1. ICB 25-09.201– Winter Plan 2025-26 DRAFT

Meeting Name: NHS Shropshire, Telford and Wrekin Integrated Care Board
Meeting Date: Wednesday 24 September 2025
Report Presented by: Ian Bett, Chief Delivery Officer, NHS STW
Report Approved by: Ian Bett, Chief Delivery Officer, NHS STW
Report Prepared by: Gareth Wright, Head of Clinical Operations UEC & EPRR, NHS STW
Action Required: For Discussion and Approval

1.1. Purpose

1.1.1 The purpose of this report is to update the Board on our planning for winter to date, and if content, to seek approval of our Winter Plan.

1.2. Executive Summary

1.2.1. The System UEC Improvement Plan 2025/26 is broadly on track. There are twin aims to support delivery of our operational plan and ensure preparedness for winter on a better footing than previous years. Against the primary performance metrics specified by NHSE committed to in our operational plan, we have achieved significant improvement on the ambulance performance required. We have made progress, but have more to do in order to reduce the time our patients are in our emergency departments. We expect to be back on plan in Q3 following delivery of our programme of improvement work.

1.2.2. Winter planning has gone further and been much earlier this year than last, both locally and nationally, and NHSE direction has been more proscriptive. We submitted our initial winter plan on 1 Aug to NHSE Midlands, who have conducted an assurance visit to our system on 4 Sep, which will be followed by an exercise to test system plans on 17 Sep. Following completion of that process, ICB and Trust Boards have been asked to complete board assurance statements no later than 30 Sep. Our proposed submission is covered in this report.

1.2.3. Detailed work that is progressing includes aligning provider plans with our system-wide approach; refining modelling of the impact upon our performance measures and capacity in the acute hospitals; and having selected where to apply our system interventions to greatest effect, moving them forward at pace.

1.2.4. The effects we intend to achieve are: to decompress our emergency departments; shift more urgent care out of hospitals to the community; maintaining a 'home first' principle for our patients; and minimise delays at each stage of the pathway. This is an ambitious agenda, but we have good grounds for optimism from the delivery of our programme of work that we will enter winter this year from a much stronger start position than previous years.

1.3. Recommendations

1.3.1 The Board is invited to:

- Note the progress of the system UEC improvement programme and delivery of our operational plan.
- Approve the system winter plan, to mitigate additional seasonal pressure, and safely maintain quality of care.
- Agree the submission of our Winter Board Assurance Statement to NHSE no later than 30 Sep, subject to finalisation by the Chair and CEO.

1.4. Conflicts of Interest

1.4.1. No conflicts of interest related to this report.

1.5. Links to the System Board Assurance Framework (SBAF)

1.5.1. Strategic Objective 3 includes: Improving Health and Care – Urgent & Emergency Care.

1.5.2. Strategic Risk No.2b: Failure to deliver the System and ICB Revenue and Capital Resource Limit Plans; due to Escalation costs not reducing as planned due to UEC pressure and links to discharge.

1.6. Alignment to Integrated Care Board

1.6.1. Improve quality of care and patient experience in the UEC pathway. Enhance productivity and value for money.

1.7. Key Considerations

1.7.1. **Quality and Safety:** Achieving the best we can for patient care and outcomes under extreme operational pressure.

1.7.2. **Financial Implications:** UEC Improvement Programme is required to contribute to the System Financial Plan 2025/26, by reducing cost of Escalation capacity and process improvements in Community pathways.

1.7.3. **Workforce Implications:** UEC Improvement Programme is required to contribute to the System Workforce Plan 2025/26, by reducing reliance upon temporary staffing.

1.7.4. **Risks and Mitigations:** Risks to programme delivery are being managed by the UEC Delivery Group; accountable to the System Transformation Group.

1.7.5. **Engagement:** Extensive winter communications plan across broad media sources.

1.7.6. **Supporting Data and Analysis:** Data used in the report is from NHS STW Business Intelligence.

1.7.7. **Legal, Regulatory, and Equality:** Addressing health inequalities will continue to be a deliverable within the UEC programme 2025/26.

1.8. Impact Assessments

1.8.1. **Has a Data Protection Impact Assessment been undertaken?** No

1.8.2. **Has an Integrated Impact Assessment been undertaken?** No, but an Equality & Quality Impact Assessment has been reviewed by our Quality and Inequalities teams, and continues iteration.

1.9. Attachments

1.9.1. NHSE Winter Planning Board Assurance Statement – ICB. This is for approval at this meeting.

2. Winter Planning 2025-26

2.1. Introduction

2.1.1. This report follows on from the presentation delivered to the Board on 30 Apr 25, which updated on delivery last winter and reflected upon UEC improvement achievements in 2024/25. The Board was apprised of our intended approach for 2025/26 as Year 2 of our improvement programme, having learned from the experience of last year. Our winter planning for this year to date was briefed to the Board Development Session on 30 Jul 25, to enable submission of our initial Winter Plan to NHS England on 1 Aug 25.

2.1.2. Performance against the trajectories we have committed to is being much closer monitored this year. Improvements made within our UEC pathway have directly contributed to this and will do more. Our programme of work includes planning across the system to mitigate the predicted increased demands over the coming winter months. We have high impact schemes that will come to fruition, which will enable us to enter winter on a stronger footing than in previous years.

2.2. Background

2.2.1. **National direction – UEC Plan 2025/26.** Ahead of release of the 10 Year Health Plan for England, NHSE published the UEC Plan 2025/26 on 6 Jun 25. A wide-ranging document, which:

2.2.1.1. Confirms **priority focus upon key metrics** that we are closely monitoring in our Operational plan: patients waiting for 4 hours and 12 hours in our emergency departments; Category 2[1] ambulance response; and confirmation of a new standard for ambulance handover delays to be a maximum handover time of 45 minutes.

[1] Patients who are categorised as Category 2 – such as those with a stroke, heart attack, sepsis or major trauma – are to receive an ambulance response within 30 minutes.

2.2.1.2. Provides **direction on preparing for winter**; principally seeking to learn from previous years, with two priority actions:

'Focus as a whole system on achieving improvements that will have the biggest impact on urgent and emergency care services this winter.'

'Develop and test winter plans, making sure they achieve a significant increase in urgent care services provided outside hospital compared to last winter.'

2.2.2. **NHSE Midlands direction**. An NHSE Midlands letter was received on 18 Jun, 'Winter 2025/26 Expectations for Planning, Preparedness, and Assurance', which informed the Board update on 30 Jul. We have submitted a winter Key Lines of Enquiry return to the regional team, our initial winter plan on 1 Aug; and hosted senior leadership from the Midlands Region team on a winter assurance visit to our system on 4 Sep. At the time of writing, formal feedback on the latter is awaited, but comments on the day were very positive; welcoming our progress and level of ambition, recognising that delivery is now key.

2.2.3. **NHSE Winter Board Assurance Statements**. On 14 Jul, the National Director of UEC & Operations, Sarah-Jane Marsh, wrote to ICB and Trust CEOs with supplementary guidance. Two specific expectations of all ICBs and Trusts, new this year, are:

- Stress test draft winter plans by participating in an **NHS England-hosted exercise** in September, to be arranged by Regional teams. The latter has been set for 17 Sep, which post-dates the finalisation of this report, so any significant outputs from that event will be covered during discussion.

- By 30 Sep, we are to submit a **Board Assurance Statement** direct to the NHSE national UEC team. The proposed statement is attached to this report, with the current status of actions leading to being able to recommend assurance to the Board are at Appendix 4. If content, the Board is asked to provide approval for submission.

2.2.4. **Improvement acknowledged by NHSE**. We are in Year 2 of our system plan to meet the Undertakings we committed to in May 24, including for operational delivery. What has been well received during our time in the national Recovery Support Programme (RSP), is that as a system, we have had a single, unified plan for improvement and delivery, and stuck to it. Tangible confirmation of achievement is:

2.2.4.1. A certificate of **compliance with the Undertakings** (not just UEC) has been issued by NHSE Midlands, on 18 Jul 25.

2.2.4.2. NHSE Midlands are reviewing whether the conditions have been met for the ICB to **transition out of RSP**. We have provided comprehensive evidence to demonstrate fulfilment of what we committed to do. At the time of writing the decision upon that is awaited.

2.3. System approach to winter 2025-26

2.3.1. **Transition from winter 2024/25**. It is generally expected that winter pressures ease after the turn of the financial year, but a conflation of factors contributed to a challenging exit from winter and start to Q1 in our system:

- **High attendances**. Ambulance conveyances to our hospitals were unusually high in March and April, with a weekly average 9.1% higher than in Dec 24 to Feb 25; and 5.8% higher than Mar/Apr 24. Overall front door attendances at our EDs were also 8.9% higher over the same period; with Type 1 at 2.3% higher.

- Taking the SaTH **Urgent Treatment Centres (UTCs)** contract back in-house resulted in a temporary reduction in activity through the UTCs and the performance achieved. The UTCs and our community Minor Injuries Units when working well, typically achieve over 90% compliance with the 4 Hour standard, which contributes strongly to our overall system performance as well as flow. Low activity through the UTCs displaces activity into our EDs.

- The start of the transition period for our **GP Out of Hours / Care Coordination Centre** provider contract; and the ending of additional capacity within it that had been funded by the national Recovery Support Programme. The effect has been to reduce options to signpost activity away from our hospitals; and in particular to reduce the ambulance service 'call before convey' for an alternative.

- **Ending of System-funded winter schemes** that contributed to flow, notably additional patient transport for discharges and transfers. This affected early outflow from our hospitals; proving the value of the intervention.

2.3.2. **Performance against Plan**. These factors increased and sustained crowding in our EDs, with a concomitant impact upon our primary performance metrics. But we remain largely on track or close to our operational plan. Our improvement programme is responsive to supporting course-correction, and our winter planning has been informed accordingly.

2.3.2.1. **4 Hour standard**. Notwithstanding these adverse pressures, our system performance overall has largely tracked, albeit fallen slightly short of the trajectory we have committed to, as shown in Figure 1 below. Importantly, the ED Type 1 performance has been closer to plan, which is generally harder to achieve than the Type 3 contribution by the UTCs, which will continue improve. The principal contributory factor to adverse 4 Hour performance is crowding in the EDs, with too many patients to be seen by too few clinicians with too few clinical spaces to see them in. It is our main effort to decompress the EDs, and several of our high impact enduring changes – as well as winter-specific schemes – are focused upon this effect.

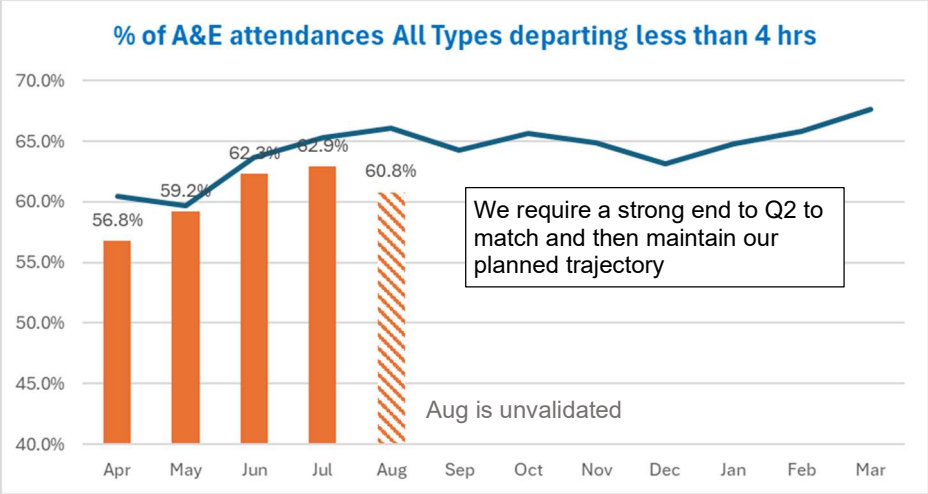


Figure 1: System 4 Hour performance against trajectory

2.3.2.2. **12 Hour waits in EDs**. This remains our area of most significant challenge, as shown in Figure 2. It is a direct result of the crowding in our EDs, which in turn is a product of too many arrivals and insufficient exit flow; not just admissions, discharge or transfer. Progress in the department slows, quality of care is diminished, and safety can be compromised. Corridor care becomes an unwelcome pressure. Approximately 60% of our 12-hour waits are for inpatient beds, with circa 20% routed to ambulatory or short stay settings; and the remainder are either discharged or transferred to other locations (such as a community bed). Additional bed capacity is due to be available on our acute sites in Q3, and several of our other schemes due to come online achieve a bed *equivalence* by providing alternatives to hospital attendance and admission, as well as facilitating more timely discharge and reducing the incidence of readmissions.

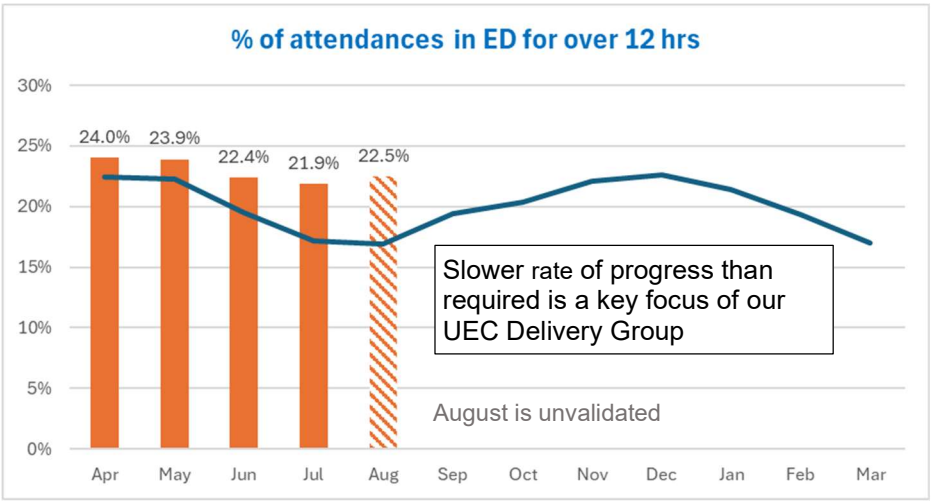


Figure 2: SaTH 12 Hour performance against trajectory

2.3.2.3. **Ambulance handover**. We have committed to an ambitious trajectory that is a 17% improvement on what we achieved each month last year. A new standard was introduced over Q4 of last year, to achieve handover within 45 mins (absolute, rather than average). This has been confirmed in the NHSE UEC Plan, and although not in the planning round so we do not have a trajectory for it, we have

committed to month-on-month improvement. August has been our most compliant month this year to date with 66.2%. Handover performance has a close connection with our financial plan, with potential penalty costs to contribute to WMAS capacity being a topical sticking point in agreeing the WMAS contract being brokered by Black Country ICB as lead commissioner. Figure 3 shows the challenging start in April but subsequent months being closer to our trajectory.

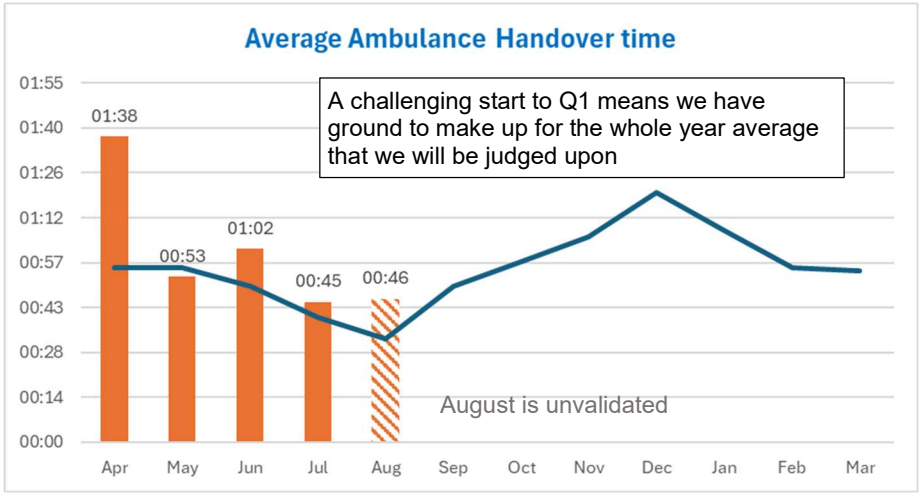


Figure 3: SaTH Ambulance handover performance against trajectory

2.3.2.4. **Ambulance Category 2 response**. This is a system metric that is a shared endeavour with WMAS, being partly a function of the resource deployed by our ambulance service colleagues and timely release of crews following handover at our hospitals, as well as finding alternatives to conveyance in the first place. In 2024/25 our system was one of the top 5 most improved nationally. Figure 4 shows the achievement this year to date.

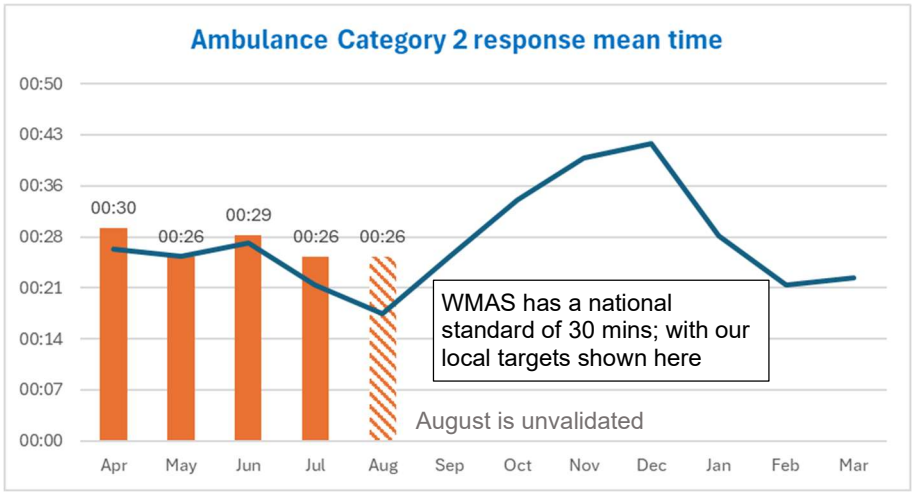


Figure 4: System Ambulance Cat 2 response against Plan

2.3.3. Learning from Winter 2024-25.

2.3.3.1. **System review and learning**. The UEC Delivery Group received a review of our System winter plan 2024/25 on 27 May 25. In summary, our ability to respond was insufficient to counter the progressive pressure that built throughout Nov & Dec 24, culminating

in declaring a system-wide critical incident on 3 Jan 25. It was recognised the significant response from system partners to ensure the incident only lasted for 48 hours. Winter pressures extended into April in terms of demand upon our pathway, which we have made provision for in our planning this year.

2.3.3.2. **NHSE Midlands**. The review of the experience across the Midlands region over winter acknowledged and confirmed the themes we had identified. A key observation made in the NHSE Midlands feedback was:

'*STW has proven it can recover under pressure. The next step is to avoid getting there in the first place*'.

2.3.4. **What we are doing differently.** Considering what has already been covered in this report, our approach has been modified based upon experience, including:

- Nationally and locally, **planning** has started much earlier.
- Our UEC Improvement **programme will complete *ahead of* winter**, not at the tail end of it, in the way intended last year.
- **Provider-specific improvement** programmes are more realistic; and complementary to the overarching system programme.
- We are **involving primary care** to better effect.
- Working with our Local Authorities on our **domiciliary care** provision.

2.3.5. **System-level interventions** will be more focused at the time and places to achieve most impact, rather than spread too thinly.

2.3.6. **Why we will be in a better place this year**. We require a more robust UEC pathway all-year round, with the ability to adjust for seasonal variations. That has been the focus of our Improvement programme. There are high impact changes being made – none of which we had last year – that are not winter-specific and therefore enduring. All these changes will contribute to our main point of effort, which is to decompress our EDs, by reducing attendance and increasing outflow. This includes an integrated out of hospital model for the services delivered by SCHT; reinvesting funds released from repurposing the Rehabilitation & Recovery Units at our acute sites. The principal changes are:

Enduring scheme	**Output intended**	**Timeframe**
Expansion of Urgent Community Response (UCR) to midnight, 7 days a week	ED Attendance avoidance	Nov/Dec
UCR Medical Model via GP cover and oversight	Safer, timelier community-based decision-making	Nov/Dec
Integrated Community services at the Front Door of our Emergency Departments	Redirection of patients into community service alternatives	Sep
2-Hour Domiciliary Care Bridging	ED Admission avoidance by supported discharge	Nov/Dec
Additional Discharge Planning capacity (5 to 8pm, 7 days a week)	Maintain discharge flow beyond core hours	Nov
Care Transfer Hub (CTH) System Manager	Enhanced operational leadership and joint working	Oct

Enduring scheme	Output intended	Timeframe
Additional Weekend Therapy cover for CTH	7-day therapy input for frail / complex patients	Nov
Care Coordination Centre / GP Out of Hours delivery under new contractor	Alternatives to ED, including reduced Ambulance conveyances	Oct
SaTH UTCs brought back in-house	Higher productivity is being incrementally achieved	In place
A modular build comprising 56 additional beds at RSH	38 additional inpatient beds available year-round, plus 18 Winter Flex inpatient beds	Nov/Dec
Reconfiguration of acute medicine beds and assessment areas at PRH (subject to Board approval 11 Sep 25).	Increase outflow options and capacity from ED	Oct/Nov

2.4. Winter Plan 2025-26

2.4.1. **Development of our Plan.** Winter planning has been a workstream in our Improvement programme, enacted from 1 Apr. The UEC Delivery Group has directed the programme, received monthly updates and made decisions on our approach. Our proposed plan has been reviewed and agreed at appropriate waypoints by the system UEC Clinical Advisory Group, the Commissioning Working Group, the System Transformation & Digital Committee ahead of Board on 30 Jul. The sequence of governance checks and balances enabled us to meet the NHSE submission deadline.

2.4.2. **Winter Plan summary.** Appendix 1 is the system winter plan, on a page. It consists of five phases with specific effects intended to match expectation of pressure and response. The phases are summarised in the table below:

Phase	Time period	Effect intended	Summary
1	Jul – Oct 25	**Deliver our programmes**	High impact changes (paragraph 2.3.5 above) will come online at varying points and coordinated to best effect.
2	Ahead of the festive fortnight	**Reduce rising pressure**	Intensive system effort to offset rise in demand and create capacity needed to get through the bank holiday period; which effectively has two 4-day weekends.
3	Early new year	**Recovery**	Having used the capacity, priority is to decompress and rebuild our reserve.
4	Feb – Mar 26	**Sustain our response**	Avoid being over-matched by pressure and set conditions for a strong Mar 26.
5	Mar – Apr	**Transition from winter**	Taper off the winter schemes and start 2026/27 well.

2.4.3. **Command & control.** Against the backdrop of the national and local NHSE / ICB reset, ICBs are required to deliver winter, and we will do so seeking any opportunities to work closer with our ICB cluster colleagues in the Staffordshire & Stoke-on-Trent ICB. Command & control will be exercised through our System Coordination Centre, which is well established and regularly tested in responding to pressures and the unforeseen. Managing the concurrency of UEC pathway winter pressures alongside an EPRR incident is being worked through.

2.4.4. **Applying system interventions**. We will have a tiered response framework this winter, which was welcomed and assured during the NHSE Midlands visit on 4 Sep:

2.4.4.1. **Enduring**. This will be our baseline increase in capacity, comprising what we have now, improved by the high impact changes detailed in paragraph 2.3.5 above. Redistribution of resources to rebalance activity into our Neighbourhoods.

2.4.4.2. **Seasonal**. This will comprise the interventions that we plan and proactively apply in a place and time of our choosing – such as a multi-agency discharge events, a GP at the ED front door, additional capacity in primary care, more patient transport.

2.4.4.3. **Responsive**. If our pre-planned interventions are judged insufficient to mitigate pressure, we will enact focused additional measures to de-escalate and avoid reaching a tipping point that would require an incident-level response. This might include extending opening hours of services; additional clinical decision-making capacity; and enhanced control by senior leadership.

2.4.5. **Allocation of ICB winter funding**. There is no general national funding again this year to resource the response required to winter pressures. We have a system budget of £740k, which is comparable to last year. Where to apply this funding to deliver the effects we require has been informed by review of what worked and what was less impactful last winter. There have been tests of change for the efficacy of schemes, such as transport capacity to be ringfenced for specific purposes. The ability to plan more deliberately is a direct benefit of starting our planning process earlier this year.

2.4.5.1. **Impact areas**. The UEC Delivery Group on 26 Aug agreed the schemes we will fund this year. This is summarised in Appendix 2. It was agreed that we would expect greatest impact from allocating system winter funding to:

- ED attendance and re-attendance avoidance by **Primary Care**, both our general practice and community pharmacy capacity.
- **Patient discharge transport** and enabling earlier facilitated discharge.
- **Communicating** with our patients to reassure, inform and empower their decision-making.

2.4.5.2. Provide a capacity **reserve for de-escalation**, under a response scenario as outlined at paragraph 2.4.4.3 above.

And that we should de-prioritise previous year schemes that have limited proof of delivery.

2.4.5.3. **Distribution of funding**. At the time of this report, providers of the selected schemes are being given authority to proceed. We await a decision on a bid we have submitted for additional funding from a national Respiratory Transformation Programme scheme. If successful, it would enable primary care seasonal respiratory

intervention on a broader basis that we can currently fund as a system. Assurance that we are using our system funding appropriately continues to be by the Commissioning Working Group.

2.4.6. **Winter-specific planning**. There are specific seasonal sub-plans that are well advanced, including:

- **Vaccination programme**, executive lead CMO supported by CNO; being developed by the Directors of Public Health for our population, and by provider leads for staff immunisation and inpatients.

- **Infection Prevention & Control**, executive lead is CNO; we will receive health intelligence input from UKHSA, and response plans by providers.

- Our **Workforce** is under the most pressure of any time of the year with staff fatigue, burnout, winter illness and the imperative to take leave all factors that will be carefully managed.

2.4.7. **Bed demand & capacity**. Our baseline bed model is derived from our Operational Plan 2025/26. This is supplemented by the impacts of our change programme activities (including SaTH modular build) and our winter-specific schemes. We continue to refine modelling of the impacts that could be realised; along with what can be achieved at an appropriate confidence level.

2.4.7.1. **Winter scenario impact effects** are based upon actual experience last year, with two levels 'surge' (1 or 1.5% increase in demand and bed closures) and 'super surge' (2 to 5% increase, depending which metric is affected). Whereas these percentages are not particularly high, such is the nature of current demand upon finely balanced service capacity, they have a cumulative effect over a succession of days if the pressure cannot be eased. Our ability to turn over beds is more significant than absolute numbers.

2.4.7.2. **Assessment**. There are plus and minus shifts intended as we rebalance our bed base, as well as measures that will provide bed equivalence in our high impact schemes. Taking all of this into account, a summary of our demand and capacity is at Appendix 3. Our most challenging month is expected to be December, both in terms of peak demand as well as a number of our change programmes rebalancing capacity and service delivery. Every effort will be made to bring forward, deconflict and coordinate provider changes with system support.

2.4.7.3. Use of **Temporary Escalation Spaces (TES)** will be minimised this winter. TES comprise the use of unfunded or unconventional care spaces, which may include one or more additional patients in inpatient wards, or 'corridor care' in an emergency department. The latter, above all, will not form part of our escalation processes this year.

2.4.8. **System partner key contributions**. Our role as the ICB is to plan and deliver 'a better winter for our patients and staff, as directed in the NHSE UEC Plan

2025/26 published on 6 Jun 25. Key contributions that our system partners are accountable for include:

2.4.8.1. SaTH will deliver the process improvements within their agreed Improvement programme; and reconfigure the acute bed base for greater optimisation of flow through the hospitals.

2.4.8.2. ShropComm will deliver the closure of the Rehabilitation & Recovery Units in order to release resources to reinvest in the Integrated Out of Hospital model. The outcome will be a significant shift of patient activity away from hospital into community settings.

2.4.8.3. RJAH will continue to focus on elective activity and backlog reduction. Over the festive fortnight, fallow capacity will be made available to SaTH to continue elective programme delivery during the forthcoming bed reconfiguration; and ease pressure upon the acute sites at this most demanding point in winter.

2.4.8.4. MPFT will maintain resilience in its community and inpatient mental health services in support of the overall system ambition to drive down unnecessary demand on primary care and acute services.

2.4.8.5. WMAS will maintain ambulance resource availability in accordance with their demand & capacity plan for winter. And bear down upon unnecessary conveyance to hospital, making appropriate use of the 'call before convey' options for lower acuity patients. Close contact is maintained daily between our Ops teams to manage pressure.

2.4.8.6. Health Hero, our provider of single point of access and GP out of hours services with effect from 1 Oct, will collaborate with our system partners to identify and provide alternative to hospital pathway referrals for our patients.

2.4.9. Risks to Quality and delivery. Key risks being managed in our preparedness, all under ICB leadership and command & control interventions are:

- **High impact schemes** being delayed in implementation; for example, estates delays and workforce consultation. There will also be sequencing and concurrency issues to be carefully managed as we make changes to the services we are delivering.

- **UEC Improvement programme** workstreams not delivering the impact envisaged by the start of November; for example more patients being discharged home, has a dependency upon reducing delay-related deconditioning in our hospitals.

- **Insufficient information to inform patient decisions** to select the right service for their needs, other than our EDs. This is the principal focus of our system winter communications campaign, which is in development.

- **The unforeseen** is a daily challenge on the UEC pathway; for example, across the NHSE Midlands region last year there was an earlier onset at higher levels than predicted of Flu.

2.4.10. **Towards Board Assurance of our Plan.** New to this year, although consistent with the direction of travel for more defined accountability, is the requirement for CEOs and Chairs of ICBs and Trusts to complete and submit a Board Assurance Statement (BAS) to the NHSE national team, no later than 30 Sep.

2.4.10.1. A **proposed BAS** is enclosed for ICB Board consideration, with a summary of evidence and rationale for recommending assurance at Appendix 4 of this report.

2.4.10.2. Although the ICB assurance is not an aggregation of our **provider Trusts' statements**, we have been monitoring progress through the system Planning & Performance Group and by the ICB Board meeting on 24 Sep all should have been reviewed by Trust Boards, as follows:

Trust	Board date	Notes
RJAH	3 Sep	BAS was reviewed and supported
SCHT	4 Sep	BAS was approved and will be aligned with SaTH by CEO in Common
SaTH	11 Sep	Not taken place at the time of writing this report
MPFT	11 Sep	Jointly comprises the assurance for Staffordshire & Stoke-on-Trent

2.5. Recommendation

2.5.1. Winter will never be a straightforward period of pressure for our system. But we have come far in setting the conditions for a more resilient UEC pathway, that is more able to absorb and recover from peaks of demand. Provided we successfully deliver the interconnected programmes of work that we have in progress, we should enter winter in a significantly better position than previous years. This will provide our basis to maintain safety and the quality of care that our patients deserve.

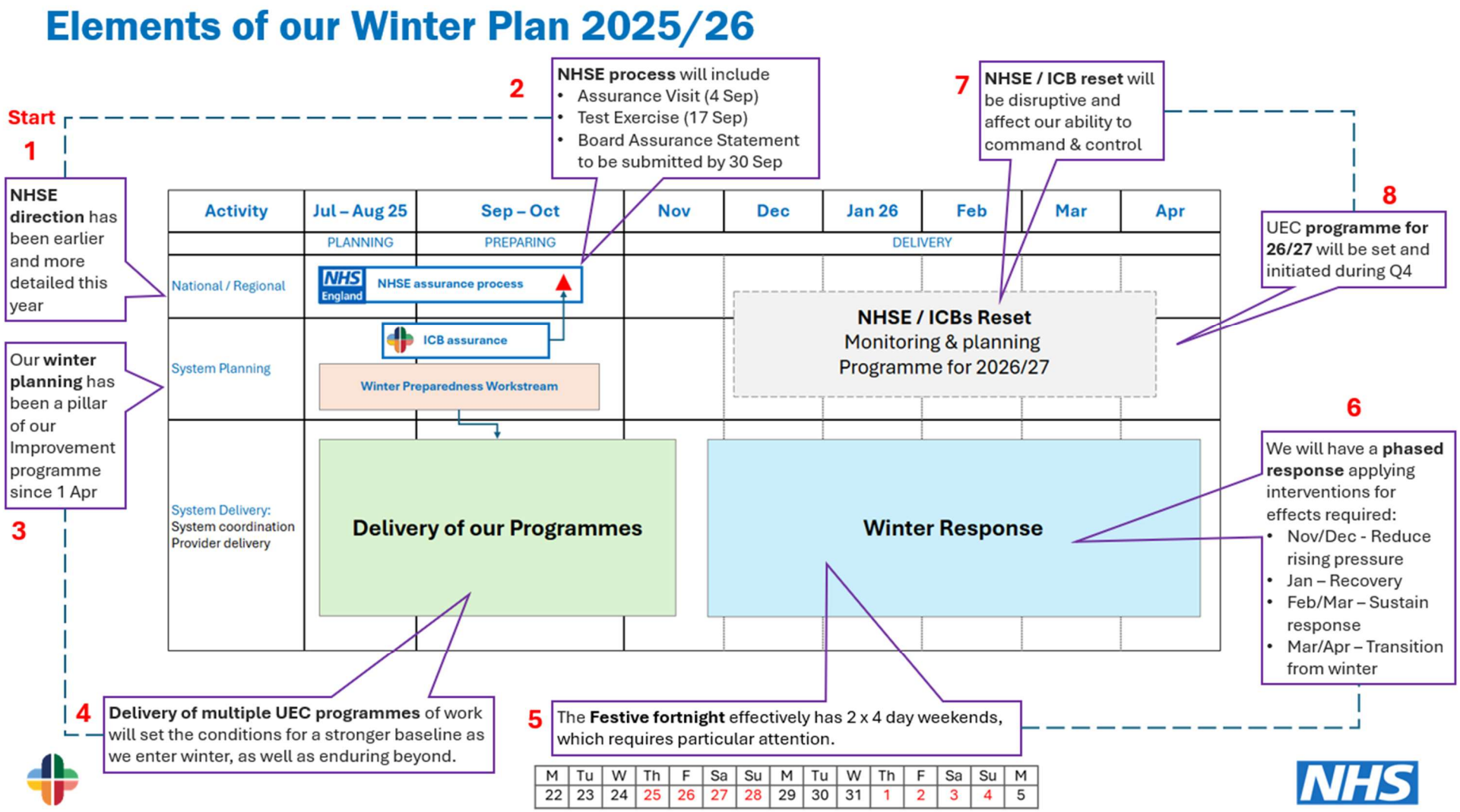
2.5.2. On this basis, the Board is recommended to:

- Note the progress of the system UEC improvement programme and delivery of our operational plan.
- Approve the system winter plan, to mitigate additional seasonal pressure, and safely maintain quality of care.
- Agree the submission of our Winter Board Assurance Statement to NHSE no later than 30 Sep, subject to finalisation by the Chair and CEO.

Appendices:

1. STW Winter Plan 2025-26 summary.
2. STW Winter funded mitigation schemes.
3. System bed model 2025-26.
4. Board Assurance Statement evidence and rationale.

Appendix 1 – STW Winter Plan 2025-26 summary



Appendix 2 – STW Winter funded mitigation schemes

System Winter schemes to be funded by ICB 2025/26

Time limited interventions for the winter period.

Scheme	Summary	Outcome expected	Effects intended
Extended Hours of UTC opening	By opening from 0800-midnight daily, we can reduce the number of patients handed back to ED; as well as easing pressure upon general practices.	*Typically 15-20 patients seen in each UTC rather than ED*	ED decompression Reduce pressure on primary care
Primary Care management of rising risk patients	Identify rising risk patients, optimise care, and support, linking with Virtual Ward and acute physicians if necessary. Funding bid pending for Respiratory Transformation Programme.	*Patients de-risked from COPD exacerbation in the community*	ED attendance avoidance
British Red Cross ED support scheme	To provide emotional and practical support to our patients, their families and carers.	*Support to 300-600 patients, subject to final model agreed*	Admission avoidance and ED decompression
System-level Communications	We need to keep our patients informed of their options including Pharmacy First and NHS 111.	*'Think Which Service' broad spectrum campaign*	Influence public and patients
Patient transport capacity	Complete work to ensure we are making best use of what we have, supplementing if the need is proven.	*Additional 1,600 patient journeys for discharges*	Earlier in the day discharge
Enhance our Discharge Medicines Service	Increase the volume of referrals and targeted support to community pharmacies to increase completion rates.	*Bed days saved from approx 15-20 beds equivalence*	Re-admission avoidance
Reserve capacity to meet peaks of demand	A range of pre-planned interventions is needed, within agreed lead times. This may include additional GP capacity in acute settings.	*Focused interventions to deliver double digit impacts*	Ease system pressure at points of greatest need on our pathway

Appendix 3 – System bed model 2025-26

The System Operational Plan 2025/26 provides progressive mitigation of the bed position at SaTH by a range of improvement programme schemes. Added here are the expected impacts of the high impact change programmes and System funded winter schemes (Appendix 2). The mitigations will offset our anticipated adverse bed position. December is our month of highest anticipated pressure, concurrent with enacting changes such as the modular build at RSH becoming available to use.

Physical beds required	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Baseline	709	741	721	719	699	683	688	718	740	710	733	684
Surge	709	741	721	719	699	683	711	750	786	754	769	707
Super surge	709	741	721	719	699	683	727	774	818	786	795	723
Beds available												
Overnight G&A available - core	768	768	768	768	768	768	768	796	796	796	796	796
Planned Escalation beds	17	17	17	17	17	17	17	17	45	45	45	45
Total beds	**785**	**785**	**785**	**785**	**785**	**785**	**785**	**841**	**841**	**841**	**841**	**841**
NEL acute beds (including SaTH schemes)	**662**	**662**	**662**	**662**	**662**	**662**	**662**	**735**	**745**	**763**	**763**	**763**
Occupancy assumption	98%	98%	98%	98%	96%	96%	96%	96%	96%	96%	96%	96%
Beds available	**649**	**649**	**649**	**649**	**636**	**636**	**636**	**706**	**715**	**732**	**732**	**732**
Bed gap (after IPC closures)	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Baseline	-68	-101	-88	-77	-73	-55	-69	-19	-33	3	-6	33
Surge	-68	-101	-88	-77	-73	-55	-92	-51	-79	-41	-43	10
Super surge	-68	-101	-88	-77	-73	-55	-108	-75	-112	-74	-69	-6
System bed mitigations include												
Out of Hospital activity shifts								8	17	18	17	17
System winter mitigation schemes							6	9	13	14	14	14
Residual bed gap	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Baseline	-68	-101	-88	-77	-73	-55	-63	-2	-3	35	25	64
Surge	-68	-101	-88	-77	-73	-55	-86	-34	-49	-9	-12	41
Super surge	-68	-101	-88	-77	-73	-55	-102	-58	-82	-42	-38	25

Appendix 4 – Board Assurance Statement evidence and rationale

By 30 Sep, we are to submit a Board Assurance Statement directly to the NHSE national UEC team. The current status of actions leading to being able to recommend assurance to the Board are detailed here.

Section A: Board Assurance Statement

Assurance statement	Assurance recommended (Yes / No)	Evidence / rationale
Governance		
The Board has assured the ICB Winter Plan for 2025/26.	Yes	Summarised in this report. Our Plan has been reviewed and assured by NHSE Midlands on a winter assurance visit to our System on 4 Sep.
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 has been extensively reviewed with input and iteration between the ICB UEC, Quality and Inequalities team. It will be reviewed on behalf of the Board at the Quality & Performance Committee on 25 Sep.
The ICB's plan was developed with appropriate levels of engagement across all system partners, including primary care, 111 providers, community, acute and specialist trusts, mental health, ambulance services, local authorities and social care provider colleagues.	Yes	Our Plan has been developed under direction of the UEC Delivery Group, at which all partners are represented, including NHSE Midlands, our Local Authority colleagues and Partners in Care. Engagement with the ambulance service is led by our UEC Improvement Director (formerly of WMAS).
The Board has tested the plan during a regionally led winter exercise, reviewed the outcome, and incorporated lessons learned.	Yes	A delegation of 9 senior leaders from the ICB and partners across our system will participate in the NHSE-led winter exercise on 17 Sep. The outcome intended is to identify any gaps in our preparedness, to incorporate ahead of the winter period.
The Board has identified an Executive accountable for the winter period, and ensured mechanisms are in place to keep the Board informed on the response to pressures.	Yes	Our Chief Delivery Officer is the accountable executive supported by the Deputy Director of Operations in Urgent and Emergency Care.
Plan content and delivery		
The Board is assured that the ICB's plan addresses the key actions outlined in Section B.	Yes	Detailed in the section below
The Board has considered key risks to quality and is assured that appropriate mitigations are in place for base, moderate, and extreme escalations of winter pressures.	Yes	This is built into our Plan, and will be assured on behalf of the Board at the Quality & Performance Committee on 25 Sep.

Assurance statement	Assurance recommended (Yes / No)	Evidence / rationale
The Board is assured there will be an appropriately skilled and resourced system control centre in place over the winter period to enable the sharing of intelligence and risk balance to ensure this is appropriately managed across all partners.	Yes	Our SCC operates 7 days each week and is the principal daily command & control mechanism to direct and coordinate system-wide response to pressures. Closer alignment will be sought with our Staffordshire & Stoke-on-Trent system cluster partners to ensure any staffing issues are mitigated. Clinical leadership to provide on call support where required from across all system partners.
## Section B: 25/26 Winter Plan checklist		
Prevention		
Vaccination programmes across all of the priority areas are designed to reduce complacency, build confidence, and maximise convenience. Priority programmes include childhood vaccinations, RSV vaccination for pregnant women and older adults (with all of those in the 75-79 cohort to be offered a vaccination by 31 August 2025) and the annual winter flu and covid vaccination campaigns.	Yes	System partnership group has been established (12 Aug) working together to improve all vaccination uptake across STW. Under leadership of Directors of Public Health. All NHS providers, ICB and Local Authorities are included. Will meet fortnightly from the 9th September. Key output is the STW Vaccination Improvement Plan delivery. Our Flu vaccination campaign delivery started 1 Sep for these groups and will run through to 31 Mar 26. Delivered through GP practices, community pharmacies and hospital trusts.
In addition to the above, patients under the age of 65 with co-morbidities that leave them susceptible to hospital admission as a result of winter viruses should receive targeted care to encourage them to have their vaccinations, along with a pre-winter health check, and access to antivirals to ensure continuing care in the community.	Yes	Patients aged 18 years to under 65 years in clinical risk groups (as defined by the Green Book, Influenza chapter 19 e.g. chronic respiratory disease, cardiac disease, diabetes, immunosuppressed) are eligible to receive a flu vaccination as per JCVI guidance. This will start from 1 Oct for these groups.
Patients at high risk of admission have plans in place to support their urgent care needs at home or in the community, whenever possible.	Yes	Our GPs work tirelessly to identify and have plans in place for individual patients. We will have improved options available to support fulfilment of urgent care needs at home with expansion of our Urgent Community Response, backed up by resilient medical oversight. Alternative to hospital pathway referrals will be more available through our care coordination centre / GP out of hours provider from 1 Oct.
Capacity		
The profile of likely winter-related patient demand across the system is modelled and understood, and individual	Yes	Our demand & capacity model for the system includes baseline, surge & super surge scenarios. This incorporates our individual provider elements.

Assurance statement	Assurance recommended (Yes / No)	Evidence / rationale
organisations have plans that connect together to ensure patients' needs are met, including at times of peak pressure.		This will be stress tested through the NHSE winter exercise process. Our understanding of likely demand will be refined upon receipt of the UK Health Security Agency scenario assessments, expected late September.
Seven-day discharge profiles have been shared with local authorities and social care providers, and standards agreed for P1 and P3 discharges.	Yes	These profiles have been built into our Improvement programme throughout. Our Integrated Out of Hospital Model being implemented by ShropComm includes additional discharge planning capacity, 7 days each week. Robust planning on going to mitigate bank holidays over festive period.
Action has been taken in response to the Elective Care Demand Management letter, issued in May 2025, and ongoing monitoring is in place.	Yes	Key point is to maintain elective activity with minimal disruption because of high pressure from the non-elective pathway. We are well placed to achieve this. SaTH is significantly ahead of trajectory on elective waiting time standards. Over the festive period RJAH fallow capacity will be made available to SaTH to continue elective (principally elective orthopaedic) programme delivery including during the bed-base reconfiguration; and ease pressure upon the acute sites at this most demanding point in time.
Leadership		
On-call arrangements are in place, including medical and nurse leaders, and have been tested.	Yes	Our ICB on-call cohort will be provided with additional training in October following the NHSE winter exercise to cover the anticipated differences in regional command & control posture this winter, as well as more specific guidance on our intra-system changes to managing pressures. We will work closely with our providers to check – and rebalance if necessary – the overall experience and competencies of the collective on-call on a given day across our system. Key point will be to ensure that we have sufficient clinical leadership.
Plans are in place to monitor and report real-time pressures utilising the OPEL framework.	Yes	This is well established in our system, using the SHREWD system that aggregates up to NHSE regional level. Additionally, we are reviewing our escalation triggers to reflect the changes in capacity and out of hospital model we are implementing.