at any one time.	• Additional nursing workforce in place to enable full utilisation of DCC accommodation. • Two additional treatment rooms operational. • Capacity increased to accommodate up to 8 additional patients at any one time. • Number of ascitic taps delivered within DCC. • Number of admissions avoided through provision of day-case procedures. • Interventional Radiology activity relocated to DCC.	• Significant expansion of DCC capacity through the staffing and utilisation of two currently underused treatment rooms. • Increased throughput, allowing up to eight additional patients to be managed concurrently within DCC. • Delivery of planned ascitic taps within a day-case setting, reducing the need for inpatient admission and supporting improved patient experience. • Relocation of Interventional Radiology activity to DCC, creating additional flexibility and treatment capacity within the system. • Capacity created to absorb up to nine displaced medical outlier beds, improving patient flow and reducing inappropriate bed utilisation.

	• Medical outlier beds reduced through creation of additional inpatient capacity in medicine.	• Improved unscheduled care performance through reduced pressure on inpatient beds and more effective use of ambulatory pathways. • Better patient experience through treatment in a dedicated day-case environment and avoidance of unnecessary hospital stays.
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2.Improving Flow Through the Emergency Department and Acute Care Pathways

Objective	Key measure	Expected outcome
ED Front Door – Medical Triage – Rapid Assessment and Treatment (CAH & DHH) Senior clinician-led model operating at the Emergency Department (ED) front door, designed to ensure patients receive timely assessment, early clinical decision-making and prompt access to the most appropriate care pathway. To support the Medical Triage Rapid Assessment and Treatment 10 x GP base appointments in Urgent Care Centre will be ringfenced each weekday to accept direct referrals from CAH ED.	• Improve patient safety and patient experience • Patients will be clinically assessed early and investigations ordered to enable rapid diagnosis and treatment of patients • Earlier identification of serious conditions – senior clinical decision will help identify time - time -critical conditions • early recognition of the deteriorating patient and high-risk presentations are recognised early • Reduce waiting times particularly to initial assessment, investigations and treatment Reduce length of stay, early	• Improve patient flow through the ED - Reduce delays in assessment and treatment by ensuring early senior clinical review at the point of arrival. • Reduce waiting times - Improve time to initial assessment and clinical decision-making for patients attending the ED. • Support admission avoidance - Increase the number of patients directed to appropriate ambulatory, specialty or community pathways without requiring hospital admission. • Improve Emergency Department performance = Contribute to reduced crowding and improved patient flow across the Unscheduled Care System. • Enhance patient experience - Ensure patients receive timely assessment and are directed to the right service first time.

	senior decisions will prevent unnecessary waits • Improves ED performance	
Social Work in-reach to Emergency Department (ED) Provision of earlier identification and support requirements for patients attending the Emergency Department (ED) with social care complications.	• Number and percentage of eligible ED patients receiving social work assessment, including same-day referrals • Median time from referral to social work assessment and intervention • Number and percentage of patients supported to avoid admission or achieve same-day discharge • Number of safeguarding, carer, housing, placement and care-package issues identified and actioned • Number of patients referred or connected to community, voluntary, housing, mental health, addiction or social care services • ED length of stay, re-attendance within 7 and 30 days, and patient/carers experience for patients receiving the service	• Earlier identification and resolution of social, safeguarding and practical barriers affecting safe care and discharge • Reduction in avoidable admissions and improved same-day discharge from ED • Reduced ED length of stay and fewer delays associated with care packages, housing, placement, family or carer arrangements • Improved patient flow and reduced pressure on ED and acute inpatient beds • Safer discharge plans, with timely escalation and management of safeguarding risks • Improved coordination between ED, acute, community, social care and voluntary sector services • Reduced risk of repeat ED attendance where underlying social needs can be addressed through appropriate onward support • Improved patient and carer experience through earlier support, clearer communication and care in the most appropriate setting
A redesigned therapy-led rehabilitation service will be introduced at Daisy Hill Hospital	• This reflects a redesigned therapy-led rehabilitation model focused on reducing length of	• Improve patient flow

to support patients in achieving greater independence and recovery while reducing unnecessary time spent in hospital	stay by 5 days and increasing patient turnover, with winter resilience maintained through strengthened Discharge to Assess, Hospital at Home and community rehabilitation pathways.	• Facilitate timely transfer of patients from acute stroke beds to rehabilitation services and onward discharge to the community. • Enhance rehabilitation delivery • Support a more focused rehabilitation model, maximising patient independence and recovery outcomes. • Increase system capacity. • Improve availability of acute stroke and rehabilitation beds through reduced LoS and more efficient patient throughput.
Establish a 34-bedded Acute Medical Unit (DHH)	• Increase in the number of patients discharged within 72 hrs enabling specialty to maintain current LoS performance of 3.9 days throughout the winter. • Implement GIRFT recommendation re the establishment of an Acute Medical Model at DHH site.	• Maintain efficient patient flow • Increase the number of patients discharged within 72 hours of admission. • Sustain specialty Length of Stay (LoS) performance • Enable the specialty to maintain the current average LoS of 3.9 days throughout the winter period. • Implement GIRFT recommendations. • Deliver the recommended Acute Medical Model at DHH, supporting best practice in acute medical care. • Reduce pressure on inpatient capacity • Improve patient streaming, assessment and treatment pathways, ensuring patients receive timely care in the most appropriate setting.
Fracture Service Winter Surge Capacity	• The Trust will monitor demand for fracture services throughout the winter period. Where increased	• Supporting timely assessment and treatment and maintaining patient flow from Emergency Departments.

	demand or surge is identified, agreed escalation arrangements will be used to increase fracture service capacity where required	This will include review of available clinic capacity, staffing and the use of additional or extended sessions where appropriate, with the response scaled according to demand and service pressures.
Clinical Coordinators to support the Hospital at Night	Increase the number of discharges before 13:00 hrs by ensuring all tasks are completed for patients that are identified for discharge the next day.	Ensure high-quality patient care at night by: - Providing senior nurse support to cardiac arrest and lysis calls, - Effective management of bleeps to streamline resident doctor workload; - Provide guidance to nursing staff on the identification and management of patient deterioration
3.Reducing Length of Stay and Supporting Timely Discharge		
Objective	Key measure	Expected outcome
‘Grand’ Multi-disciplinary ward round Enhanced Multi-Disciplinary Review Process. A weekly senior clinical review will bring together doctors, nurses, therapists and other healthcare professionals to discuss patients with more complex needs and ensure care plans remain focused on recovery and discharge goals	- Number of twice-weekly Grand Ward Rounds delivered. - Number of longest-stay patients reviewed at each ward round. - Number of discharge barriers identified and resolved.	- Earlier identification and resolution of discharge barriers. - Increased numbers of complex patients discharged in a timely manner. - Reduction in the number of long-stay patients across the hospital. - Reduced delayed discharge bed days and improved bed utilisation. - Improved patient flow from admission through to discharge. - Enhanced multidisciplinary decision-making and accountability.

		• Improved coordination between acute, community, social care, and independent sector providers. • Increased availability of acute hospital beds for patients requiring admission. • Improved patient experience through reduced time spent in hospital once medically optimised. • Reduced risk of deconditioning and hospital-associated complications associated with prolonged hospital stays.
Strengthening the Discharge to Assess (D2A) model Strengthening the Discharge to Assess (D2A) model to support patients to leave hospital as soon as they are medically fit, with any ongoing assessment of their long-term care, rehabilitation, or support needs taking place in their own home or a community setting.	• Number of patients supported through the D2A pathway • Average length of stay for D2A patients • Number of delayed discharges • Acute bed days released through D2A • Percentage of patients discharged to their usual place of residence	• Reduce delayed discharges • Increase the number of patients discharged promptly once medically fit. • Improve patient flow • Release inpatient capacity by reducing unnecessary lengths of stay and supporting timely movement through the hospital system. • Support care closer to home • Ensure patients are assessed and supported in the most appropriate environment, promoting independence and recovery. • Enhance patient experience • Reduce the risks associated with prolonged hospital stays and enable patients to return home sooner. • Optimise bed capacity • Improve the availability of acute inpatient beds during periods of increased winter demand.
Trusted Assessor (Care home/packages)	• Facilitate 60 discharges per month to stat res	• Contribute to reduced bed occupancy • Improved patient flow

The Trusted Assessor role will support the further development of Statutory Residential (Stat Res) beds, Home First, Sensible Care, and Trusted Assessor models by providing a dedicated interface between acute hospitals, community services, and independent care home providers. The post will focus on facilitating timely and complex discharges for patients who are medically optimised and require ongoing care within care homes or residential settings.	• Ensure patients who are medically fit referred to stat homes are discharged same day • Trusted Assessor will also cover DHH site to facilitate discharges to 20 per month to independent care homes • Reduce the number of breaches across DHH (medically optimised over 48 hours) 3 per week. • This role facilitates the most complex discharges to care homes, reduced bed days, interface between community and acute and links to independent care homes.	• Better patient outcomes through earlier transfer to the most appropriate care setting.
Establish Rapid Access Hot Clinics for DHH Medical Patients	• Maintain Length of Stay (LoS) performance for non-complex patients – 3.9 days • Increase the number of discharges within a 72-hour period by 10% • Facilitate specialist medical assessment following an earlier hospital discharge for an average of 16 patients per day.	• Maintain Length of Stay (LoS) performance • Support the specialty to maintain the average LoS for non-complex medical patients at 3.9 days throughout the winter period. • Increase early discharge rates • Achieve a 10% increase in the number of patients discharged within 72 hours of admission. • Provide timely specialist follow-up • Facilitate rapid access to specialist medical assessment following discharge, supporting an average of 16 patients per day through the Hot Clinic pathway.

		• Reduce avoidable admissions and readmissions • Provide an ambulatory care alternative for suitable patients requiring ongoing medical review and monitoring. • Improve patient experience
A dedicated frailty area within the Acute Medical Unit will provide focused assessment, treatment and support for patients living with frailty within a 72-hour length of stay.	• Reduce Length of Stay (LoS) of patients coded under DHH Geriatric Medicine by 3 days.	• Reduce Length of Stay for frail older patients • Achieve a 3-day reduction in the average LoS for patients under DHH Geriatric Medicine. • Improve patient flow • Support rapid assessment and management of frail patients, reducing delays in admission and discharge processes. • Enhance care for frail older people • Ensure patients receive timely Comprehensive Geriatric Assessment (CGA) and multidisciplinary input within a dedicated frailty pathway. • Reduce pressure on inpatient beds • Increase turnover of frailty patients through a targeted 72-hour model of care and prompt discharge planning. • Support admission avoidance and early discharge • Maximise opportunities for onward care through community, rehabilitation and Discharge to Assess pathways.

4.Operational Readiness and Workforce Resilience

Objective	Key measure	Expected outcome
Christmas & New Year Medical Staffing Plan (CAH & DHH) The workforce response will consider the wider multiprofessional team required to maintain assessment, treatment, diagnostics, discharge and community pathways across the holiday period. Additional Medical Staffing: Coverage: 11-day Christmas and New Year period.	• Maintain timely ward rounds and post-take reviews. • Expedite diagnostics and discharge planning. • Support weekend and holiday discharges to optimize bed availability.	• Reduced delays in patient reviews, diagnostics and discharge processes • Improved patient flow and reduced ED boarding. • Increased discharge rates during holiday periods. • Enhanced patient safety and experience through timely clinical decision-making
Diagnostics extended Portering Hours in both hospitals Extend evening portering services beyond 7pm to support patient flow and diagnostic capacity	• Extended portering hours delivered beyond 19:00 at CAH and DHH, measured against the agreed rota. • Number of diagnostic transfers completed after 19:00 hrs, by hospital and modality. • Median time from transport request to patient collection and	• Faster and more reliable access to evening diagnostics for ED and inpatients at both hospitals. • Reduced delays caused by patients awaiting transport to and from diagnostic departments. • Improved utilisation of available evening diagnostic capacity and fewer unused or cancelled slots.

	arrival at diagnostics during extended hours. • Number and percentage of evening diagnostic appointments delayed, cancelled or carried forward because portering was unavailable. • Diagnostic capacity utilised after 19:00, including planned slots completed and additional patients accommodated. • Time from diagnostic request to test completion and report availability for ED and inpatients requiring evening transport. • Portering-related incidents, complaints and staff feedback during the extended-hours period.	• Earlier clinical decision-making, treatment, admission, transfer or discharge following timely completion of investigations. • Improved patient flow through ED and acute pathways, with reduced overnight carry-over of diagnostic work. • Reduced length of stay and avoidable bed occupancy where diagnostics are the rate-limiting step in care progression. • Reduced pressure on daytime portering and diagnostic services through more even distribution of workload. • Improved patient safety and experience through timely transport, reduced waiting and better continuity of care.
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Conclusion

The SHSCT Winter Plan 2026/27 sets out a comprehensive whole-system approach to winter preparedness, bringing together prevention, community services, primary care, social care, acute services and partner organisations to ensure safe, timely and effective care throughout the winter period. Through robust governance, targeted investment and strengthened partnership working, the Trust will improve patient flow, reduce avoidable demand, support vulnerable populations, protect elective services and enhance resilience across the health and social care system.