



Shropshire, Telford and Wrekin
Community and Hospitals
NHS Group

Joint Health Overview & Scrutiny Committee

September 2026

The agreed alliance between Shropshire Community Health NHS Trust and The Shrewsbury and Telford Hospital NHS Trust

System Care Coordination Single Point of Access – Health Hero

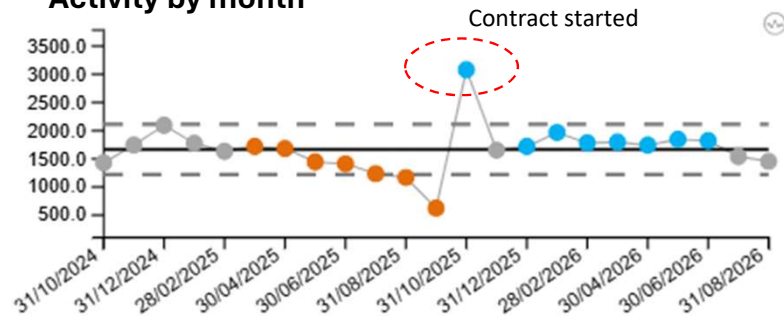


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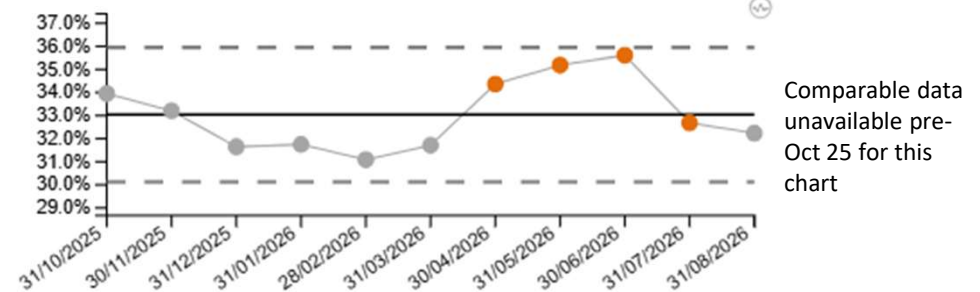
The ICB monitors KPIs for Health Hero through our standard commissioner-provider assurance process. And output performance is formally reviewed monthly by our Urgent & Emergency Care Delivery Group.

The charts below show the step change in demand in the first month of Health Hero assuming the contract from 1 Oct 25. But to their credit, this was stabilised and subsequently, there has been consistently higher activity by volume than before, with fewer cases given an outcome to attend our Emergency Departments, with more patients found alternatives to ED attendance. There is opportunity to improve this further.

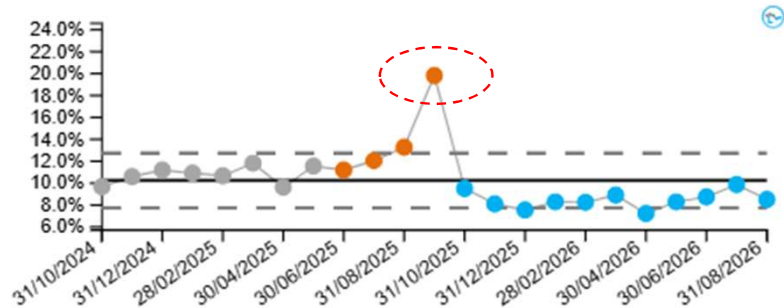
Activity by month



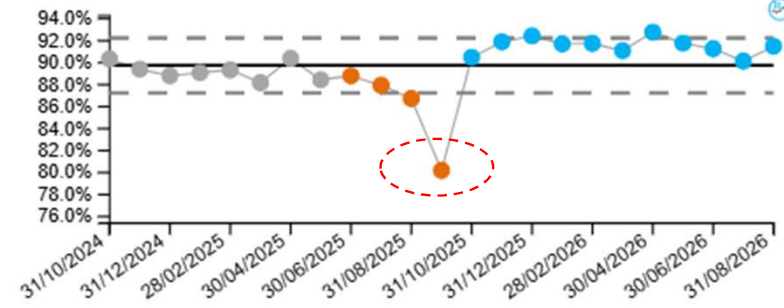
% WMAS cases returned



% SPOA recommended to Emergency Department



% SPOA recommended to Other Pathway



National Ambulance performance comparison



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How does WMAS compare nationally? Response times and handover delays

National Category 2 performance 2026/27

M5 2026/27

Trust	Cat 2 Data from Ambulance AQIs (Year to date)	Cat 2 agreed target	Rank (By Category 2 performance)	Handover delays >15 minutes Data from AACE (Hours YTD)	Hear & Treat	See & Convey
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Hours lost from handover delays over 15 minutes – by ICB



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How do the ICBs compare on handover delays ?

SUMMARY OPERATIONAL HANDOVER LOST HOURS

	2025				2026							
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Shropshire, Telford And Wrekin	3627:13:30	3632:24:33	3734:05:06	4626:39:01	4466:30:04	3097:30:23	1823:25:00	697:54:04	883:30:22	866:12:52	1419:22:29	3063:57:11
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Lost hours by hospital across the region 2026/27

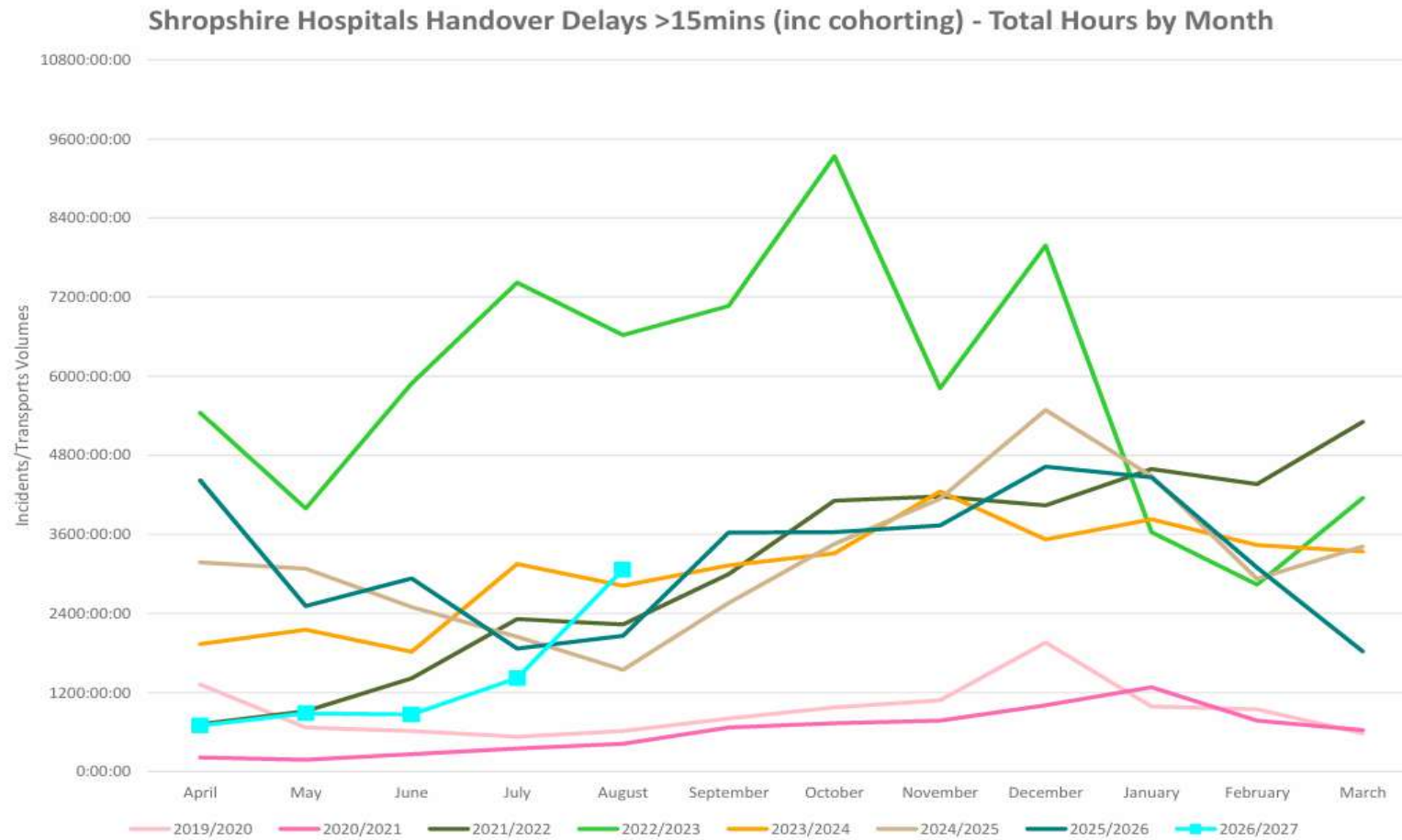
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Handover delay trend 2019-2026

STW performance – handover trend



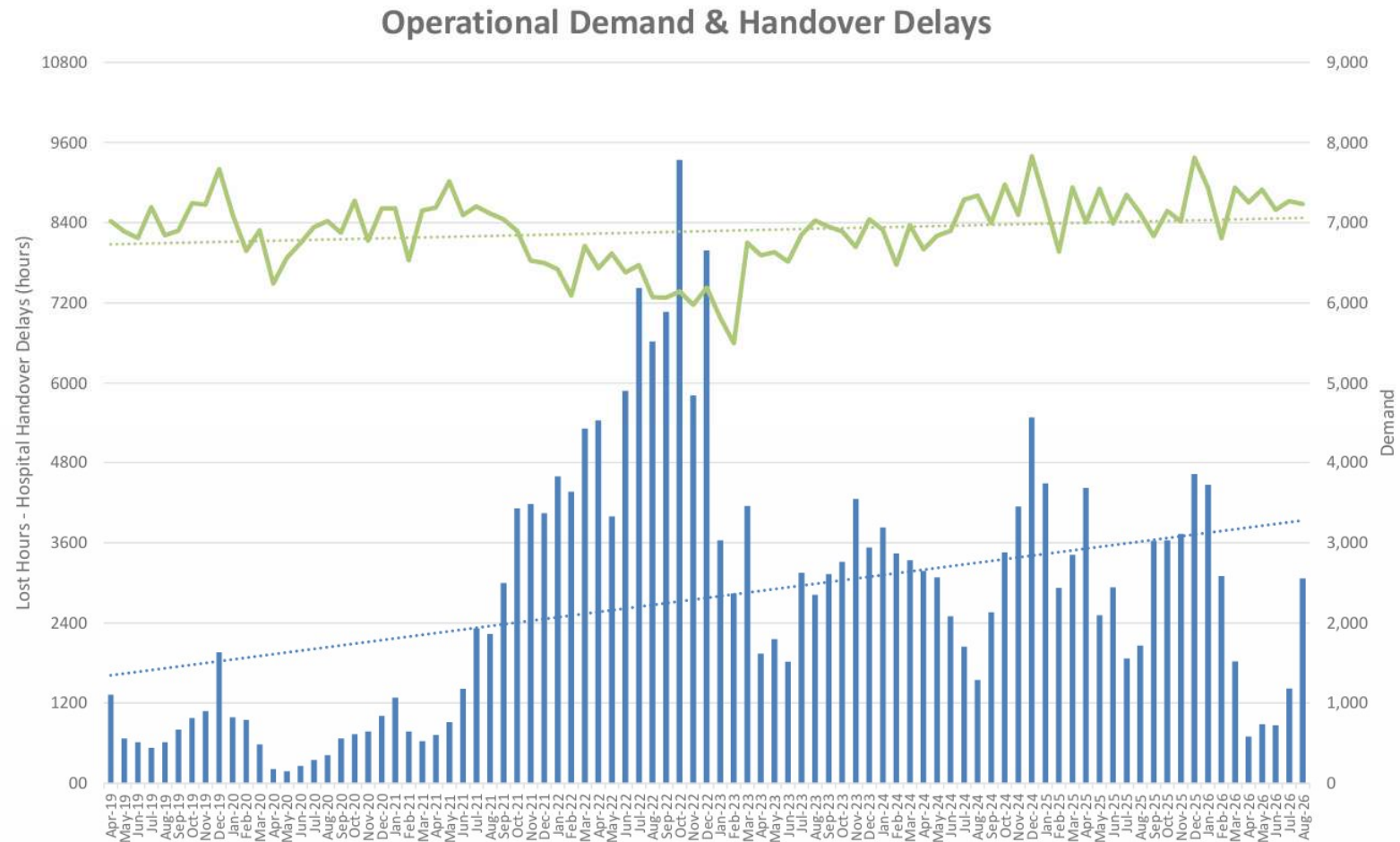
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Demand and handover delays - STW



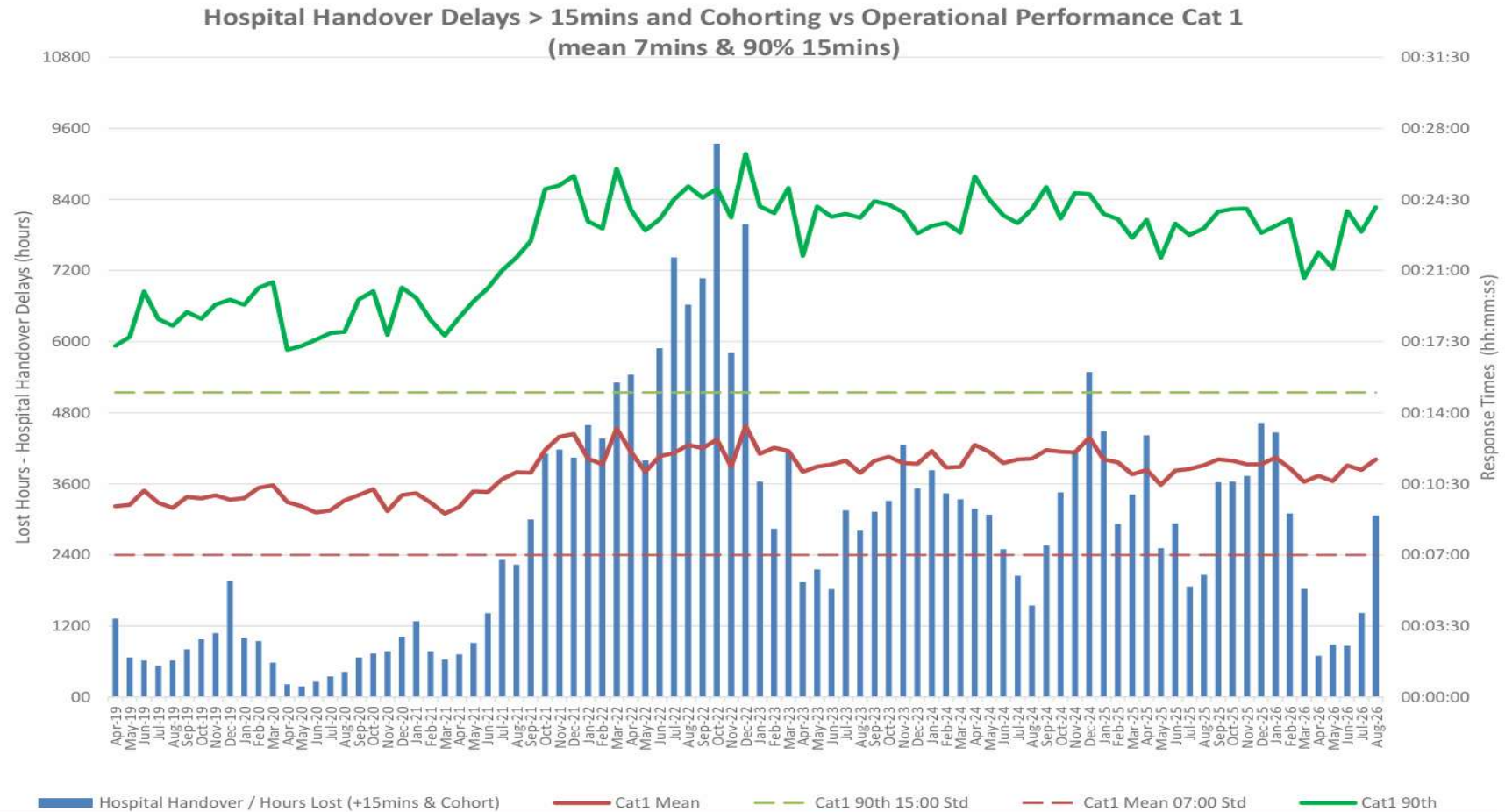
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Category 1 Response performance 2019-2026



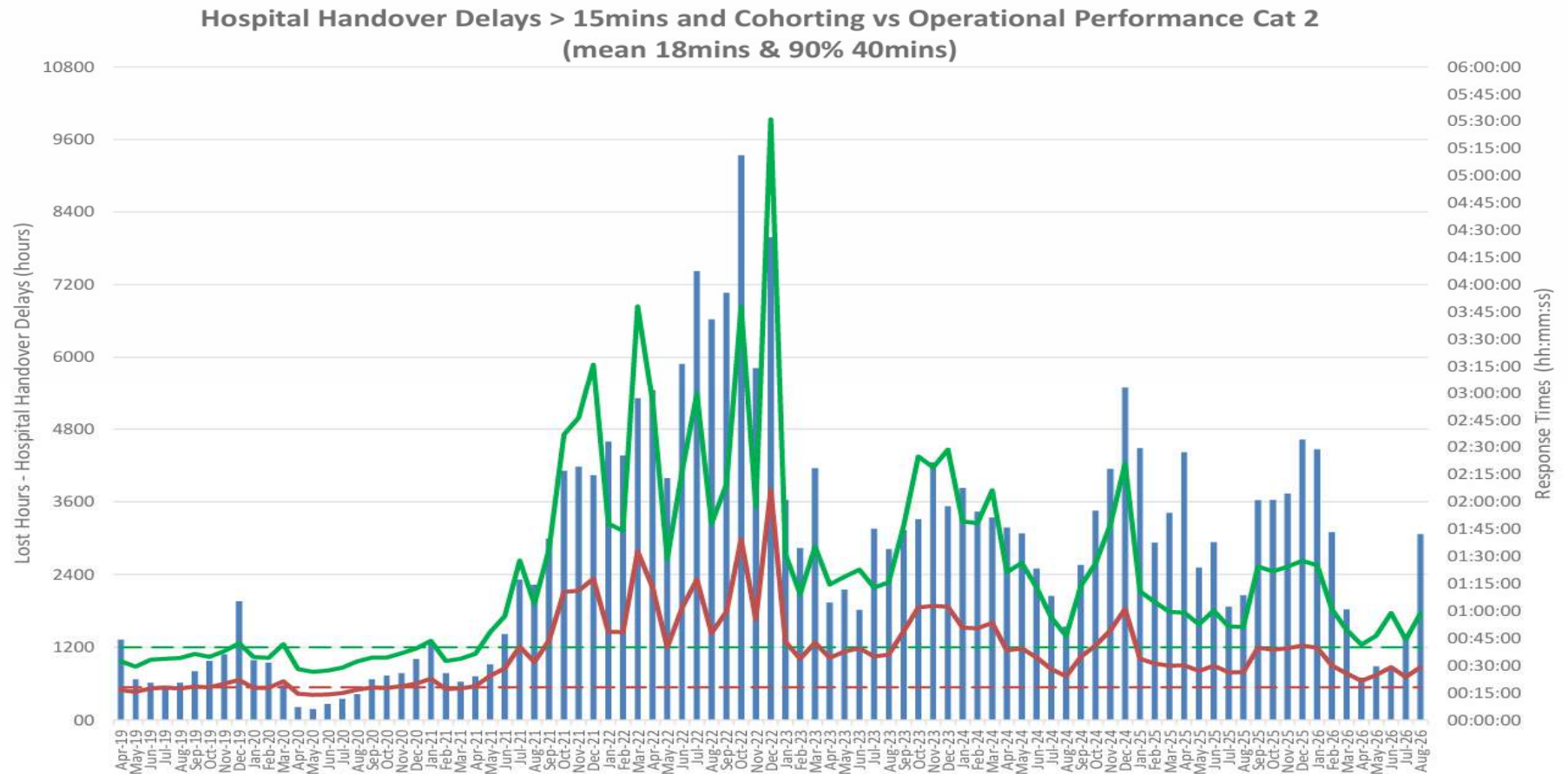
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Category 2 Response performance 2019-2026



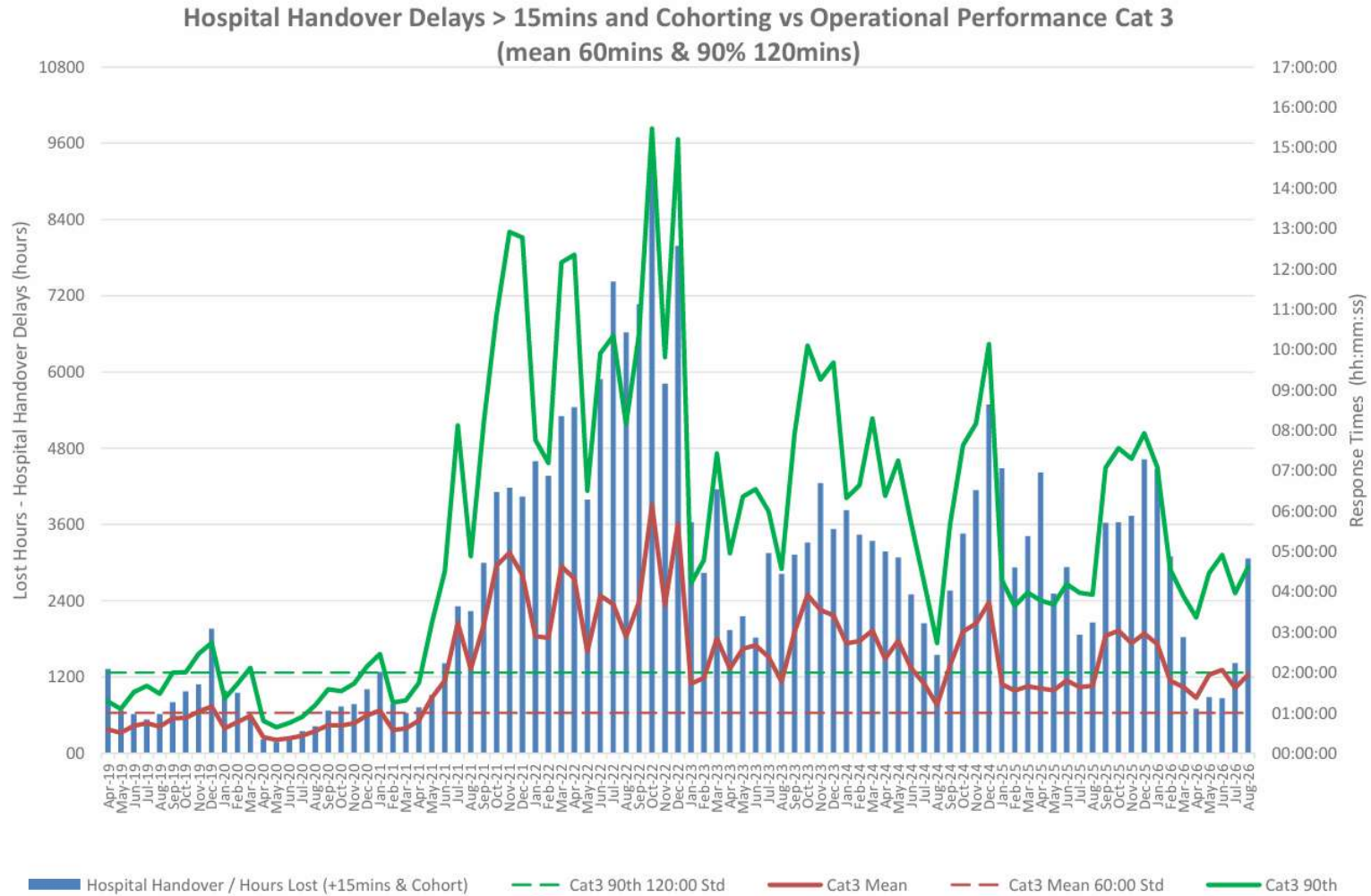
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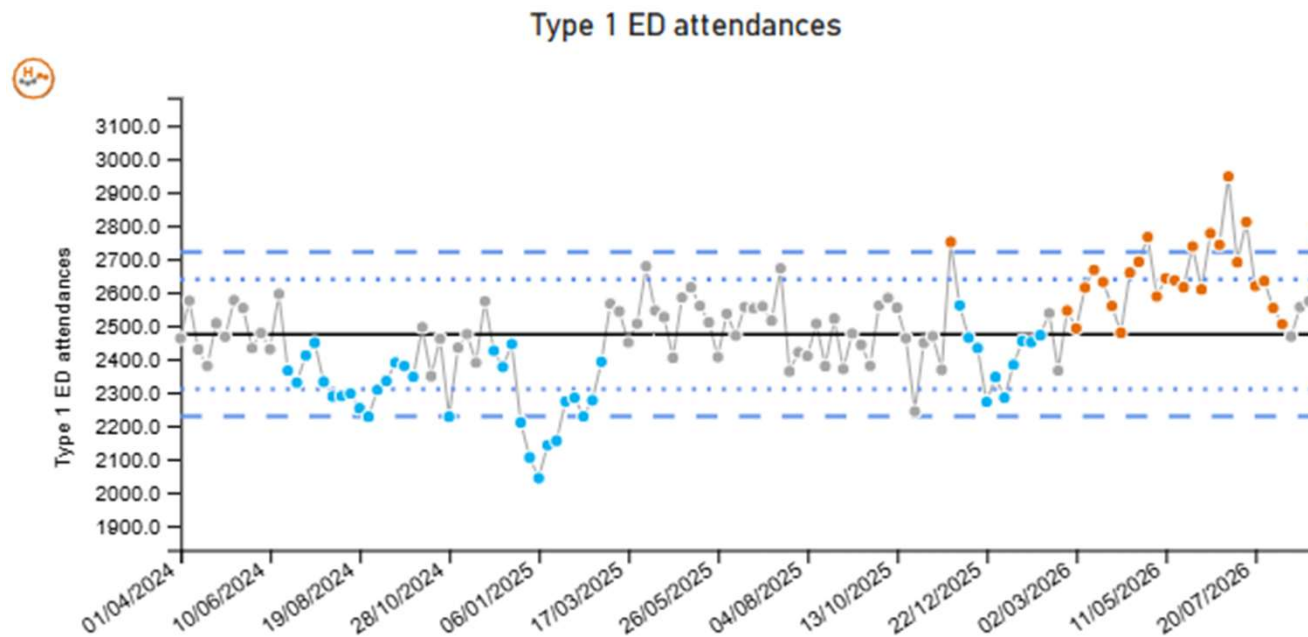
Category 3 Response performance 2019-2026



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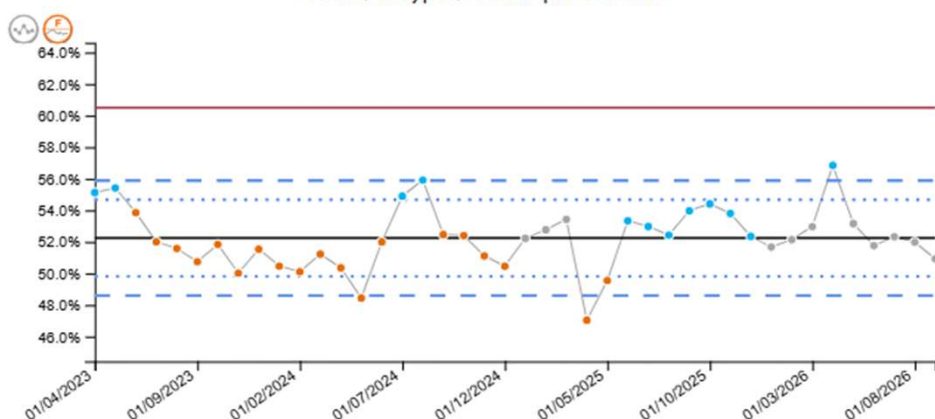
ED Attendances



- Following a sharp increase of ED attendances in July 2026 (the highest on record at SaTH) numbers reduced towards more typical levels, however we have seen a sharp rise from WC 24th August.

4 Hour Performance

SaTH (All Types) 4-hour performance



Recovery actions:

- Nexus Consultancy are supporting SaTH with improving 4 hour performance
- Tests of Change have been undertaken in both EDs in the last 2 weeks
- Provisional results are encouraging with improvement across a number of key performance indicators
- Improvement in Radiology request to report has been identified as a significant opportunity to support 4 hour performance
- Improvement in the time from blood test taken to report is also another opportunity that will support 4 hour performance.

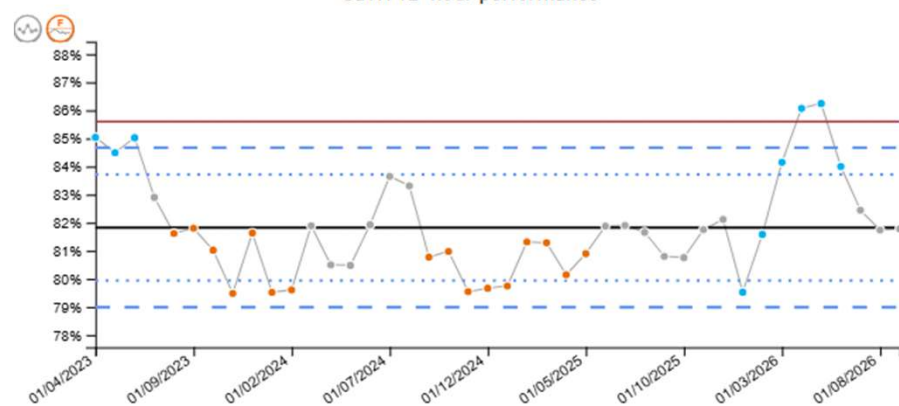
SaTH 4 hr performance remains in common cause natural variation in August at 52% against a plan 60.1%.

12 Hour Performance



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SaTH 12-hour performance



In August 78.0% of patients were seen, discharged or transferred to another area of ED within 12 hours against a plan of 85.6%, moving to common cause variation.

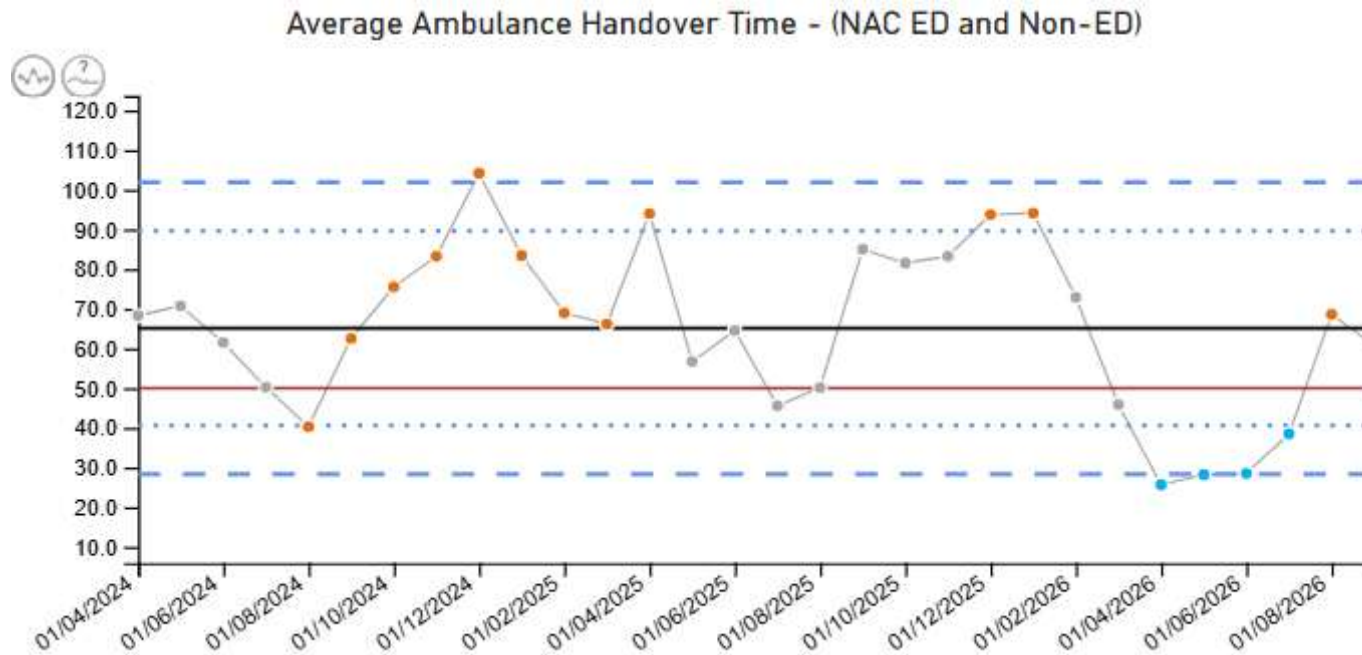
What caused our Summer UEC challenges?

- Decrease in simple discharges in Medicine
- Associated with increase in long stay (14+) inpatients, with CTR
- Latest RSH ED reconfiguration associated with HTP

Recovery actions:

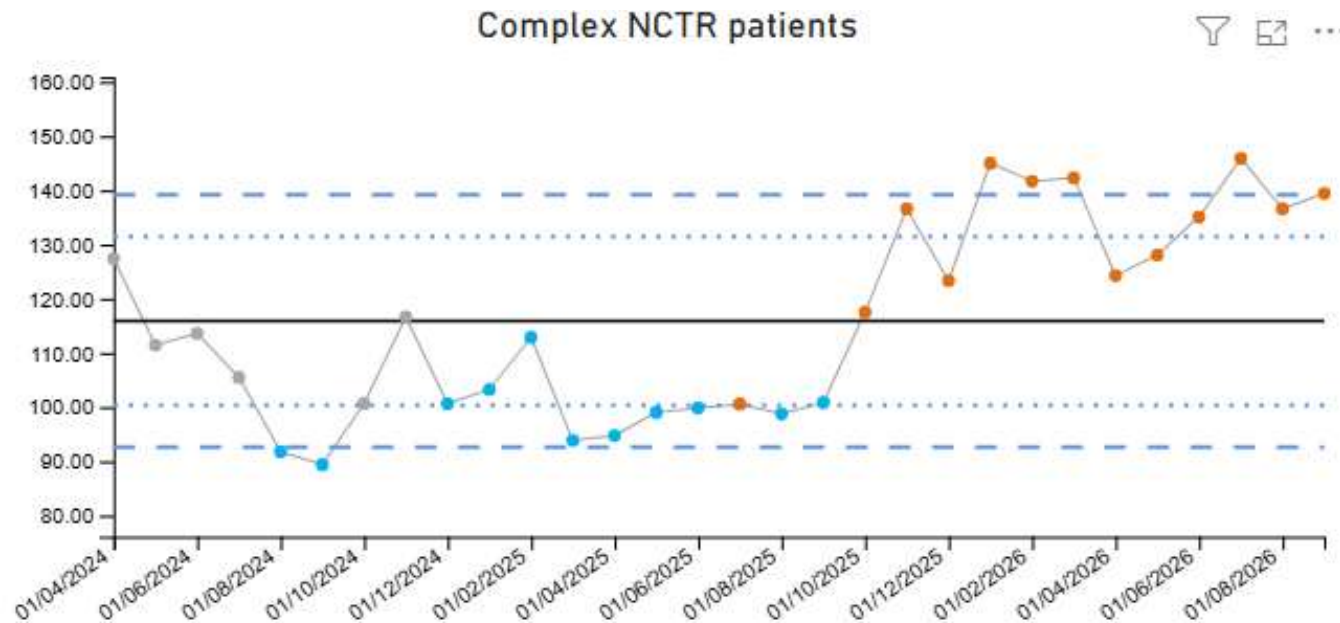
- Nexus Consultancy are supporting SaTH with reducing the number of patients in both hospitals with “no criteria to reside”.
- During the summer we have seen a decrease in the number of “simple” discharges on some wards at SaTH. To address this we have commenced a peer review process to reduce the length of stay for these patients targeting the wards where the greatest opportunity exists.
- This has resulted in the strongest 3 consecutive weeks of simple discharges for 3 months just delivered.
- The Standard Operating Procedure for ED escalation has also been reviewed and refreshed in light of the recent RSH ED reconfiguration.

Ambulance Handover



- Weekly average ambulance handover performance moves to common cause variation with an average of 68.6 minutes in August 2026. Following recovery actions, w/c 07/09/26 best week of ambulance handover performance for 2 months.

NCTR



- The number of acute inpatients with “no criteria to reside” (NCTR) remains stable but above the mean and in special cause concerning variation.

The case for change

FOCUS ON THE NON-ADMITTED MAJORS PATHWAY AND REMOVE THREE CONTROLLABLE BOTTLENECKS



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>7 hrs

Average time in department for non-admitted Majors

38.2%

Majors four-hour performance baseline

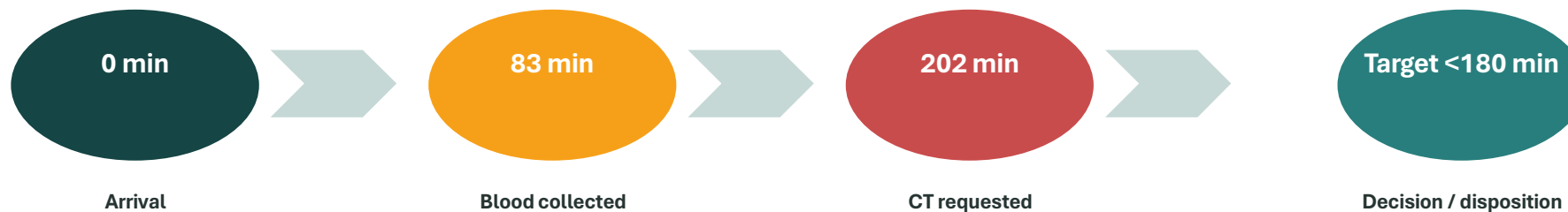
3,543

Annual breaches avoided from a 10% reduction

4 people

Typical hand-offs before a decision maker

Where the delay occurs



Executive conclusion

The greatest and most achievable impact comes from redesigning non-admitted Majors flow. Prioritise faster assessment, earlier bloods and earlier CT requests before layering in digital and management-system enablers.

How the programme will deliver

TEST, LEARN AND SCALE A STANDARD FRONT-DOOR MODEL ACROSS RSH AND PRH



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Two-phase delivery

PHASE 1

Remove bottlenecks

- Earlier blood results
- Faster decision-maker review
- Earlier CT request and result

PHASE 2

Embed visual management, digital and EEMAC enablers

Walk-in test model

Patient arrives

Streaming + registration

Front-door RAT / Pitstop

Ringfenced capacity

RSH: 2 adult rooms | PRH: 3 adult rooms + 1 paediatric room

Key test dates

Dates and times marked “likely” remain subject to whole-group confirmation.

9 Sep

RSH test 1

10:00–16:00

COMPLETE

16 Sep

PRH test 1

10:00–16:00

ON TRACK

22–24 Sep

RSH test 2

Likely 09:00–21:00 daily

TO CONFIRM

29 Sep–1 Oct

PRH test 2

Likely 09:00–21:00 daily

TO CONFIRM

Potential next step: a five-day test at both sites in the week commencing 5 October, dependent on learning and performance from the preceding tests.

1. Community services protect emergency flow



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April–August 2026 increases show greater use of community alternatives

SERVICE + CURRENT ROLE	CURRENT BENEFITS REALISED	EMERGENCY-CARE CONTRIBUTION
URGENT COMMUNITY RESPONSE Rapid assessment and treatment at home.	UCR referrals rose 17% (472→553), April–August 2026.	Avoids ED attendance or admission where clinically appropriate.
VIRTUAL WARD / STEP-UP Remote monitoring and clinical support at home.	Step-up referrals rose 84% (117→215), April–August 2026.	Provides monitored step-up care and can support earlier transfer home.
INTEGRATED FRONT DOOR Clinical streaming and links into community pathways.	IFD community discharges rose 14% (199→227), April–August 2026.	Routes suitable patients before an acute admission is made.
STEP-DOWN / COMMUNITY BEDS Community hospitals	IFD discharges to Community Hospital Pathway 2 rose 79% (19→34), April–August 2026.	Creates a route from acute care for patients not yet ready for home.
HOME FIRST / D2A CTH, therapy, intermediate care and domiciliary support.	Supported discharges rose 38% (104→143), April–August 2026.	Enables supported discharge home and releases acute beds.

SYSTEM CONTEXT

Demand is rising, but access remains strong: average Greater use of UCR, step-up, IFD and community-bed pathways can help absorb demand and protect acute flow; these are related trends, not proven service-attributed effects.



Sources: SA Admission Avoidance Activity Pack (Apr–Aug 2026), pp. 3, 38, 43; Virtual Wards Monthly Referrals & Activity Pack, p. 2; Integrated Community Front Door Monthly Pack; Winter Plan 2026/27; UEC Monthly.

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3. Winter actions add capacity, with readiness required before January



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Winter Plan 2026/27 | actions, targets and milestones are commitments

ADDITIONAL ACTION BY SERVICE

FRONT DOOR	Expanded IFD, January ring-fence, Care Coordination and enhanced Admissions Service.
UCR	Maintain rapid response; target ≥85% within two hours all winter.
VIRTUAL WARD	Expand pathways and respiratory monitoring; target >86% occupancy.
STEP-UP / STEP-DOWN	TES beds, community hospitals, intermediate care and improved transfers.
DISCHARGE / HOME FIRST	D2A, seven-day therapy and enhanced bank-holiday discharge.
NEIGHBOURHOODS	Winter clinics, diagnostics and MDT support for high-risk patients.

TARGETS + READINESS

NCTR BED DAYS	24,449 → <20,000
NCTR-TO-DISCHARGE DELAY	23.18d → <18d
BANK-HOLIDAY DISCHARGE	10/day → ≥20/day

DELIVERY GATES

1 OCT	All schemes and unified OPEL live
22 DEC	SCC daily calls; enhanced discharge
JAN	Pre-deployed capacity at full readiness

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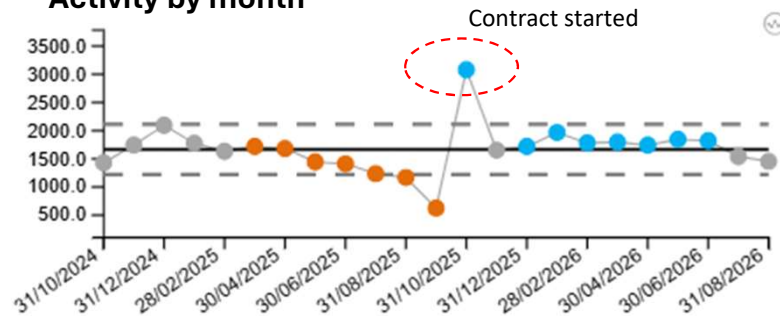


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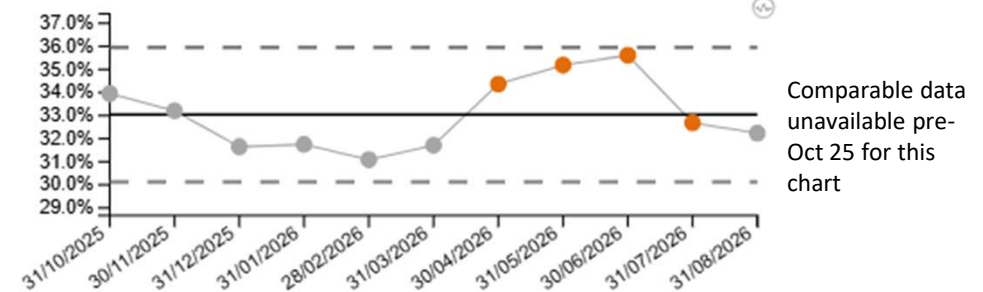
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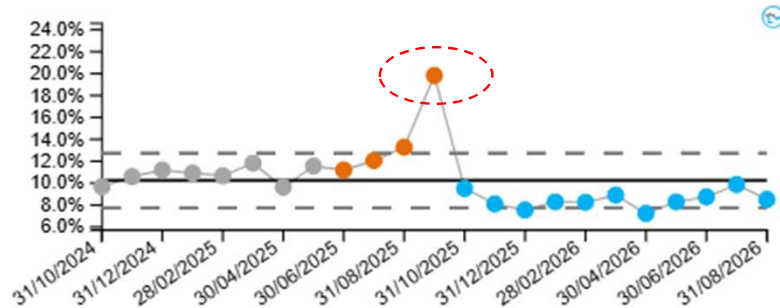
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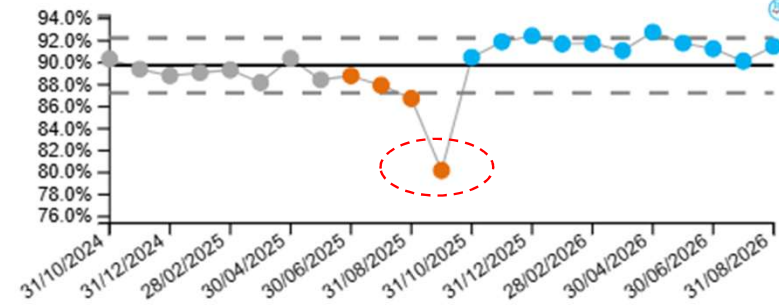
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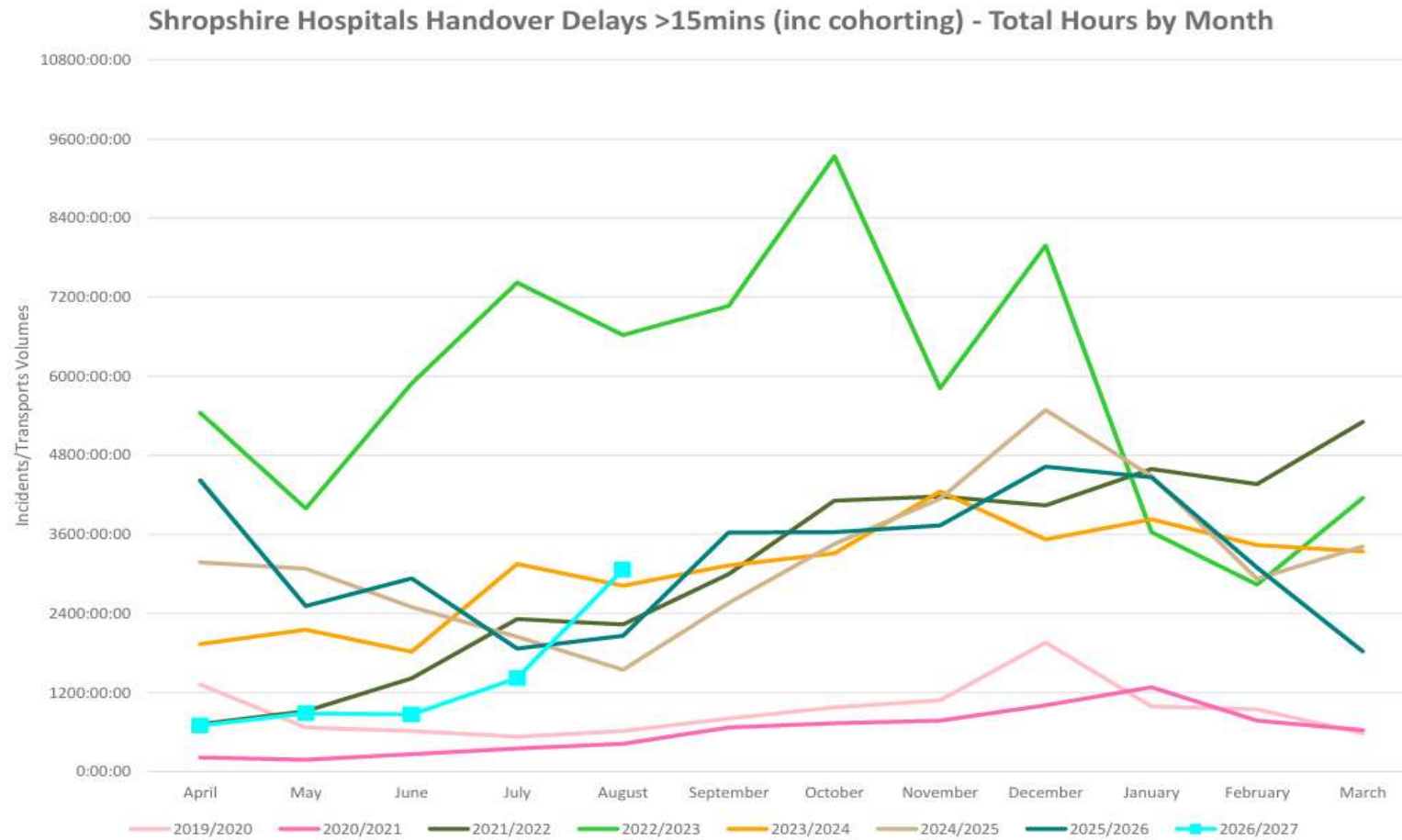
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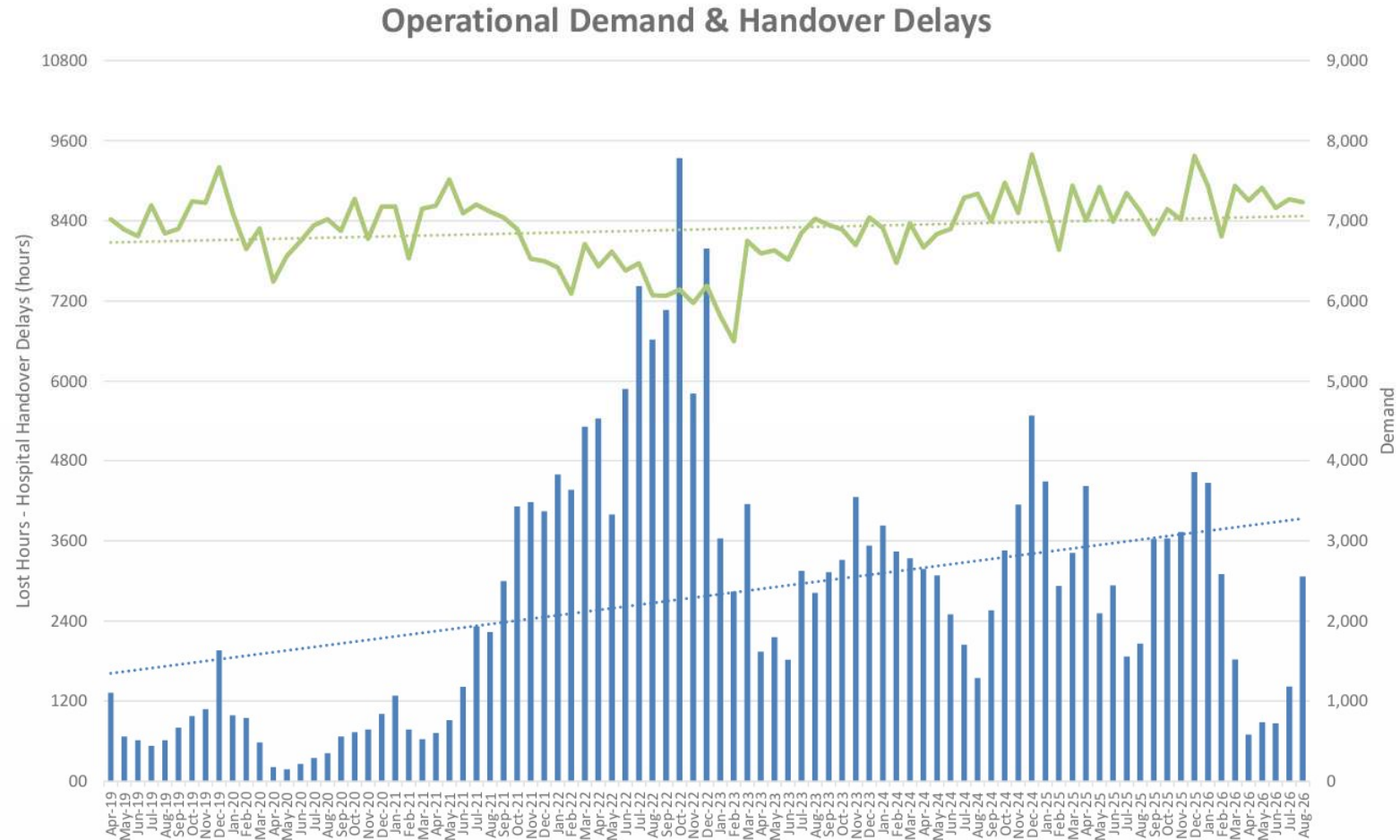
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Demand and handover delays - STW



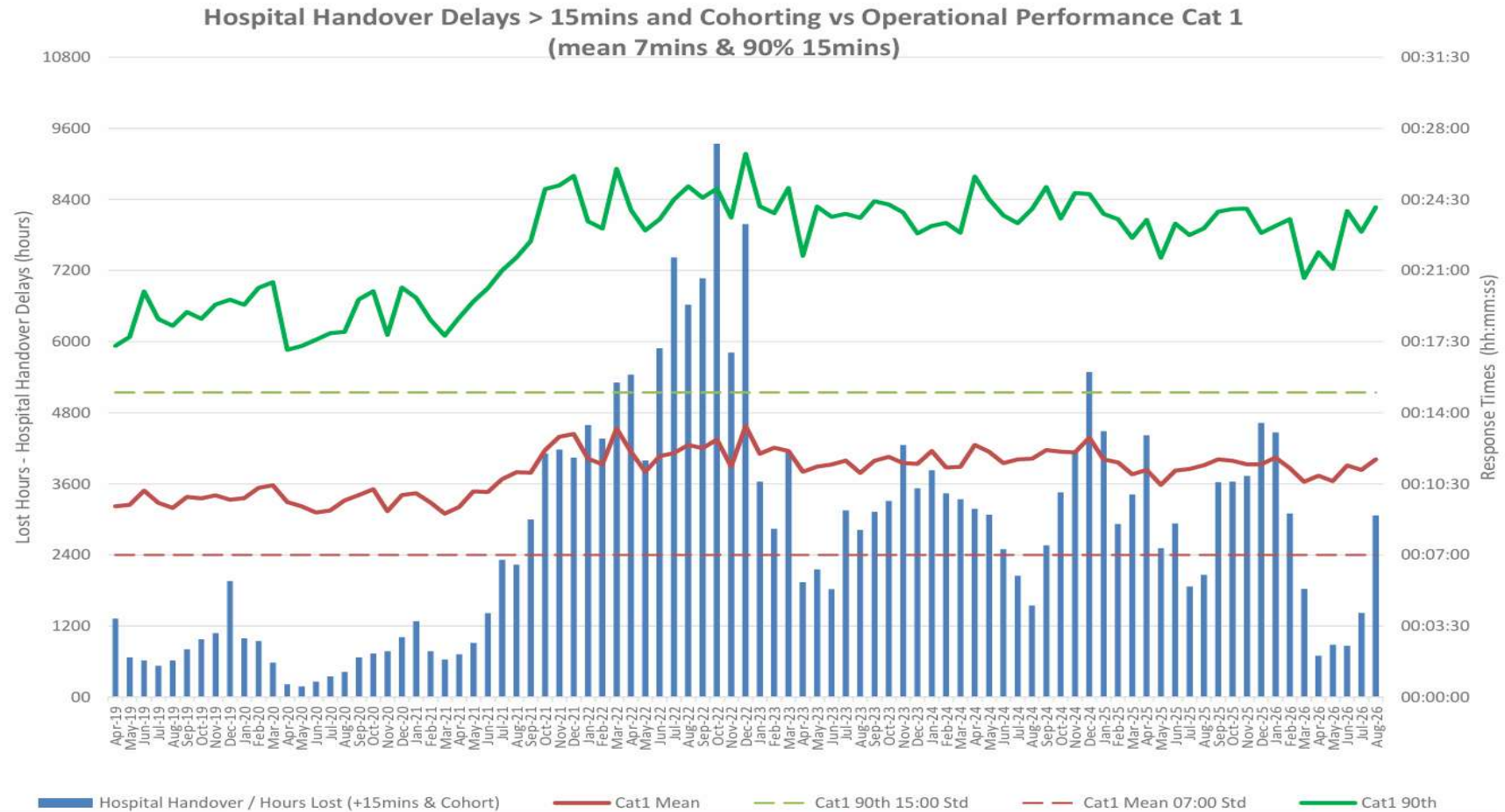
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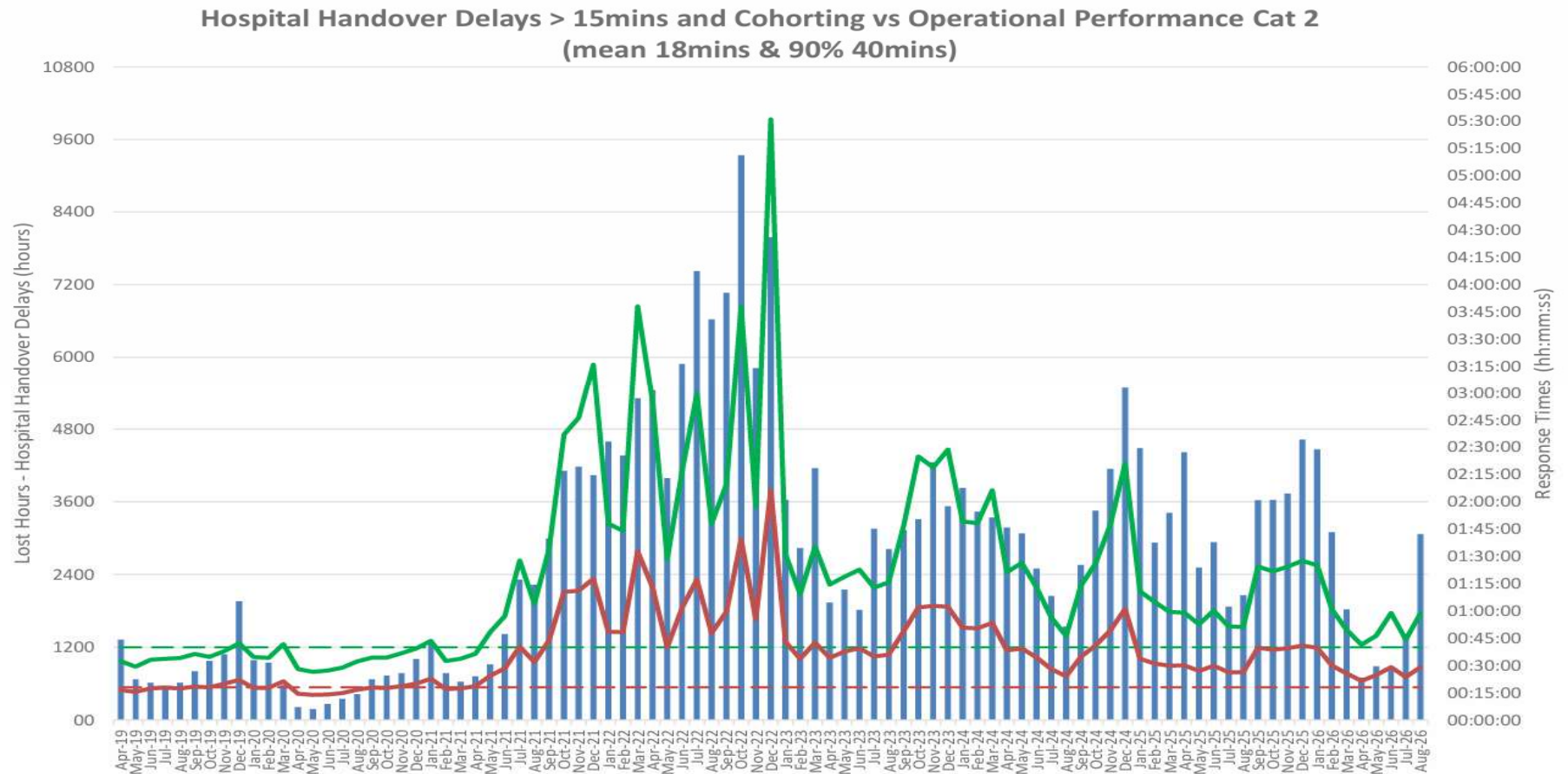
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Category 2 Response performance 2019-2026



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Category 3 Response performance 2019-2026



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