SHROPSHIRE HEALTH AND WELLBEING BOARD
Report

Meeting Date	13th February 2025					
Title of report	**Winter Resilience**					
This report is for (You will have been advised which applies)	Discussion and agreement of recommendations		Approval of recommendations (With discussion by exception)	x	Information only (No recommendations)	
Reporting Officer & email	Ian Bett, Interim Chief Delivery Officer, NHS Shropshire, Telford & Wrekin Integrated Care Board ian.bett2@nhs.net					
Which Joint Health & Wellbeing Strategy priorities does this report address? Please tick all that apply	Children & Young People		Joined up working	x		
	Mental Health		Improving Population Health			
	Healthy Weight & Physical Activity		Working with and building strong and vibrant communities			
	Workforce		Reduce inequalities (see below)			
What inequalities does this report address?						

Report content - Please expand content under these headings or attach your report ensuring the three headings are included.

1. **Executive Summary**

   This paper provides the Board an update on update on the winter pressures being experienced on our Urgent & Emergency Care (UEC) pathway and our system response to date.

   December has been particularly challenging with sustained and increasing pressure that overmatched our ability to respond, necessitating declaration of a system-wide Critical Incident on 3 Jan 25 that de-escalated on 5 Jan 25 having decisively achieved the effects required.

   Our Winter Plan approved by the Integrated Care Board on 27 Nov 24 highlighted predicted pressures on acute bed within January 2025. Actions and mitigations continue to be enacted and remains appropriate to meet the challenges as far as practicable within our resources

2. **Recommendations**

   The Health & Wellbeing Board is recommended to note progress and plans in relation to resilience and management of risk for the coming winter.

3. **Report** - attached

Risk assessment and opportunities appraisal (NB This will include the following: Risk Management, Human Rights, Equalities, Community, Environmental consequences and other Consultation)	The pressures both nationally and upon our system UEC pathway – particularly during the onset of winter – are severe and it has been somewhat normalised to be static at a high level of escalation. We continue to work hard to break that cycle, with closer control of identifying and pursuing de-escalation at the earliest opportunity.
Financial implications (Any financial implications of note)	Integrated Care Board Winter budget circa £725k

Climate Change Appraisal as applicable	Not applicable	
Where else has the paper been presented?	System Partnership Boards	The Integrated Care Board has received the contents of this paper on 27 Nov 24 and 29 Jan 25.
	Voluntary Sector	
	Other	
List of Background Papers (This MUST be completed for all reports, but does not include items containing exempt or confidential information)		
Cabinet Member (Portfolio Holder) Portfolio holders can be found here **or your organisational lead e.g., Exec lead or Non-Exec/Clinical Lead**		
Appendices Appendix A – System Winter Resilience Report 2024-25		

System Winter Resilience 2024-25

1. Introduction

1.1. This paper provides the Health & Wellbeing Board an update on the improvements that are being made within our Urgent & Emergency Care (UEC) pathway, and the plans and activity associated across the system to mitigate the increased demands over the winter months.

2. Planning for winter

2.1. **Governance of UEC Quality & Performance**.

2.1.1. The UEC Delivery Group is accountable to the Integrated Care Board for the delivery of quality of care and operational performance, which is monitored by ICB sub-committees as appropriate and the Joint Health Overview and Scrutiny Committee. The ICB approved the System Winter Plan at the 27 Nov 24 public Board meeting. JHOSC received an update on Winter Preparedness on 16 Dec 24.

2.1.2. The UEC Delivery Group set the direction for our approach to winter at the 24 Sep and 22 Oct 24 meetings, with reaffirmed resolve that delivering the quality of care we require is our primary aim; when we get that right, performance is delivered and the contribution to our financial objectives follows. In practical terms, we need to decompress our Emergency Departments (EDs), which:

- improves safety, quality of care and patient experience;
- reduces the waiting time for patient progress through the departments;
- reducing the number of 12 Hour length of stay waits, improvement in 4 Hour performance is then achievable; and
- reduces reliance upon escalation beds or temporary escalation spaces, at additional cost.

2.2. **UEC Improvement programme**. Our system-wide improvement programme was agreed with NHS England regional and national support in Apr 24 as being the most appropriate and impactful to recover our position. A summary is at Appendix 1. The five workstreams areas of focus are:

- Improving 4 hr Performance in length of stay in our EDs
- Improving ward processes and internal professional standards
- Providing Alternatives to ED
- A system-wide focus on Frailty
- Improving System Discharge

2.3. **Winter 2024/25**

2.3.1. **The national approach** to winter this year was set out in the NHSE winter priorities letter that was issued on 16 Sep 24, outlining actions for ICBs and providers for winter and the second half of the Year to Mar 25. The shift of

emphasis and spending intentions signalled by the new government is manifest in there being no additional funding for winter this year.

2.3.2. **Our system approach to winter**. Our system approach is summarised in Appendix 2. We continue to deliver the process improvement impact from our existing programmes of work in our UEC pathway. We do not have the ability to generate additional beds in or out of hospital. Moreover, we have an imperative to close the remaining escalation beds/spaces to deliver safe care and contribute to our Financial Improvement Programme. However, within current resources we have revised command & control arrangements through our System Coordination Centre, with a revised daily rhythm of management and oversight of daily pressures. We continue to develop a more dynamic risk assessment methodology, clinically led, to identify and mitigate relative areas of pressure across the pathway.

2.3.3. **Our ICB funded winter schemes**. Our funded interventions this year are, therefore, complementary to the existing programmes of work and to focus upon what is not in an existing programme but nevertheless needed to respond to the additional pressures anticipated through the winter period. These aims can be achieved by targeting effects with interventions to achieve the following effects:

- ED attendance avoidance
- Earlier facilitated discharge with reduced length of stay, supported by our partnership with the British Red Cross
- Earlier in the day discharge to provide flow, including additional patient transport
- Communications to inform and influence our public and patients
- Enhance our operational pressures decision support mechanism

2.3.4. **Additional winter mitigations**. The UEC Delivery Group considered all the factors above at the meeting on 22 Oct 24. It was concluded that the programme of work is focused in the right areas but confirmed our belief that the attainable trajectories from our existing programme could be at risk due to increased demands and therefore at risk of delivery without further interventions. Opportunity areas with high impact potential were identified as additional winter mitigations. They do come at a cost, and funding opportunities are being sought both locally, regionally, and nationally to:

- Expand what we have that works.
- Reinstating service areas for their intended purpose, such as unbedding assessment areas.
- Enhancing our options for alternatives to admission, to community care settings.
- Strengthening the support from our specialist orthopaedic hospital, RJAH, to SaTH.
- Revisiting pathways between our acute hospitals and our recovery & rehabilitation units, with a particular focus upon Frailty

3. Current situation

3.1. **Operational Performance**. There are two key performance criteria that are indicators of pressure – ambulance handover times and the length of stay of our patients in our

Emergency Departments (EDs). In neither have we achieved the levels we want for our patients.

3.1.1. **Demand for our UEC services**. A key indicator of the complexity of demand is the proportion of patients classified as 'Majors' – with serious and life-threatening conditions. There has been a sustained increase in the final third of December as shown in Figure 1:

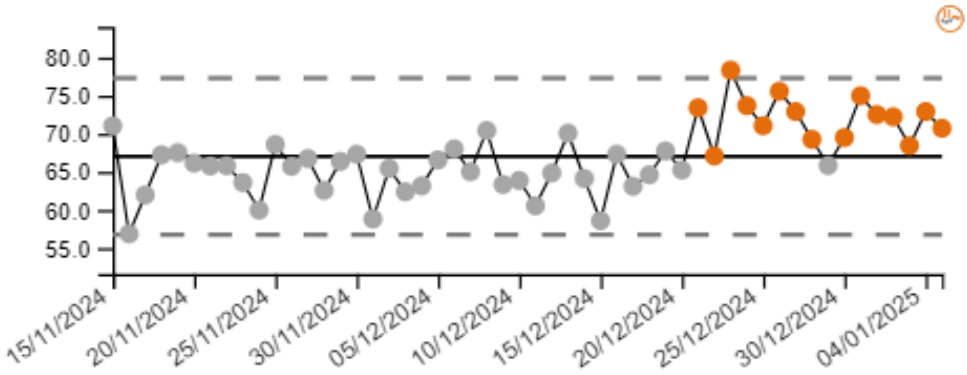

Figure 1 – % of Emergency Department attendances Majors

3.1.2. **Ambulance handover**. This is frequently seen as a bellwether indicator of operational pressure. It is relatively easy to understand, in a common 'currency' allowing regional and national comparisons. Delay in receiving handover is invariably a product of over-occupancy of EDs, in addition to the volume and rate of arrival of ambulances. We experienced higher than normal arrivals consistent with the increased Majors demand, as shown in Figure 2:

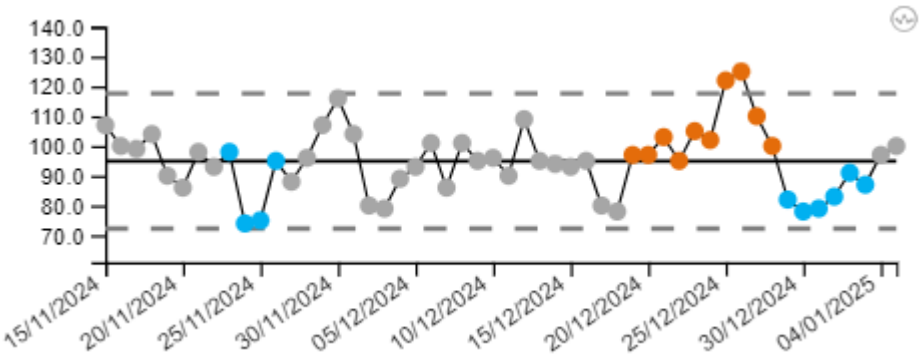

Figure 2 – Ambulance arrivals by day

This conflation of high demand and relative sickness of our patients inevitably impacted upon our ability to receive ambulance handovers at the rate we require. The average time to do so increased from Christmas Day onwards, as shown in Figure 3:

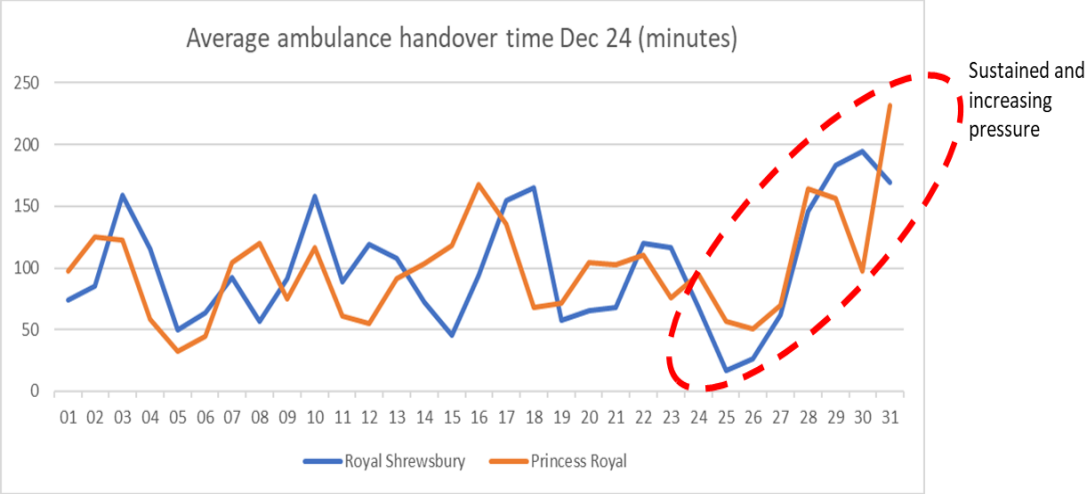

Figure 3 – Average ambulance handover time by day

3.1.3. **Length of stay in our Emergency Departments.** Our capacity to outflow the EDs has been highly challenged by demand, relative to the rate at which we have been able to discharge patients. Our non-elective admissions have been reasonably consistent, with only common cause statistical variation around a daily average of 184. However, there were below average discharges of these patients over the Christmas period and generally increased patient Length of Stay in SaTH throughout the second half of December. A tipping point was reached, and the impact was to reduce flow out of the EDs.

3.1.4. **Performance relative to the Midlands region**. From the data we have available, generally speaking, we have held our ED performance at static levels for key indicators. Whereas other systems in the region have mainly reduced in performance. We remain in the lower quartile on the 4 Hour performance standard, for example, as shown in Figure 4, but are slowly making progress and are only 2 or 3% away from others. This provides a solid start point for further improvement when the winter pressures ease.

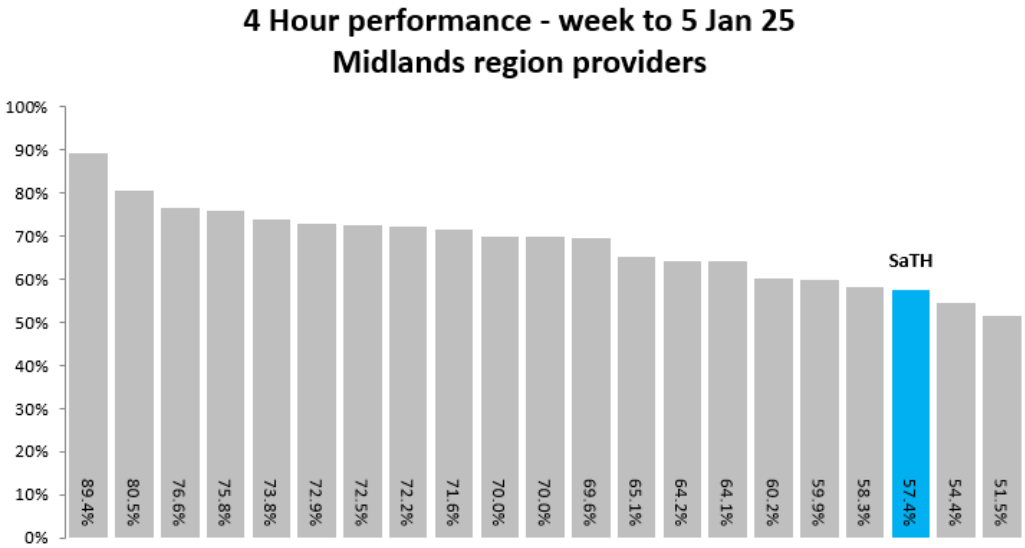

Figure 4 – 4 Hour performance relative to the NHSE Midlands region

3.1.5. **Patients with No criteria to reside (NCTR)**. The total number of our patients with no medical reason to be in our hospitals did increase post the festive period as demand increased however due to a significant system partner repone that has since reduced the number of patients in the acute Trust to approximately 100 patients.

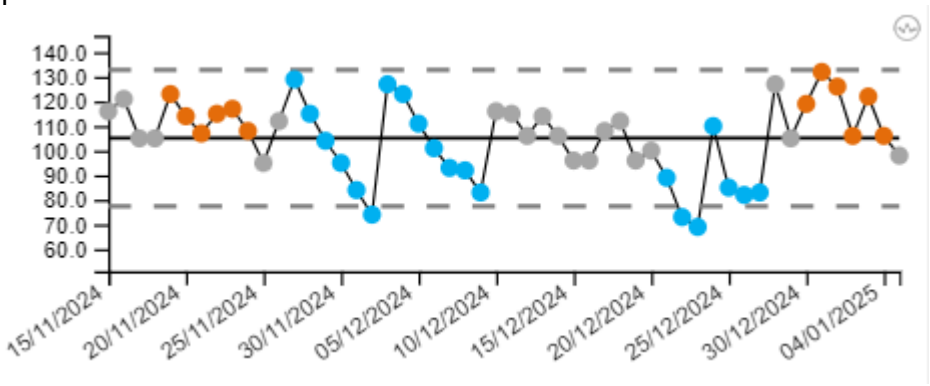

Figure 5 – Patients with NCTR not yet discharged (SaTH)

The system continues to ensure that patients who are ready for discharge who are identified as having no criteria to reside continues to reduce despite the winter pressures. The average length of stay for patients in 2023 was over 4 days. In December 2024 this had reduced to just over 2 days. This is illustrated in Figure 6.

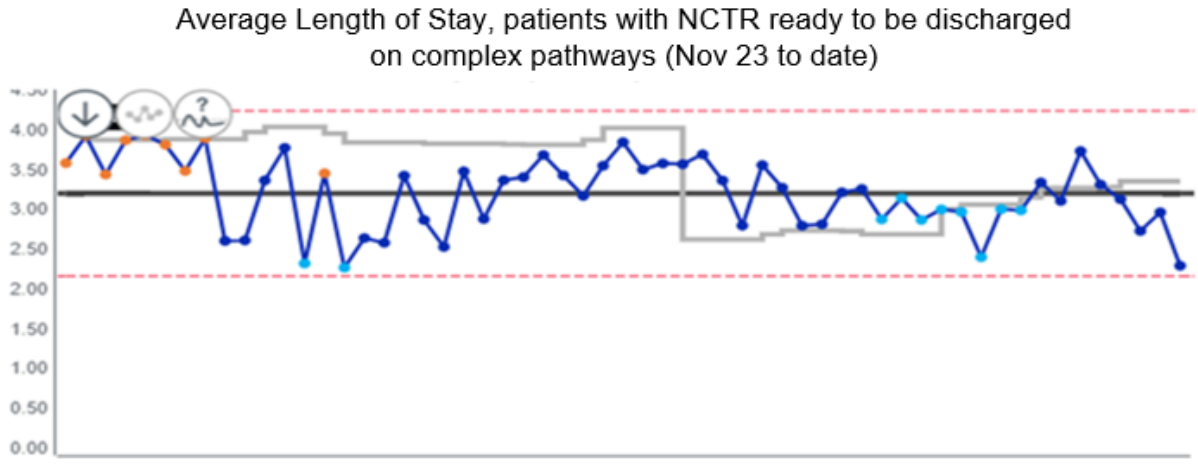

Figure 6 – Reduction in Length of Stay, complex pathways

4. Responding to the winter pressures 2024/25

4.1. **System Critical Incident 3-5 Jan 25.** The extreme pressures that built up to the end of December were sustained and overmatched our ability to respond with our available resources and level of escalation. Our CEOs took the decision to declare Critical Incidents (CI) at SaTH and as a System on Fri 3 Jan 25. The intent, which was achieved, was a short, sharp intervention and concentration of effort to decompress our EDs, restore safety and flow along our UEC pathway. CEO SaTH stood down the CI on Sat and 4 Jan and our System CEO stood down the CI on Sun 5 Jan having been satisfied that the more favourable conditions achieved were sustainable. At the time of writing that remains the case and we are reflecting on the events that led up to the imperative

to declare, and what the key interventions were that enabled de-escalation so rapidly. A number of other providers and systems have declared CIs across the region and nationally. We appear to have exited quicker than some others, which indicates the right approach.

4.2. **Process Improvement**. The extant system-wide Improvement Programme outlined in the Plan is judged to have stood us in good stead. In particular:

- Our Care Transfer Hub that coordinates patients with complexity in their discharge made a very significant contribution to our CI response by achieving a record day number of complex discharges (62).
- Our Integrated Care Coordination service continues to provide alternatives to ED attendance, typically handling circa 900 cases daily, with only around 1 in 10 being sign-posted to the EDs.
- The SaTH Ops team continues to achieve resilience in both sites to absorb and recover from pressure; with fresh approaches to leading the daily pressures.

4.3. **System winter schemes and mitigations**. A summary of the mobilisation and progress of our schemes introduced above is as below.

4.3.1. **Pre-planned schemes**. The schemes enacted with our limited ICB winter funding (£725k) are already delivering impact, with some delayed as we have had to adjust to our budget and mobilisation realities:

- Our mental health trust ED Attendance Avoidance team supported an additional 19 older adult patients that would otherwise have been admitted in December.
- British Red Cross has assisted 76 patients in their discharge.
- The System-level Communications Campaign continues to empower our patients with information and choice to Think Which Service best meets their needs.
- Additional patient transport capacity is enabling timely discharge daily.
- Our Virtual Ward & Urgent Community Response team is now making use of Point of Care testing that would otherwise have been needed in an acute setting.

4.3.2. **Additional mitigations**. Having concluded that process improvement and our ICB schemes would not meet the shortfall in capacity needed, the opportunity areas with high impact potential we have been able to enact to date are:

- We have used beds over the Elective fallow period of Christmas and New Year at RJAH to provide additional capacity, which was particularly welcome and extended during our CI response.
- We will be placing a clinical leader in each ED from our community trust to signpost and actively select for suitability to use alternatives to admission. This is expected to start later January following mobilisation.
- The System has commissioned increased domiciliary care to allow for increased discharge and provide the necessary support to our patients.,

5. Conclusion

5.1. This has been a predictably highly challenging winter so far for our system, which has mirrored the broader regional and national experience.

- Our system approach to winter has been appropriate to date, although ultimately insufficient to absorb the severe peak of demand late December that resulted in declaring a Critical Incident.
- After declaring a CI, our response was decisive and rapidly achieved the conditions to de-escalate quicker than the experience in other systems.
- System winter schemes and mitigations will continue to be enacted within affordability and focused to achieve impact.
- All winter schemes and mitigations will be formally reviewed in terms of impact in April 2025 as to ensure as a system we identify best practice.

6. Recommendations

6.1 The Health & Wellbeing Board is recommended to note progress and plans in relation to resilience and management of risk for the coming winter.

Appendices within the paper

1. System UEC Improvement Programme summary.
2. System Approach to Winter 2024/25.

Appendix 1 – System UEC Improvement Programme summary

System UEC Improvement 2024/25

System UEC Improvement Programme

Our system is placed in national improvement support Tier 1 (highest level of support, with the highest level of oversight)

We receive best practice support from the national programmes:
Getting It Right First Time (GIRFT) and the Emergency Care Improvement Support Team (ECIST)

Closely related SaTH Plans:

- Emergency Care Transformation
- Medicine Transformation
- CQC / Dispatches Action Plan

System-wide UEC Improvement Programme workstreams

4 hr Performance (with Tier 1 resource)
Sustainable improvement towards 78% by end 24/25

Acute Med & IPS (with Tier 1 resource)
Improve ward processes, referral response and speciality engagement

Alternatives to ED (with ECIST support)
Safe, timely coordination of alternative impactful pathways.

Frailty (with GIRFT support)
System-wide integrated Frailty pathway, coordinated care and admission avoidance.

Discharge (support from Newton Europe)
Responsive & effective System-wide care transfer hub, reducing LOS in right setting.

Workstream	Intervention
TOTALS by end 2024/25 (from operational plan)	
4-hour	**Overall workstream**
	Increase UTC utilisation
	Increase SDEC utilisation
	Increase use alternative pathways (direct access and hot clinics)
	Improve CYP wait times
	Improve minors wait times
	Improve flow through ED
	New medical staffing model
Acute / IPS	**Overall workstream**
	Ward process standardisation (SHOP model) including weekend discharge
	Interprofessional standards response time of specialities & Diagnostics TAT
	Reconfigure acute floor at PRH and Discharge lounge – Discharge actions under review
AtED	**Overall workstream**
	Address gaps and sequencing in the Directory of Services
	Develop Out of Hours community provision
	Develop care co-ordination centre
	Transition of MIUs to UTCs
Frailty	**Overall workstream**
	Establishing Frailty Assessment Units
	Adopting Rockwood as system-wide Clinical Frailty Scale
	Improve indwelling catheter care attendance and discharge arrangements
	Enhance Falls community prevention and Urgent Falls Pathway
	Comprehensive Geriatric Assessment in Care Homes
Discharge	**Overall workstream**
	Improve the pathway profile to promote Home First
	Reduce LoS for NCTR patients
	Develop a Care Transfer Hub (CTH)

Appendix 2 – System Winter Plan on a Page 2024/25

STW System Winter Plan 2024/25– on a page