Herefordshire and Worcestershire Integrated Care System

NHS Herefordshire and Worcestershire

Winter Plan

2025-26

Herefordshire & Worcestershire ICS

The ICS provides health and care services to over 806,000 residents in Herefordshire and Worcestershire and 40,000 people from Wales.

Signatories to Herefordshire and Worcestershire ICB winter plan 2025/26

Approved by Wye Valley NHS Trust

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Contents

Guide to Acronyms used in this Document

Acronym	Expanded Term
A&E	Accident & Emergency (Emergency Department)
CDC	Community Diagnostic Centre
CHC	Continuing Healthcare
DMS	Discharge Medicines Services
EAS	Emergency Access Standard
ED	Emergency Department (Accident & Emergency)
ESTC	Emergency Surgical Triage Clinic
FAU	Frailty Assessment Unit
GAU	Gynaecology Assessment Unit
GIRFT	Getting It Right First Time
GP	General Practitioner
H&W	Herefordshire and Worcestershire
HWHCT	Herefordshire and Worcestershire Health and Care NHS Trust
ICB	Integrated Care Board
ICS	Integrated Care System
KPI	Key Performance Indicator
LoS	Length of Stay
MAU	Medical Assessment Unit
MDT	Multidisciplinary Team
MGPA	Modern General Practice Access
MIU	Minor Injuries Unit
MSDEC	Medical Same Day Emergency Care
NHS	National Health Service
PAU	Paediatric Assessment Unit
PCN	Primary Care Network
R2G	Red to Green
RSV	Respiratory Syncytial Virus
SCDU	Surgical Clinical Decisions Unit
SDEC	Same Day Emergency Care
SPoA	Single Point of Access
UCR	Urgent Community Response
UEC	Urgent and Emergency Care
WAHT	Worcestershire Acute Hospitals NHS Trust
WMAS	West Midlands Ambulance Service
WVT	Wye Valley NHS Trust

1. Executive Summary

The Herefordshire and Worcestershire (H&W) Integrated Care System (ICS) winter plan has been in development since May 2025 and has been influenced by national best practice, guidance issued this year and learning from previous winters within our system.

Purpose:

- The winter plan will provide broad demand and capacity scenarios covering the period October 2025 to March 2026, it will seek to provide assurance on the ability of the system to achieve the key Urgent and Emergency Care (UEC) Key Performance Indicators (KPIs) by March 2026.

- The winter plan will outline key areas of focus from the ongoing urgent care improvements across Herefordshire and Worcestershire ICS which relate to planning for winter 2025/26.

- The ICS winter plan will provide overarching ICB level analysis, it is not intended to produce or replicate individual providers operational plans for the period mentioned.

Looking ahead to Winter 2025, the ICS is in a strong position to meet the challenge of what is sure to be another testing winter period.

As we look the further improve our patients experience across Winter, the core priorities of the ICB and ICS are delivery of the following standards throughout winter:

- **Delivery of 30-Minutes Category 2 Mean Performance**
- **Delivery of 45-Minutes Maximum Ambulance Offload aiming for 85% from October**
- **Delivery of 78% Emergency Access Standard Performance (EAS) by March 2026**
- **Improve the numbers of children see within 4 hours of arrival at the emergency department (confirming data position currently)**
- **Reduce the percentage of patients waiting 12 hour's or over for admission or discharge to under 10%**
- **Reduce the numbers of patients waiting 24 hours or over in ED for a mental health admission (confirming data position currently)**
- **Reduce discharge delays / Returning to discharge to assess**
- **Eradication of Corridor Care**

As a direct consequence of our collective efforts, we enter the winter period in a much stronger footing. In relation to Urgent and Emergency Care, both Places have robust improvement/sustainability plans, parts of which are already demonstrating their effectiveness, through the 'green shoots' of improving performance we are starting to see. This can serve as a catalyst to ensure all of our patients in receipt of care through winter have a positive experience as a result.

Key Messages and Commitments:

- ***The delivery of the winter plan is overseen*** by place-based urgent care committees which is overseen by our ICS UEC Board.

- ***The Winter Plan*** is under constant review and development and identifies the actions that will enable delivery of core UEC indicators while maintaining patient safety and clinical

quality.

- ***All system partners*** recognise that the winter period will be challenging, balancing the need to deliver key performance improvements whilst delivering financial savings through the UEC Cost and Productivity Improvement Programme (CPIP). ***Acute capacity:*** Entering winter 2025/26 we will have ***less acute bed capacity*** than the ***previous winter***. ***The system is committed*** to working together to ***mitigate these challenges***.

- ***The system commits*** to being driven by data intelligence. We will use our near real-time information system (Shrewd) to anticipate and manage system pressures, and our work across the ICS on developing a truly integrated UEC dashboard will enable us ***to better understand the impact of our schemes*** on winter while informing us on alternative approaches.

- ***The System Coordination Centre*** will work closely with all system partners aligned to its roles and responsibilities, covering: Integrated Operational Pressures Escalation Levels (OPEL) infrastructure, Flow, Escalation management as well as being the initial contact point for regional colleagues.

- ***Demand management***: we will build on demand management initiatives such as ***continued commissioning of Same Day Urgent Access in primary care,*** and we will continue with the expansion of ***Pharmacy First***

- We will take the learning from the recent ***three ED audits*** and ensure the agreed actions are delivered across all partners

- ***We will enhance the Single Point of Access (SPoA)*** in Herefordshire by implementing NHS 111 to ED (SPoA first), we will continue to collaborate with West Midlands Ambulance Service on ***Call before Convey*** and ***Pit Stop initiatives***, we will ensure that place based ***Urgent Community Response*** service delivery services in accordance with national specifications including ***enhancing the 'pull from ED model'***, we will **provide funding** to '***enhance our virtual hospital model'***, where required.

- We will continue to drive reductions in care home activity presenting to our emergency departments and lead significant work across the ICS to ***improve out responsiveness and coordination of care for end-of-life patients.***

- ***We will support work being*** undertaken at provider level to promote the transfer of care into alternative settings, we will conduct further point prevalence analysis to support this direct of travel and to influence the agenda.

- ***We will support acute providers*** in developing, refining and enhancing '***front door streaming models'*** and ensure best practice use of Same Day Emergency Care Services.
- ***We will continue work with*** and support providers to ***reduce occupancy levels*** and reductions to long length of stay; by ***returning to discharge to assess*** across the ICS and promoting and embedding the home first agenda. Within **Worcestershire Place** we will ensure successful delivery of the **'System Wide Complex Discharge Transformation Program'**

- ***We will support the length of stay reduction*** programs within Wye Valley and Worcestershire Acute Trust,

- ***We will support Wye Valley Trust*** in their valuing patients time program, and we will provide bespoke support to **Wye Valley Trust** on ***reducing out of county discharge***

delays.

- ***We will support the system*** as we continue to deliver the elective recovery program
- ***Proactive public communications:*** we will implement our Communications Plan which includes a concerted system effort to promote alternatives to the Emergency Department through targeted use of social media and other channels for specific population groups
- We will relaunch the ***"Home Before Lunch" and the "improving patient flow and reducing deconditioning risk" campaign*** as part of winter preparations
- ***Festive weeks:*** we will produce detailed operational plans for the Christmas and New Year period. This will include building up community capacity pre- Christmas to ease expected pressures in late December / early January
- ***Vaccinations:*** Significant focus will be placed on ensuring improvements to public and staff take up of the 'COVID/Flu Jab Campaign'

The ICS has utilised the Urgent and Emergency Care Plan 2025/26 and Getting it Right First Time (GIRFT) clinical operational standards – Emergency Care Pathways to aid its production of our Winter Plan 2025/26.

2. Review of Winter 2024/25

Prelude to Winter

Ahead of the Winter Period, continued operational pressures in all Places dominated the pre-winter preparation. Handover delays, lost paramedic hours and deteriorating EAS performance continued to be the main focus for recovery, specifically within Worcestershire Place. Although similar challenges have become more prevalent within Herefordshire place (albeit not as substantial at Worcestershire Place).

Already in Tier 2 for UEC recovery, Worcestershire Place continued operational concerns threatened the possibility that place would find themselves in Tier 1. This is driven by the continued pressures and insignificant progress against many recovery plans.

Winter Plan Assurance Visit

The ICS hosted regional colleagues at Worcestershire Royal Hospital on 4th November 2024 as part of the region's winter plan assurance sessions. Following the visit, the following feedback was received:

- Strong Clinical Leadership: The clear passion, vision and direction provided by Worcestershire Acute's clinical leadership team are commendable.
- Multidisciplinary Single Point of Access: The establishment of a multidisciplinary single point of access is a significant achievement and is a great opportunity to maximise alternatives to the Emergency Department.
- Various concerns were raised in relation to capacity and demand, handover delays, flow within the emergency department, low Same Day Emergency Care (SDEC) utilisation and mental health delays.

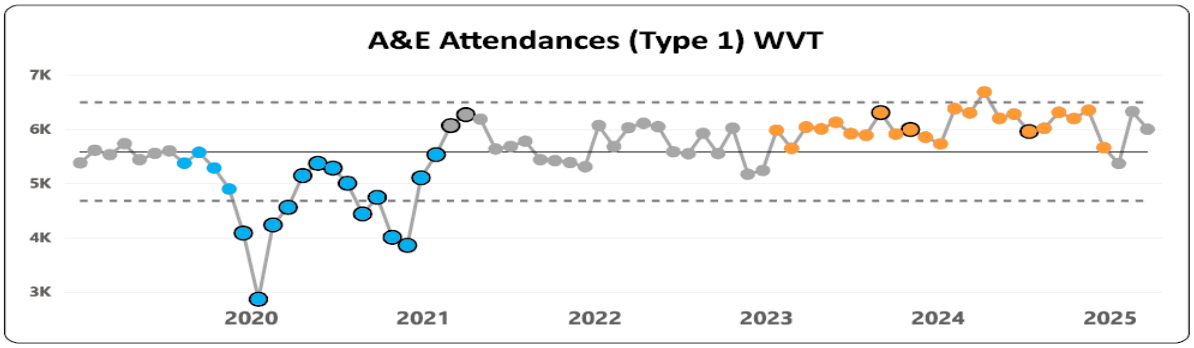
The assurance team concluded that the ICS Winter Plan, together with observations made during the visit, were sufficient to manage winter dependent upon successful delivery of the winter plan actions.

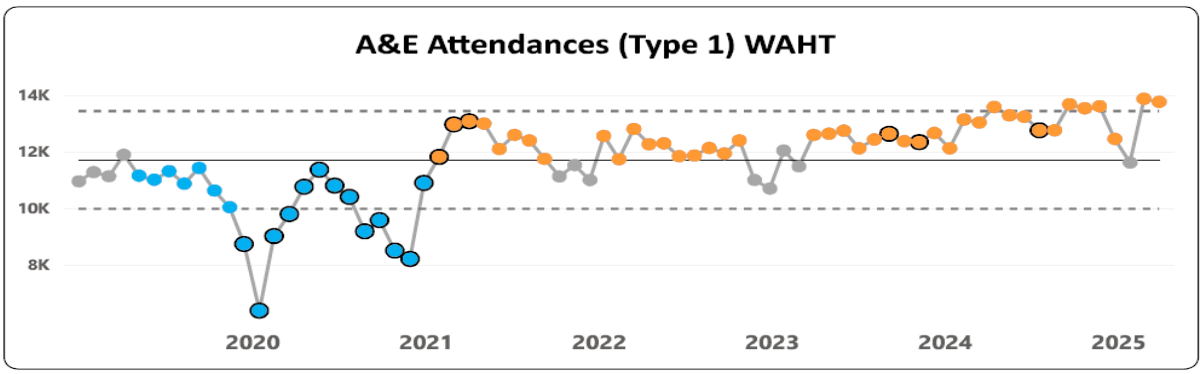
Activity

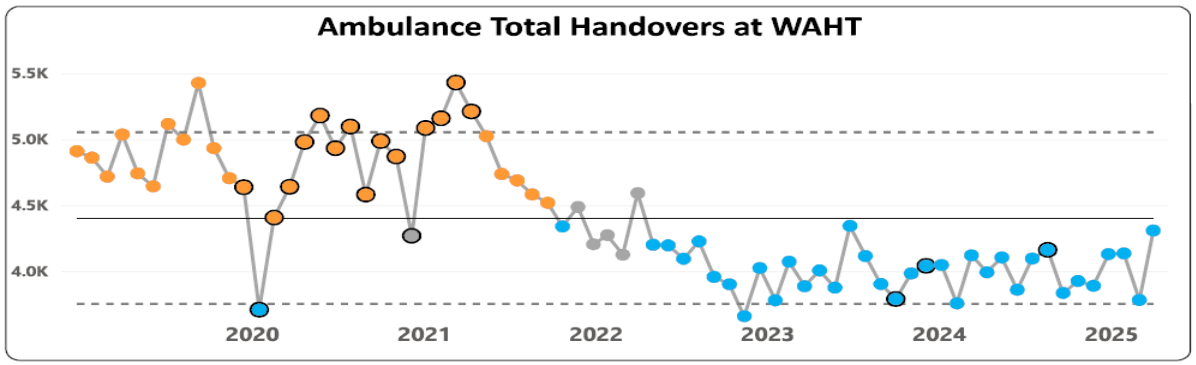
Aligned to the national position, in the first half of winter across our ICS, overall front door Emergency Department demand was up 5.5%, which continued the late autumn trend. This was evident in the substantial winter infections seen, which for flu itself was far in excess of the modelling predictors. This pattern subsided towards the end of December, with the January position showing demand had abated and was 6% below the demand experienced during the summer period.

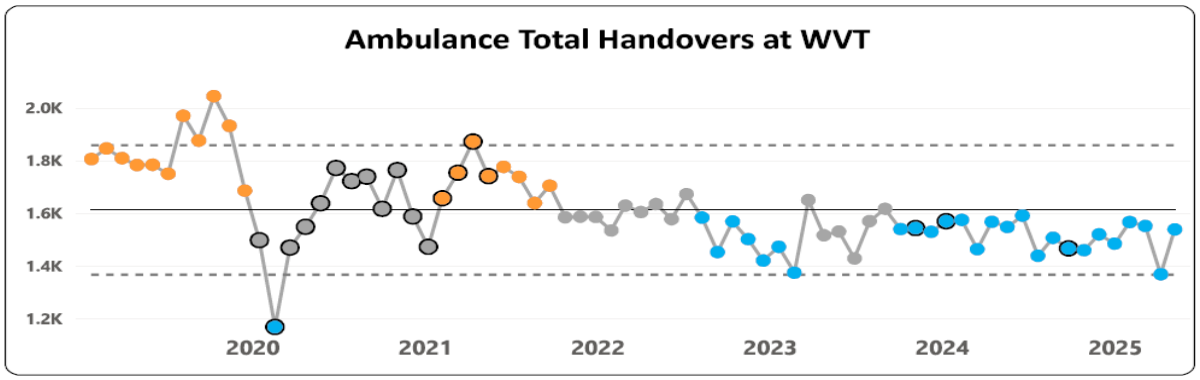
Activity continued to be flat throughout February before returning to seasonal norms towards the end of March.

Ambulance activity continued to be at historic lows, with walk in presentations increasing.







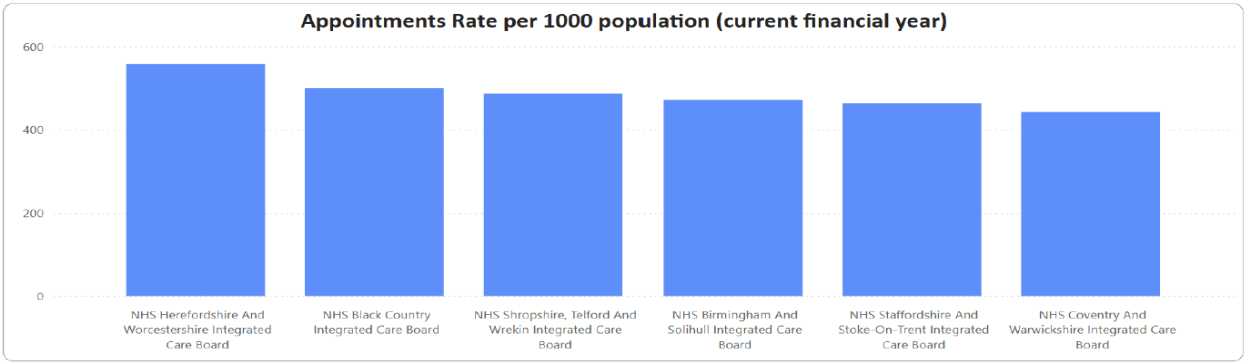


Ahead of winter, both place-based systems produced detailed winter plans, aiming to mitigate the demand and capacity challenges of winter using national best practice urgent care programmes to improve the service provided to patients and aspiring to improve performance across several key urgent and emergency care (UEC) indicators.

Primary Care Access

Recognising the impact of positive primary care access on the UEC system with the prevention of unnecessary demand to emergency departments, the ICS has continued to further enhance the access at key times of the day when attendances are highest. For last winter, this was in the form of Same Day Urgent Care hubs.

For Worcestershire, service provision was via ten Hubs, all operational by December 2024. From October to January, this offered 15,320 appointments (26% virtual, 74% Face to Face) with 84.2% utilisation and 3.8% did not attend (DNAs). In Herefordshire, service provision is via one provider and was operational from October 2024. From October to January, the population was offered 7,847 appointments (100% virtual) with 86.5% utilisation and 1.0% DNAs. The outcomes for GP appointments benchmark well against other system within the region, as outlined in the graph below:



Worcestershire-Specific Winter Schemes

Within Worcestershire, the following initiatives were the key elements of the Winter Plan:

- Improvements to operational oversight within the acute hospital and across the system – with a particular focus on long overnight ambulance delays

- Delivery of transformation schemes aimed at improving ambulance handover, with robust front door streaming. A “pit stop” was launched on the Worcestershire Royal Hospital site for ambulances to access same day emergency care pathways, reducing the need to go to the emergency departments first

- Consistent delivery of complex discharge pathway performance

- A range of UEC efficiency programmes largely aimed at reducing length of stay, including Chronic Obstructive Pulmonary Disease (COPD) virtual wards

Herefordshire-Specific Winter Schemes

In Herefordshire, the same winter objectives applied, with the ambulance handover position more stable, the specific winter focus at a place level included:

- Reductions to acute trust length of stay, maximizing use of the Better Care Fund

- Development of frailty virtual wards

Vaccinations – 2024/25 Outturn

Vaccination campaigns were a key part of the winter planning cycle, both for our population and our workforce; the population campaign in Herefordshire and Worcestershire started delivery in October 2024. The end of season overview for vaccination rates is provided below:

Vaccination End of Season Overview

	Local	Regional	National
Covid Vacc – All cohorts	61.5%	49.4%	51.3%
Covid Vacc – Care Homes	81.3%	70%	72%
Flu Vacc – All Cohorts	61.10%	50.9%	50.1%
Co-administered Flu & Covid	59.27%	44.4%	43.5%
RSV Catch Up	56.5%	52.2%	47.6%
RSV Pregnant Women 3rd Trimester	47.4%	34.8%	37.5%

- Herefordshire and Worcestershire consistently had the highest uptake in the midlands for COVID -19 vaccinations
- The system was 4th highest uptake in the country for COVID-19 vaccinations
  - This is behind 3 other ICBs in the southwest region.
- Collaborative working across Community Pharmacy and Primary Care which allowed for the efficient completion of housebound vaccinations as well as an increase in uptake.
- The RSV vaccination programme started on the 1 st September. In the first month of delivery 1 in 3 women who gave birth in September received the RSV vaccine

1

Flu vaccination percentages were higher than the regional average, but slightly lower for frontline healthcare workers. Frontline social care workers nationally have a low uptake- under 30% nationally and this is mirrored in our system. However, for Covid-19 vaccinations, local uptake levels have been higher than both regional and national uptake, with social care worker vaccination uptake at 49.59%; the highest percentage in the region.

Impact of the Winter Plan

The first half of winter, with its increased demand, multiple infection challenges and the early implementation of some of these schemes saw compromised performance. However, the mid to end part of winter (mid-January to early March) witnessed some key improvements across the ICS for many UEC indicators. Examples of high-level improvements include**:**

- 55% reduction of paramedic lost hours
- 20% reduction in ambulance handover delays
- 14.3-minute improvement in mean response time to Category 2 ambulance calls, largely driven by increase in ambulance capacity.
- EAS performance improved by 13% within Wye Valley NHS Trust compared to the same period last year. EAS performance for Worcestershire Acute Hospitals NHS Trust remained static compared to the same period last year.

- The level of patients spending over 12 hours in the Emergency Department remained static compared to the same period the previous year.

Learning from winter 24/25 has been captured and linked to operational planning, sustainability and continued improvement actions. All acute trust sites maintained a very high bed occupancy and they are taking additional actions at ward level to manage flow of patients from the emergency departments. In addition to sustaining the improved ambulance handover position, the challenge ahead is to reduce the bed occupancy and length of stay across ICS acute sites, with further embedding enhancing and maturing of the UEC strategy and delivery plans.

Herefordshire and Worcestershire ICS Winter Plan 2025/26

Keeping our population healthy and demand management

3. Maintaining health and managing demand

Vaccination Programme

The annual flu vaccination programme can help reduce the morbidity and mortality from flu and pressure on health and social care services in winter. This is especially important in 2025/26 due to the risk of increasing respiratory illnesses across the system for both vulnerable cohorts and the frontline health and social care workforce.

Immunisation 2025/26 Plan

Commencement of covid – 19 and Flu Autumn program:

- Health Inequality outreach program
- Current ongoing procurement for two outreach providers across the system to deliver outreach vaccinations to areas of low uptake and high deprivation, as well as to promote Making Every Contact Count (MECC.)
- Community pharmacy pilot has launched to support the delivery of flu vaccinations to those aged 2/3 years old. This is to supplement the general practice offering.

Core model of delivery through PCNs, practices and community pharmacies supported by GP federations.

- 75+ delivery sites across the system
- Providing increased access and support throughout local communities
- Weekend super clinics planned

Immunisation outreach program

- Community venues and three outreach vehicles targeting vulnerable communities, unregistered populations and those who struggle to access services.
- Utilising community venues and three outreach vehicles following a data driven plan
- Areas will include but not limited to Index of Multiple Deprivation (IMD) areas 1-4, rural & farming communities, Gypsy, Roma and Irish Traveller (GRT) groups and migrant communities

Frontline health and social care staff will be offered the seasonal flu vaccine with a 45% uptake target

- Care home staff offered/ can access vaccination as part of the care home clinics provided by practices.

- To support increased uptake within this group, both mobile (roving) services and fixed-site clinics are going to be utilised.

- Have a stronger focus on the messaging as to the benefits of flu vaccinations and gain empowerment from NHS clinical leaders within the system
- Through targeted communications, staff will be made aware of the benefits of the flu vaccine, to not only themselves but their patients too.

C-19 target to vaccinate over 60% of our eligible populations

- Including over 82% of our care home, housebound and over 75 populations.

Monitoring uptake of Respiratory Syncytial Virus (RSV) Older Adult and Maternal vaccinations. Increase Pertussis vaccination uptake

- Support practices with the roll out of the routine program and identify areas which need support where necessary with alternative providers.

- Promote national messaging on the benefits of admission avoidance by receiving the vaccine

- Make use of the call and recall initiatives to invite all eligible patient groups

Assurance, monitoring and review of the Delivery of the vaccination programme

- Via 1-1 provider delivery meetings in addition to operational oversight meetings and ICS immunisation programme board/ICS UEC board

We await flu and Covid predictions to triangulate with plan.

NHS 111

Our NHS 111 provider is DHU Healthcare which is a CQC rated Outstanding large-scale contact centre healthcare operation across the country.

The service operates from 4 locations. By the start of the winter pressures period, DHU 111 will have over 800 seats across all sites, and this will provide significantly greater seating provision in the event of contingency situations.

The service operates 24 hours a day, 365 days a year covered by a wide range of skillsets in the clinical and non-clinical teams, including service advisors, health advisors, clinical practitioners, pharmacists, mental health specialists, nurses, paramedics, paediatric clinicians, and dental nurses.

DHU Healthcare is an integral part of our UEC services ensuring that patients receive the best possible care irrespective of the time of day.

DHU 111 has specific plans to manage this increased activity over the winter period, and although the DHU111 Winter plan has not been received by HWICB in time for this report deadline, we understand the following identify the key areas that the organisation incorporates as part of its annual winter planning exercise. This is distributed into several key business areas:

Seasonal project planning	Business Contingency Planning
Recruitment	Motivational Event Planning

Forecasted Activity	Communications Planning
Resource and Capacity Planning	Estates Planning
Operational Planning	Technical Infrastructure Planning

As part of the DHU workforce planning process, they have a Capacity Planning Team, who provide analysis based on the forecast and resource plan, so that an assessment can be made in respect of how many desks will be required at peak times, and what additional desks may be required from peripheral sources, such as support function desks and training rooms. Full details will be provided in the DHU Winter Plan due in September.

Whilst activity usually starts to increase from October onwards, the main peak of activity over the winter period is centred on the Christmas and New Year bank holiday periods where call volumes are anticipated to reach the most critical levels for the year. As part of the winter planning cycle, DHU 111 reviews and analyses the winter period call activity from previous years and applies statistical forecasting (linear regression) assumptions on potential increases to activity for the forthcoming year.

Forecast - It is important to recognise that any forecast produced this far in advance of winter is indicative. It does not account for significant variables such as potential industrial action, severe weather, or the impact of seasonal illnesses.

Methodology - The following forecasts were developed as follows:

- **Data Source:** Historic regional call volume data was extracted from the DHU daily sitrep.
- **Calculation:** Each ICB's known percentage share of regional triaged activity was applied to the historic data to extrapolate an ICB-level forecast.
- **Growth Assumption:** Although year-on-year call volumes are currently stable, Herefordshire & Worcestershire ICB have added a 3% uplift to regional volumes to cover any significant variables, as detailed above.

Herefordshire & Worcestershire Weekly & Daily Winter 111 Forecasts:

Hereford & Worcester Split of Midlands 111 Call Volumes (3% uplift)	
W/C	Call Forecast (+3%
29/09/2025	4208
06/10/2025	4490
13/10/2025	4578
20/10/2025	4468
27/10/2025	4365
03/11/2025	4556
10/11/2025	4687
17/11/2025	4792
24/11/2025	5051
01/12/2025	5047
08/12/2025	5102
15/12/2025	5205
22/12/2025	5312
29/12/2025	4918
05/01/2026	4302
12/01/2026	4123
19/01/2026	4265
26/01/2026	4390
02/02/2026	4310
09/02/2026	4411
16/02/2026	4452
23/02/2026	4317
02/03/2026	4162
09/03/2026	4212
16/03/2026	4504
23/03/2026	3908
30/03/2026	4349

Key Dates Christmas & New Year		
Date	Day Of week	Call Forecast (+3%)
20/12/2025	Saturday	1,121
21/12/2025	Sunday	955
25/12/2025	Thursday	538
26/12/2025	Friday	990
27/12/2025	Saturday	1,161
28/12/2025	Sunday	990
01/01/2026	Thursday	597

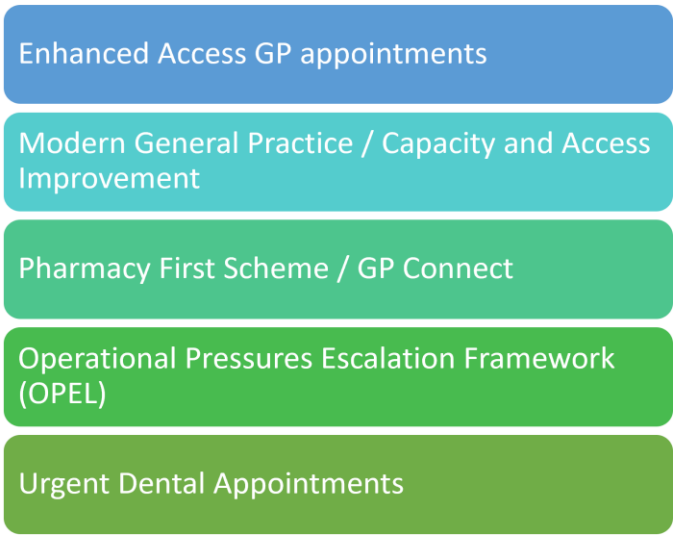
And embedded further detail:

DHU Winter Plan 2025-2026 v3 DRAFT

NHS 111 Midlands Regional Winter Call

Primary Care (Including Urgent Dental Appointments)

Primary Care plays a fundamental role in managing increasing demand for medical services, often exacerbated over the winter period. In addition to the core in hours general practice services, primary care capacity is extended during out of hours periods by two Nationally directed access services, which aims to contribute towards minimising the impact on other parts of the healthcare system.



Enhanced Access Appointments Over Winter

- Primary Care Networks (PCNs) provide Enhanced Access (EA) appointments outside of core GP surgery hours – that means that patients can attend surgery between the hours of 6.30 pm and 8 pm Mondays to Fridays and between 9 am and 5pm on Saturdays

- At least 15 bases are running simultaneously during these hours across the 15 PCNs.

- For Herefordshire and Worcestershire patients, over 3,000 hours of Enhanced Access appointments are provided (in addition to appointments in core surgery hours) at various bases each month.

- A blend of appointments (F2F/virtual/online) mirroring the offer from Primary Care are available from a variety of clinicians.

- During Winter months (October-March), this will provide approximately. 100,000 appointments.

- H&W appointment split approximately 26,000 Herefordshire and 81,000 Worcestershire (based on 5 appointments per hour).

- Availability of these appointments adds to the resilience of Primary Care and supports patients in the management of their health and prevents unnecessary ED and hospital attendances

Modern General Practice Supporting Winter (MGPA)

- All 78 GP practices participated in Modern General Practice actions in the previous two financial years increasing all forms of access, by types of appointment or with more clinicians. This is continuing to embed and mature for the remainder of this year.

- At all practices, the first point of contact is a care navigator who can book into appointment slots, book into other provider services such as Enhanced Access, Pharmacy First, or signpost to the most appropriate health professional e.g. a MSK practitioner, freeing up GP appointments/time for the more complex patients.

- Part of MGPA is to utilise technology to aid access to primary care for patients. This can include:

- Offering online access via practice websites. All practices offer online consultations - On average about 1,000 Online consultations/contacts are made per practice each month. Patients can also access online booking and the NHS App via practices' websites. All practices have webpages that are now compliant to NHS standards offering easy, full access to a range of services. The NHS App, Accurx messaging, and webpages also promote self-care and where appropriate self-referral, therefore freeing up capacity within the system.

- The implementation of online consultation requirements will be supported and monitored once the regulatory changes are made available.

- All H&W practices utilise Cloud Based telephony systems with full functionality which improves access options for patients as full functionality is being used, e.g. callback when lines are full

Capacity Access Improvement Plan (CAIP)

- All 15 PCNs are involved in delivery of the CAIP

- CAIP is a set of initiatives aimed at improving the overall patient experience of access by implementing interventions that make transition between services easier and support navigation within the healthcare system and continuity of care where appropriate

- As part of participation in our Primary Care Network (PCN) Directed Enhanced Service (DES), PCNs are implementing the CAIP initiatives aimed at better understanding their patient cohorts' needs – they are working with their constituent practices to 'stratify' patients to ensure that patients that would benefit from continuity of care are identified

- Practices are generally focusing on frailty measures as part of this process and identifying patients that will be managed more effectively – implementation will be between October – March. Patients will be 'flagged' on the practice system to ensure that continuity is considered when determining the appropriate response to the patient's query. This will support effective management of frail patients in Primary Care

Same Day Urgent Access Hubs

Learning from winter 2024/25 when primary care was commissioned to implement same day urgent access hubs to further absorb the urgent care requirements in primary care. The ICB has commissioned this service for 2025/26 with 30,000 additional face to face appointments during the 2025/26 winter period.

Pharmacy First / GP Connect

The expansion of Pharmacy First will play a key role in supporting the NHS and local systems during winter 2025/26 and beyond, when urgent care pressures typically spike. More funded consultations means pharmacies can see and treat more patients for common minor illnesses without needing GP or A&E input. By treating minor illnesses like sore throats, sinusitis, and UTIs, Pharmacy First frees up GP appointments and reduces inappropriate A&E visits.

There will be other expansions which will also help reduce the need for GP appointments such as:

- Expanding the New Medicines Service (NMS) from October 2025 to introduce depression which will help relieve pressure on general practice by ensuring patients are followed up and are taking their medication correctly.

- Expanding the Contraception service to include Emergency Contraception (EC) from October 2025. Pharmacies already offer regular contraception advice and consultations for

H&W pharmacies have been increasing during 2024-25 averaging over 500 per month in the last four months of the year.

- H&W pharmacies already deliver the blood pressure screening and monitoring service and in the last four months of 2024-25 delivered an average of 2310 checks per month.

- All of these consultations support the system in managing patients appropriately and relieving pressure on general practice and other parts of the system.

Urgent Dental Appointments

- As part of the Government's commitment to deliver 700,000 additional urgent dental care appointments annually during this Parliament, Herefordshire and Worcestershire have been allocated 12,970 appointments for delivery between April 2025 and March 2026.

- 39 of our contractors (dental practices) are participating in this, and all 12,970 appointments have been commissioned from 1st April 2025

- Contractors are required to reserve urgent care appointments proportionate to their financial uplift – this will ensure consistent availability of appointments for patients with urgent dental issues.

- Patients will be directed to providers via NHS 111 – this will support prompt utilisation of the pathway.

Out of Hours Primary Care Services

There are two GP Out of hours contracts within the ICS at Place level. Herefordshire is provided by Malling Health Ltd, with elements subcontracted to Taurus Healthcare Ltd. The Worcestershire service is provided by Practice Plus Group (Urgent Care) Ltd. Current contracts end on 7th July 2026, and although we are currently out to tender for new contracts to commence on 8th July 2026, we don't anticipate any issues with continuity over the winter period, with the providers maintaining an active role in UEC local delivery.

Both contracts are performing well across all key performance indicators. Herefordshire are meeting all and Worcestershire have 2 areas of improvement. Remedial actions plans are in place, with both now nearly achieving target (less than 5% improvement required).

Workforce recruitment is in a strong position across both counties, complaints and incidents are low and patient satisfaction feedback rates at circa 90% for both services.

Business continuity plan outlined below

Hereford out of hours service business continuity plan

SWHC Business Continuity Plan v1.4

GP Federation business continuity plan:

Taurus (Business Continuity Plan).pdf

Neighbourhood Health

Starting in October 2025, enabled by a local Neighbourhood Delivery Framework contracting mechanism with PCNs, the formation of multi-disciplinary teams as described in the 2025/26 Neighbourhood Health Guidelines will deliver proactive, personalised and preventative care for those with severe frailty, patients in the last year of their life and those living in care homes. These cohorts are driving admissions, ED attendances and re-admissions in our system as well as impacting upon length of stay.

The model of care, systems and processes which will be applied consistently include detection of those with unidentified frailty, risk stratification, care co-ordination, comprehensive geriatric assessments, advance care planning and monthly multidisciplinary team (MDT) case reviews. Emergency admissions in our priority neighbourhoods are also of concern and a focus throughout this period. Commencing in October, MDTs will work with Voluntary, Community and Social Enterprises (VCSE) and preventative services to improve outcomes and reduce attendances for those with a non-medical need.

Throughout Winter 2025, in-line with Neighbourhood Health guidelines, local teams will focus on ensuring proactive personalised and preventative care for people living with frailty and patients in their last year of life, including those in care homes and people with unidentified frailty and unmet needs with rising risk of acute deterioration.

All 6 core components of the guidelines have been allocated workstream leads.

- Population Health Management
- Modern General Practice
- Standardising Community Health Services
- Neighbourhood Multidisciplinary Teams (MDTs)
- Integrated Intermediate Care with a ‘Home First’ approach
- Urgent neighbourhood Services

To support delivery of these core components a range of training, support, workshops and initiatives will be held/undertaken focussing on:

- System wide workshop planned for ***July*** for a range of system providers, including VCSE. Focused on engaging all partners in developing a vision for Neighbourhood Health and prioritising key deliverables for Winter and Spring.

- Increased coordinated management and timely holistic assessment and advance care planning

- Training to be provided ***throughout autumn*** for West Midlands Ambulance Service (WMAS) clinical staff and care home staff around the recognition and management of patients who are approaching end of life, including adopting a frailty sensitive approach to avoid multiple ED attendances and provide high quality care.

- Expected development of direct SDEC pathway from SPoA in Herefordshire to reduce ED attendances

- Learning from neighbourhood health accelerator sites to be embedded across all sites through winter

- Integrated MDT for each Neighbourhood which will ***meet monthly*** to discuss, review and triage patients at highest risk of deterioration

- Governance restructure to support new Neighbourhood Health guidelines, decision making and implementation at Place.

Community Pharmacy

Clinical Pathways: The NHS Pharmacy First Service enables community pharmacies to assess and treat seven common conditions through defined clinical pathways, including the supply of prescription only medicines where appropriate. Patients can access these services directly without a referral. Where patients present at NHS111, UEC settings or General Practices for these conditions, a referral should be sent to the community pharmacy.

The seven conditions include:

- Acute otitis media (1 to 17 years)
- Impetigo (1 year and over)
- Infected insect bites (1 year and over)
- Shingles (18 years and over)
- Sinusitis (12 years and over)
- Sore throat (5 years and over)
- Uncomplicated urinary tract infections (Women 16-64 years)

In 2024-25, HWICB pharmacies undertook an average of 2338 clinical pathway consultations each month. The ICB is working with GP practices, Minor Injuries Units (MIUs), community pharmacies and patients to increase use of the pathways, ensuring patients are managed by the most appropriate clinician.

Urgent Repeat Medicine Supply
Pharmacists can provide an emergency supply of a patient's regular medication when they run out and cannot access their GP in time.

NHS Referrals for Minor Illness
Patients with minor illnesses should be referred to community pharmacies by NHS 111, GP practices and UEC settings to a pharmacy for advice and treatment. Referrals ensure continuity of care and consultation outcomes are sent to the patient's GP practice.

Discharge Medicines Service (DMS)
DMS plays a key role in supporting the NHS during winter by reducing readmission rates and supporting patients on discharge (Sabir et al, 2019). All patients with any medication change whilst in hospital (starting, stopping or changing a dose) can benefit.
For every 10 DMS, 1 avoidable re-admission can be prevented with an associated cost saving of £2251

DMS can also improve safety: https://www.hssib.org.uk/patient-safety-investigations/workforce-and-patient-safety/fifth-investigation-report/

All pharmacies in H&W can provide DMS and the ICB is working with the trusts to optimise use of DMS.

To initiate DMS, NHS Trusts electronically send a copy of the discharge summary to the patient's choice of community pharmacy. DMS includes medicines reconciliation, confirmation of the next prescription and a patient consultation/medicines review using shared decision making to check the patient's understanding of their medicines' regime.

This helps:

- Prevent medication errors

- Identify and resolve discrepancies
- Support adherence to new or changed prescriptions

This is especially important during winter when hospitals face high demand from respiratory illnesses and seasonal conditions

Flu and COVID-19 Vaccinations
Many community pharmacies deliver the national flu and COVID-19 vaccination services. These services are accessible and convenient for patients, helping to increase vaccination uptake and reduce pressure on other healthcare providers during winter.

Public Health Campaigns
Community pharmacies have to participate in public health campaigns, two of which can be directed by the ICB. For 2025/26, the local campaigns are:

- Know Your Numbers which will support the blood pressure screening service
- NHS App which will support patients ordering their medicines using technology, freeing up valuable time in pharmacies and practices.

Healthcare professionals can check if a pharmacy provides a service by using Service Finder for Healthcare Professionals - Service Finder
Public facing searches:

- Find a pharmacy that offers the contraceptive pill without a prescription - NHS
- **Find a pharmacy that offers free blood pressure checks**
- **Find a pharmacy that offers free COVID-19 rapid lateral flow tests**

4. What Our System Looks Like - Winter 2025/26

ICS Urgent Care Strategy

Over the last six months, UEC pressures have stabilised and have seen some improvement in the length and frequency of ambulance handover delays. However, we continue to face substantial challenges across our system within urgent and emergency care – delivery of constitutional standards, particularly EAS performance and long waits in the emergency department remain a cause for concern.

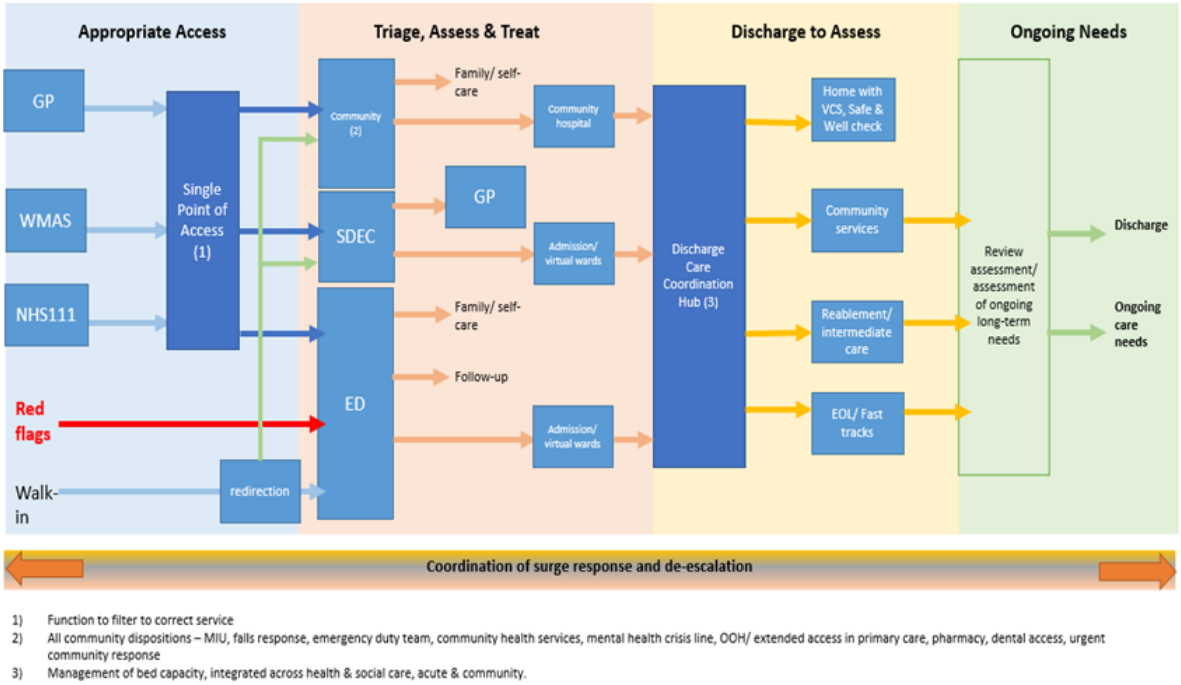
These challenges are compounded by ongoing demographic growth and predicted rising demand for services, providing the imperative to our system to change the way in which we plan and deliver health and care services. Preventing urgent health needs arising is key, with a focus on staying healthy

Herefordshire and Worcestershire ICS has developed its short to medium-term intentions for urgent and emergency care. With alignment to national priorities and addressing local population needs, the strategy sets out the improvements expected for 2025-2028, with the **red** shaded boxes detailing the performance improvement expectations through Winter 2025/26.

This strategy sits within a systemwide strategic framework and specifically addresses the priorities and population needs for the specific area of focus, as set out in the H&W Integrated Care Strategy 2023-2033 and the UEC Plan 2025, with these plans focusing on issues relating to self-care and independence, health behaviours, personalised care, population health management and sustainability to deliver tangible improvements to health inequalities, delays to care, reducing waste and improving efficiencies.

Within Urgent and Emergency Care, the ICS strategy incorporates many of the prerequisites detailed within the UEC plan 2025/26, recognising that our starting point is a recently stable UEC position, high demand across primary care and the ED front door, excessive occupancy levels and performance within the key UEC indicators, while improving, still being behind trajectories.

Through the ICS Urgent and Emergency Care Board through to place based committees, the ICSs future view for UEC is shown below.



1) Function to filter to correct service
2) All community dispositions – MIU, falls response, emergency duty team, community health services, mental health crisis line, OOH/ extended access in primary care, pharmacy, dental access, urgent community response
3) Management of bed capacity, integrated across health & social care, acute & community.

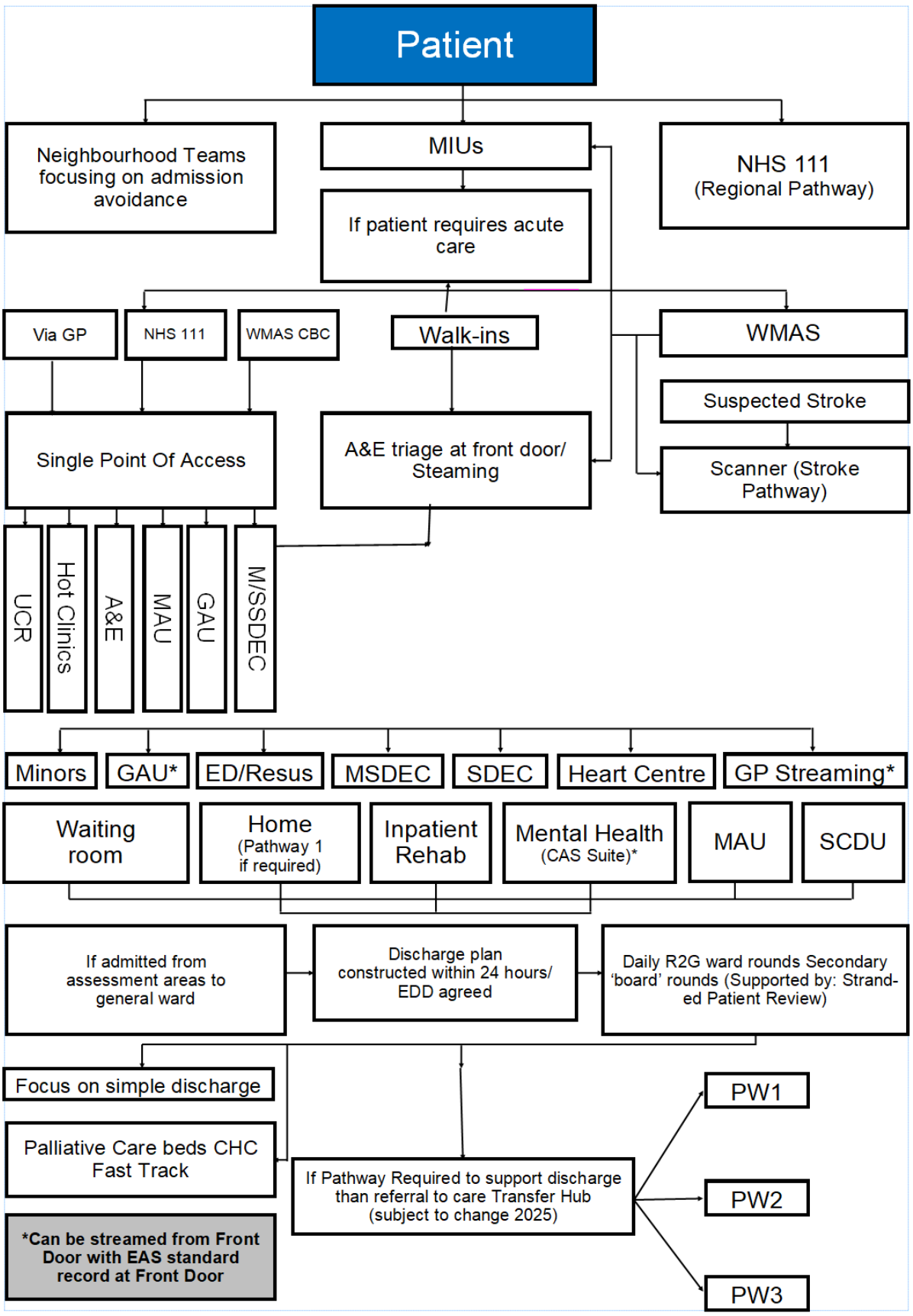
We recognise the importance of all local health and care providers and commissioners working together to deliver the strategy and to provide the best services we can to the patients we serve. With our mature relationships, we are developing even closer ways of working at a system level (ICS) to ensure patients get the safest, most effective and efficient services when they are needed.

As an ICS we now largely have all the best practice elements of an effective UEC system from a service perspective. The focus for this winter and beyond is to mature and ensure best practice standards are embedded across the entire system and organisations.

Within Worcestershire Place, now a Tier 1 system, we welcome the support and focus the agreed concordat brings to continue the improvement journey.

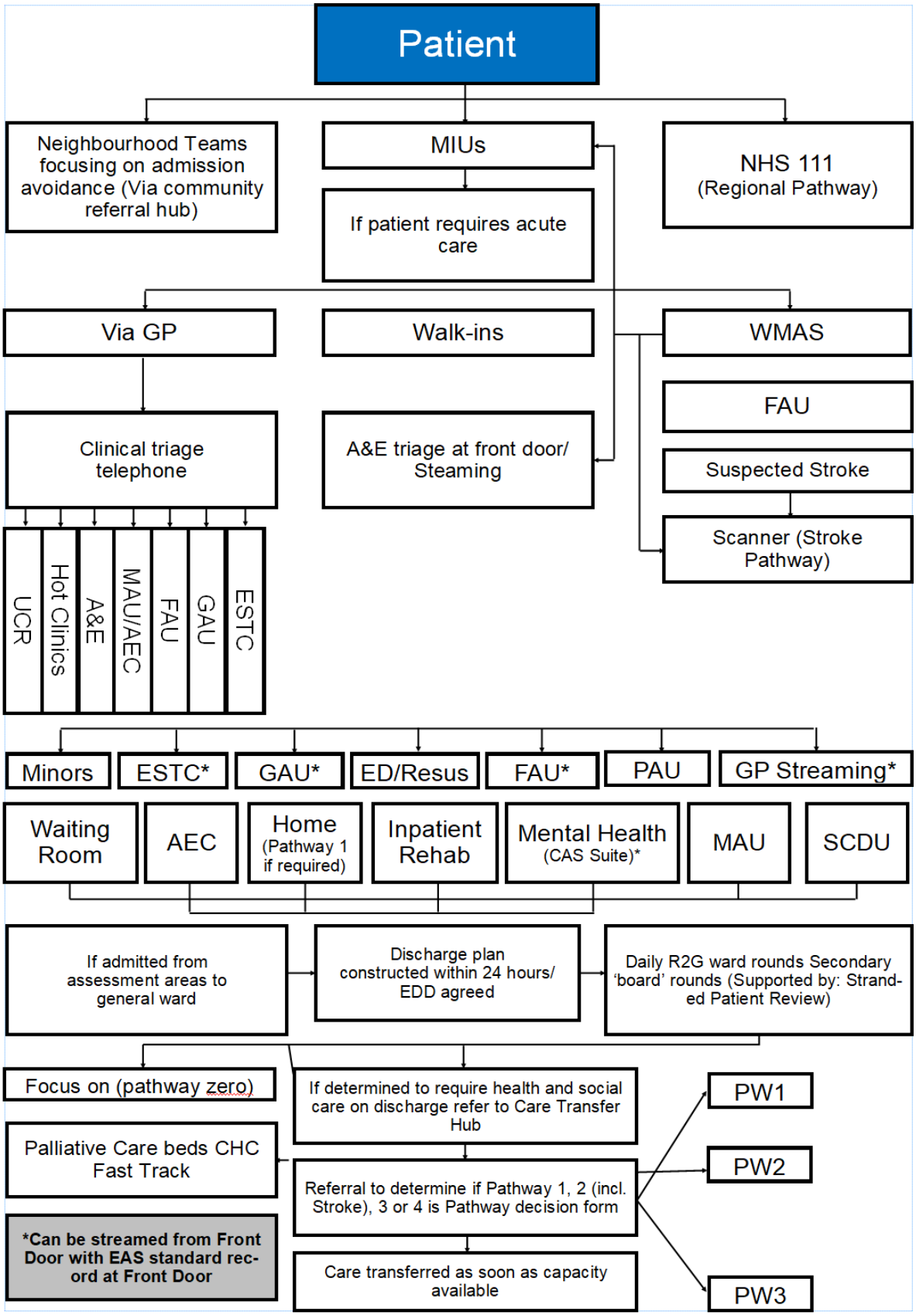
Worcestershire

What Our System Looks Like:



Herefordshire

What Our System Looks Like:



Frailty & End of Life – Managing the Clinical Risk

The ICS Neighbourhood health focus is on those living with severe frailty and those likely to be in their last year of life. This is as a result of data intelligence and the spring/summer in-depth ED audits across our three ED departments that provided evidence and case studies that care of frail elderly and end of life (EOL) patients in not in line with UEC strategy planning.
Ahead of/during/following winter a significant program of work will be undertaken which will emphasise our commitment on improving the frailty offer across the system, these programs of work include:

- Improved access to senior clinical decision makers to support frailty sensitive and home first approach to management

  - Frailty GPs co-located in SPoA Currently embedded in Herefordshire, ***commencing October 2025 Worcestershire***
  - Launch SDEC pathway from SPoA in Herefordshire, in place for Worcestershire
  - Increased use of advice and guidance for geriatric medicine and addition of Acute Medicine advice and guidance pathway
  - Pathway for care home staff to get advice and support from senior SPoA clinicians being developed, ***October 2025***

- Improve links with neighbourhood Frailty Teams and acute Clinicians/Geriatricians to facilitate frailty sensitive approach and timely discharge from acute and community hospitals. This will reduce length of stay including utilisation of hospital at home in-reach to identify suitable patients for early discharge, ***commencing October 2025***

- Development of agreed system escalation pathway for patients living in care homes (including increased utilisation of direct access to SPoA for advice), ***during October 2025***

- Development of a clinical decision support tool for care homes to support management of the deteriorating patient, ***November 2025***

- For when conveyance to an acute trust is necessary, to increase numbers of patients seen by and streamed directly to frailty SDEC/Geriatric Evaluation Management Strategy (GEMs) services, ***commencing October 2025***

- Optimisation of out of hospital pathway use when patients deteriorate which supports a home-first approach when appropriate, including work with WMAS to increase use of call before convey and expansion of Worcestershire hospital at home service, and review of Herefordshire model, ***commencing November 2025***

- Development of agreed system out of hospital long lie pathway, ***during November 2025***

- Promoting timely discharge from acute to community by increasing awareness of community pathways to manage complex patients and ensure these are routinely considered during board rounds, ***October 2025***

- Review of community hospitals within Worcestershire, including the Intensive Assessment and Rehabilitation Pathway to reduce length of stay and the likelihood of deconditioning and need for long term care placements, ***November 2025***

- Focus on proactive care for patients living with severe frailty in primary care neighbourhood health contract, offering timely advance care planning discussions and identify those patients who are most of risk of sudden acute deterioration for proactive care planning, commencing

October 2025

- Optimisation of SPoA pathways to support a home first approach, review benefits realisation for Worcestershire followed by Herefordshire, ***November 2025***

- Implementation of learning from a deep dive into patients in the last 90 days with 3 or more ED attendances to include actions around coordination of care, quality of ReSPECT (Recommended Summary Plan for Emergency Care and Treatment) documentation and timely recognition of patients approaching the last year of life ***November 2025***

In addition to the above, the ICB has prioritised improving our systems responsiveness to identifying those patients likely to be in their last year of life and coordinating their management to reduce unnecessary admissions in the last 90 days of life.

During September, a system 'managing risk' meeting was held with wide ranging clinical representation across the ICS. The meeting proved extremely beneficial and the outputs included specific actions, enablers and solutions which will be implemented at pace ahead of winter.

A key element of this discussion focussed on more appropriate balancing of risk throughout the system and moving away from the 'status quo' of the acute trust or emergency departments acting as the 'catch all' place of safety.

The system also conducted local and regional stress test exercises aimed at testing the resilience of the winter plan. Outputs/Actions from these exercises will be progressed by Chief Operating Officers across the ICS.

ReSPECT (Recommended Summary Plan for Emergency Care and Treatment)

ReSPECT is currently being embedded across Herefordshire and Worcestershire Health economy. It is a process for collating personalised recommendations for a person's clinical care in a future emergency in which they are unable to make or express choices and is part of a wider process of Advance Care Planning (ACP) or anticipatory care planning.

ReSPECT provides health and care professionals responding to an emergency with a summary of the patient's wishes, with the aim of supporting immediate decisions about that person's care and treatment. People with a ReSPECT plan in place are more likely to avoid unwanted and unnecessary interventions, including hospital admissions which allows people to be cared for and die in the place of their choosing.

Digital ReSPECT is being piloted (via the Shared Care Record) in the summer and aiming to launch ***Autumn 2025*** across the system. This will enable partners; including WMAS, SPoA, secondary care and primary care providers, to advocate for patients wishes and support robust clinical decision making.

Documentation will be a co-production with WMAS for suggested wording to ensure clear interpretation of ReSPECT documentation. The local work will support national ReSPECT eLearning expected ***during the Autumn.***

In addition, it allows partners to update contemporaneously and not be reliant on paper forms being transferred with the patient. It is anticipated this will not only improve quality of care for patients but support with system pressures by reducing inappropriate conveyances and admissions. Whilst Care Homes are not included in the initial launch due to IT and integration, workstreams are ongoing to increase care home calls directly to SPoA to still enable the ReSPECT document to support clinical decision making.

Learning from recent in-depth ED audits across ED departments over the summer have informed and supported the frailty and end of life work and as a consequence additional actions agreed across partners as outlined below.
The aim the ED audits across the system was to understand factors contributing to rising ED attendances, particularly among walk-in patients, by identifying patterns and evaluating whether alternative care pathways are being effectively used to prevent unnecessary attendance.

The second part of the audit included reviewing the utilisation of the SPoA by WMAS Call Before Convey process.

Additionally, the review included the effectiveness of ED front-door streaming in directing patients to appropriate internal and external care pathways.

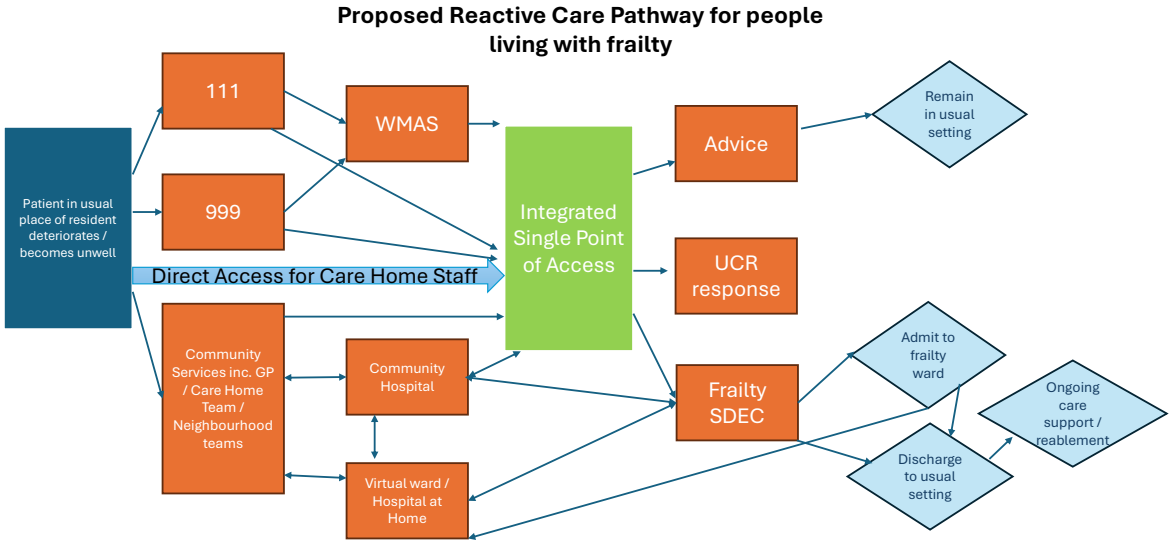
Agreed actions:

WMAS

- **Resuscitation Guidance**: Confirm WMAS policy when a RESPECT form is in place.
- **Training**: Work with the ICB to deliver frailty and end-of-life care training at WMAS bases across the ICS.

ICB

- **Frailty Reactive Care Pathway**: Review and agree the frailty reactive care pathway through the UEC Programme Board and implement across all Places.



- **Care Coordination**: Ensure clear plans for managing patients at high risk of deterioration and those on end-of-life care pathways within neighbourhood health plans.

- **111 to SPoA Review**: Assess effectiveness of current 111 to SPoA arrangements by PLACE.

- **Primary Care Messaging**: Reinforce consistent messaging that SPoA should be the route to acute services (not 999 unless life-threatening); Hereford activation date pending.

- **Care Home Support**:
  - Finalise deterioration pack and SPoA-based algorithm
  - Develop a feedback loop to primary care when a conveyance is not needed.

- **SPoA Access for RESPECT Patients**: Ensure families of patients with a RESPECT form have access to SPoA contact numbers across counties; include in UEC specification.

- **Digital Integration**: Explore the feasibility of a cross-boundary UEC IT solution.

Acute Providers

- **Community Diagnostic Centre Access (CDC)**: Explore direct access to CDCs in each county to reduce ED attendance.
- **Front Door Streaming**: Ensure front door streaming is established with automatic access to SDEC services ahead of winter.
- **Frailty SDEC**: Further develop and enhance SDEC services for frailty.

It is planned for these actions to be delivered over winter with an evaluation of impact in the form of follow up ED audits in February/March 2026

Children and Young People

For winter 2025/26 we are committed to:

- Through system engagement / representation at Children and Young People (CYP) board with wider system partners to ensure escalations can be raised and to ensure consistent messaging can be shared with wider stakeholders, ***commencing August 2025***

- Maintain same day urgent access initiatives across the ICB, ensuring additional capacity within General Practice offering a combination of face to face and virtual appointments across a county wide footprint.

- Update and distribute the Common Conditions guidance document to primary care providers, as well as exploring the development of educational videos on common conditions.

- Provide parent education on appropriate healthcare access points (“where to go” guidance), ***commencing July 2025***

- Continued engagement sessions are across the ICS to understand parent/ carer/ CYP feedback

- Promote Pharmacy First through posters and leaflets tailored to school-age health concerns, as well as supporting national media campaigns
- Further promotion of the Paediatric HANDi App, with a focus on parent/carer and school communities via local press and social media.

- Support for school staff on how to effectively signpost parents/ carers to appropriate services.

- Deliver asthma training, guidance, and factsheets to schools, supporting the development of Asthma Friendly Schools.

- Enhanced Social Media messaging about managing RSV, clinical information for parents on HandiApp. Parent information within General Practice, ***commencing July 2025.***

- There is an agreed MH urgent care multiagency pathway which is available 7 days a week, with assessment capacity, for adults and children. Children and Adolescent Mental Health (CAMHS) Crisis Team operate 7 days per week, to ensure that CYP have the most timely and appropriate Interventions in the right place.

- Out of hours CYP needs are met through the adult mental health crisis teams. This will be refreshed in ***October / November 2025.***

Mental Health Services

A full range of mental health services is commissioned for the local population, consistently across the year. Specifically, to support the Urgent Care System during winter the following services are available:

- Mental Health Liaison
- Crisis Resolution Team
- 24/7 Mental Health Phoneline

The local Directory of Services contains all relevant mental health services.

The Mental Health Liaison service provides a comprehensive assessment to all people, regardless of age, who attend the Alexandra Hospital, Worcestershire Royal Hospital or Hereford County Hospital following an episode of self-harm, attempted suicide or presenting with symptoms of a mental illness.

The Crisis Resolution Service operates twenty-four hours a day, 365 days per year, providing mental health assessments and support for individuals in urgent and acute mental health crisis. The team will remain involved with the patient until the crisis has been resolved and/or arrangements are in place for their continuing care and management. Monday to Friday 09:00-17:00 the Crisis Resolution Team (CRT) will provide support and intervention to patients aged between 17 ½ years and 65 years (or older if open to Adult Mental Health Services).

Out of hours the Team will also accept referrals for assessment for people of all ages. Generally, patients are referred by their GP, or through local A&E services, although the CRT does respond to requests from other services such as the police or ambulance service.

In addition, there is a Crisis Assessment Suite (CAS) within the Elgar Unit on the Worcestershire Royal Hospital site. People experiencing a mental health crisis who require an immediate response/assessment from mental health services, who do not need physical health treatment, will be diverted from A&E departments and conveyed directly to the suite by West Mercia Police or West Midlands Ambulance Service (WMAS). A&E staff can also refer when patients access A&E independently or have been conveyed by police or ambulance services without contacting CAS. The service is available to patients aged 18+.

Worcestershire has a health-based Place of Safety within the Elgar Unit on the Worcestershire Royal Hospital site. The health-based Place of Safety, or Section 136 Suite, is for people detained under Section 136 of the Mental Health Act (legal powers police use to safeguard people with severe mental health problems) as an alternative to detention in police custody. The Elgar Unit has the capacity to manage all ages twenty-four hours a day, seven days a week, with flexible provision around the suite and its family room.

Herefordshire has a health-based Place of Safety within the Stonebow Unit on the WVT Hospital site. The health-based Place of Safety, or Section 136 Suite, is for people detained under Section 136 of the Mental Health Act (legal powers police use to safeguard people with severe mental health problems) as an alternative to detention in police custody. The Hatton Suite has the capacity to manage all ages twenty-four hours a day, seven days a week.

Herefordshire and Worcestershire Health and Care NHS Trust provide a mental health 24/7 helpline for people who experience a sudden deterioration of an existing mental health problem or who are experiencing problems for the first time. This covers people living in Worcestershire and

Herefordshire and is designed to offer urgent advice and support. It is operational 24 hours a day, 365 days a year.

New for Winter 2025/26 – Supporting Flow / Reducing ED delays

- Recovery and improvement plan progressing ahead of schedule to improve MH inpatient flow. Focus on proactive discharge planning, purposeful admissions, and therapeutic inpatient care as primary drivers. Daily system sitreps in place, inappropriate Out of Area Placements (OAPs) reduced to nil, Length of Stay (LoS) reducing in line with projection.

- Multi Agency Discharge Events (MADE) events and Executive-Led MDTs in place to support discharge of patients with long length of stay

- Social Worker roles being implemented within wards to support discharge planning and integration of services

- 72-hour admission pathway implemented to ensure timely assessment and discharge planning.

- Extraordinary funding panels or out of panel decision-making undertaken as required to ensure rapid decision-making on packages of care.

- 24/7 Mental Health Liaison service in place across all Emergency Departments within ICS providing 1-hour response, assessment and brief interventions. Establishment review underway to be undertaken to align with Royal College of Psychology recommendations.

- Clinically-led SMS crisis support commissioned (via SHOUT) to provide alternative means of contacting crisis services.

- Mental Health Response Vehicle (MHRV) provision in place supporting reduction in ambulance conveyances to ED.

- Safe Haven services (x2) in place and well-established, providing immediate crisis de-escalation to prevent ED attendance.

- Access to community mental health services (adults and children) above or significantly above target to support early intervention.

- Providing a 24/7 Urgent Mental Health Line in place and ensuring 95% of calls answered within 5 minutes.

- Dedicated Housing and Mental Health role in place across mental health and housing teams, supporting strategic planning, MADE events and discharge planning.

Social Care

The Councils support some of the most vulnerable people in society, have responsibility for visible public services like maintaining roads and pavements, street lighting, household waste sites, libraries, and country parks to name but a few. They currently oversee around £900m of public expenditure per year. Around 60% of our net revenue budget is spent on social care services for vulnerable children and adults.

The Core services provided by the Councils to support the system during winter are the following:

- Continued support to facilitate complex discharges through effective use of resources such as developing an intermediate care service and refreshed Onward Care Team model

- Purchasing of Domiciliary Care to secure flow

- Here2Help community support service will deliver e.g. food parcels to individuals needing support as well as those who are socially isolated being linked with local resources. This is a 7 day a week service and is being developed into a long-term service to support residents with early support, advice and information, using a variety of methods, to promote independence.

The Council will provide the following support to the system:

- In support of the wider health and social care system, the People Commissioning Unit and senior social care practitioners are providing support to care transfer hubs and the emergency department front door.

- The Councils will continue to provide social worker support to our community hospitals helping to facilitate onward discharge.

- The Council will provide the following support to its people:
    - All staff will be encouraged to take up flu vaccination via on-site centres, GP, or Pharmacy
    - The mental health of staff is supported by trained Mental health first aid teams, with general well-being support via occupational health and other employment policies

- The most fundamental impact the council will make over the winter is to ensure their services comply with the Discharge to Assess process – primarily in Worcestershire.

Patient Transport Service

Our Patient Transport Service (PTS) provider, EMED, play a crucial role supporting the transport of patients to outpatient appointments in addition to provide transport home to patients who meet appropriate eligibility.

For Winter 2025/26 EMED will provide:

- Onsite command and control functionality by providing a patient transport liaison officer working in conjunction with acute sites capacity teams.

- EMED will seek to prioritise discharge activity and be responsive to particular given challenges.

- The ICB has also reviewed eligibility for transport and as part of this review significant capacity will be deployed supporting timely hospital discharge which will reduce the numbers of delayed and failed discharges as a consequence of transport challenges.

See attached policies below for further information on contingency arrangements and winter rota.


PTS-POL-28d EPRR - Strategic Winter Fr


Herefordshire - SOP Winter PressureSno


Worcestershire - SOP Winter Pressure


PTS WINTER ROTA HEREFORD.pdf

The system has undertaken a review of PTS services as demand has grown significantly. The

outcomes and actions outlined below will allow the system resource to be focussed on supporting necessary flow.

Phase 1: Review of the 'Walker' Category
In 2024/25, approximately 14,000 patients were recorded under the 'walker' category, indicating no significant impairment to mobility. The purpose of this phase was to bring local eligibility criteria back in line with national guidance, which states that patients should only qualify for Non-Emergency Patient Transport Services (NEPTS) if they have a significant mobility impairment.

This proposal was formally approved in July 2025 through both executive and clinical governance forums, supported by a comprehensive Quality Impact and Equality Impact Assessment (QIA and EIA).

Next Steps:

- A comprehensive review of NEPTS patient information materials will be undertaken to reflect the updated eligibility criteria. This will be supported by a clear communication and patient engagement plan, developed in collaboration with Healthwatch and other key stakeholders.

- A meeting is scheduled with EMED, the NEPTS contract provider, on 1st August to review the findings and agree a plan for implementation by 31st August.

Phase 2: Review of Non-Procedure Follow-Up Appointments
In 2024/25, approximately 19,00 patients were requiring NEPTS to attend non-procedure-based follow-up appointments. Initial analysis suggests a significant opportunity to explore whether these appointments could be delivered more appropriately via virtual platforms or telephone consultations, reducing the need for in-person attendance and associated NEPTS usage.

Next Steps:

- Present findings and proposed approach to all clinical specialty teams to discuss clinical appropriateness, implementation considerations, and secure engagement.

- Incorporate feedback into a final implementation plan, to be delivered through a phased approach. This will require a full Quality Impact Assessment (QIA) and Equality Impact Assessment (EIA), and formal approval through the appropriate executive and clinical governance forums. The target implementation date is 31st October 2025

5. Demand & Capacity Modelling

Herefordshire and Worcestershire ICS have undertaken detailed modelling of demand and capacity to test whether planned actions will manage the winter pressures effectively, focusing on ensuring sufficient capacity to meet demand, delivery of 45-minute maximum ambulance handover delay and delivery of 78% EAS performance.

The focus on these areas will deliver a 'trickle down' impact which will reduce significantly our reliance on corridor care and Temporary Escalation Spaces (TES) (as the norm) and contribute to a reduction in those patients waiting longer than 12 hours (from time of admission) in the emergency department.

The demand and capacity modelling undertaken ahead of Winter 2025/26 suggests four key areas of focus for our system during winter which are critical in ensuring our urgent care system is able to manage winter.

- Demand Management
- Effective ED Front Door Processes
- Best practice in-hospital Flow – returning to discharge to assess
- Creating more virtual hospital capacity

The overarching aim is to ensure that there is sufficient capacity to absorb the forecast additional demand, so patients can be seen and treated in a timely way in the most appropriate care setting.

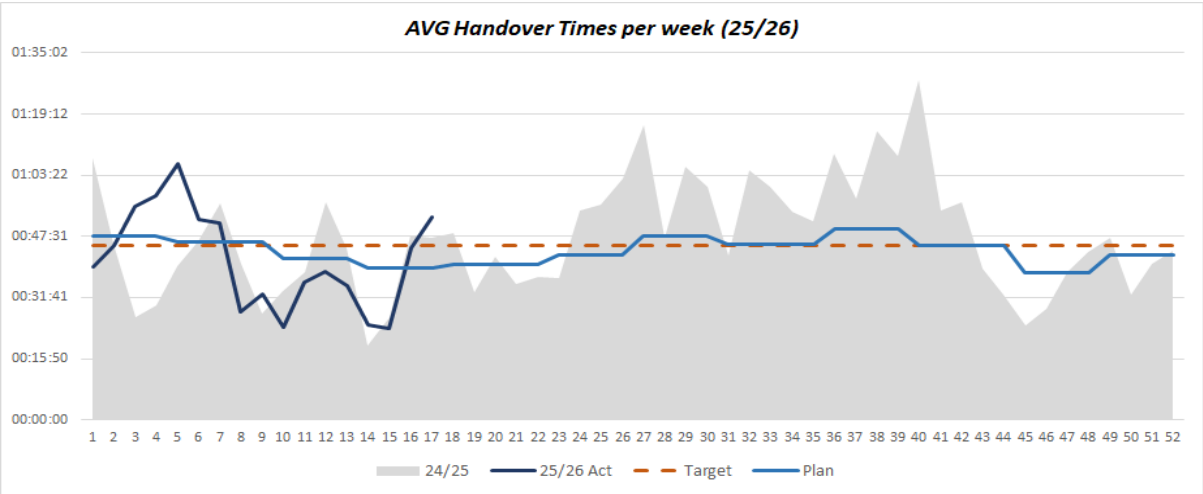
Methodology for demand & capacity modelling for winter 2025/26

The capacity model maps the daily flow of patients at each main hospital site in H&W area, utilising historic A&E and admissions data to forecast demand for this winter. The forecast demand for the remainder of 2025/26 is based on actual activity this year and activity forecasts submitted via annual planning for the future months of the year.

The modelling then indicates the impact of interventions described in the following chapter, which then produces eventual outturn for the winter period. These interventions are detailed in the Place based delivery plans.

Worcestershire demand & capacity modelling

45-minute handover



EAS Performance

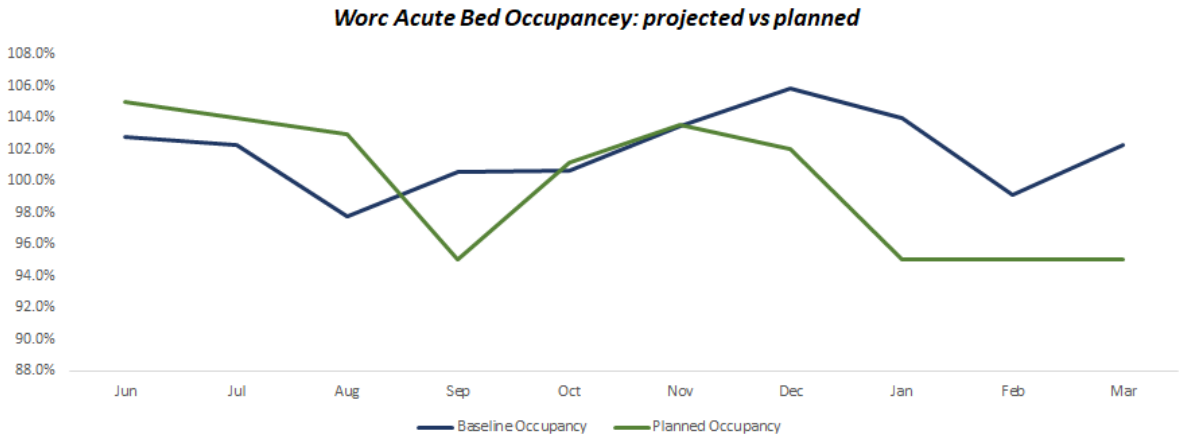
Forecast 2025/26			Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total
Predicted Atts (Main Type 1 A&E)			13,650	13,949	13,863	14,980	13,385	13,399	14,331	14,216	14,230	13,047	12,212	14,617	165,879
Predicted Breaches based on current Daily AVG			7,565	7,067	6,816	7,306	7,306	7,071	7,306	7,071	7,306	7,306	6,599	7,306	86,028
Total Attendances all Types (1 &3)			19,508	20,513	20,339	21,242	19,578	19,311	20,331	19,524	19,203	18,307	17,204	21,105	236,166
Average number of Atts per day (Type 1)			455	450	462	483	432	447	462	474	459	421	436	472	454
Interventions	Demand Reduction	ICB 4% Walk in reduction					182	364	390	387	387	355	332	398	2613
	Breach Reductions	NANR to 80%					735	1470	1519	1470	1519	1519	1372	1519	10388
		NANR additional (Navigator)					225	450	465	450	465	465	420	450	3165
		Internal Professional Stds					15	30	31	30	31	31	28	31	212
		Flow - red. Pathway delays					150	300	310	300	310	310	280	310	2120
		Flow - 'out of 5'					75	150	155	150	155	155	140	155	1060
		Flow - 'Hospital@Home'					15	30	31	30	31	31	28	31	212
		Flow - 'LLOS reduction'					12.5	25	25	25	25	25	25	25	175
		Flow - Ward Efficiency's					125	250	250	250	250	250	250	250	1750
Revised Attendances			19,508	20,513	20,339	21,242	19,396	18,947	19,941	19,138	18,816	17,952	16,871	20,708	233,371
Revised Breaches			7,565	7,067	6,816	7,306	5,954	4,366	4,520	4,366	4,520	4,520	4,056	4,535	65,593
Revised Performance (%)			61.2%	65.5%	66.5%	65.6%	69.3%	77.0%	77.3%	77.2%	76.0%	74.8%	76.0%	78.1%	71.89%
Quarterly Performance (%)				64.47%			70.42%			76.84%			76.39%		
Performance Gain						0.0%	6.6%	13.6%	13.3%	13.4%	14.0%	14.7%	14.3%	12.7%	8.3%
Planning Submission 2025/26			55%	57%	59%	63%	67%	68%	71%	75%	73%	76%	76%	78%	

ED Attendances per month	Current 4 HR EAS	Current Breaches Per day	Breach Threshold to achieve 78%	% of Pts > 12 Hrs in ED (Jun 2025)	Number of 12 hr breaches	AV number per day
20,120	66.49%	236	146	14.80%	2049	68
		90 less breaches per day			1386 is 10%	46 is 10%

Capacity

Baseline	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Emergency Admissions	2,982	3,264	3,103	3,100	3,206	3,201	3,394	3,325	2,845	3,263
AVG LOS (Em)	7.32	6.98	6.98	6.98	6.98	6.98	6.98	6.98	6.98	6.98
Bed Days (EM)	22,153	22,783	21,659	21,638	22,378	22,343	23,690	23,209	19,858	22,776
Unmet ED Demand (17 per day)	515	527	527	510	527	510	527	527	476	527
Unmet Bed Day demand (2.5 LOS)	1288	1318	1318	1275	1318	1275	1318	1318	1190	1318
Non Elective beds required	781	777	741	764	764	787	807	791	752	777
Elective beds required	52	52	52	52	52	52	52	52	52	52
Beds Required	833	829	793	816	816	839	859	843	804	829
Beds Available	811	811	811	811	811	811	811	811	811	811
Baseline Occupancy	102.8%	102.3%	97.8%	100.6%	100.7%	103.5%	105.9%	104.0%	99.1%	102.2%

					Winter Focus					
Final	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Beds Required	852	843	835	770	794	824	811	765	746	746
Beds Available	811	811	811	811	785	795	795	805	785	785
Planned Occupancy	105%	104%	103%	95%	101%	104%	102%	95%	95%	95%

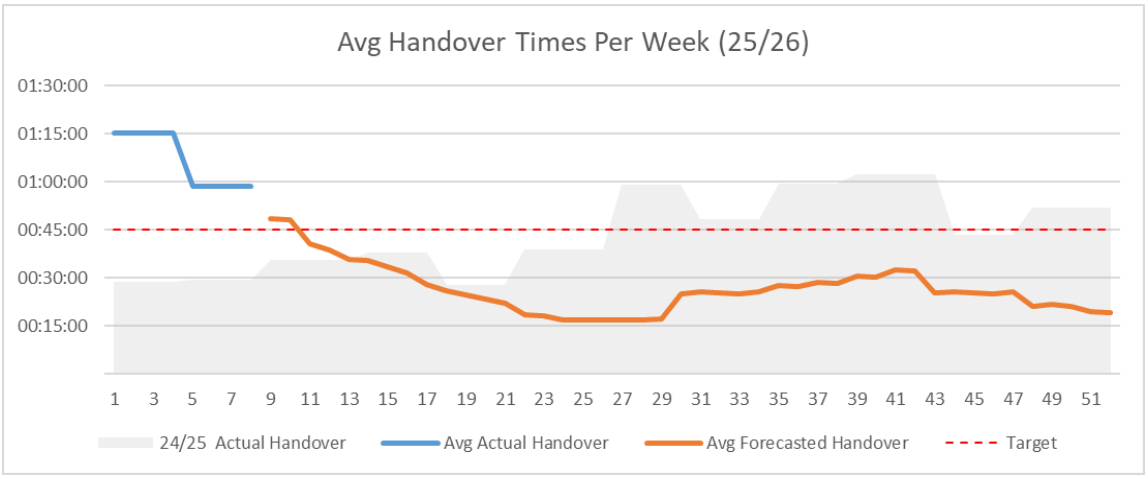


The Waterfall charts suggest on these scenarios there should be sufficient ‘head room’ to manage winter.

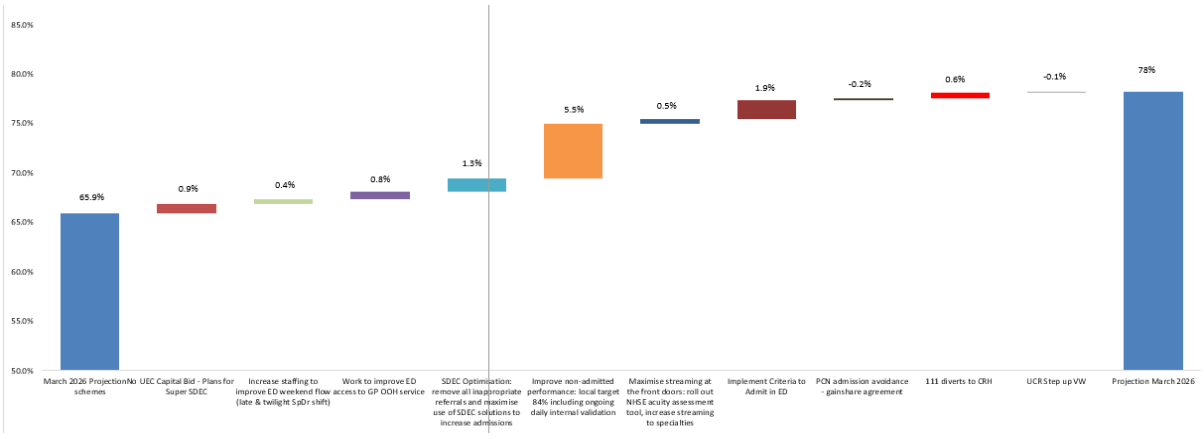
Please note that for Worcestershire this does not yet include the impact of returning to Discharge to Assess within WAHT over August and September 2025 and the predicted 2.3 day reduction in length of stay. Further triangulation work required during August 2025 to update waterfall chart.

Herefordshire demand & capacity modelling

45-minute handover

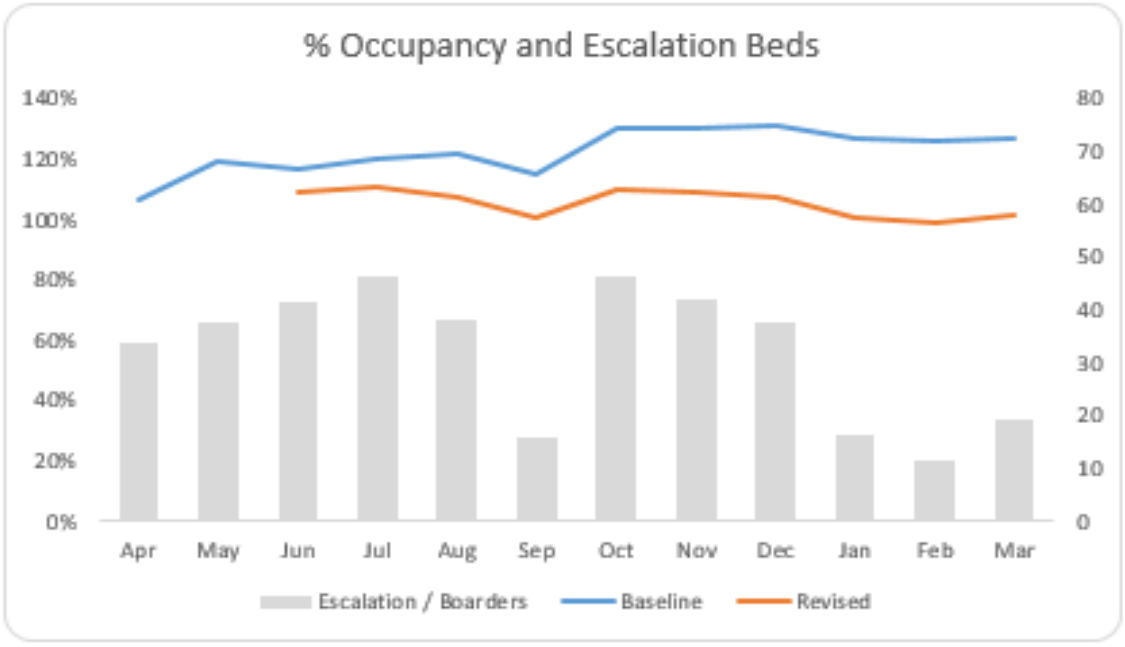


EAS Performance



Forecast 2025/26		Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total
Predicted Attendances (main A&E)		6,119	6,295	6,382	6,479	6,378	6,393	6,767	6,485	6,675	6,134	6,071	6,863	77,041
Predicted Breaches based on current average daily		3,084	2,915	2,760	2,666	2,635	2,490	2,666	2,520	2,790	2,635	2,352	2,803	32,316
Total Attendances - All Types		**7,241**	**7,355**	**7,693**	**7,809**	**7,644**	**7,661**	**8,111**	**7,770**	**7,998**	**7,346**	**7,268**	**8,224**	**92,120**
Average Number of Attendances per day (main A&E)		204	203	213	209	206	213	218	216	215	198	217	221	211
Total	Footfall reduction	0	0	0	0	170	215	220	225	230	235	235	235	1765
	Breach reduction	0	0	0	165	340	409	464	490	506	580	651	1043	4647
Revised Attendances		7241	7355	7693	7809	7474	7446	7891	7545	7768	7111	7033	7989	90355
Revised Breaches		3084	2915	2760	2501	2295	2081	2202	2030	2284	2055	1701	1760	27669
Revised Performance (%)		57.4%	60.4%	64.1%	68.0%	69.3%	72.1%	72.1%	73.1%	70.6%	71.1%	75.8%	78.0%	69.4%
Quarterly Performance (%)				60.7%			69.7%			71.9%			75.1%	
Performance gain		0.0%	0.0%	0.0%	2.1%	3.8%	4.6%	5.0%	5.5%	5.5%	7.0%	8.2%	12.1%	4.5%
Planning Submission 2025/26		68.3%	68.6%	69.6%	69.9%	70.6%	71.8%	71.0%	71.9%	70.2%	71.9%	75.7%	78.0%	

Capacity



The Waterfall charts suggest on these scenarios there should be sufficient ‘head room’ to manage winter.

6. Providers Headline Winter Initiatives

Worcestershire Acute Hospitals NHS Trust (WAHT)

High Level Aims:

<table>
<tr><td colspan="2">Across all Divisions
Improved Ward and Board rounds
Reduction of outliers – right bed, right place
Robust monitoring of internal professional standards
Reduced internal delayed days between discharge ready date and discharge
Reduced external delayed days between discharge ready date and discharge – supported by partners
Improved specialty review times and removal of unnecessary bed moves
Reduction of Long length of stay patients (supported by system partners)</td></tr>
<tr><td>Medical Division
Length of Stay reduction via use of:
Hospital at Home – phased increased capacity / increased use of community step down
Out by 5 – General Medicine and Frailty
Streaming navigation / improved triage times at front door
Improve non admitted, non-referred performance
Service review for Frailty at front door</td><td>Surgical Division
Length of Stay reduction via use of:
Reconfiguration of T & O
Hospital at Home – FNOF</td></tr>
<tr><td>Specialised Clinical Services Division</td><td>Women's and Children's Division
Optimisation of assessment pathways
Enhanced senior medical decision-making support for paediatrics during peak times</td></tr>
<tr><td colspan="2">Enablers
Implementation of EPMA – will identify areas for improvement in ordering and delivery of TTOs.
Reduced delayed days between discharge ready date and discharge, supported by D2A improvements
Constitutional standards bid for bed management system to prevent outliers and increase 'pull and push' from ED and SDEC.
Strengthened community collaboration with Acute management of community hospital wards for rapid discharges / enhanced UCR support, care home neighbourhood team support, Frailty Delivery Plan.
Increased access to alternative services via the single point of access.</td></tr>
</table>

Hospital @ Home:

- 8-week Plan, Do, Study, Act (PDSA) cycle complete (11th July 2025).
- Patient feedback training via Care Opinion has taken place.
- Delivery efficiencies are being realised and implemented via PDSA, including Board Round, Visit Allocation and triage paperwork efficiencies.

Locally it has been agreed at Worcestershire Place to rebrand virtual wards; *Hospital at Home*. This new model helps to develop a blueprint and governance structure which will enable services to support hospital reduced length of stay and admission avoidance through their specialist virtual/Hospital at Home wards. The Hospital at Home model will support clinicians to refer, monitor and support patients in their own homes.

A phased approach will be taken with the hospital at home model to ensure it is evidencing positive patient outcomes and value for money:

- Phase 1 - Include an 8 week PDSA incorporating an Acute Medical Hospital at Home ward centralised through the Single Point of Access. The Single Point of Access is a central hub receiving calls from the ambulance service, NHS 111, Primary Care and Community Nursing services to support admission avoidance. This commenced at the end of May 2025. Phase 2 is expected to launch by December 2025. Initial plans propose an increase of 26 beds, focusing on admission avoidance as well as step down from the Acute Trust, with a focus on care homes as well as some additional COPD Virtual ward capacity.

- Phase 1 focused on the stepping down of patients from assessment areas within WAHT; this includes Medical Short Stay Unit, Acute Medial Unit and the Emergency Department. These areas have been selected following a scoping exercise that identified patients that could be transferred to a Hospital at Home ward prior to a ward admission. The Hospital at home workforce (Nurse consultants and Advanced Clinical Practitioners (ACPs) have actively in-reached into these areas Monday to Friday to identify patients suitable for hospital at home. There is an assumption that over time, culture changes and education will lead to the need for in-reach to be reduced as practice will be embedded to refer to the service via the SPoA. This approach will support scalability and cost-effective development as less Nurse Consultant and Advanced Clinical practitioner time will be needed providing in-reach.

This model has included:

- Additional advice and guidance available from Geriatricians and/or Acute Medical team as needed. Urgent Community response will also available.

- Advanced Clinical Practitioners will be aligned to the SPoA and will hold the caseload. They will be doing visits as needed and working alongside the local Neighbourhood teams who will also support with the face-to-face visits as appropriate/ needed.

- Daily Board round to review NEWs/Bloods/ plan of care.

- Escalation route back set up via SPoA and into Medical Same Day Emergency Care / Frailty assessment unit as appropriate. In times of no capacity, patients may need to attend via the Emergency Department.

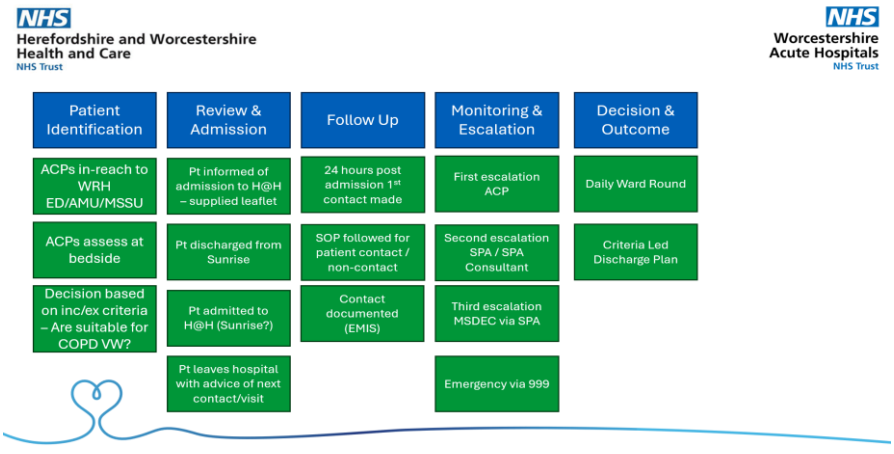
- Inclusion and Exclusion criteria as detailed in a local standard operating procedure (Draft in Appendix 1)

- PDSA methodology being built into daily board rounds to foster learning culture, including learning from readmissions with assessment of risk and adjustment to processes.

- All patients (Rockwood >5) to have a Comprehensive Geriatric Assessment whilst on the Hospital at Home ward.

- Staged on-boarding of beds. Initial aspirations were 15 beds, and to increase to 20-30 beds within the first 3 months. However, due to concerns of limited workforce numbers at weekends, it is currently running with 9 beds.

The image below demonstrates the process for the in-reach model.



Initial Benefits:

- To date 33 patients admitted onto Hospital at Home, including 2 from outside of WAHT
- Average Length of Stay on Hospital at Home is currently around 4.4 days per patient.
- With patients from the Acute having an average length of stay of 1.2 days prior to being admitted to Hospital at Home
- 18/33 patients have been admitted direct from A&E with 9 from Acute Medical Unit (AMU) and 6 from Medical Short Stay Unit (MSSU).
- 9 have these patients have been re admitted.
- There has been an estimated total of ***137 Acute bed days saved*** which equates to around ***4.75 days per patient***.
- At the time of writing this report, 4/33 patients were currently still under the Hospital at Home, with one patient having been there for 18 days

Frailty Front Door:

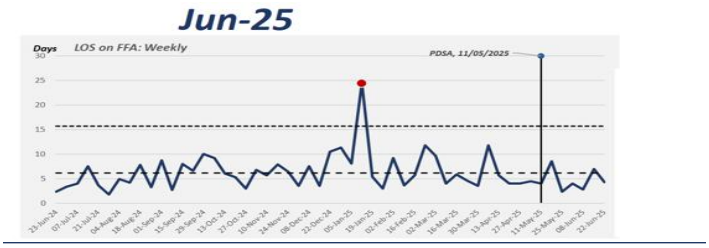
Early Hours

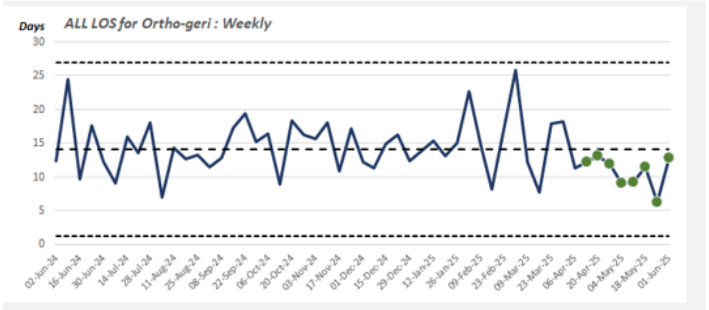
- New pain, fascia iliaci and nutrition protocols currently being reviewed for approval
- Proposed PDSA to cohort all Neck of Femurs (NOFs) in Trauma A & utilise Beech C as a step down for medically fit patients waiting for a pathway or patient appropriate for 'out by 5'

Standardisation of treatment

- 5-day service in reach service implemented and PDSA developed to test the change. Report out Mid July 2025.
- Reconfiguration of surgical beds approved and implemented. All NOFs admitted on Trauma A, then Beech after 48 hours
- Solution developed to record NOF Comprehensive Geriatric Assessment (CGA) review on Sunrise by utilising Acronym expansion

Progress so far:





Single Point of Access:

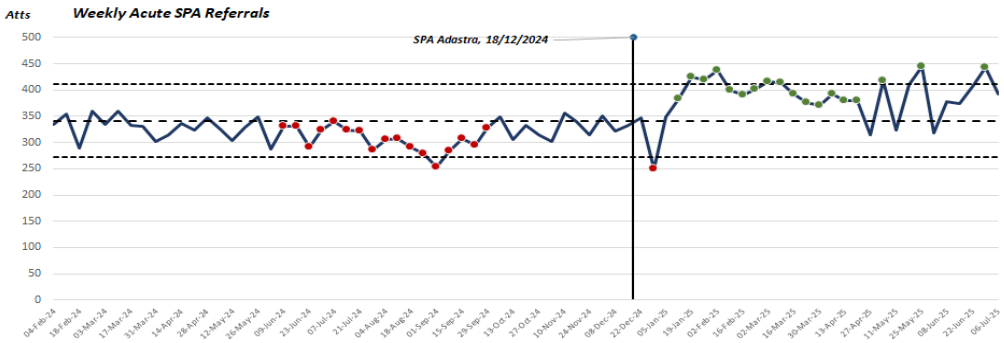
- The service went live December 2023 and has implemented a continuous improvement approach to increase the volume and type of referrals received into the SPoA and the outputs available to it.

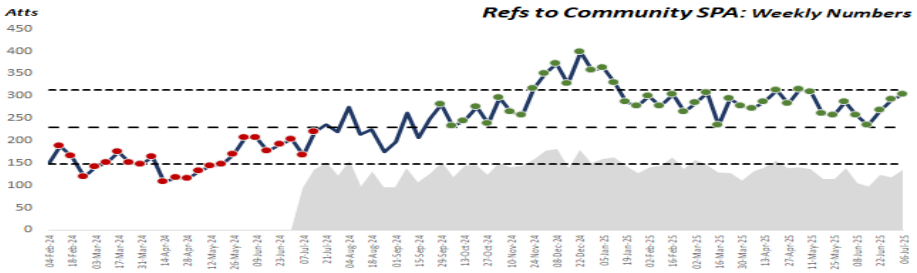
- Continue to work with Directory of Services lead and 111 to increase Adastra numbers to reduce ED attendance and to improve patient experience.

- Complete options appraisal document to look at the rescoping of the SPoA to include single line management options.

- Aim to reduce ED attendances by 4% over winter 2025

Progress so far:





Improvement Initiatives covering site management, flow, Internal Professional Standards, Operational management:

Flow and Discharge

- Emergency Care Improvement Support Team (ECIST) support for Board round review and best practice – timescale TBC. 2 wards at Worcester Royal Hospital and 2 wards at the Alex initially, with train the trainer approach to be adopted. Model board round to be recorded by executive triumphant.
- Internal discharge process: planning for discharge programme
- Ward based LoS reduction plans and discharge targets developed
- Long LoS reduction trajectory developed
- Discharge Ready Date relaunch

Acute Operational Management and Oversight

- ED care navigator pilot commenced – week 2, with navigator streaming at front door to alternatives – week 2 focus on surgical pathways, after positive Transfer of Care in medical pathways week 1

- Reconfiguration of surgical bed base complete – initial metric review underway
- Reconfiguration of medical bed base – 1st August 2025 target date
- GP in ED relocation plan developed
- ECIST 12 patient pathway review this week – findings to inform next steps
- ED huddle relaunch – August 2025
- ED rota assessment – moving shifts to support delivery – from August 2025

Internal Professional standards

- Adopting GIRFT Acute Care Standards
- Divisions and Directorate developing gap analysis and implementation plans
- Circulated and socialised with clinical team
- Metrics and monitoring agreed – dashboard development

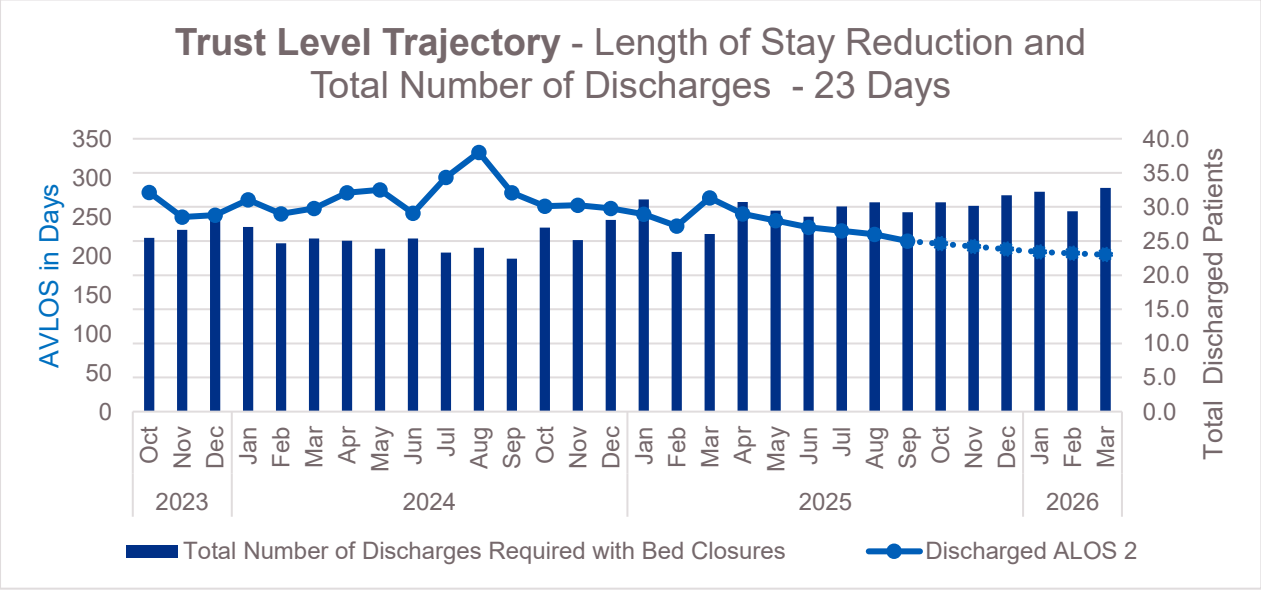
Herefordshire and Worcestershire Health and Care NHS Trust (HWHCT):

Delivering the System Wide Discharge Programme

- Returning to Discharge Assess for complex pathways **by September 2025.** This will contribute to reducing the number of patients waiting over 21 days within the Acute Trust Setting, by reducing community hospital length of stay by 2.3 days
- Delivery of bespoke in-reach services to Acute Frailty Unit (AFU)/Acute Medical Unit (AMU) and pulling patients from assessment areas ahead of admission to in-patient wards

Improving Community Bed Optimisation

- Phase 1, Length of Stay reduction programme in place – delivering reductions from 29 days LoS to 25 days LoS **commencing September 2025**
- Phase 2, Length of Stay reduction programme – delivering reductions from 25 days LoS to 23 days LoS **by March 2026**
- Stroke Rehab LoS programme in-place – delivering reductions from 42 days LoS to 30 days LoS **by March 2026**



Improving Urgent Community Response (UCR) responsiveness and increasing activity

- Planned 4% increase across UCR activity **through Winter 2025/26** to support:

- Wound Closure Pilot and roll out
- Hospital at Home activity
- Enhancing nighttime cover / effectiveness
- Further collaboration with the Single Point of Access and preventing ED attendances
- Optimise utilisation of UCR GP – leading to increased activity being accepted via the SPoA & WMAS portals

Children and Young People

- Sustained delivery of the children's community respiratory pilot, contributing to significant reductions in ED attendances **through Winter 2025/26**
- Increase in children's community nursing to support end of life patients ***through winter 2025/26***

Wye Valley NHS Trust: (WVT)

Valuing Patients Time Programme

The Valuing Patients Time 2025/26 plan has been designed by both clinical and operational leads, cross referenced against the UEC GIRFT checklist and aligned to the 2025/26 WVT UEC planning submission and the ICS Sustainable Future Programme around Frailty (Including end of life management).

Valuing Patients Time UEC workshops were held over May and June 2025 with MDT Clinical and Operational teams co-designed measurable tests of change to be delivered between 16th June – 11th July 2025.

High Level Aims:

Integrated Care Division • Rapid Emergency Assessment Care Team (REACT) implementation • Support delivery of Neighbourhood health • Support discharge processes (linked to D2A improvements reported via One Herefordshire) • Increase use of Community Integrated Response Hub and support increased Call before Convey / 111 referrals away from ED • Increase VW step up and IVOPAT	Medical Division • Ambulatory Care Improvements incl. UEC Bid & SDEC flow improvements • Criteria to Admit implementation • Internal Professional Standards and Length of Stay improvements • Strengthen Navigation at the Front Door to internal and external pathways • Deliver sustainable VW • Increase external referral to SDEC pathways
Surgical Division • Internal Professional Standards and Length of Stay improvements • Surgical SDEC optimisation	Clinical Support Division • Optimise Clinical Support Division contribution to opportunities for pre-hospital & acute floor pathways e.g CDC & Front Door Pharmacy

Specific Interventions: Urgent Community Response/ ED/Attendance Avoidance:

Priority	Service	Intervention
Increase UCR activity and enhance virtual ward capacity / utilisation VW- Primary Care step up FSDEC Bridging UCR/SPOA enhancements	Urgent Community Response – Admission/Conveyance/Attendance Avoidance Virtual Ward – Reducing LOS/Admission Avoidance	**Deliver Neighbourhood Health – Urgent Neighbourhood Services** Continue to increase activity utilising Call before convey/ED navigation/Call Before Admit/111 redirection/Support SDEC discharges Increase occupancy- remodel based on GIRFT recommendations to ensure occupancy maximised
Increase the number of patients receiving urgent care in primary , community and mental health settings PCN Frailty	Primary and Community Care – Admission Avoidance	**Deliver Neighbourhood Health- Multi Disciplinary approach** Avoid admissions by supporting patients at home through formal MDT approach at PCN level focusing on agreed cohorts

Specific Interventions / Milestones – Emergency Dept & Same Day Urgent Care:

Milestone	Action Owner	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
UEC Capital bid • ED walk around 22/05 to finalise plans. • Implementation by March 2026 (SDEC plans submitted within this)	Alan Dawson (SRO)								
Increase staffing to improve ED weekend flow • Increased Friday late Spdr shift from 11/04 and will 'watch & wait' to monitor improvements to weekend flow • ED medical staffing (night) business case transition plan to be costed up for exec sign off	SB								
SDEC Optimisation • Engage with Surgical Division for SDEC moves • Super SDEC related to UEC Capital Bid development • Re-socialise SDEC admission criteria & greater use of 'pull models'	DH/SB								
Remove FUPs in MSDEC • Review, refine and re-share SDEC criteria stopping all inappropriate referrals from 19/05 • Monitor Type 5 attendances to identify efficiencies (today's work today) • Possible workaround solution for SDEC referrals if permitted to upgrade Symphony • Move inappropriate SDEC procedures to MDCU/MRU	SB/JC								
Grip on Flow: Nursing • Nurse leadership in line with ED Nursing Business Case (B7 leadership/B6 NIC rotation) • Ambulance handover policy will be refreshed and go to PAG SOP 59/57 staff aware of and implemented • ED Practice Education nurse tasked with ongoing education of ED nurses									
Grip on Flow: Management • Reintroduced ED Capacity Role following adapted plans for March TOC • Reviewing roles & responsibilities for escalation & flow organisation wide incl. Medical Capacity role • Increased visibility of senior leadership in the ambulance triage area to facilitate earlier ambulance handover and improve patient flow and safety.	SB/LW								
Improve non-admitted performance • Local target 84%; ongoing internal validation. • Minors relocated to ED footprint following test of change. • Explore opportunities to increase capacity in ED (medical model BC) • Radiology conversations – Radiology runner as piloted in March 2024 TOC • Further work with specialties to reduce delays to be seen	SB/JC								

Specific Interventions: Flow

D2A Board- monthly oversight	Integrated Board with partners from system- monitor commissioned D2A services and drive improvement
Discharge delays – daily monitoring	Monitored daily for Herefordshire, Powys, Worcs, Shropshire and others by IDT management team Daily meeting with Hfdshire partners to review delays Weekly silver call with Herefordshire and Powys to review delays Fast track/CHC delays escalation direct to ICB Other counties- escalation via ICB if no plans

	Total	Herefordshire P1	Herefordshire P2	Herefordshire P3	Fast track	Powys	Worcs	Shrop	Other
Optimum Level s of Delays to maintain low 21day LOS / Low Bed Occupancy	22	5	3	4	0	7	1	1	1
Average delay position	38	6	6	5	2	12	2	2	3
Trigger for escalation outside of silver meeting	46	8	8	6	3	14	3	3	4

Priority	Service	Intervention
Reducing Levels of delayed discharges VW OPAT D2A Improvements	D2A-Reducing delays/LOS	Support Powys Transformational Programme to deliver improvements related to discharge delays-ring fencing capacity and access to Powys community services for SDEC capacity Continue to work with system to further improve D2A process with focus on bedded capacity Discharge follow up to prevent readmissions

7. System Functions

System Co-ordination Centre

This System Co-ordination Centre (SCC) specification builds on the previous version released in August 2023. It reflects the expansion of the national OPEL Framework and broad learnings following implementation of version 2.0.

The System Co-ordination Centre is open 7 days per week, 08:00am to 20:00pm.

- 'System' refers to Integrated Care System (ICS). The SCC provides an operational platform within the ICS for the whole health economy, including local authority, primary care, and voluntary, community and social enterprise partners.

- This SCC specification makes clear the purpose, key deliverables and minimum operating requirements, referred to as the Required Operational Standards (ROS), that all SCCs should meet.

- The SCC exists to be a central co-ordination function for providers of care across an ICS footprint, with the aim to support patient access to the safest and best setting possible

- As part of their role, SCCs will be responsible for the co-ordination of an integrated system response using the Operating Pressure Escalation Level (OPEL) frameworks alongside constituent ICS providers and ICB policies. The OPEL frameworks contain specified and incremental core actions for the SCC at each stage of OPEL escalation

- The SCC is responsible for facilitating interventions across the ICS on key systemic issues that influence **patient flow**. This would include a concurrent focus on UEC and the system's wider capacity including, but not limited to, NHS111, Primary Care, Intermediate Care, Social Care, Urgent Community Response and Mental Health services.

- The SCC is a constituent part of the ICB and, as such, should facilitate collaboration within the system through its operational and clinical leadership. It is important that the SCC is recognised as the ICB's 'real-time' forum for operational oversight, co-ordination, communication and decision-making.

Complementing the role of the SCC as defined in the OPEL Frameworks, the ICB will ensure that the SCC has a defined role within system policies, covering but not limited to:

- **Local provider Full Capacity protocol (or similar)** that seeks to maintain the timely flow of patients through the emergency department (ED), mental health, community settings and other parts of the health system. This may include the role of the SCC in brokering conversations between health and social care providers on identifying capacity to support providers within the ICS footprint at times of surge.

- **Protocols covering ambulance conveyance and handover pressures (or similar)** that ensures an effective response to increased pre-hospital demand, long waits in the community for ambulances and/or an incident that requires specialised resources. This may cover ambulance handover waits in excess of local and national thresholds.
- **Protocols covering access to mental health inpatient services (for all ages) or similar** that would specify system actions to mitigate risk of patient waits in excess of local thresholds, heightened clinical risk and poor patient

- **System communication policies or similar** that would cover the interface between the SCC and the ICB communication team. Enabling patient choice or providing guidance to the public during critical events or dates should be a key aim of a joint communications plan.

- **Inter-hospital and intra-hospital transfers or similar policies** that would cover the role of the SCC in monitoring, actioning and escalating cases of patients awaiting specialised care or return to local hospital or place of care in excess of local and national thresholds. It would also define a minimum level of information required to support with such transfers.

- **Incident management including Emergency Planning Resilience and Response (EPRR)**, ensures that the role of an SCC is outlined in the ICB Incident Response Plan and describes how it will provide real-time data and system intelligence to the Incident Co-ordination Centre (ICC)

- **Protocols covering escalation of primary care pressures** that seek to ensure patients who can be treated in primary care remain in primary

- **Protocols covering access to intermediate and social care including escalation of issues** to ensure a joined-up approach to co-ordination of actions in the wider system, and to support with delays for patient transfers. This may also cover interface between the SCC and Transfer of Care Hubs, and access to intermediate care data collections to support monitoring of discharge delays and balancing of risk within the system

Operational Pressures Escalation Levels (OPEL) 2024-2026

The NHS Constitution of England establishes the principles and values of the NHS, outlining the rights of patients, the public and staff. It sets out the rights to which patients, the public and staff are entitled. Patients always come first in everything we do, and the welfare of staff providing and supporting this care should also be prioritised. The OPEL framework supports this and ensures patients get the right treatment in a timely manner and support staff within organisations to respond consistently to operational demands.

This 2024 to 2026 framework for the management of operational pressures is for NHS acute trusts, community health service (CHS) providers, mental health (MH) service providers, NHS 111 providers, ICSs, and NHS England regional and national teams. Throughout this document we collectively refer to NHS acute trusts, NHS CHS providers, NHS MH service providers and NHS 111 providers as ‘providers’, but differentiate specific types of providers where necessary.

This framework provides the core parameters that each of these types of provider must use to determine their OPEL. It also details the process for aggregating the OPEL scores for ICSs, NHS England regions and NHS England nationally. This ensures the operational pressures across all levels of the NHS in England are consistently and accurately represented.

Changes from the 2023/24 OPEL framework

In developing this iteration, we have considered feedback and wider consultation on the previous framework, undertaken empirical testing and collaborated with a broad and expert range of system and provider representatives from across the NHS. We have also taken account of progression within the Urgent and emergency care (UEC) recovery plan and 2024/25 priorities and operational planning guidance.

The significant changes from the 2023/24 version are:

- Comprehensive revision of the existing acute OPEL parameters, including their definitions, scores and weighting, to ensure they continue to give an accurate and reflective representation of current needs

- Updated proportional representation for acute OPEL using the latest emergency department (ED) attendance data to accurately reflect the current proportionality

- Introduction of 3 new pillars of OPEL, with new OPEL parameters for MH services, Community Health Services (CHS) and NHS 111 as well as the actions to be taken in response to changes in operational pressures within these pillars

- Introduction of a process for OPEL score normalisation to provide consistent OPEL scoring across all pillars and organisations using OPEL

- Implementation of an overall ICS OPEL score based on the parameter scores for the acute, CHS, MH and NHS 111 pillars. This provides an aggregated overview of the operational pressures across the ICS using a consistent scoring method, as well as an indication of the OPEL for each pillar

- Updated actions for acute trusts, ICSs and NHS England regions to ensure they remain effective and aligned with the current and evolving operational requirements

The system escalation plan is enclosed below.

Worcestershire
System Escalation Ma

Integrated OPEL framework scores
The Integrated OPEL framework 2024 to 2026 assesses operational pressure for the 4 pillars of the UEC pathway using a set of parameters for each. This produces a numerical OPEL score and corresponding ‘escalation level’ from 1 to 4. Compared to the OPEL framework 2023/24, this updated framework is an iterative step towards a whole ICS representation of system pressure and will produce the following scores:

ICS overall OPEL score
This is derived from parameters across the acute, mental health, and community health service OPEL pillars and is based on proportional representation of each ICS using ONS population data. NHS111 is a standalone pillar and does not contribute to the integrated OPEL score.

The table below shows the normalised OPEL score ranges, their corresponding operational pressure escalation level and an indication of the clinical risk for each level. The ranges and corresponding escalation levels are standard across every pillar of OPEL, ICSs and NHS England, both regional and national.

(Normalised) OPEL score	Corresponding escalation level	Clinical risk
0–15	OPEL 1	Low
>15–40	OPEL 2	Medium
>40–70	OPEL 3	High
>70–100	OPEL 4	Very high

Acute OPEL Parameters

Parameter	0 points	1 point	2 points	3 points
1. Average ambulance handover since midnight (minutes)	<15	15-30	>30-60	>60
2. Current 4-hour ED performance percentage (percentage)	**>95%**	**>78-95%**	**>60-78%**	**≤60%**
3. Current ED majors and resus occupancy (percentage)	**≤80%**	**>80-90%**	**>90-100%**	**>100%**
4. Current median time to treatment since midnight (minutes)	**≤60**	**>60-120**	**>120-240**	**>240**
5. Patients in ED over 12 hours (percentage)	**≤2%**	**>2-5%**	**>5-10%**	**>10%**
6. Patients in ED referred to service (percentage)	**≤2%**	**>2-5%**	**>5-8%**	**>8%**
7. Bed occupancy (percentage)	**≤85%**	**>85-92%**	**>92-98%**	**>98%**
8. Patients no longer meeting Criteria to Reside (percentage)	**≤10%**	**>10-15%**	**>15-20%**	**>20%**
9. Patients discharged (percentage)	**>30%**	**>20-30%**	**>10-20%**	**≤10%**
10. Beds closed due to infection prevention control (percentage)	**≤0.5%**	**>0.5-2.5%**	**>2.5-5%**	**>5%**

Community OPEL Parameters

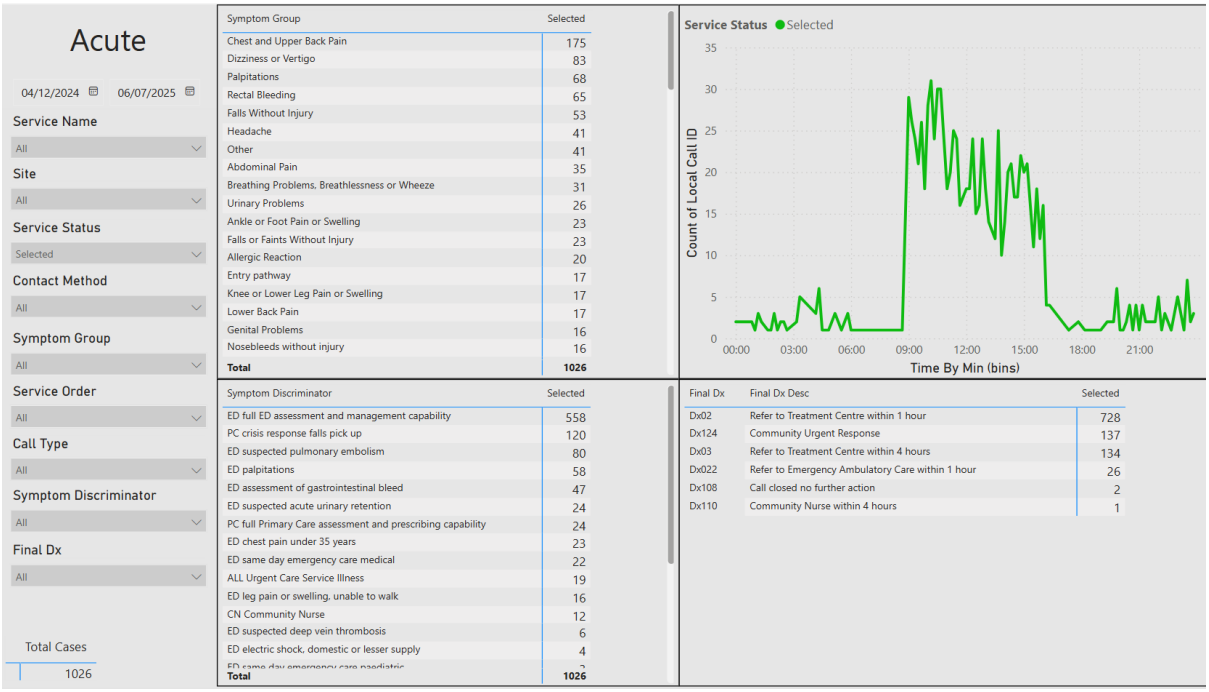
Parameter	0 points	1 point	2 points	3 points
11. Community bed occupancy (percentage)	≤85%	>85-92%	>92-98%	>98%
12. No longer meeting criteria to reside (percentage)	0-5%	>5-15%	>15-25%	>25%
13. Virtual ward occupancy (percentage)	<80%	≥80-90%	>90-95%	>95%
14. Pathway-2 capacity and flow (percentage)	>100%	>90-100%	>80-90%	≤80%
15. Community nursing caseload vs scheduled (percentage)	>95-100%	>85-95% OR >100-105%	>75-85% OR >105-110%	≤75% OR >110%
16. Intermediate care contacts vs scheduled (percentage)	>95-100%	>85-95% OR >100-105%	>75-85% OR >105-110%	≤75% OR >110%
17. UCR 2-Hour response (percentage)	>80%	>70-80%	>60-70%	≤60%

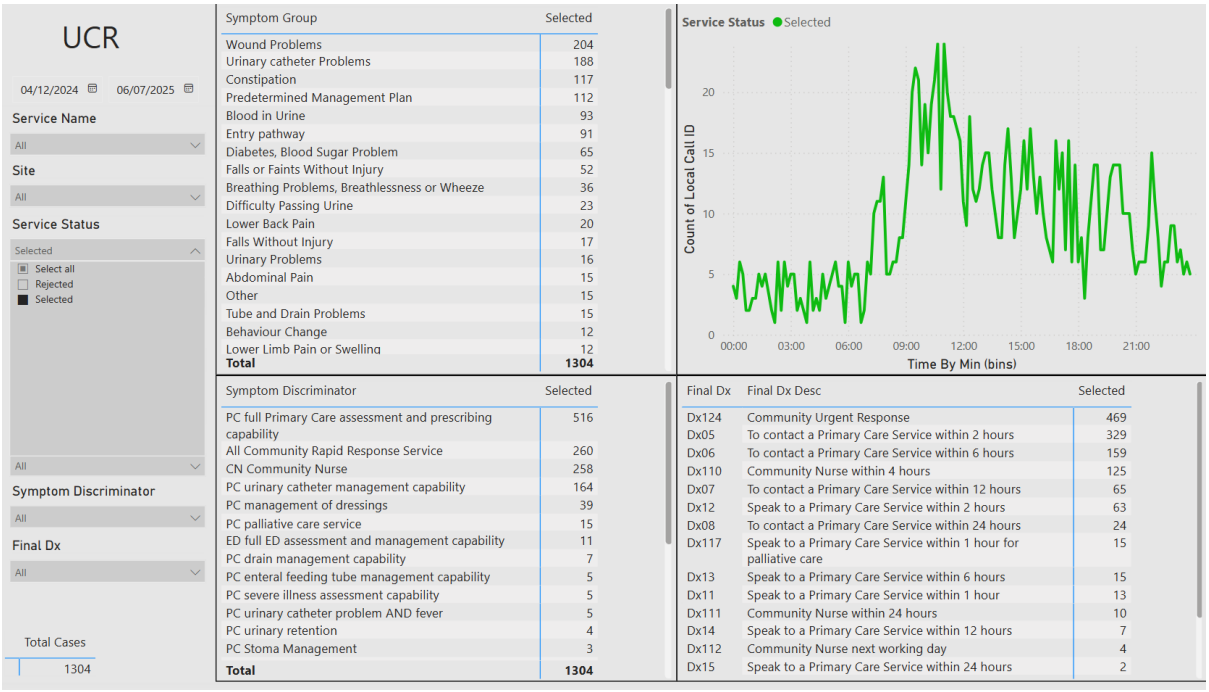
Mental Health OPEL Parameters

Parameters	0 points	1 point	2 points	3 points
18. Bed occupancy – adult mental health	≤85%	>85-95%	>95-98%	>98%
19. Bed occupancy – older adult mental health	≤85%	>85-95%	>95-98%	>98%
20. Patients clinically ready for discharge	≤10%	>10-15%	>15-20%	>20%
21. Inappropriate out of area placements	0	1 – 5	6 – 15	>15
22. Planned mental health discharges	>3%	>2-3%	>1-2%	≤1%
23. Achieved mental health discharges	>3%	>2-3%	>1-2%	≤1%
24. Mental health beds closed to admission – adult and older adult	≤0.5%	>0.5-1.5%	>1.5-3%	>3%
25. Patients waiting for mental health inpatient admission (percentage of beds)	≤1%	>1-5%	>5-10%	>10%

Directory of Services

The ICS has a comprehensive Directory of Services (DOS), to support access to all urgent care services and pathways. The directory of services is regularly reviewed and plays a critical part in ensuring the appropriate use of alternative services other than the Emergency Department.





SHREWD, SHREWD Action, SHREWD Reporting

SHREWD: Single Health Resilience Early Warning Database

What is SHREWD Resilience?

- SHREWD Resilience is a real time view of system pressure, which informs system response and individual provider actions
- SHREWD Resilience enables front line teams and operational leaders including the ICB to identify ‘where’ pressure is across the health system within a few seconds
- Data is captured live or in real time wherever possible and shared with all providers across the health economy
- Data is accessible on any computer, smart phone, or tablet

What is SHREWD Action & Reporting?

In addition to the existing SHREWD Reporting suite, VitalHub UK will also provide the advanced Insights functionality as part of the existing package, this will include the following:

SHREWD Pulse Checker (Real-time KPI vs Forecast)

The Pulse Checker report provides a near real-time view of key performance indicators, across all providers in the ICB, offering hourly updates to track and compare metrics against three benchmarks: the previous day, the same day last week, or the forecasted values. This dynamic tool is designed to deliver quick insights into current performance trends, enabling users to identify patterns, spot anomalies, and make data-driven decisions promptly.

SHREWD Insights (Monthly / Weekly Performance Report)

SHREWD Insights delivers monthly activity and performance analysis reports straight to your inbox. Utilising data from the SHREWD system, our service will provide a semi-bespoke presentation style report, with highlights, charting and narrative on performance and data trends across the ICB. The data can be displayed in a variety of chart formats and analysed at a Site, Trust or ICB level.

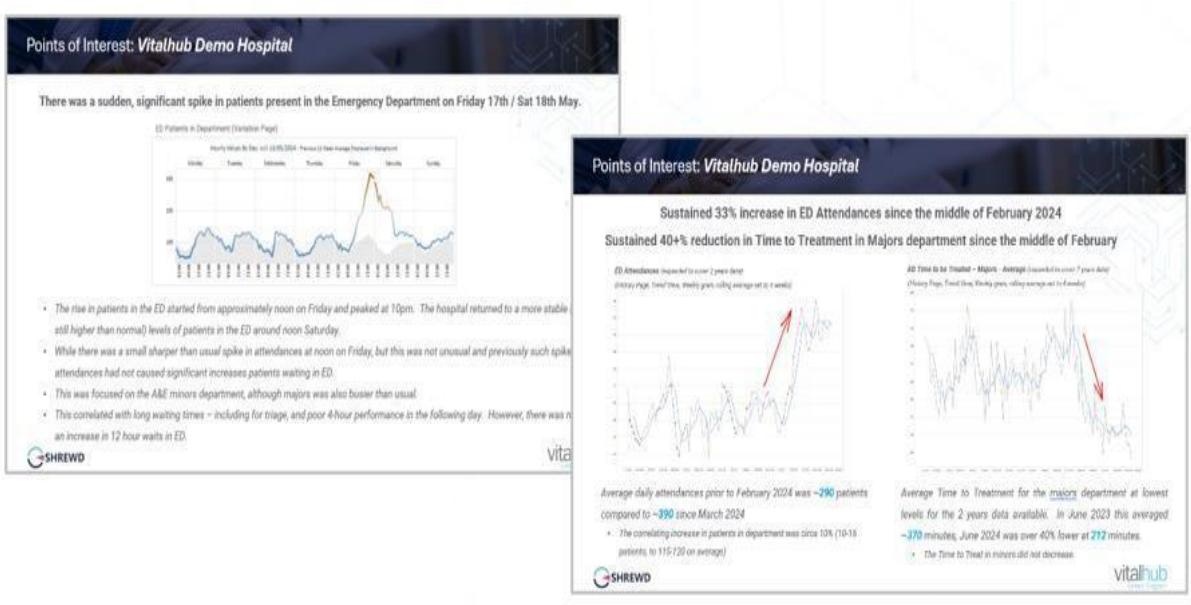
SHREWD Health Check (Quarterly Deep-Dive Review)
Our analytics team conducts a comprehensive review of SHREWD data each quarter, focusing on two key areas to ensure optimal performance and data integrity:

1. Performance Insights:

We identify and analyse notable trends and performance outliers from the past three months. Our team provides detailed narratives and expert commentary to highlight key themes and opportunities for improvement.

2. Data Quality Assurance:

We proactively detect any data issues related to key indicators, particularly where data may be incomplete or inaccurate. Our team offers actionable recommendations to resolve these concerns and enhance data reliability.



Business continuity arrangements

All NHS organisations have a duty to put in place business continuity arrangements and have a Business Continuity plan, under the Civil Contingencies Act 2004 and the Health and Social Care Act 2012. The NHS England Core Standards for Emergency Preparedness, Resilience and Response (EPRR) set out these requirements for all organisations. This means that services should be maintained to set standards during any disruption or recovered to these standards as soon as possible.

Business continuity management (BCM) ensures organisations have a framework in place for identifying and managing risks that could disrupt normal service due to different scenarios i.e. Adverse weather (cold and heat), its outage, power outage etc. The holistic process of business

continuity management is an essential requirement to establish an organisation's resilience, to ensure providers of NHS funded care meet their business continuity management obligations.

For winter 2025/26 a further review of these plans will be undertaken as preparedness across the system.

Please see below the SCC business continuity plan

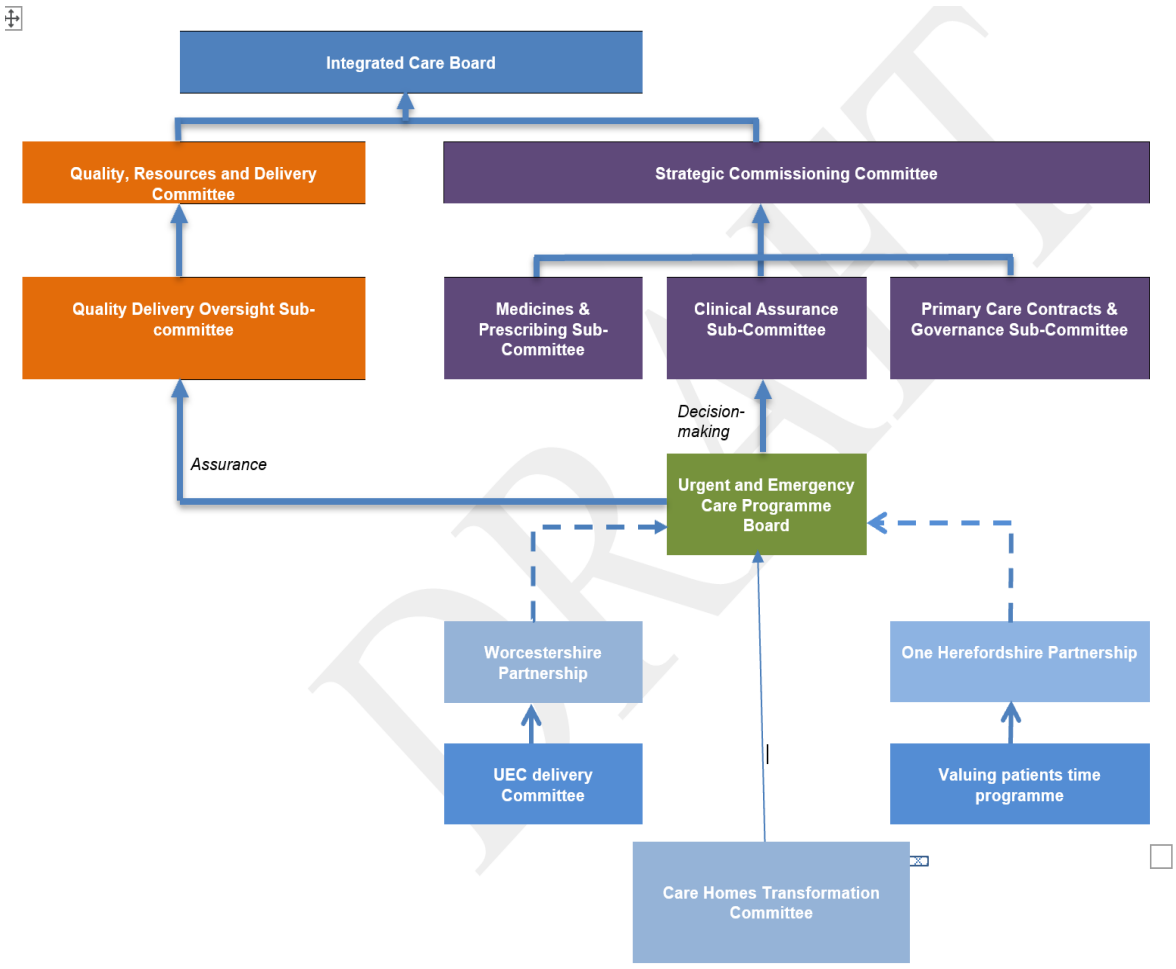
2025.05.08 HWICB UEC_PMO_SCC Team

8. Governance Arrangements for Winter 2025/26

The ICS Urgent Care Board has strategic responsibility for ensuring that the system has robust plans for local delivery of Health and Care consistently throughout the year, in accordance with National Health and Care standards, and in compliance with statutory frameworks. Each place-based system via its urgent care/general committees will be focused on performance, quality and safety in urgent care and patient flow during winter and beyond and is accountable to the Hereford and Worcestershire ICB Board.

As shown in the reporting structure for the ICB Board below, each place has their own UEC place based governance arrangements, with the UEC delivery committee in Worcestershire also framing the Worcestershire system's formal Tier 1 response.

Reporting and Relationships:



The terms of reference for H&W UEC ICS Board are enclosed below.

ICS UEC Board - ToR April 25 .docx

9. ICS Communications

All partners across Herefordshire and Worcestershire agree that a joint system approach has been successful since 2017/18 and remain committed to adopting a single plan.

A local communications plan has been co-produced with ICS partners communication leads and sets out the approach for communicating and engaging with patients, public and stakeholders.

It will support the National campaigns as well as include locally designed campaigns.

This system winter communications plan has three main aims:

- **Prevention** - Support on preventing avoidable health complications by keeping people well this winter
- **Where to go for help** - Supports urgent and emergency care pressures by promoting alternative services
- **Our staff will understand the Winter plan –** Detailed ICS staff comms plan explaining what we are doing and feedback from winter planning sessions

Objectives:

- Amplify national campaign messaging – Help Us Help You (vaccines, cancer, pharmacy, NHS111)
- Promote winter preparedness – 6 Things (people can do themselves), Use the Right Services local campaigns
- Raise awareness of ways to access General Practice and Pharmacy First (MDTs, online/digital access, pharmacy and NHS App)

We will be **relaunching** our two successful campaigns related to reducing the risk, largely to the frail elderly of keeping people in hospital for any longer than needed. This campaign will be agreed at the September ICS UEC board and rolled out between October 2025 and February 2026 across the ICS.

Campaign materials:

10. ICS Monitoring, Evaluation and Risks

The Winter plan is produced at a point in time and the operational position, including activity numbers and predicted demand may change at any point due to the varying challenges our system experiences.

All organisations should continue to produce their own operational plans for how organisations plan to manage winter.

The Winter Plan will be monitored via:

- Weekly monitoring of the Winter Plan, including system winter initiatives via the weekly winter directors meeting, which will review performance and impact of the winter plan.
- Weekly monitoring of UEC KPIs across the ICS.
- Use of the Integrated System UEC Dashboard.

Evaluation

A formal review on winter plan progress will be undertaken in January 2026.

To support this

- A further point prevalence study will be undertaken in September 2025
- A further 3 ED audit will be undertaken in February/March 2026

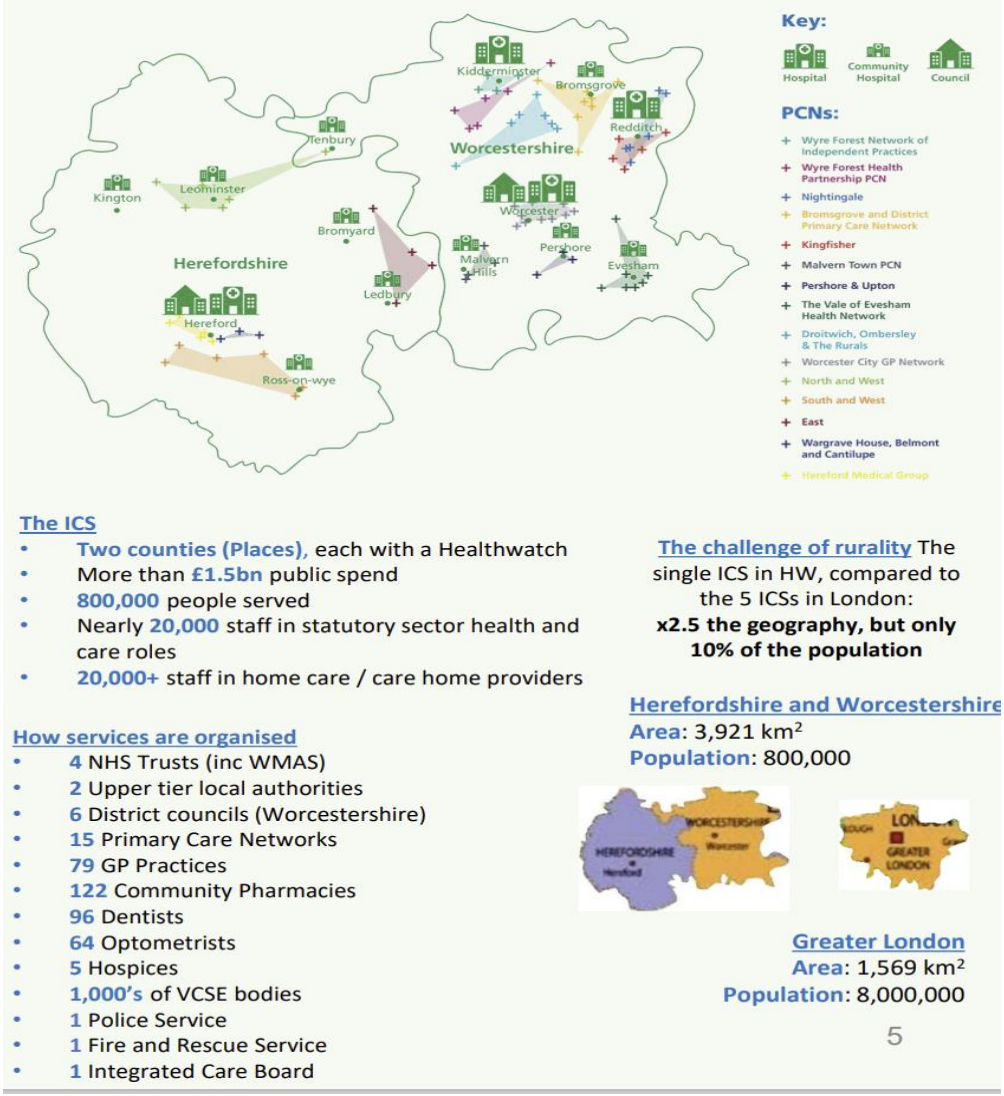
Key winter plan risks and mitigation

Risk	Mitigation
Unknown schedule of industrial action over the winter period	Maintain same effective approach to planning and EPRR system wide process over winter
Financial recovery of system related to UEC with reduced bed numbers/spaces over winter	To ensure full delivery of Place based UEC plans, with particular focus on returning to discharge to assess

11. Appendix 1 – Overview of ICS and Partner Profiles

Overview of ICS

Our system comprises of a variety of NHS bodies, local authorities, primary care providers and other organisations who together spend more than £1.7bn on providing health and care services.



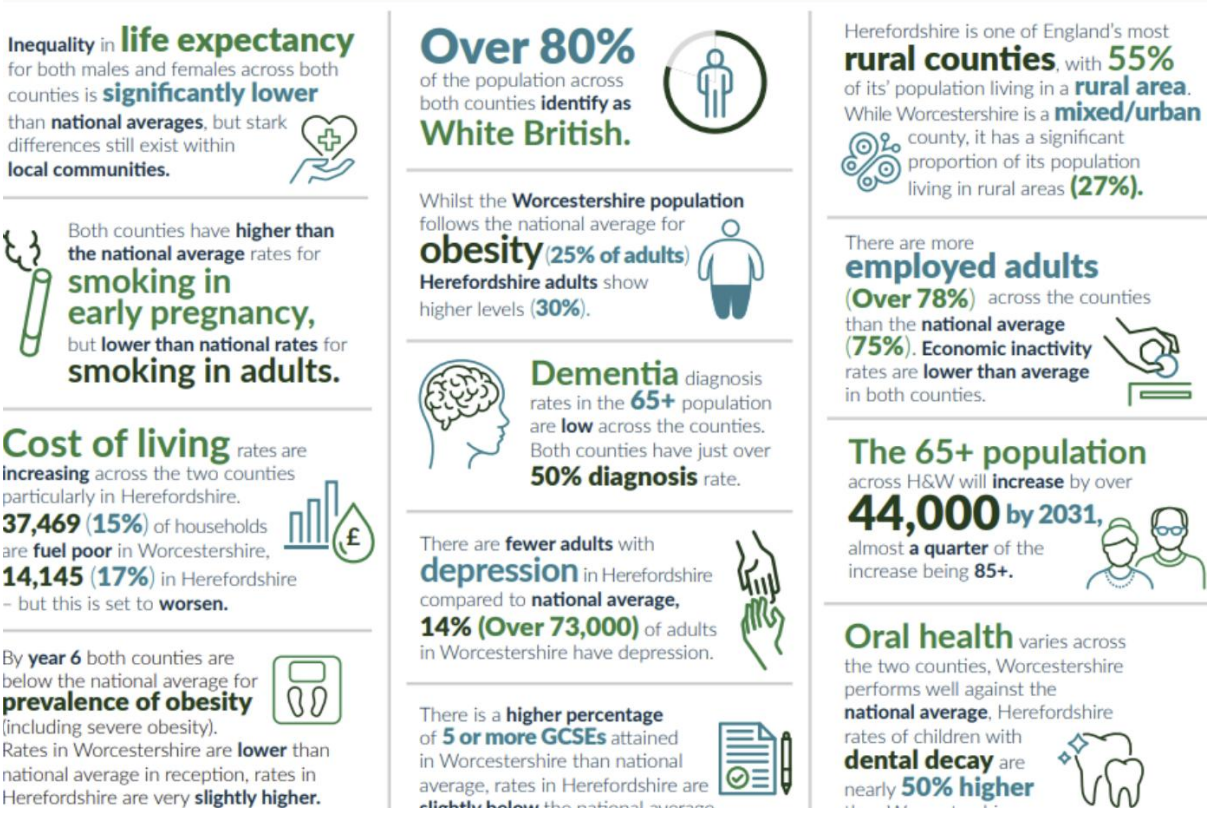
Our system is sparsely populated, covering 1,500 square miles with significant rural areas bringing challenges for travel and access to services for some citizens, as well as being a low wage economy and a cold spot for social mobility. This is in the context of a relatively high, and increasing, proportion of our population being aged over 65 compared with regional and national figures.

We have developed our ICS operating model around the principle of subsidiarity and local partnerships.

There are two 'places' in the ICS and these are aligned to upper tier local authorities. Herefordshire Council and Worcestershire County Council. In Herefordshire, the partnerships are built around 5 Primary Care Networks (PCNs) and a local partnership board called One Herefordshire Partnership (OHP). In Worcestershire, the partnerships are built around 10 PCNs working alongside 6 District Collaboratives, coming together under the support of the Being Well Strategic group, a

subcommittee of the Health and Wellbeing Board and working with the Worcestershire Place Partnership.

Across the ICS we employ over 37,000 to deliver health care services. In addition, there are 1,400 jobs in adult social care, directly employed by the local authorities. We also have a vibrant voluntary and community sector, alongside high levels of volunteering and social capital.
The national challenges for health and social care providers are well documented. Our system, in common with others, continues its recovery journey following on from the Covid-19 pandemic.



Overall, there has been an increase in demand and complexity of need across many services. At the same time the population is ageing, with an estimated 44,000 more over 65 years olds living in H&W by 2031, over a quarter of the increase being over 85-year-olds. We know that in general older people need more access to health and care services.

Social care continues to experience increased demand and complexity of need. Promoting independence and supporting people to live within their own homes/local community is key. The increasing demand across the system presents challenges to maintain the core principles of the Care Act 2014- namely to prevent, reduce or delay an individual's needs.

Primary Care continues to see record numbers, with offered appointments being the highest across our regional peers, wating times are on the decrease for Cancer and elective care and Urgent & Emergency Care (UEC) performance is more stable than at any-point over the last 5 years.

ICS partners

Worcestershire Acute Hospitals NHS Trust

Worcestershire Acute Hospitals NHS Trust provides hospital-based services from three main sites - the Alexandra Hospital in Redditch, Kidderminster Hospital and Treatment Centre, and Worcestershire Royal Hospital in Worcester provide a wide range of services to a population of more than 600,000 people in Worcestershire as well as caring for patients from surrounding counties.

Last year, they provided care to more than 250,000 different patients – that is over 40% of the Worcestershire population that received care at one of our hospitals.

- 170,000 A&E attendances
- 143,000 Inpatients
- 670,000 Outpatients
- 4,600 births
- 4,700 babies
-

They employ over 7,500 people and around 400 local people volunteer with them helping to deliver care. They have an annual turnover of over £400 million.

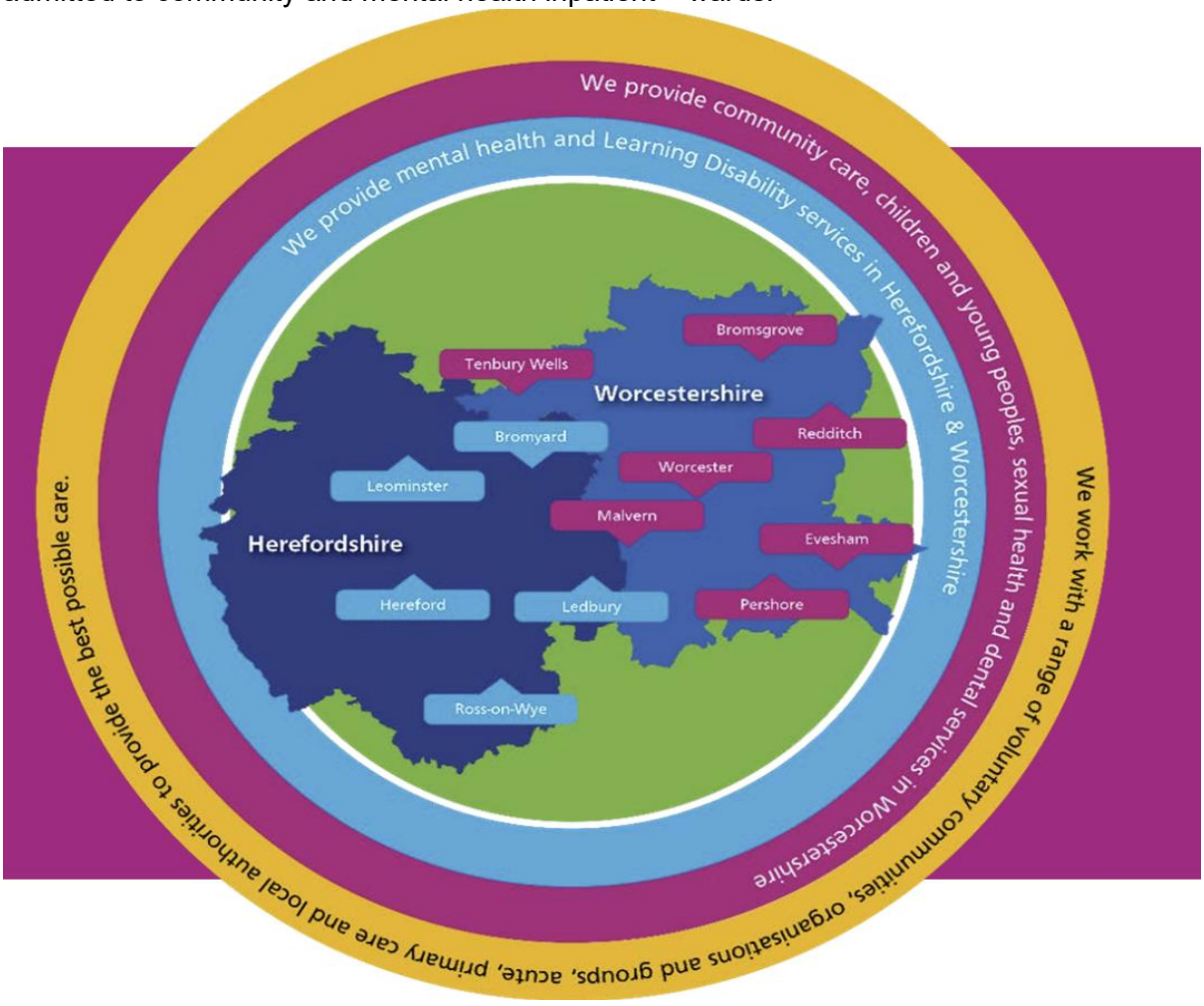
In 2024, Worcestershire Acute Hospital's Trust joined the Foundation Group family of South Warwickshire NHS Foundation Trust, Wye Valley Trust and the George Elliot Trusts. Since joining the Foundation Group, they have identified ten priority areas which are the focus of our current work and which help staff in all parts of the Trust to understand the part they have to play in delivering and sustaining improvements, with flow and HomeFirst mindset being extremely key in relation to UEC.

Herefordshire and Worcestershire Health and Care NHS Trust

Across Herefordshire and Worcestershire the trust provide mental health and learning disability services for children, adults, and older people. Care is provided in the community, in clinics, inpatient wards and through crisis services.

In Worcestershire, the trust also run local community hospitals, recovery units and minor injury units, and deliver nursing and therapy care in people's homes, care homes and other community centres. The trust provides children's paediatric services deliver a range of 'early years' support, including health visiting and school health nursing. They also run sexual health services through a combination of clinic and outreach teams and provide community dental care for people who may need some additional or more urgent care.

During 2024-25, the Trust received 1,169,435 patient contacts, of which 369,145 were contacts to mental health services, while 41,830 patients visited the trust MIU's, and over 3,000 patients were admitted to community and mental health inpatient – wards.



Wye Valley NHS Trust

Wye Valley NHS Trust is the provider of healthcare services at Hereford County Hospital, which is based in the city of Hereford, along with a number of community services for Herefordshire and its borders. The Trust provides healthcare services at community hospitals in the market towns of Ross-on-Wye, Leominster and Bromyard.

The Trust has a workforce of around 4,290 providing a range of specialist and generalists functions. The Trust has strong clinical network connections with trusts in Birmingham, Worcester, Gloucester and Cardiff. The Trust provides community care and hospital care to a population of approximately 195,000 people in Herefordshire and a population of more than 40,000 people in mid-Powys, Wales.

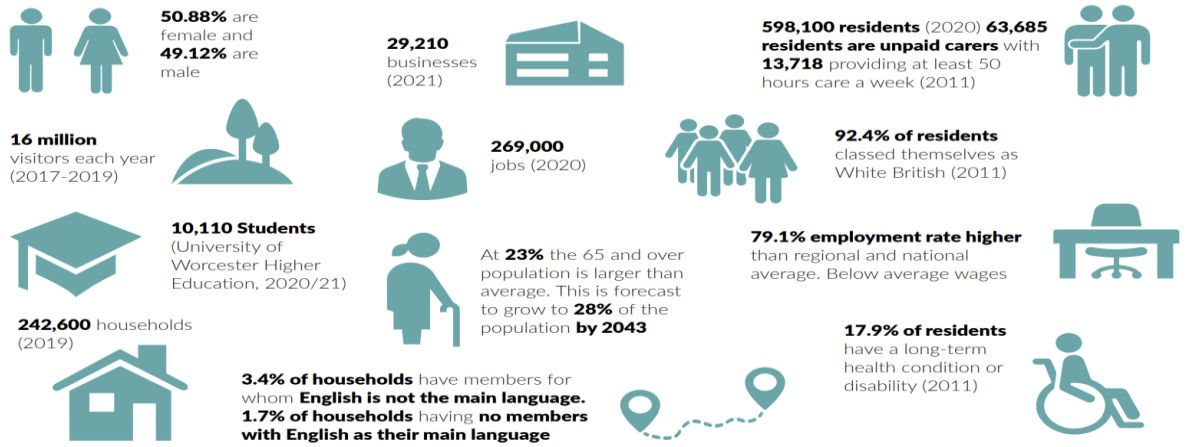
The Trust's catchment area is characterised by its rural nature and remoteness, with over half (53 per cent) living in areas defined as 'rural', with the majority of these (42 per cent of the total) in the most rural 'village and dispersed' areas. Just under a third of the population live in Hereford city. The Trust is the only secondary care provider for an area where the average age of the population is older than the national average. This demographic is driving health and social care needs that are often more complex than in areas where the average age of patients is lower.

Worcestershire County Council

Promoting...
Health & Wellbeing

Ensuring good Health and Wellbeing for our residents remains a key priority for the Council. We'll work ever more closely with residents and communities to encourage active lifestyles, enabling people to live longer, healthier and happier lives. Our work with the NHS and other care partners through the Integrated Care System will help co-ordinate our services and ensure residents receive the right care at the right time to meet their needs.

Worcestershire is a prosperous area where residents have high expectations for good quality services. However, we also have areas of significant deprivation within our communities where customers rely on us to provide the support they need.



Healthy life expectancy in years of Worcestershire residents (England av. 64.7)	Increase in the % of physically active residents (England 63.7%)	Increase in the number of people aged 65+ living independently for longer	People who meet the service definition of 'housing with support'.	Permanent residential/ nursing placements per 100,000 people aged 65+
63.42	63.7%	2.3%	815	545.79
2021 to 2023 (latest figure)	2023/2024 (latest figure)	2024/2025 Quarter 3	2024/2025 Quarter 4	2024/2025 as at 28th Feb

"'Worcestershire residents are healthier, live longer, have a better quality of life, and remain independent for as long as possible. We will work together with partners and communities to enable Worcestershire residents to make responsible choices, when planning their lives to achieve the best possible outcomes. We will enable individuals to become or remain independent, self-reliant and an integrated part of their local communities."

In order to help people to achieve these goals we recognise that adult social care has an essential role to play:

- Helping people to stay healthy and supported to live in their local community with choice and control
- Providing information and services to help prevent and postpone the need for care and support and educate people about the choices they may have if they do need care
- Ensuring social care is responsive to residents' needs and is seamless between different parts of the system
- Buying and providing services that are safe and ensuring people are satisfied with the quality of their care and support

Herefordshire County Council

Herefordshire Council was established in April 1998 and took over the responsibilities of South Herefordshire District Council, Herefordshire City Council and Hereford-Worcester County Council and some of Leominster District Council and Malvern Hills District Council.

Herefordshire is big hearted, welcoming and friendly. We have strong and independent communities and idyllic countryside, situated in the South West Midlands and bordering Wales. The county sits between Worcestershire and the Malvern Hills to the east, and Bannau Brycheiniog (the Brecon Beacons) in Wales to the west. Historically Herefordshire has been the gateway to the Marches.

What you told us

The council's plan has been developed with residents, partners and stakeholders across the county.

We consulted widely to gather feedback on our priorities for the next four years. We held in-person and online events, along with a survey on the council's website.

Nearly 1,000 people took part in the consultation over 20 direct engagement events including voluntary and community groups, parish and town councils, the sixth form college and a wider range of groups.

Top five objectives

The top five objectives that participants felt should be responded to most urgently were:

1. Support people to feel safe and respected in their communities.
2. Ensure that residents can live healthy lives within their communities.
3. Value nature and uphold environmental standards.
4. Tackle inequality and facilitate social mobility by focusing on early intervention and prevention activities that enable people to live independent and fulfilling lives.
5. Expand and maintain the transport infrastructure network in a sustainable way to improve connectivity across the county.

People - Helping the most vulnerable is important - help those who need it

Place - Tackling pollution of the River Wye, making the built environment more attractive

Growth - Road infrastructure needs to happen before employment land is developed to enable growth in a sustainable way

Transformation - Departments working better together, for the customer