Lancashire and South Cumbria Integrated Care Board

Integrated Care Board

Date of meeting	22 January 2026
Title of paper	Urgent and Emergency Care Delivery and Winter Planning 2025/26
Presented by	Professor Craig Harris, chief operating officer and chief commissioner
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Agenda item	15
Confidential	No

Executive summary

This report provides an overview and update on the various programmes of work to support urgent and emergency care (UEC) delivery and winter planning 2025/2026, including:

- Winter planning update 2025/26
- Key UEC performance metrics
- System Coordination Centre winter update
- Local UEC improvement plans
- UEC capacity investment funding
- Key updates requested by members of the ICB Board:
  - Virtual Wards/Hospital at Home
  - Single Point of Access
  - over 12-hour waits in emergency departments
- UEC Capital 2026/27
- Key risks for UEC

Public and Stakeholder Engagement

Engagement is undertaken on various elements included within this report:

- Routine updates are presented and discussed at UEC Delivery Boards e.g. UEC capacity investment funding, winter plans
- Shared learning discussions are held via the Strategic System Improvement Group for UEC and Flow
- An update on UEC capacity investment funding was presented to the Finance & Contracting Committee 7 January 2026
- To support the UEC delivery plan and winter planning, the ICB, Trusts and partners are actively promoting a "Good Health Starts…" campaign which has been developed and tested with local people. Since the previous report, this has received regional media attention for promoting self-care, mental health support and appropriate use of NHS services.

Recommendations		
The Integrated Care Board is requested to note the content of the report		
Which Strategic Objective/s does the report relate to:		**Tick**
SO1	Improve quality, including safety, clinical outcomes, and patient experience	✓
SO2	To equalise opportunities and clinical outcomes across the area	✓
SO3	Make working in Lancashire and South Cumbria an attractive and desirable option for existing and potential employees	✓
SO4	Meet financial targets and deliver improved productivity	✓
SO5	Meet national and locally determined performance standards and targets	✓
SO6	To develop and implement ambitious, deliverable strategies	✓

Implications				
	Yes	**No**	**N/A**	**Comments**
Associated risks	✓			Outlined in section 10
Are associated risks detailed on the ICB Risk Register?		✓		
Financial Implications	✓			Outlined in section 6

Where paper has been discussed (list other committees/forums that have discussed this paper)		
Meeting	**Date**	**Outcomes**
ICB Finance and Contracting Committee	7 January 2026	Update on UEC capacity investment funding

Conflicts of interest associated with this report
Not applicable

Impact assessments				
	Yes	**No**	**N/A**	**Comments**
Quality impact assessment completed			✓	
Equality impact assessment completed			✓	
Data privacy impact assessment completed			✓	

Report authorised by:	Professor Craig Harris, chief operating officer and chief commissioner

Integrated Care Board – 22 January 2026

Urgent and Emergency Care Delivery and Winter Planning 2025/26

1. Introduction

1.1 The purpose of this report is to provide an update to the Board on the status and/or progress of:

- Winter planning update 2025/26
- Key UEC performance metrics
- System Coordination Centre winter update
- Local UEC improvement plans
- UEC capacity investment funding
- Key updates requested by members of the ICB Board:
    - Virtual Wards/Hospital at Home
    - Single Point of Access
    - over 12-hour waits in emergency departments
- UEC Capital 2026/27
- Key risks for UEC

2. Winter planning update for 2025/26

2.1 NHS England North West requested an additional Festive Delivery Position specifically focussing on the period from 19 December 2025 to 12 January 2026 to provide assurance of the plans in place to respond to pressures during this period.

2.2 The key areas of focus included the top three to five risks, trusts of concern, mental health, primary care, community services, discharges, bed occupancy, and SCC hours of operation.

2.3 All trusts in Lancashire & South Cumbria were included, highlighting their challenges in and plans for meeting key performance metrics such as four-hour A&E target, twelve-hour waits in emergency department, criteria to reside, 45-minute ambulance handovers and corridor care.

2.4 The plan was submitted to NHS England North West on 16 December 2026. NHS England subsequently requested further clarification via key lines of enquiry, which were submitted by the required timeline on 22 December 2025.

3. Key UEC Performance Metrics

3.1 Monthly UEC performance and delivery review meetings continue with the NHS England North West and the ICB, which focus on acute trusts' performance in key areas, including four-hour A&E targets, over twelve-hour waits in emergency

departments, ambulance handover delays, corridor care, and the actions required to return performance to planned levels.

3.2 Performance across LSC for the four key UEC metrics from April 2025 is outlined in the table below:

4-hour performance (78% target)									
	Apr-25	**May-25**	**Jun-25**	**Jul-25**	**Aug-25**	**Sept-25**	**Oct-25**	**Nov-25**	**Dec-25**
LSC	77.4%	77.5%	77.2%	77.4%	76.8%	76.2%	76.1%	75.5%	75.7%
Over 12-hour waits in ED* (<10% target)									
LSC	15.4%	14.0%	13.8%	13.4%	14.4%	15.5%	16.7%	15.9%	16.2%
Category 2 response (30 minutes target)									
LSC	23:07	23:12	24:10	23:34	21:37	24:53	25:30	27:00	29:43
Within 45-minute ambulance handover									
LSC	86.6%	86.3%	90.4%	88.0%	95.3%	93.7%	90.8%	90.7%	88.4%

** Note: the performance data on 12-hour waits in ED is based on type 1 ED attends, not all-type A&E attends, as this metric is one of the priority actions of the national UEC plan 2025/26 (as referred to in Section 2), NHS England is closely monitoring this metric.*

4. System Coordination Centre (SCC) Winter Update

4.1 The Lancashire and South Cumbria system saw significant increases in pressure through the early part of winter, peaking in the first two weeks in December. The system then experienced further periods of pressure week commencing 29th December.

4.2 The Operational Pressures Escalation Levels (OPEL 4) framework has been consistently applied and there have been two incidents of OPEL 4 triggered by BTH and UHMB to date. The SCC has convened and facilitated Local Escalation Response Calls for the Morecambe Bay, Fylde Coast and Central Lancashire systems during November/December to support this.

4.3 Infection prevention and control issues were a feature of November and December across LSC. Flu peaked at 104 inpatients on 1 December, then reducing from 8 December down to 28 inpatients by the end of December. A number of pockets of Norovirus were also reported through November and December affecting flow and bed availability but have not become sustained outbreak-type situations. Primary Care and Paediatrics are reporting continued prevalence of flu and wider respiratory infections in the community which may continue to translate into hospital activity over the coming weeks.

4.4 Utilising the OPEL framework, and working with NHS England North West, SCC will provide the point of communication and escalation for the system and support the ICB with coordination of escalation responses.

4.5 This includes monitoring delivery of the 45-minute ambulance handover standard in real-time, with interventions at agreed trigger points to liaise with sites where delays arise to ensure all necessary actions are being taken and provide updates and assurance to NWAS and NHS England. It should be noted that, since late November, our system has experienced more ambulance handovers exceeding 45 minutes, and in early January there was an increasing number of long ambulance handover delays and breaches.

4.6 The SCC has been leading the implementation of the SHREWD system which provides real-time visibility of pressures across the whole health and care system. This moved into business-as-usual from the start of November and is in use across the LSC system. Further work will commence in the New Year to roll out reporting and forecasting functions.

4.7 The SCC has updated its operating model to ensure maximum support and impact for system coordination and optimise the utilisation of SHREWD to reduce demands for provider data manual submissions. This will be reviewed further, under the "Do It Once" programme, to identify opportunities for efficiency and consolidation across the North West Region in line with Model ICB and Model Region blueprints and the anticipated new SCC Required Operational Standards.

4.8 We are expecting increase pressures across our system throughout January. At the time of writing this report, during week commencing 5 January, trusts have been under significant pressure, for example we have seen Blackpool Teaching Hospitals declare OPEL 4 and a level 2 critical incident led by the ICB in accordance with Emergency Preparedness, Resilience and Response (EPRR) requirements. System partners have worked together to help manage the pressures and risks across our system, including through Local Escalation Response Calls when required.

5. Local UEC improvement plans

5.1 The local improvement plans 2025/26 are supporting system de-escalation, recovery and transformation. Key themes running through the plans are prevention, admission avoidance, reducing length of stay in hospital, keeping safe and well at home, navigating patients to the most appropriate care and support, and maximising the use of community services.

5.2 The local UEC improvement plans will be refreshed for 2026/27 with a particular emphasis on metrics, impact and outcomes. Reporting is currently via UEC Delivery Boards and the Strategic System Improvement Group for UEC and Flow.

6. UEC capacity investment funding

6.1 The ICB approved the UEC capacity investment schemes for continuation in 2025/26. The Board agreed that allocations should not exceed 2024/25 expenditure of £16,528,213, and that providers are reimbursed on actual expenditure up to the maximum allocation for each scheme.

6.2 The schemes include virtual wards/hospital at home, respiratory provision, intermediate care, palliative and end of life service, and support from the voluntary, community, faith and social enterprise sector. Key performance indicators, outcome and actual spend continues to be monitored monthly and expenditure forecasts are updated quarterly, which is and will continue to be reported to the Finance and Contracting Committee.

6.3 An update of the UEC capacity investment schemes was presented to the Finance and Contracting Committee on 7 January 2026. The report included an overview of the actual spend, forecast underspend and high-level impacts/outcomes.

6.4 A proposal for investment in 2026/27 is being developed and will be presented to a future Finance & Contracting Committee and ICB Board meeting.

7. Key updates requested by members of the ICB Board held on 27 November 2025

Virtual Wards/Hospital@Home

7.1 Virtual Wards, increasingly referred to as Hospital@Home, continue to provide a safe, effective and efficient alternative to hospital care for patients who would otherwise be in an acute bed. We are adopting the Hospital@Home terminology because it better reflects the reality of the service – hospital-level, face-to-face care delivered in people's homes – and this shift is also based on service user feedback, which highlights that the term 'virtual ward' can create misconceptions about remote or digital only care.

7.2 Capacity and utilisation are consistently in line with national averages, with average utilisation at 76% between 1 October and 10 December 2025, which is just below NHS England's 80% target. On 4 January, utilisation reached 89% supporting winter resilience. Alongside this, our system has among the highest patient throughput of systems in England – a measure we believe is essential to consider alongside utilisation because it reflects the true volume of patients supported and the positive outcomes achieved. Between April and November 2025, 14,276 people were cared for through Hospital@Home.

7.3 Importantly, the model continues to deliver strong hospital admission avoidance, with 74% of referrals being 'step-up' from the community – higher than many systems nationally – avoiding 10,564 hospital admissions and supporting 3,712 people with earlier hospital discharge. The average length of stay is 4.36 days, contributing to 57,981 acute bed days avoided since April 2025. In 2024–25, 19,408 people were supported, saving 81,550 bed days; for an investment of £5.6m, this equated to £68.66 per bed day – a much lower cost than hospital inpatient care.

7.4 Our system is making excellent progress in embedding the generalist model in line with the ICB's commissioning intentions, improving utilisation and enabling

greater flexibility in responding to patient need and demand fluctuations, for example during periods of increased seasonal respiratory viruses. This progress is supported by a unified service specification and an acuity tool ensuring that patients admitted to Hospital@Home are genuinely those who would otherwise require hospital-level care.

7.5 While overall performance is strong, some variation persists, particularly in West Lancashire where an improvement plan is in place, and there remains clear opportunity for further development, including strengthening referral pathways, enhancing clinical engagement and improving the digital health offer. Momentum is positive, and with continued focus, our system is well placed to build on its strong foundations and further expand the reach and impact of Hospital@Home, including through the connection with, and roll-out of, Single Point of Access (section 7.6 onwards).

Single Point of Access (SPoA)

7.6 Single Point of Access national guidance was published on 29 August 2025. The guidance outlines that a SPoA simplifies access to services by offering clinicians advice and guidance to support onward referral, ensuring patients get the right care for their needs quickly and safely and to improve patient outcomes regardless of where they present.

7.7 The implementation of SPoA has been prioritised at both national and local levels, and this programme has been designated as a commissioning intention by the ICB.

7.8 The guidance outlines foundation components e.g. operating model, core multidisciplinary team (in person/hybrid/virtual), system collaboration, system integration/technology and established referral pathways.

7.9 The four core foundation component referral pathways for implementation include Virtual Wards/Hospital@Home, Urgent Community Response, Same Day Emergency Care and Urgent Treatment Centres.

7.10 SPoA across Lancashire & South Cumbria is being implemented at a local level, aligned with the Urgent and Emergency Care Delivery Board and acute trust footprints. Effective connectivity has been established between Lancashire & South Cumbria, Merseyside, and West Lancashire to enhance support for patients residing in West Lancashire.

7.11 Each local delivery model is overseen by a Senior Responsible Officer who has formed local groups to progress implementation. Additionally, an LSC Programme Group convenes monthly to review progress, address challenges, share learning and determine subsequent actions.

7.12 It is recognised there are different levels of maturity across LSC which is monitored via a self-assessment.

7.13 The key priorities from January to March 2026 are:

- Establishing a Lancashire & South Cumbria single telephone number
- Collation of the national core minimum dataset.
- Review of the Directory of Services, focussing on the four cores. foundation components noted above.

Over 12-hour waits in Emergency Departments

7.14 The performance metric for over 12-hour waits in ED is being monitored nationally. As outlined in Section 3 of this report, LSC 12-hour performance is showing an increase from July. To support performance improvement, local UEC improvement plans are in delivery and there is an opportunity to strengthen them further through the 2026/27 refresh.

7.15 In addition, regular discussions are held through the NHS England tiering process. During these meetings, relevant Trusts (i.e. those in tier 1 or 2) are reviewed based on their performance data and the actions being taken to improve performance. This systematic approach ensures that Trusts receive appropriate oversight and support according to their performance.

7.16 NHS England has closely monitored ambulance handover compliance, with data in Section 3 showing improvements. However, efforts to enhance performance has the potential to create pressures elsewhere in the system e.g. ED overcrowding. NHS England North West is evaluating the impact of HO45 to ensure benefits are not undermined by unintended consequences in other areas of healthcare delivery and monitoring.

7.17 On 14 December, NHS England North West emailed Trusts and ICB CEOs, CMOs, and COOs the new ‘Standards for care of acutely unwell patients in their first 72 hours in hospital’.

7.18 The guidance outlines that 1.7 million patients are spending 12 hours or more in emergency departments before or instead of being transferred to more appropriate setting. Therefore, one of the key objectives of the standards is to reduce 12-hour waits in ED and corridor care.

7.19 The key themes of the standards are:

- Early senior decision making, with patient and carer involvement
- Continuity and coordination of care
- Care in the right place at the right time
- 7-day working
- Accurate capture of decisions and activity

7.20 Trusts and the ICB are required to undertake an initial baseline assessment of their performance against 15 standards, to identify areas for development or where support may be required.

7.21 The acute trusts will be required to ensure that the standards are reflected in an internal professional standards document. They must assure their board of compliance with the standards and robust plans, owned at an executive level, put in place to achieve compliance where necessary.

7.22 The trusts will be required to submit their completed assessment to the ICB by 30 January 2026 to enable the ICB to complete the respective requirements and return to NHS England North West by 6 February 2026.

7.23 Two webinars will be held on Tuesday, 13 January and Wednesday, 14 January 2026, offering additional guidance and information pertaining to the standards.

8. UEC Capital 2026/27

8.1 Following a spending review in 2025, NHS England announced a 4-year capital settlement, extending to 2029/30.

8.2 For 2026/27, the NHS capital allocation will be split into 3 broad categories:

- Provider operational capital and integrated care board allocations
- Nationally allocated funds for major programmes
- Other national capital programme investments

8.3 NHS England regions will oversee capital planning, working closely with ICBs to develop proposals for investing in transformation and increased capacity which aligns with ICBs' strategic commissioning plans.

8.4 The UEC capital funding across the North West for the 4-year period equates to £274m. The table below outlines the investment each year:

2026/27 £000	2027/28 £000	2028/29 £000	2029/30 £000
£93,250	£72,000	£62,500	£46,250

8.5 NHS England North West will be responsible for developing a balanced portfolio of strategic schemes and continued targeted investment in maintenance to address urgent operational risks.

8.6 The proposed prioritisation for UEC capital schemes is noted below:

- alignment with any agreed pan-regional or pan-ICB strategic priorities
- support alternatives to ED
- support delivery of improvements against constitutional standards (4-hour and 12-hour performance)
- support delivery of the Model ED/standards of care for 72 hours (as outlined from 7.16)

9. Impact and outcomes

9.1 The ICB, in collaboration with system partners, developed several versions of winter plans through close coordination with NHS England North West to establish the most effective strategies for the winter period. With SCC's data insights and provider relationships, system responses are effectively coordinated, ensuring accountability to NHS England North West. The daily contact point overseen by the SCC offers real-time operational visibility, facilitates risk identification, and supports the implementation of mitigation measures.

9.2 The completion of winter planning, improvement, and transformation efforts is bringing positive developments throughout the UEC pathway. This work is ongoing, with many initiatives continuously being embedded and sustained.

10. Key risks for UEC

10.1 Given the sustained operational and financial pressures across our system, there remains a risk that intended delivery of local UEC improvement plans and associated de-escalation plans may not be fully achieved, particularly during the winter period where additional escalation beds may be required to manage a potential increase in demand.

10.2 During the winter period, there continues to be a considerable level of risk regards to achieving local UEC performance indicators that are crucial for patient safety and quality care. As a result, acute trusts might be placed in higher intervention categories within the national UEC tiering system.

10.3 The resident doctors strike was held from 17 to 22 December 2025. This development complicated the management of winter viruses and further exacerbate efforts to reduce waiting lists.

10.4 We will mitigate these risks and manage ongoing winter pressures through quarter 4 by:

- Focussing on hospital avoidance e.g. roll out of SPoA and maximising virtual wards and urgent community response
- Strengthening HO45 escalation policy and ensuring practice is in line with this working with trusts and NWAS
- Trusts' continuous improvement plans for in-hospital flow and the implementation of the standards for the first 72 hours in hospital
- Continuing to work in partnership to expedite hospital discharges
- Ongoing delivery of UEC improvement plans and winter plans
- Oversight and response through EPRR, SCC, local escalation response calls and via UEC governance arrangements

11. Recommendations

The Integrated Care Board is requested to note the content of the report

Wendy Lewis, director of system coordination and flow
Craig Frost, associate director urgent and emergency care

8 January 2026