Telford & Wrekin Co-operative Council

Protect, care and invest to create a better borough

Borough of Telford and Wrekin

Health Scrutiny Committee

Thursday 5 March 2026

2.00 pm

Council Chamber, Third Floor, Southwater One, Telford, TF3 4JG

Democratic Services:	**Paige Starkey**	**01952 380110**
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Committee Members: **Councillors D R W White (Chair), F Doran (Vice-Chair), M Boylan, C Chikandamina, N A Dugmore, G Luter, R Sahota, P Thomas, J Urey**

Co-optees H Knight, D Saunders and J Suckling

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7.0	**NHS 10 Year Plan - Virtual Wards and Admission Avoidance**	**3 - 14**

To receive an overview of how virtual wards are supporting the shift from hospital-based to community-led care, including their role in reducing hospital admissions.

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LGC Awards 2025 COUNCIL OF THE YEAR WINNER

NHS 10-year plan – Virtual Wards and Admission Avoidance .

Health Scrutiny 5/3/26

Gemma McIver, Sana Qureshi and Michael Bennett

10-year Plan and Neighbourhood Health guidance – link to Community UEC pathways

•NHSE published the NHS 10 Year Plan and later 3 year Medium Term Plan, which reiterates the need to develop a **Neighbourhood Health service** as one of the cornerstones to making the 3 shifts: from hospital to community, from sickness to prevention and from analogue to digital.

•Neighbourhood Health aims to create healthier communities, helping people of all ages live healthy, active and independent lives for as long as possible- *bringing care into local communities, convening professionals into patient-centred teams, and ending fragmentation*

The guidance sets out 10 components that contribute to the delivery of the Neighbourhood Health service, that has been developed through the year through the TWIPP programme

- Population Health Management
- Modern General Practice
- Integrated Multi-Disciplinary Teams
- **Urgent Neighbourhood Services**
- **Integrated Intermediate Care with a 'Home First' Approach**
- Standardising Community Services
- Digital
- Workforce
- System Architecture and Model of Care
- Clinical and Professional Leadership

Maximising Community UEC Services

URGENT CARE, DELIVERED WHERE IT MATTERS MOST - IN PATIENTS OWN HOME.

Transition from acute inpatients to community UEC pathways

Strategic Reinvestment

The £3.6 million reinvestment was redirected from the closure of RRUs to strengthen community services. This shift was part of the system's move towards proactive, community-led models, supporting NHS priorities around delivering more care at home, reducing avoidable admissions, and improving winter resilience. The reinvestment also enabled scaling services with a proven impact on patient safety, sustainability, and performance.

Where exactly did the reinvestment go?

- Urgent Community Response expansion to midnight (from 8pm) (2 hour community response)
- Additional GP decision maker at the front door
- Integrated community front door team
- 2 hour domicillary care bridging
- Extended discharge planning (until 8pm)
- Additional weekend therapy cover for care transfer hub
- Care Transfer Hub system leadership role

New Integrated Community Front Door Service Helps Residents Stay Safe and Well at Home

19 November 2025

A new health and care initiative is helping residents across Shropshire, Telford and Wrekin get the support they need quickly, often avoiding unnecessary hospital admissions, by providing enhanced help straight from Emergency Departments (A&Es) so they can return home sooner.

The Integrated Community Front Door acts as a 'front door' providing an alternative to Emergency Departments (A&Es) at both the Royal Shrewsbury Hospital and the Princess Royal Hospital, Telford. It provides rapid assessment and same-day care for patients who arrive at hospital but can be safely supported within the community.

The service brings together health and social care professionals from both hospital and community services including nurses, therapists, GPs and social workers. The service ensures people receive the right care, in the right place, at the right time.

Sarah Robinson, Divisional Clinical Manager – Urgent and Emergency Care for Shropshire Community Health NHS Trust, said:

"This is a great example of integrated working in action. It's not just about avoiding hospital admissions it's about improving outcomes, supporting independence, and making sure people feel cared for and supported wherever they are."

The service is designed for those who are unwell or in crisis, particularly older adults and people with long-term conditions, who may not need hospital care but do need urgent help. By offering fast, coordinated care in the community, the service aims to keep people safe and well at home, prevent unnecessary hospital admissions, and ease pressure on Emergency Departments (A&Es).

Since its launch, the Integrated Community Front Door has already helped residents avoid hospital stays, supported early discharges, and connected people with community services such as Virtual Wards, home-based therapies, and social care support.

Elizabeth Slevin, Divisional Director of Nursing for Urgent and Emergency Care at Shrewsbury and Telford Hospital NHS Trust, said:

"This service is transforming how we respond to urgent care needs. By working collaboratively across hospital and community teams, we can assess patients quickly and connect them with the most appropriate support often enabling them to recover safely at home. It's about improving outcomes, reducing pressure on Emergency Departments (A&Es), and helping ensure patients are seen by the right clinician, in the right place, at the right time."

Lorna Clarson, Chief Medical Officer at NHS Shropshire, Telford and Wrekin, added:

"This fabulous new initiative is a testament to the power of collaborative working across our system. By integrating hospital and community services, we're not only improving patient flow and reducing pressure on our hospitals, but also ensuring people receive timely, compassionate care closer to home. It's a real step forward in delivering joined-up care for our residents."

The Integrated Community Front Door is available seven days a week 8am to 8pm.

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Page last updated 19 November 2025

UCR and Virtual ward

Performance

UCR 2hr%	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
25/26 actual	87.9%	82.8%	85.0%	88.6%	92.5%	87.8%	73.8%	84.8%	88.7%			
25/26 Plan	70.0%	70.0%	70.0%	70.0%	70.0%	70.0%	70.0%	70.0%	70.0%	70.0%	70.0%	70.0%
%Var	17.9%	12.8%	15.0%	18.6%	22.5%	17.8%	3.8%	14.8%	18.7%			

VW Occupancy	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
25/26 actual	69.2%	65.4%	64.5%	72.7%	62.4%	66.2%	68.0%	78.7%	82.9%	90.1%		
25/26 Plan	65.3%	70.1%	74.9%	80.2%	65.9%	65.9%	80.2%	80.2%	80.2%	80.2%	80.2%	80.2%
%Var	3.9%	-4.7%	-10.4%	-7.5%	-3.5%	0.3%	-12.2%	-1.5%	2.7%	9.9%		

Focus

- Sustain strong UCR 2-hour performance while managing rising activity volumes and ensuring admission avoidance impact is maximised.
- Optimise Virtual Ward throughput, with focus on reducing length of stay and improving step-down velocity to maintain capacity headroom.
- Maintain occupancy at or above 80% while preventing LOS creep that constrains admission avoidance benefit.
- Embed the Integrated Out-of-Hospital model within routine UEC governance, ensuring community pull directly supports reduction in NCTR, LOS and ED pressure.

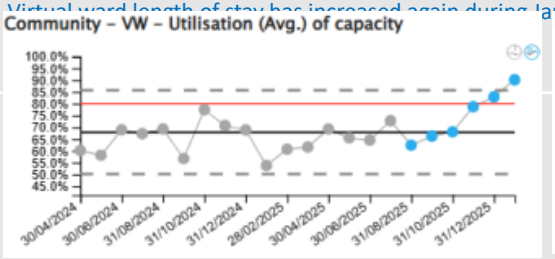
Performance Discussion

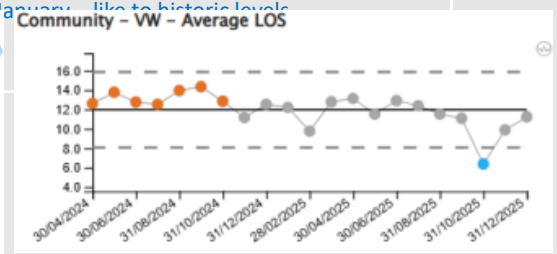
UCR 2hr response published data always reports one month behind with December 25 reporting an increased position of 88.7%, **achieving** plan, while activity volumes have slightly increased.

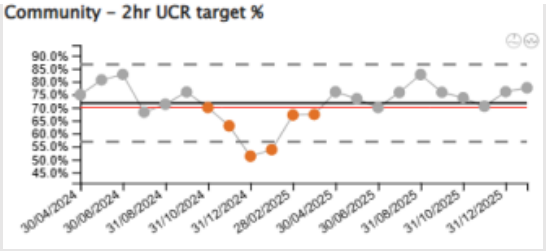
VW occupancy level reports a continued **increased** position of 90.1% in January 26, **achieving both the local plan and the national target (80%)** .

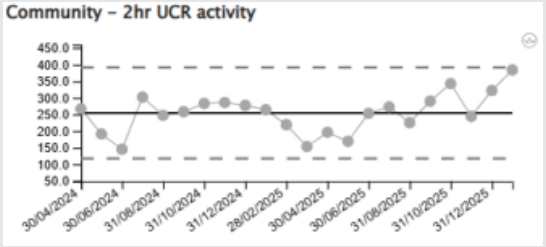
Virtual ward length of stay has increased again during January – like to historic levels

Secondary measures

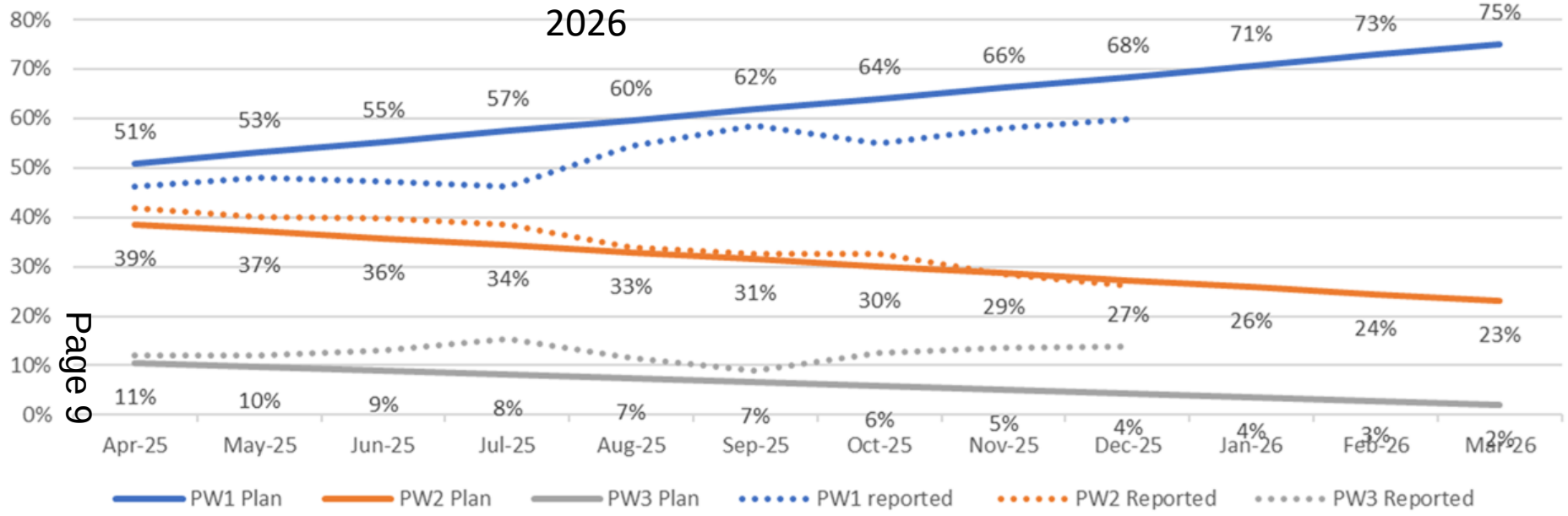








Pathway split April 2025 – March 2026



Since the improvements of Care Transfer Hub and the additional funding into the service we have seen an increase in the amount of PW1 discharges

Council supporting Neighbourhood Health and Integrated services

- Social Workers integrated with the Urgent Community Response Team (UCRT) and Virtual Ward (VW) and supporting alternatives to hospital in the community and hospital Front Door.
- Social Workers integrated within the Care Transfer Hub to support discharge from hospital and through Intermediate Care services
- Brokerage staff source the care for alternatives to hospital and hospital discharge.
- 'Home First' approach being imbedded within the daily culture of the team, supporting system partners with Urgent Care delivery improvements showing improvements in Pathway 1 discharges from hospital.
- Enhancing the Intermediate Care provision through
    - Enablement Extra Care flats as an alternative to care beds supporting admission avoidance and discharge from hospital.
    - Re-commissioned domiciliary care to accelerate discharge Home and support Enablement objectives
    - Additional therapists to improve long term outcomes
- Enhance Early Help Preventative offer.
    - Stirchley House ILC and Increased functional assessments in the community.
    - Making Prevention Real Transformation programme.

Alignment of and with the Better Care Fund (BCF) 2026/27

- BCF will be reformed as part of the 10-year Plan
- The BCF plan for 2026/27 has some initial changes in Priority and must be agreed and submitted by 19th May 2026
- A priority (National Condition) is to '**effectively support the delivery of integrated and preventative care'.**
- Further develop specific Neighbourhood Heath guidance components
    - Urgent Neighbourhood Services including:
        - Single Point of Referral.
        - Align demand and capacity across urgent care pathways e.g UCTR, Virtual ward, Same Day Emergency Care,
    - Integrated Intermediate Care/ Home First including:
        - MDT discharge planning and further develop the Care Transfer Hub functioning.
        - Therapy-led Intermediate Care.
        - Increase alternatives to hospital admission.
- Align with and to the STW system Urgent Care Transformation Programme for 2026/27 and 2026/27 (in advanced development)
- BCF metrics will again focus on reducing avoidable admissions; reducing discharge delays; improving Enablement outcomes and reducing permanent admissions to care homes.

Case Example

•Mrs T was conveyed to Princess Royal Hospital A and E, seen by Frailty/Admission Avoidance teams. She came to hospital with severe Neck and Shoulder pain and diagnosed with rotator cuff tendinopathy.

•Mrs T lives at home independently prior to this injury. Due to shoulder pain, she was now struggling with managing her personal care and meal preparation.

•Admission Avoidance Social worker liaised with her son who supported to agree a care plan at home. A Key safe was put in place, equipment checked and 4 care calls a day started.

•1-week later Mrs T had improved, and her care support was reduced to 3 calls a day. The following week she felt well enough to reduce the support down to 2 calls a day.

•Mrs T was discharged from all services the week after with no formal care.

•Recognition of the positive impact the integrated team can have on outcomes for people.

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