Tony Kershaw
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17 November 2022

Dear Member,

Health and Adult Social Care Scrutiny Committee - Wednesday, 23 November 2022

Please find enclosed the following documents for consideration at the meeting of the Health and Adult Social Care Scrutiny Committee on Wednesday, 23 November 2022 which were unavailable when the agenda was published.

Agenda No	Item	
5.	**NHS Winter Preparedness**	(Pages 3 - 22)
7.	**South East Coast Ambulance Service Update**	(Pages 23 - 194)

Yours sincerely

Tony Kershaw
Director of Law and Assurance

To all members of the Health and Adult Social Care Scrutiny Committee

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Heath and Adult Social Care Scrutiny Committee

23 November 2022

NHS Winter Preparedness

Report by Director of Law and Assurance

Summary

The Health and Adult Social Care Scrutiny Committee (HASC) identified scrutiny of NHS preparedness for seasonal pressures this winter as a priority. NHS Sussex has provided a report (at Appendix A) setting out its plans relating to West Sussex residents, highlighting any specific challenges and risks and how these are being addressed.

Focus for scrutiny

The focus for scrutiny is to seek assurance that the approach taken by the NHS across West Sussex responds adequately to expected pressures this winter.

Key lines of enquiry include:

1) NHS capability and capacity to deliver the plans as set out in the Appendix, including consideration of workforce challenges.

2) Whether the plan focuses on the right, evidence-based priorities.

3) Any linkages with Adult Social Care and how these are being addressed.

4) How plans have taken account of patient outcomes and how this will be assessed

5) To identify any related issues where scrutiny could add value in future

The Chairman will summarise the debate, which will then be shared with NHS Sussex.

1. Background and context

1.1 The background and context to this item for scrutiny are set out in the attached report. There are no resource or risk implications directly affecting West Sussex County Council, as this is a report by the NHS, relating to NHS services.

Tony Kershaw
Director of Law and Assurance

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Appendices

Appendix A: Report on Winter Planning by NHS Sussex

Background Papers: None

NHS Sussex

NHS Sussex Winter Plan

Report for Health & Adult Social Care Scrutiny Committee

November 2022

Better health and care for all

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NHS Sussex Winter Plan

1.0 Introduction

This report provides a summary of the overall Sussex Winter Plan. The plan spans the period from October 2022 to April 2023. The report highlights the Sussex wide and West Sussex specific elements of the plan for assurance for the Health & Adult Social Care Scrutiny Committee.

The Sussex Winter Plan is a whole system health and social care plan, recognising the interdependencies of the system to meet the needs of the local population. It is an annual national planning requirement and provides assurance that the system and partners have the necessary measures in place to deliver health and care for the local population.

2.0 Background

The Sussex health and care system faces an extremely challenging winter. Locally and nationally, health and care systems are experiencing significant operational pressure across many of their services. Some patients are experiencing delays in accessing both planned and unplanned healthcare, despite the best efforts of our workforce. There has been no reduction in operational pressures over the summer months and providers are entering winter with significant capacity pressures (availability of workforce and beds) for all organisations.

In addition to the current pressures, we face a range of hard to quantify risks such as the potential for further waves of Covid-19, high incidence of flu cases mirroring the Southern Hemisphere, increases in respiratory illnesses, and the impact of the cost of living on both our workforce and our patients.

Recognising this risk, on 12 August 2022, in the letter titled '*Next steps in increasing capacity and operational resilience in urgent and emergency care ahead of winter (*B1929_Next-steps-in-increasing-capacity-and-operational-resilience-in-urgent-and-emergency-care-ahead-of-winte.pdf (england.nhs.uk)), NHS England (NHSE) described the actions they expected all systems and providers to take to increase capacity and operational resilience in urgent and emergency care ahead of winter.

Since the receipt of that letter on 12 August there have been two further national communications relating to winter. The Secretary of State for Health's 'Plan for patients', issued on 22 September (Our plan for patients - GOV.UK (www.gov.uk)), and a further communication on 18 October titled 'Going further on our winter resilience plans' (NHS England » Going further on our winter resilience plans). Both set out additional measures which systems and providers are expected to implement to improve service delivery this winter.

The NHS Sussex Winter Plan addresses the requirements of the national letters and plans, and has been built bottom up, to respond to the capacity challenges surfaced through the modelling of expected pressure for this winter. In addition to locally agreed actions to address the capacity challenges, we have established rapid improvement workstreams that are being applied across the system, led jointly by NHS Sussex executives and executives from partner organisations. These workstreams are drawing on best practice examples to ensure people receive the right care, from the right organisation, at the right time, and are supported to return to their normal place of residence at the earliest opportunity.

3.0 Development of the NHS Sussex Winter Plan

NHS Sussex has developed its Winter Plan in conjunction with partners to ensure that we can deliver safe and effective services for Sussex residents throughout the winter. It has been developed taking into account feedback and learning, following evaluation of the Winter Plan for 2021/22.

Contributors to the Plan include:

- East Sussex Healthcare NHS Trust (Acute and Community).
- University Hospitals Sussex NHS Foundation Trust (Acute).
- Sussex and Surrey and Sussex Healthcare Trust (Acute).
- Sussex Community NHS Foundation Trust (Community).
- Sussex Partnership NHS Foundation Trust (Mental Health).
- Local Authorities (Adult Social Care, Children's Services, Public Health) and District Councils.
- South East Coast Ambulance Service NHS Foundation Trust.
- Primary Care.
- The Voluntary Sector.

The plan incorporates the requirements set out within these national communications. There are three key elements to our approach:

- The establishment of a system wide winter operating model.
- The development of our winter operational plan for delivery, incorporating the use of the National Urgent and Emergency Care (UEC) Assurance Framework – a framework developed by NHS England, designed to be a helpful tool to support Integrated Care Boards (ICBs) in managing winter pressures.
- The mobilisation of several targeted rapid improvement workstreams targeting admission avoidance and timely discharge from hospital.

These three elements are described in more detail in the remainder of this paper.

4.0 The Winter Operating Model

Considering the significant operational challenges and associated risks anticipated this winter, it is important that the system's winter operating model delivers a responsive, well-coordinated and effective approach to delivery of the winter plan and management of surge

pressures. While our Winter Plan outlines **what** it is that we intend to deliver, the Winter Operating Model describes **how** we will deliver it.

4.1 System Operations Centre

The national 'Going further on our winter resilience plans' letter issued on 18 October 2022 (BW2090-going-further-on-our-winter-resilience-plans-letter-october-22.pdf (england.nhs.uk)), sets the requirement for all systems to have in place a System Control Centre from 1 December 2022. NHS Sussex recognised the importance of having a Control/Operations Centre in supporting the management of a safe winter, and so has already instigated the establishment of its System Operations Centre (SOC) in September 2022.

The SOC went live on 3 October. The core team are supported by 'subject matter experts' (SMEs) from across NHS Sussex, including finance, nursing, medical, communications, transformation, digital, primary care, workforce, and operations. This team will co-ordinate the system response to any emerging pressures and work to help unlock issues and identify solutions.

4.2 Governance

The Winter Operating Model has a weekly cycle of system wide executive level meetings, supported by the outputs of the SOC, to ensure we have a mechanism for taking executive decisions on critical issues, in a joined-up way across system partners. Along with daily data insights there is a weekly data information pack which facilitates the monitoring and responding to emerging risks and trends.

A weekly Winter Board has been established, chaired by the ICB Chief Executive, and attended by NHS Provider Chief Executive Officer's, System Executives and Local Authority colleagues. The purpose of the Winter Board is to ensure we take leadership decisions in a joined-up way in response to any issues being escalated by the SOC, or through national or regional bodies. We recognise that there will be challenging decisions to be taken over the course of this winter to ensure that people can receive the care and support they need, and the Winter Board ensures that we have a mechanism to do that in a way that considers the needs of our entire population and the needs of staff working across both health and care.

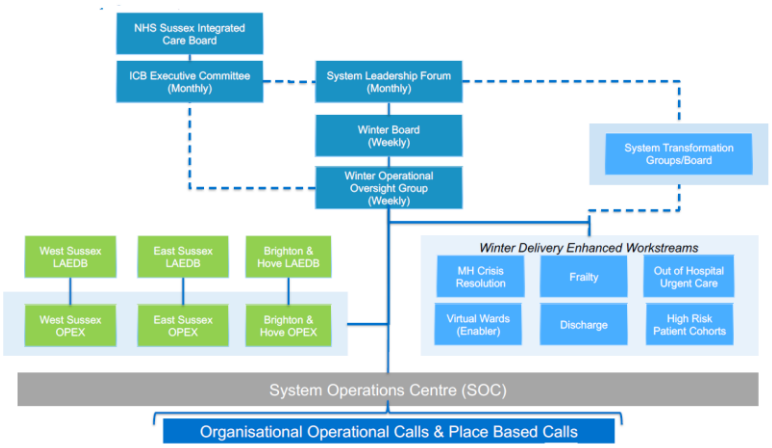

Figure 1: System Winter Governance and Oversight

5.0 The Winter Operational Delivery Plan

The NHS Sussex winter plan has been developed by building on individual provider and partner plans, and aligning with the areas covered by the NHSE assurance framework across the following core domains:

- aligning demand and capacity,
- discharge,
- improvements in ambulance service performance,
- improving NHS 111 performance,
- avoiding admission and alternative 'in hospital' pathways to improve flow,
- preparing for new Covid-19 variants/respiratory challenges,
- workforce, and
- communications.

The process for developing the system winter plan was agreed by the three place Sussex Local A&E Delivery Boards and covers all service areas across health and care, including the Voluntary Sector.

5.1 Aligning demand and capacity

The system has undertaken detailed demand and capacity modelling, informed by public health intelligence and seasonal trends, incorporating likely known pressures such as Flu and Covid, to understand the likely pressure on service capacity. Work is ongoing with UK Health Security Agency (UKHSA) to understand the potential health impact of the cost-of-living crisis so that this can also be incorporated into the modelling.

The plan includes a range of actions being taken to mitigate the capacity risks identified by the modelling and our approach to delivering safe and effective care.

The impact of these winter plan actions will be monitored through the system SOC throughout the winter period to understand whether these actions are delivering the expected impact or whether we need to increase our focus in particular areas where we continue to see pressures build or new issues emerge.

5.2 Discharge

Timely discharge is essential in supporting the right care in the right place. Discharging patients, with the right support, once they have no further need for acute medical care is key to the quality of care received and ensuring a good experience for local people It also supports improvements in flow through the hospital and a reduction in waiting times for patients in the Emergency Department (ED). This helps reduce the time ambulances may need to handover safely to hospitals. in a timely way and ensure people are admitted to the right wards where they receive care by the specialists they need to see.

The system is committed to discharge to assess pathways, supported by voluntary sector home support provision, and are working to optimise workforce capacity through technological innovations including the implementation of a virtual care and virtual ward model.

All providers have local plans to address the '100 Day Discharge Challenge' which is a national initiative of 10 key actions to improve flow through hospitals to support timely safe and effective discharges.

A system wide workstream to further improve discharge and system flow, building upon the continual improvement programmes at place, has been established as a key area for rapid improvement focus over the winter period. Detailed process mapping and evaluation of current pathways has been undertaken to inform the programme of improvement work.

While the majority of patients will be discharged back to their own home with no further care requirements, a number of patients will need additional support from community services or social care. Consequently, the work described above is a multi-agency approach involving all health, social care and voluntary sector organisations who play a role in supporting patients to be discharged from our acute, community or mental health beds.

5.3 Improvements in ambulance service performance

Improvements in ambulance service performance are a key area of focus for this winter, with a particular focus on reducing handover delays and improving ambulance response times.

In respect of reducing handover delays, a clear system escalation framework is in place, which identifies actions for acute providers to take if there are handover delays at the hospitals. In addition, the Sussex Winter Board has committed to significantly reduce long ambulance delays and the system escalation framework has been amended to reflect this as a key metric.

In respect of improving response times, South East Coast Ambulance Service (SECAmb) have fully implemented their 2018-23 fleet strategy and fleet requirements are in line with their current delivery model. St Johns Ambulance (Ambulance auxiliary service) are in place to support SECAmb and a Care Home line supporting direct access to NHS111CAS to reduce avoidable conveyances.

Within our system plan rapid improvement workstreams there are areas of focused work to improve the response of urgent community services, including the falls response service to reduce the number of category 3 and 4 conveyances, which will in turn improve ambulance response times.

5.4 Improving NHS 111 performance

To support the improvement in NHS 111 performance additional investment has been made to enable SECAmb to recruit an additional 111 whole-time-equivalent call handler, which should enable the service to ensure that 95% of calls are answered in 60 seconds and to

reduce call abandonment rate to <5%. Recruitment plans are in place and progress is being regularly monitored.

Action is also being taken to improve NHS 111 in respect of Mental Health (MH) crisis response ensuring that 24/7 MH Crisis lines are in place, integrated with NHS111. SECAmb have seven embedded MH professionals across their footprint, working in their Emergency Operations Centres (EOC) and Clinical Advisory Service (CAS), providing specialist advice and support for people with mental health concerns who access services via both 111 and 999 routes.

5.5 Avoiding admission and alternative 'in hospital' pathways to improve flow

Action to avoid unnecessary admission and alternative 'in hospital' pathways to improve patient experience, ensure the right service is available to best support people and to improve flow, is a key component of the winter plan, with rapid improvement workstreams mobilised to focus on out of hospital urgent care and the establishment of a consistent single point of access to urgent community response services across the whole county being implemented ahead of winter. In addition, there is a focus on strengthening existing community falls response to reduce pressure on the ambulance service where no acute medical support is required, and additional action being taken to provide preventative personalised care to individuals at high risk of hospital admissions. Further examples of admission avoidance actions include:

- Expansion of Acute Same Day Emergency Care (SDEC) pathways in acute and community services including links to acute multi-disciplinary assessment teams in emergency departments.
- A system wide clinical model for virtual ward (VW) care has been agreed for patients with frailty, respiratory and heart failure conditions. There are currently 54 virtual ward beds available across Sussex and this will increase to 125 by January.
- Urgent Community Response (UCR) to deliver streamlined admissions avoidance pathways to help support people in their usual place of residence.
- Consultant access for advice and guidance to health care professionals in Community and Primary Care services to support decision making and avoid unnecessary referrals to secondary care.
- Self-management advice materials for patients.
- Long Covid services and treatment services for those particularly vulnerable to Covid are in place including supply of oximeters for at risk patients in primary care.

5.6 Infection Prevention and Control

Given the challenges identified for this winter it is critically important that we maintain the highest standards of infection prevention control across our system and the following core prevention and control measures are in place:

- Provision of Infection Prevention Control (IPC) teams across acute and community settings.
- Daily Covid-19 monitoring.
- Established infection prevention governance monitoring and reporting.

- Specialist infection prevention support across Sussex to provide outbreak management across health and social care providers.

Additional controls being implemented across Winter 2022/23 include:

- Development of an updated Seasonal Infection Prevention Surge Plan.
- System infection prevention cell meeting weekly.
- NHS support to social care providers via local authority Public Health teams.
- Provision of additional specialist training for new infection risks identified.
- Provision of specialist FFP3 mask FIT testing to ensure compliance with National requirements.
- Mutual aid support across IPC teams such as personal protective equipment (PPE).
- Updated Respiratory Syncytial Virus (RSV) and Paediatric Surge Plan for managing increased activity in paediatrics caused by seasonal RSV.

5.7 Seasonal vaccination programme:

Ensuring that we maximise the uptake of both the flu and Covid-19 vaccination in eligible members of the population and our workforce ahead of winter is a key priority, ensuring that we continue to work with system partners and local communities to improve uptake in parts of our community where there is lower uptake identified.

As of 8th November 2022 53.4% (West Sussex 56.7%) of the eligible Sussex population have taken up an offer of the Covid-19 autumn booster vaccination with 94.3% (West Sussex 97.7%) of care home residents and residential workers, and 79.5% (West Sussex 83.1%) of over 80s having taken up the offer.

To support vaccine uptake across West Sussex, we are working with system partners on the following:

- Mobilised 2 Vaccination Units in West Sussex that are running 4-5 days a week to focus on low uptake areas such as Crawley, Littlehampton & Bognor Regis.
- There is a dedicated Vaccine equity co-ordinator who proactively engages with the local community of Crawley to highlight the importance of the vaccine and dispel any vaccine hesitancy in the community.
- Increased capacity across West Sussex to meet the demand trend in the month of October. This included a satellite site at the Hindu temple, Crawley, which not only improved uptake by 1-1.5k per week but also improved vaccine awareness in the Hindu faith community.
- Mobilised an additional 4 community pharmacy in key area of low uptake and hard to reach communities to improve access points.

As of 30 October, 38% (West Sussex 38.8%) of the eligible population have taken up the offer of a flu vaccination with 64.4% (West Sussex 45.7%) of all 65 and over, having been vaccinated. Practices and providers continue to plan and host flu clinics at practice sites, flu vaccinations are widely available for eligible patients at community pharmacists, local vaccination centres and practices. Plans for Mobile Vaccination Units in each area are underway to provide additional capacity for the delivery of both Covid-19 and flu vaccination in areas showing low uptake.

5.8 Workforce

Workforce capacity over winter is an identified risk within our system plan. Therefore, whilst we have been able to increase our workforce number, it is important that we continue with recruitment and retention activity, including overseas recruitment, and ensure that processes are in place to support the health and well-being of our workforce during the winter period and beyond.

The following measures are in place to ensure that optimum workforce levels are in place:

- Robust safe staffing escalation processes in place within each provider.
- System wide mutual aid systems and processes in place to enable the sharing of workforce across providers to maintain safe staffing levels and service provision.
- Sharing of pay rates across the system.
- Assessment of staffing levels daily, and implementation of local response actions to meet shortfalls in capacity.
- New roles and ways of working are being explored, for example the virtual ward programme.
- As a system we are a vanguard nationally in a violence reduction and prevention programme to keep colleagues safe in the workplace.
- Our workforce vaccination programme commenced in September to support protection of colleagues from contracting flu and covid infection in support or sickness absence position.

5.9 Communications

To support the winter plan, a Sussex communications and engagement approach has been agreed by all system partners. This aims to provide clear information about services and how people can access the health and care they need, influence behaviour change, maintain public trust and confidence and gain insight to support further operational solutions and responses.

The overarching approach follows the national ‘Help Us Help You’ campaign, and is structured over four key focus action areas:

1) Behaviour change campaigns – We will run a series of campaigns under the ‘Help Us Help You’ banner to signpost to services to encourage greater understanding and usage
2) Public Engagement – We will carry out targeted engagement with identified communities and groups to gain a greater understanding of their barriers/motivations to support operational interventions and delivery
3) Workforce – We will focus on specific communications and engagement with our workforce to support morale and wellbeing
4) Public confidence – We will develop a series of communications that outlines progress and issues in an honest and open way to help maintain public confidence

For each there is a focused action plan to share clear and effective communications with the public, stakeholders and patients. Materials and resources will be shared with all health

and care partners, and wider VCSE and community partners to ensure wider sharing to the public and our communities.

Effective communication both with our citizens and our staff is key to ensuring that we can deliver high quality services and treat patients in the most appropriate service and setting for their needs.

5.10 Planned Care Recovery Programme

As a system, our priority is to ensure that the recovery of elective and cancer care services continues, by securing capacity across Sussex which will not be impacted by emergency admissions. This will include using mutual aid between NHS providers, use of the independent sector where necessary, and the further development of Community Diagnostic Hubs. This will help us to continue with our elective recovery plan to diagnose and treat both the most clinically urgent and those that have waited the longest.

There is a Planned and Cancer Escalation Framework which sets out the underpinning principles, key triggers, and actions at each stage of escalation to protect the continuity of planned care and cancer services.

5.11 Mental Health

Mental health services have seen a rapid increase in need which has placed considerable pressure on the services that are available. Children and Adolescent Mental Health Services have seen particularly significant rises in need as a consequence of the pandemic.

One of the main objectives of the mental health winter plan is to reduce the number of patients having to receive inpatient support outside of the county, recognising the challenges that this creates both for the patient and their families. The plan does this by:

5.11.1 Reducing the need for admission to hospital by

- Creating 2 new Mental Health Havens (Worthing and Crawley)
- Creating a new Mental health clinical decision unit at Worthing
- Developing plans for a Mental Health emergency cohort facility at the Royal Sussex County Hospital

5.11.2 Supporting better clinical decisions at the point of admission

5.11.3 Reducing length of stay (LoS)

- Creating an Assessment / Triage Ward.
- Developing a clinically led complex case review processes
- Tackling unwarranted variation in length of stay.

5.11.4 Reducing delays in discharging patients by:

- Maximising the use of Discharge to Assess model in Brighton and Hove
- Review of the SPFT approach to bed management and patient flow from admission to discharge
- Expanding the West Sussex Discharge Hub model to Brighton & Hove.
- Engaging staff in the new Let's Get You Home Policy.

6.0 Enhanced Work Streams (Rapid Improvement Pathways)

The third component of the system winter plan relates to five rapid improvement pathways, which have been agreed by the senior leadership of the Sussex Health & Care system including local authority colleagues, which are summarised below:

6.1 Out of hospital urgent care

The focus of the out of hospital workstream is to improve ambulance response times

Objectives:

- To improve access to and utilisation of community pathways including a consistent single point of access
- Develop clear standardised referral and handover pathways into consistent admissions avoidance and other community pathways, to increase direct referrals and reduce conveyances where appropriate.
- Identify alternative pathways to safely convey suitable patients to destinations other than Emergency Departments (EDs)

6.2 Frailty pathways

The focus of the Frailty workstream is to ensure we have clear and effective frailty pathways including falls services in place Sussex-wide, with a focus on enhanced admission avoidance, through early support and intervention in the community, in care homes and in EDs.

Objectives:

- To improve access to and utilisation of community pathways to keep patients closer to home
- Establish core clinical principles of frailty pathway for Sussex.
- Deliver agreed targeted actions across Frailty Pathway

6.3 Discharge

The focus of the Discharge workstream is to ensure full implementation of each Place's discharge plan aligned to the Sussex agreed model, delivering the 100-day discharge challenge.

Objectives:

- To evaluate and optimise the current agreed discharge model
- To agree and establish a set of system metrics across the end-to-end pathway
- To agree and identify the high impact areas of focus, which will deliver improvements to ensure patients who are "medically ready for discharge" can be safely discharged in a timely way.

6.4 High Risk Cohorts

The focus of the High Risk cohorts workstream is to identify and support people who maybe at high risk of hospital admission over the winter, for example people with long term conditions.

Objectives:

- To offer proactive, personalised care for individuals at high risk of hospital admissions
- Maximise support through social prescribing link workers, health and wellbeing coaches, and care coordinators
- Improve symptom and condition self-management
- Increase access to a broader range of support options in their communities,

6.5 Mental Health crisis resolution

The focus of the mental health workstream is to reduce the number of patients, adults, children and younger people who are receiving their acute inpatient psychiatric care outside of Sussex

Objectives:

- Reduce number of inappropriate out of area placements (acute psychiatric care).
- Reduce length of stay within acute adults and older adults' inpatient units.
- Reduce number of patients who are identified as medically ready for discharge and not yet able to be discharged.

7.0 Local Plans – West Sussex

All the Sussex wide elements of the NHS Sussex Winter Plan apply to all parts of Sussex. The section below provides details that are additional actions West Sussex are taking.

7.1 Local Plans – West Sussex

Partners across health and social care have collaborated to develop detailed place based plans to address the current and expected challenges in demand across the winter months.

The general principles that have been agreed across West Sussex will help to support resilience across all partners to secure delivery of, and access to, health and care services, to maximise reablement and minimise the risk of harm.

The system is working together to support as many patients as possible to be treated away from emergency departments by increasing alternative options such as Urgent Treatment Centres and Urgent Community Response. The system will do all it can to support the timely discharge of patients and reduce the number of patients that are currently in acute and community beds who are medically ready to be discharged.

Local system oversight arrangements are in place across the West Sussex partners with senior operational touchpoint calls increased to daily (from twice weekly) during winter to help support the delivery of urgent and emergency care and discharge objectives. There

also weekly joint Executive oversight to solve any escalated issues or make timely decisions on new proposals so that we can remain responsive and flexible throughout the winter.

7.2 Acute Hospital Urgent Care Services

The main acute emergency departments used by the population of West Sussex are at the University Hospitals Sussex sites at Worthing, St Richard's Chichester and Princess Royal Haywards Heath and at Surrey and Sussex Healthcare Trust (SASH) site in Redhill. The SASH catchment area covers both north of West Sussex and Surrey. Generally, Sussex patients make up between 50-55% of attendances to SASH emergency department.

All the emergency departments at have seen a significant drop in performance following the Covid-19 pandemic with an increase in patents waiting to be admitted to the hospital. An increasing number of patients are choosing emergency departments as their first port of call with medical conditions who could often be treated in a different urgent care setting. As such, work is ongoing to improve flow to the co-located and stand-alone Urgent Treatment centres in order to maximise the number of patients that can be seen there, therefore freeing up more time for the Emergency medics to treat the seriously unwell.

This challenge to maintaining performance is also associated with an increased number of people who are ready to be discharged but are delayed which reduces the ability to admit patients through the emergency department.

Princess Royal, St Richard's and Worthing emergency departments are small and often busy with challenges admitting patients into hospital beds. This also results in long waits for patients before they are transferred to the wards. Both departments at St Richard's and Worthing have recently had building work and reconfiguration to help support patients entering the hospital from ambulances. Ambulance handover escalation triggers and actions have been agreed to provide a mechanism that all partners can react to provide support during time of challenged handovers.

University Hospitals Sussex has an Urgent and Emergency Care Improvement Programme which focusses on improving flow through the organisation to support the decongestion of the emergency departments. Escalation areas are open to increase the amount of bedded capacity to admit into, with further capacity to come online in the peak of winter.

Surrey and Sussex Healthcare NHS Trust have escalation areas open to increase capacity to admit into and a recent reconfiguration has seen the establishment of a medially fit for discharge ward. Plans are being explored to further increase inpatient capacity for winter.

7.3 Admission Avoidance

The Sussex wide enhanced work stream is developing an enhanced admission avoidance access point building on existing infrastructure of the community access point known as OneCall in West Sussex. The enhanced workstream is also enhancing the frailty response that will help support patients remain in their own home rather than being treated in an emergency department. This will build on and enhance existing West Sussex Urgent Community Response Services (UCR) provided by Sussex Community NHS Foundation

Trust (SCFT). The UCR services are developing improved access and responsiveness to non-injurious falls including supporting call outs to Care Homes to support them with assessing residents who have fallen but have not sustained any obvious injury. The UCR teams are working closely with the Ambulance Trust and its crews to increase awareness of the service offer and enable direct clinician to clinician decision making to support referrals into community as an alternative to conveyance

LIVI is a remote GP service which has been commissioned to provide remote consultations to 111 patients to prevent then having to attend face to face appointments. LIVI have successfully completed 70-80% of these consultation through remote consultation, saving the patient having to attend face to face and freeing up this valuable resource to be directed to those with more urgent needs.

An enhanced offering in the West Sussex Urgent Treatment Centres (UTCs), which can treat most injuries or illnesses that are urgent but not life threatening, will also help direct patients away from the main emergency departments if their condition is better suited to treatment there. In Worthing and Chichester an increase in available capacity in the UTC is to be directed toward support 'walk in' attenders to the emergency department

In north of West Sussex, SASH will benefit from redirecting West Sussex patients with suitable clinical conditions towards Crawley UTC which is open 24 hours a day 7 days a week. In addition, work is underway to enable SECAmb to directly convey appropriate patients to the Clinical Assessment Unit at Crawley which operates 8am to 8pm, for 6 days per week. This will be for patients who meet a defined medical need and who would benefit from an enhanced medical assessment but do not require treatment in an ED or UTC. This should be in place for December.

During the weekdays patients are also able to access the minor injury services at Queen Victoria Hospital in East Grinstead, Horsham Hospital and at Bognor War Memorial Hospital. Winter communications are encouraging people to use these services alongside other options such as community pharmacists as well as the 111 service.

Same Day Emergency Care (SDEC) access will be expanded with mechanisms for direct referral from SECAmb crews. A set of clinical condition criteria is being developed with each acute medical service to allow SECAmb to directly convey patients with predefined medical conditions to SDEC. These are patients who would benefit from the experience of an acute medical consultant, but who otherwise would have had to go through ED and potentially have led to an unneeded overnight stay. This will by-pass ED and take the patient to the right clinician the first time with the goal to treat the patient and discharge within the same day, thus avoiding an overnight stay, whilst also freeing up more capacity within ED.

7.4 Discharge

In West Sussex there are well established discharge pathways for people who are able to go straight home with no or very little further health or social care support; for people who can go home with some immediate health and social care assessment through "Home First" before being referred onto core community services; and for people who first need a period of rehabilitation in a bedded setting or who may need to go into longer term residential or

nursing care. These pathways are all continuing to be developed and reviewed to improve efficiency.

West Sussex continue to prioritise Home First as a preferred discharge pathway aligning to the strategic principle to allow patients to return to their own homes following an acute hospital stay wherever safe and practical, with funding going into the service for both clinical and domiciliary care capacity. A full pathway review of home first is underway with health and social care colleagues to identify areas of process improvement to help increase efficiency.

In addition to Home first, there is also some patients who continue their rehabilitation journey in a community rehabilitation bed provided by SCFT. The use of these beds is kept under review to make best use of capacity for people who could benefit from a period of further rehabilitation. SCFT will open super surge beds in their West Sussex facilities if necessary to increase the number of patients that can be discharged from the acute services for winter. SCFT also plans to open an additional 12 beds at Horsham hospital to support discharges over the winter period.

A key aspect to finding placements and care for patients is the Combined Placement and Sourcing Team (CPST) at West Sussex County Council. This team been recruiting to increase the number of staff that can support placement finding. New ways of working have been developed to ensure maximum efficiency within the team. A placement seeking agency has also been providing support to CPST in areas of high demand to help bring lists to a manageable level. This has proved very successful and exploration to roll out more widely is underway.

Some people may need a little bit of extra help to get home but do not need formal support. We are working to ensure our hospitals work effectively with our voluntary sector services who play an essential role in the local health and care system, for example through the Take Home and Settle service.

7.5 Primary Care Winter Planning

The approach to this winter has been informed by patient feedback highlighted and the experience of last winter. A £1.5m winter fund has been made available to those areas with the highest health inequalities to ensure better access to primary care. The key areas of focus will be to increase capacity; maximise its effectiveness; and improve communication between providers and with patients as described in the separate paper submitted to the committee entitled West Sussex HASC Briefing: Access to Primary Care.

7.6 Public Health

The West Sussex winter plan includes ongoing joint work with Public Health. This includes the work of the West Sussex vaccination cell to maximise vaccine uptake among target groups such as those living in deprivation, minority groups, homeless people and migrant workers. They are also maximising uptake of shingles and pneumococcal vaccines in eligible older adults. Public Health protection team and the ICB infection control teams also work closely together to prove support to the West Sussex provider care market with infection prevention control support.

8.0 Summary

There has been significant engagement from all system partners to develop a robust winter plan for the system, support local people to have access to the right services to support their need, and to put in place the mechanisms necessary to support delivery and respond in an agile way to pressures experienced across our services. Consequently, we are well placed both to deliver on the requirements set out in the national letters and plans issued in recent months, and to manage winter as effectively as possible with the resources available to us.

The plans set out the mechanisms through which we will remain sighted on the key issues, respond in an agile way to pressures and ensure that system leadership remains aligned on the key actions that we take.

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Heath and Adult Social Care Scrutiny Committee

23 November 2022

South East Coast Ambulance Service NHS Foundation Trust Improvement Update

Report by Director of Law and Assurance

Summary

South East Coast Ambulance Service NHS Foundation Trust (SECAmb) provides the ambulance and NHS 111 service across the whole of Sussex, Surrey, Kent and North East Hampshire. The Trust was inspected twice in 2022 by the Care Quality Commission (CQC). The first inspection, which took place in February 2022, focused on management and leadership and the NHS 111 service. As a result of this inspection, the associated 'well led' domain rating reduced from 'good' to 'inadequate', whilst the NHS 111 service retained its 'good' rating.

The most recent inspection, which took place in August 2022, looked at SECAmb's urgent and emergency care as well as its resilience teams, whilst also checking on the progress of recent recommendations. This inspection saw the Trust's overall rating move from 'Good' to 'Requires Improvement'. The report at Appendix A provides an update on the overall improvement journey for scrutiny by the Committee.

Focus for scrutiny

The focus for scrutiny is to assess the performance of services provided by SECAmb and whether these have improved in line with the requirements set out by the CQC.

Key lines of enquiry include:

1) Assurance that SECAmb has the capability and capacity to deliver the necessary improvements.

2) Whether SECAmb is meeting its operational performance targets, including response and handover times.

3) Assurance that specific areas identified by the CQC, including culture and leadership and urgent and emergency care are being addressed in improvement planning.

4) How patient outcomes are being impacted by current challenges experienced by SECAmb, and how these are being addressed.

5) The anticipated Winter 2022-23 pressures affecting SECAmb and how these are being addressed.

6) To identify whether any further scrutiny of this matter could add value (and if so, when and what the focus for this should be).

The Chairman will summarise the debate, which will then be shared with NHS partners.

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1. Background and context

1.1 The background and context to this item for scrutiny are set out in the attached report. There are no resource or risk implications directly affecting West Sussex County Council, as this is a report by the NHS, relating to NHS services.

Tony Kershaw
Director of Law and Assurance

Contact Officer
Rachel Allan, Senior Advisor (Democratic Services), 0330 222 8966

Appendices

Appendix A: Report on South East Coast Ambulance Service Update

Background Papers: None

West Sussex Health and Adult Social Care Scrutiny Committee

Wednesday 23 November 2022

South East Coast Ambulance Service Update: Winter 2022/23

Report from: Emma Williams, Executive Director of Operations
David Ruiz-Celada, Executive Director of Planning and Business Development
Author: Helen Wilshaw, Strategic Partnerships Manager

Summary

This report updates the committee on South-East Coast Ambulance Service NHS Foundation Trust's (the Trust's) planning and preparation for the anticipated Winter 2022-23 pressures alongside current performance. This report also updates on the current Urgent Emergency Care (UEC) transformation initiatives, and the ongoing improvement journey to respond to the 2022 Care Quality Commissioner inspection findings and recent NHS Staff Survey feedback. Lastly, additional development initiatives for West Sussex are included.

Introduction

1. The NHS frontline experiences considerable pressure over the winter period as demand for services tends to increase significantly with the onset of cold weather and flu. Winter pressures and associated planning is therefore a key issue for acute, mental health, community, and ambulance services across the NHS However, in recent years this pressure has been building not just in winter but throughout the year.

2. Winter planning is an annual process, during which all providers and Integrated Care Systems (ICS) are required to produce an assurance update for NHS England (NHSE) as part of the preparation for the predicted winter pressures. The UEC winter planning process has evolved during the last two years, resulting from the COVID-19 pandemic response and the transformational activities deferred to 2022/23 as a result. Key 111/999 winter planning is outlined alongside area relevant initiatives.

3. The most recent NHSE UEC Winter assurance documentation includes several ambulance service focus areas, recently reinforced with the 'Going further for Winter' assurance letters, as follows: -

    - Requirements for systems to improve coverage of community-based falls response services across their footprint, focusing ambulance capacity where it is needed most and building on existing community-based provider models in preparation for winter.

    - Working closely collaboratively with care homes to determine what alternative appropriate responses might be required to support more residents in their care home where appropriate and reduce unnecessary conveyance.

    - Reducing conveyances to A&E departments through improving the use of the NHS directory of services (DoS), and increasing the provision of same day emergency care, acute frailty services, acute respiratory infection hubs and virtual wards, presenting alternate and often more appropriate pathways for all system users.

    - Supporting high frequency users through proactive personalised care, focusing on complex and frail individuals and patients with multiple long-term conditions.

    - Implementation of System Control Centres (SCCs) to always ensure the safest and highest quality of care possible for the entire population across every area by balancing the clinical risk within and across all services.

4. As a regional provider of urgent and emergency care (UEC) services covering the counties of Kent, Surrey, Sussex, and part of Hampshire, covered by Frimley Health ICS, the Trust produces a winter plan, which combines updates on 999-provision (trust-wide) and NHS 111/Integrated Urgent Care (IUC) services provided within its operational footprint.

5. The Trust delivers the NHS 111/IUC contract across Kent & Medway, and Sussex. This service provision is centred around protecting emergency care 999 and acutes via enhanced clinical validation of these 111 triage dispositions. There are recent and planned additions to this service, namely the:

    - Open Access Crisis - enabling 111 to support mental health patients by routing calls at the national messaging level to local mental health lines. This was activated in Sussex on 1st November 2022, with Kent & Medway due to go live during March 2023.

- Single Virtual Contact Centre (SVCC) - working with regional 111 providers, commissioners, and NHS England representatives on supporting the SVCC framework to support call handling demand management at a national scale.

6. The Ageing Well programme has provided focus for Primary Care Networks (PCNs, groups of GP surgeries and multidisciplinary teams, supporting around 50,000 patients) to better support elderly and vulnerable community residents. Urgent Community Response (UCR) has been a key programme deliverable from April 2022, available to support common presenting conditions within a 2-hour timeframe to prevent avoidable admission to an acute hospital. All providers are being funded to deliver a 2-hour response to at least 80% of all referrals by October 2022. This is supplemented by virtual wards bed creation from November 2022, accessed by one single point for all appropriate community provision pathways, including other same day urgent and emergency pathways.

7. The Trust is working closely across all 4 ICSs to fully embed these priority pathways during Winter. This includes working to retain a core level of operational consistency to enable a responsive, effective, and high-quality service for all patients, whilst local place engagement supports place-specific population priorities.

8. Additionally, the Trust is progressing with its improvement journey, building on the organisational priorities developed in earlier in the year, alongside the NHS Staff Survey feedback and deliverables determined by the February and August 2022 CQC inspections.

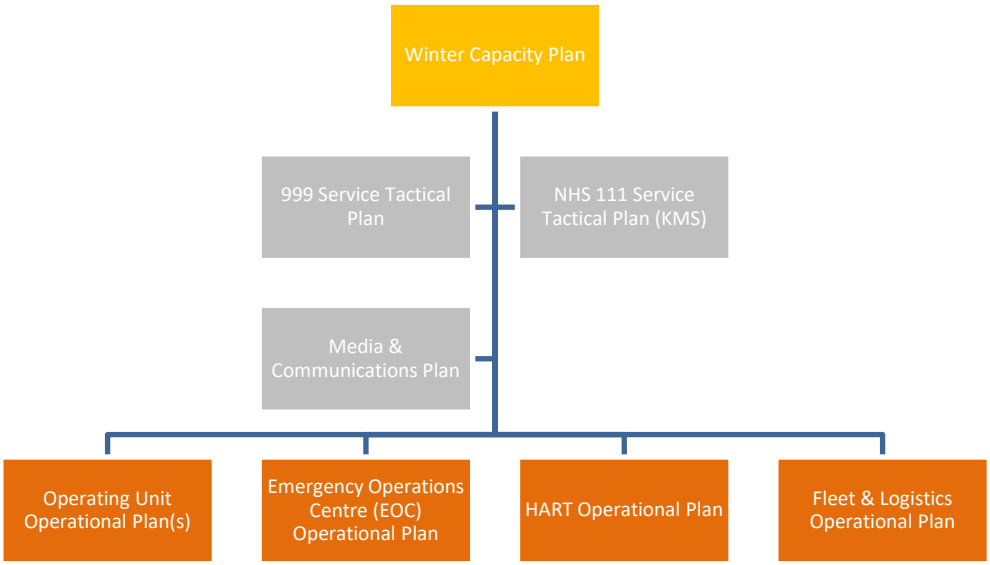
Winter Preparedness

Winter Planning 2022: Process and Timelines

9. The Trust Winter planning process was signed off by the Executive Management Board and Trust Board the end of September and was subsequently approved by lead commissioners Surrey Heartlands ICB. Winter preparedness also included a tabletop exercise which took place during October 2022. The Winter 2022 plan is attached in **Annex A**.

Key Focus Areas

10. The Winter plan includes the following component parts.



11. The core focus areas covered are the:

- Southeast region and local context
- System surge and winter planning factors
- Surge and demand forecasting and assumptions
- Workforce and resourcing
- ICS escalation frameworks
- Resource Escalatory Action Plan (REAP) and regional escalation processes
- Incident response framework
- High level actions
- Assurance and monitoring
- Local tactical plans for all 10 Operating Units, EOC, 111 and corporate directorates, including prior year learning.

12. Workforce remains challenged across the Trust in the post COVID-19 pandemic period, with reduced take up of overtime shifts and availability of bank staff hours and private ambulance provider hours. The recruitment element of the workforce plan is mostly on trajectory, however with higher than forecast attrition rates, sustained high levels of sickness absence, COVID-19 annual leave carry over and Core & Clinical Key Skills training delivery, these all add to workforce pressures. To mitigate this risk the Trust is recruiting additional international frontline staff. This is not an isolated issue when seen in the context of the increased levels of the Resource Escalation Action Plan (REAP) that ambulance trusts have been operating at during the summer.

13. With regards to escalatory processes, the Trust continues to apply its Surge Management Plan (SMP), and this fluctuates dynamically by minute/hour across each 24hr period. This mechanism enables dynamic decision making to mitigate clinical risk, particularly when demand outstrips resources. It is reported as between level 1 (lowest) and 4 (highest). The REAP level sits alongside the SMP also at a similar level 1-4 and is reviewed weekly based on several factors including activity demand, operational resourcing, levels of abstractions, performance and other system factors including acute systems Operational Performance Escalation Levels status (OPEL). There is no anticipated change of escalatory process internally, or with systems externally for Winter 2022/23

14. System engagement follows a standard weekly pattern with an NHSE/I call on Friday morning, further conference calls with system partners on the Saturday & Sunday ROC (Regional Operations Centre) calls and escalation calls managed at acute trust or system level (where multiple trusts are under pressure).

15. In addition, every Wednesday morning there is a weekly touchpoint between SECAmb and Commissioning leads. These meetings follow a standard agenda, reviewing Trust performance and quality, local system issues and specific issues for attention.

Additional 111 Planning

16. Call activity is planned with increasing granularity as the service approaches the winter period. The forecasts and staffing requirements are calculated at fifteen-minute intervals and utilise a complex workforce planning tool. The forecasts consider key metrics such as Average Handling Time (AHT), call profiles, and staff shrinkage (a combination of sickness and other types of non-attendance). All Annual Leave and rota changes at holiday periods must be authorised by the respective Contact Centre Manager, and escalation following the usual process to ensure 111 Senior Leadership Team (SLT) oversight.

17. Recent winters (2020-21, 2021-22) have been adversely impacted by COVID-19 with calls fluctuating dependent on lockdown status and other NHSE commissioned service capacity. COVID-19 activity into 111 replaced the normal winter illness surge attributed to flu, norovirus, and respiratory conditions.

18. As part of ensuring winter resilience in 111, no service closure (“red status” on DoS) is authorised without full stakeholder consultation and commissioner approval.

19. The escalation actions at the service’s disposal consist of a suite of options including:

    - Suspension of non-telephony activities for specific staff

- Patient Safety Callers nominated to manage low-acuity cases in the Clinical Queue
- Selection of Front-End Messages (FEMs)
- Flexible skilling of agents across the wider Trust.
- Utilisation of appropriate case “streaming” to designated downstream

20. SECAmb’s KMS 111 Team has extensive experience of being the gateway of the urgent and emergency care system, coping with the intensive pressures of holiday periods and the extended whole system pressure generated by winter pressures. The service has adopted learnings from previous winters and the COVID-19 pandemic, having expanded its collaborative network across partner organisations/services.

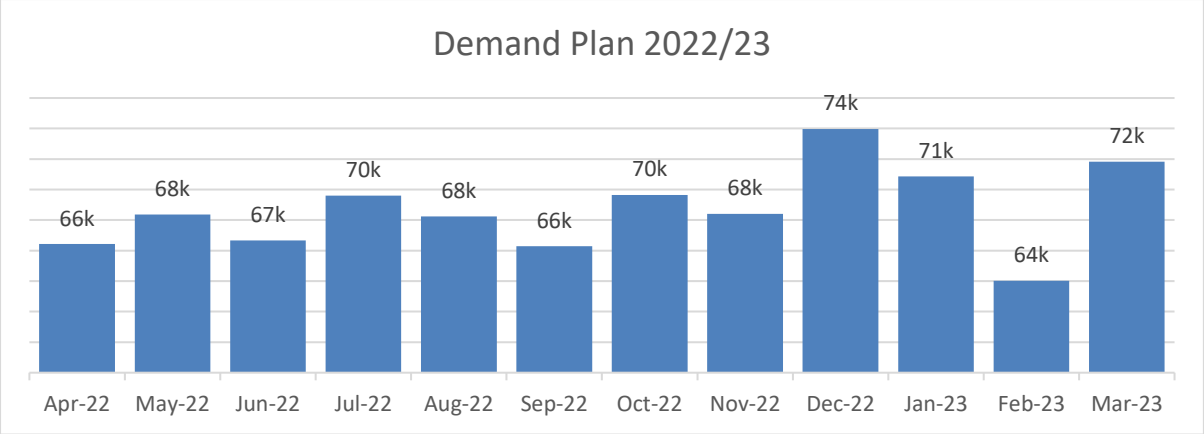
21. Additionally, in preparation for Winter 2022/23 there is a special focus being placed on delivering the Trust’s Improvement Journey key priorities (People & Culture, Quality Improvement, Leadership & Engagement, and Responsive Care) with staff engagement and feedback incorporated as part of the winter planning process.

22. The Trust works closely with its partners, including the ICSs across our region, to ensure we provide timely and useful information to the public ahead of and throughout the winter period and to explain the challenges faced by the ambulance service. This involves communicating with stakeholders, including the public, staff, and system partners, via multiple communication channels such as social media to traditional broadcast and print media as well as specific briefings.

23. These communications remind stakeholders to dial 999 only in the event of an emergency and making use of alternative urgent services such as 111 Online.

Planning and Performance

24. The Trust’s financial plan for the year was developed in line with 999 call activity expectations and this follows an approved demand profile as shown below:



25. Through the annual planning process, workforce and financial forecasts are aligned to this profile using a combination of abstraction management and productivity improvement to maintain or improve the performance across the winter months.

26. The committee is asked to note that, whilst there is no budget deficit to the 2022/23 plan submission, it does not provide the budgetary resources for the Trust to meet the Ambulance Response Programme (ARP) performance standards, against which all NHS ambulance services are benchmarked. The Trust continues to engage in dialogue with its commissioners to look at the resources available across the four Integrated Care Boards (ICBs) to mitigate this for the coming financial year.

27. Additionally, there has been a change in activity profile and acuity of calls being received with the percentage of the combined higher acuity C1 and C2 calls, growing from 55-60% of all ambulance responses to over 70% since October 2021, requiring increased resources to meet the targets. Throughout 2021 and continuing into 2022, the Trust has struggled to achieve its ARP targets. This is not isolated to the Trust, where the performance challenges of the past two years have been experienced by all ambulance trusts across the UK.

28. During 2022 the Trust's ARP performance has generally performed either in line or slightly better than the 'mean' results for ambulance services across England. **Annex C** illustrates the Trust's July to October ARP performance for all categories and the national position against national average. The comparable performance is particularly notable across C2, where the Trust has averaged 2nd or 3rd as a direct comparison between the 11 English ambulance services for both the 'mean' and '90th percentile' performance. The Trust's position for C1 has also improved in recent months from 8th in January 2022 to 2nd in July and mid table to October. C3 and C4 performance is more challenged and remains the focus of several development initiatives (outlined in this paper) which are beginning to show improved results, with the Trust moving

from bottom of the table to 7th in October with still more improvements initiatives rolling out through Winter.

29. The West Sussex geography is served by 3 dispatch desks, Worthing, Tangmere and Gatwick. The combined ARP October 2022 performance is highlighted in **Annex D** and is also showing an improved position in October versus the Summer months. Performance links closely with increasing handover challenges at both Worthing District General Hospital and St. Richards Hospital, however continuous local dialogue to provide a more effective front door process, alongside ongoing development work for a full and consistent Same Day Emergency Care pathway offer as a non-bedded alternate to the Emergency Department presentation aims to support handover improvement.

30. Local system partnership working, and Ambulance workforce recruitment over the Winter will further support improved performance. The Trust drive for increased 'Hear and Treat', increased senior clinical support to crews for enhanced decision-making using community response services, and an emergency community first responder scheme pilot being targeted for the A272 corridor will all contribute to greater support response to this area.

31. Planned productivity improvements are monitored monthly through the Trust's Annual Planning Group and in addition to the workforce commentary already provided, the current report shows that Hear and Treat (H&T) continues to be above the planned assumptions, however the gap between job cycle time and the assumption has increased to almost 3 minutes due to handover delays and increased travel to scene times.

32. Hospital handover assumptions are aligned to achieving the 2022/23 NHSE planning guidance to:

    - Eliminate handover delays over 60 minutes
    - Ensure 95% of handover take place within 30 minutes
    - Ensure 65% of handovers take place within 15 minutes
    - This assumption equates to a target handover of 18 minutes 45 seconds.

33. As shown in **Annex E** the ambulance handover performance across the hospitals serving the Sussex population averages at 23 minutes 8 seconds for the current financial year and the mean handover duration has an increasing trend over the last twelve months whilst the mean wrap-up time has decreased same time.

34. The Trust has regular tactical and operational handover reviews with each acute trust to jointly identify and agree key areas for improvement against the handover principles agreed Trust wide, alongside the prior focus areas outlined

at paragraph 24 for the West Sussex hospitals. East Surrey Hospital and Royal Sussex County remain challenged but with key improvement initiatives agreed jointly with each Trust. The Trust continues to work on additional UEC transformation initiatives to reduce Emergency Department (ED) conveyances further.

CQC Inspection, Rating and Improvement Journey

35. The Trust is committed to making improvements following the two recent CQC reports published in July and October 2022.

36. The first inspection, which took place in February 2022 looked at the Trust's management and leadership, the emergency operations centres (EOCs) and the NHS 111 service. The associated 'well led' domain rating reduced from 'good' to 'inadequate', whilst the NHS 111 service retained its 'good' rating.

37. The Trust was pleased that the excellent care provided by its staff was recognised in the report and that their kind, compassionate and supportive approach towards patients was noted, and was especially pleased to see the NHS 111 service retain its 'good' rating following a challenging two years which has placed significant strain on the service.

38. However, feedback received through the NHS Staff Survey and CQC findings highlighted a failure to demonstrate the thread of quality within the Trust, a disconnect amongst senior management and the wider organisation and a lack of understanding of the Trust's vision.

39. The Trust's Leadership Team has set out key priorities for the 2022/23 including building a culture that fully reflects the Trust's values, supports its vision, ensures the satisfaction and wellbeing of its people, and embeds quality improvement.

40. To address the concerns outlined by the CQC, the Trust has developed an Improvement Journey plan designed around its key priorities, staff engagement and feedback. The plan is formed from 4 key programmes People & Culture, Quality Improvement, Responsive Care and Sustainability and Partnerships, set out to deliver short-term targeted actions that will address the CQC warning notices, must-do, and should-do actions, as well as providing a vehicle for delivery of improvement beyond the initial period of recovery.

41. Additionally, the Trust has appointed a new Interim Chief Executive, Siobhan Melia, who took up her role on 12th July 2022, has a strong clinical background and is an experienced Chief Executive with good knowledge of the region and the Trust's partners.

42. The serious concerns surrounding culture and leadership highlighted by the CQC are being taken extremely seriously and the Trust has already begun the work to implement improvements at pace, including an important campaign – 'Until it Stops'. This key campaign has been launched to raise awareness of sexual harassment, increase support to make it easier to act quickly, safely and eliminate any such behaviours across the Trust. Key components include strengthening policy, recruiting Dignity at Work Advocates, sexual safety training for line managers, and implementing an interactive bystander tool kit which provides all employees with the tools needed to challenge unacceptable behaviour.

43. The most recent inspection, which took place in August, looked at SECAmb's urgent and emergency care, as well as its resilience teams, whilst also checking on the progress of recent recommendations. This inspection saw the Trust's overall rating move from 'Good' to 'Requires Improvement'. The individual rating for Caring remains rated as 'Good'.

44. SECAmb is pleased the care provided by its staff was recognised with a 'Good' rating and that inspectors found and were encouraged that Trust leaders were showing a sense of urgency in prioritising the issues previously identified.

45. The improvement plan focuses on four pillars, each led by a Trust executive: -

    Quality Improvement - "We listen, we learn and improve"
    Led by Robert Nichols, Executive Director of Quality and Nursing

    Responsive Care - "Delivering modern healthcare for our patients"
    Led by Emma Williams, Executive Director of Operations

    People and Culture - "Everyone is listened to, respected, and well supported"
    Led by Ali Mohammed, Executive Director of Human Resources & Organisational Development

    Sustainability and Partnerships – "Developing partnerships to collectively design and develop innovative and sustainable models of care"
    Led by: David Ruiz-Celada, Executive Director of Planning and Business Development

46. **Annex F (1)** illustrates the key improvement milestones for the coming year and **Annex F (2)** the key deliverables under each improvement pillar.

47. Work includes improving learning from incidents, as well as further recruitment and greater retention of staff. It also involves growing the Trust's voice within the wider NHS system to support improved patient pathways, reduce hospital handover delays and develop new partnerships.

48. Through the Recovery Support Programme, the Trust will receive intensive support from NHS England to help it improve and the Trust must set out clear actions and objectives on how it will bring its services up to the required standard.

Other Urgent Emergency Care Transformation Initiatives

49. The Trust is progressing several UEC transformation initiatives in response to the NHSE 2022-23 priorities and operational planning guidance, which link in with the recent UEC Assurance framework launched August 2022 (see paragraph 6). Relevant documents are attached at **Annex B** for information.

Acute Interface

50. The Trust was at the forefront of the roll-out of the initial NHSE national 'Think 111 First' (T111) initiative and worked closely with commissioners to facilitate the deployment of the region's digital interoperability roadmap. The KMS 111 service is now consistently validating almost 50% of emergency department dispositions reached in 111 and this will continue to be an area of key focus to avoid unheralded demand in the region's acutes.

51. Hospital handover - The Trust is one of the highest performing ambulance trusts with regards to handover hours lost and whilst this still has considerable impact, the consistent usage of the delayed and immediate handover policies with acute partners has provided a lower risk environment during increased levels of surge, when category 1 and 2 calls are awaiting an emergency response.

Category 3 and Category 4 response

52. To reduce the number of inappropriate 999 incidents, the Trust is operating within the NHSE protocol to place all non-emergency C3 and C4 dispositions into the clinical queue for ambulance validation. This is incredibly effective with Kent & Medway, and Sussex (KMS) 111 consistently validating more than 95% of calls, sent through as non-emergency ambulance dispositions in 111. This results in downgrading more than 60% of 999 dispositions to other appropriate urgent or primary care services. In doing so, this reduces the pressure on the 999 service and enables more resource for the C1 / C2 responses.

53. In addition, the Integrated Care Senior Leadership Team is responsible for both the NHS 111 service and the Trust's Emergency Operations Centres. This enables the Integrated Care (999 & 111) clinical team to flex clinician resource between the 999 and 111 services, where appropriate and share best practice, this is equally applied to 111 and 999 C3 / C4 validation.

54. With the implementation of the NHS Digital Pathways Clinical Consultation Support system (PaCCS), specialist paramedics in the Trust's emergency operations centres in Crawley and Ashford, alongside the ten Urgent Care Hubs hosted in local operating units trust wide, provide the ability to perform remote consultations in integrated urgent care settings. This increases the opportunity to clinically triage risk assessed 999 incidents, direct to a more appropriate community or acute pathway, such as Urgent Community Response (UCR) or Same Day Emergency Care (SDEC), without dispatching a physical ambulance resource, or necessarily needing to speak directly with the service provider.

55. The Trust is working to maximise the potential of PaCCS, via a focussed training plan to upskill the remaining workforce. The 111/IUC training plan continues with courses planned each month in line with recruitment for all skillsets. The 999 rollout for all band 7 Paramedic Practitioners (PPs) and experienced band 6 paramedics who have submitted an expression of interest will also booster capacity over the Winter. The training will start from 21st November with weekly courses planned, a 3-day course for 12 clinicians, followed by 1 weeks mentorship in one of the Emergency Operations Centres (EOC). Delivered 3 times a month, this will provide additional capacity for 36 staff per month.

56. The Urgent Care Hubs are manned by PPs to support review of Category 3 and Category 4 calls awaiting dispatch as well as supporting crews on scene with the most appropriate patient decision. The new rota provision will result in an uplift to 10 Hubs across the Trust operating 24/7 when fully covered, to maximise the appropriate usage of the acute SDEC and community urgent care pathways, such as UCR and Urgent Treatment Centres (UTCs) for lower acuity incidents. These pathways are rapidly changing with new additions monthly, and effective profiling of pathways on the DoS is imperative to support operational crews locating the appropriate pathway depending on the patient's location.

57. The Trust is undertaking a detailed audit to ensure the consistent profiling of these pathways on the NHS Digital platform *Service Finder*, for which SECAmb has the highest uptake nationwide with over 2,000 users.

58. Additionally, there is ongoing investment in the clinical support structure through the establishment of the Practice Development Leads (PDLs) to provide local clinical support, education, and interface to Trust clinicians. The PDL role also provides enhanced clinical capacity to work across ICSs to further develop effective UEC patient pathways across the acute and community footprint.

Admissions Avoidance * Appropriate Pathways

59. The Sussex Urgent and Emergency Care Transformation Board provides ICS oversight for the development of all appropriate pathways to reduce admissions to ED. The current focus is on consistent presentation of community 2-hour UCR, acute Same Day Emergency Care (SDEC) and Virtual Ward (VW) pathways, with Frailty being the initial focus for rollout from November.

60. The ICS is leading the way on building a single access point into all appropriate pathways, for ease of use by all health and social care professionals initially and expanding access during Winter to non-registered system staff to include Care Home and domiciliary care workers. It is recognised that increased utilisation of these urgent and emergency pathways by other health and care providers will lessen the demand on 999 services for C3 and C4 incidents, which in turn will release 999 resource to support higher acuity C1 and C2 calls, whilst reducing conveyances to ED.

61. The Trust is also working with lead commissioners to secure winter monies to fully mobilise a single access point into community pathways and will further support an enhanced community falls response pathway requested in the NHS England “Going Further for Winter” assurance. This aims for Level 1 non-injury and Level 2 minor injury falls to receive a community-based response, with 999 ambulance response reserved for the Level 3, serious injury or illness related incidents. This is further supported by the 999 contract CQUIN (Commissioning for Quality and Innovation framework) to improve care for elderly fallers.

62. This CQUIN contains a programme of activities to deliver improved care to this patient group over the coming financial year by:

    - Developing a better understanding of the elderly faller’s data.

    - Working with local careline provider’s and care homes to educate on the initial assessment and quicker response potential to prevent the associated deterioration with long lies and better support elderly fallers at first contact.

    - Raising the profile of the Urgent Community Response service and associated falls teams that should be available to support 8am-8pm daily ahead of calling 999 where risk appropriate.

    - Providing rollout of a more rapid response via a 999 community falls responder, where available and supported virtually with clinical oversight or a backup ambulance crew where required. Responses would be prioritised for residents in their own home rather than in a Care Home residence.

63. First initiated in the West Sussex area, Worthing Tangmere and Gatwick dispatch desks developed a ‘Champions Launch’ approach, jointly with our

community partners, Sussex Community Foundation Trust, for full local testing, familiarisation, and feedback on pathways ahead of a wider pathways' communication campaign, designed to embed usage longer term. This is ongoing throughout Winter as service provision and confidence builds between us.

64. Finally, we are providing local support to frequent caller homes, alongside the Care Home matrons to make more appropriate triage decisions for residents, with a focus on the falls response pathway to reduce the harm caused by falls long-lies, and development and usage of anticipatory care plans that reflect a patient's wishes for treatment.

65. All these initiatives will combine over the coming winter to provide enhanced decision making for patients in physical health crisis, ensuring that they receive the right care – be that at home with Urgent Community Response (UCR) services, providing follow up assessment and triage into appropriate wraparound health and social care, or conveying to a non-ED SDEC to provide a non-bedded acute intervention from which, if appropriate, they can return home on the same day.

Mental Health Response – Ambulance Conveyance

66. During 2022, the *Improving the Ambulance Response to Mental Health: Long Term Plan Commissioning Guide* was released placing a focus on education and training, and the integration between mental health, NHS 111 and integrated urgent care (IUC) providers, ensuring ambulance services are considered an integral part of the planning and delivery of local urgent mental health care.

67. In line with this guidance, the Trust is focussing on:

- Providing enhanced mental health training and education to frontline staff.
- Enhancing and building on the mental health practitioner provision within the emergency operations centres, to support patients in crisis, triaging to the most appropriate pathway.
- Working with commissioners to consider an appropriate enhanced ambulance response model of care.

68. The Trust is also working in partnership with the Sussex Partnership Foundation Trust to develop a resource effective, patient focussed response, known as the Blue Light Triage (BLT) model. This is being piloted from June 2022 with the BLT team providing telephone and on scene support to crews to expedite the most appropriate response for the person in crisis.

69. Initial patient and provider feedback is positive, with early indications showing that most incidents can be resolved with telephone support and where there is a need to converge on scene, this is taking place within the 1-hour target from time of agreement to assessment outcome.

70. Using a Plan Do Study Act (PDSA) methodology, the initial 3-month review is underway. Initial data shows significantly reduced ED conveyance outcomes, even in the longer more complex incidents. However, this has resulted in increased on scene times, which we will look to better understand through using the special cause variation method. If the BLT model is deemed successful, it will be presented for Sussex ICS rollout during Winter.

West Sussex Stroke Reconfiguration

71. The Trust has supported the West Sussex stroke reconfiguration programme since inception 2018 and fully support the preferred option presented for public consultation. We will attend the forthcoming January Committee update.

Conclusions

72. SECAmb requests the Health and Adult Social Care Scrutiny Committee to note:

- The winter planning in place across all emergency service provision, together with the UEC assurance focus areas outlined.
- The performance and planning section highlighting the workforce challenges and remedy outlined.
- The recent CQC inspection report and the Trust's Improvement Journey outlined for update in November 2022.
- The additional UEC transformation updates provided with key focus on Category 3 and Category 4 response, Acute non-ED pathways, and developing response models to empower improved service for elderly fallers and those suffering a mental health crisis.

Recommendations and Next Steps

73. To note the report provided and seek clarity where required.

Report contact
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Annexes

Annex A - SECAmb Winter Plan 2022 - 23

Annex B - NHSE documentation

Annex B1 - NHSE 2022-23 priorities and operational planning guidance

Annex B2 - NHSE UEC Assurance capacity and planning for Winter 2022

Annex B3 - NHSE UEC Assurance framework

Annex C – Ambulance Response Performance Metrics – July – October 2022

Annex D – West Sussex ARP Performance metrics – October 2022: Gatwick, Worthing, and Tangmere Dispatch Desks

Annex E – Ambulance Handover Performance – Sussex Health & Care Partnership ICS April 22 – October 22

Annex F – CQC and Improvement Journey 2022/23

Annex G - Glossary of Terms

SECAmb Winter Plan 2022-23

v0.10

Document Control

Version:	1.0
Name of originator/ author:	Dave Williams, Head of Resilience and Specialist Operations
Responsible management group:	Resilience Forum / SMG
Directorate/team accountable:	Operations
Approved by	Emma Williams, Executive Director of Operations

Version control

Version No.	Comments
0.1	Initial draft by Dave Williams, Head of Resilience & Specialist Operations
0.2	Initial responses added
0.3	OU Responses added
0.4	Elements from Scheduling, performance cell and CFR
0.5	Objectives
0.6	General review and edits
0.7	Addition of EOC & 111 components
0.8	Final OU response added (Dartford & Paddock Wood)
0.9	IPC Element updated
0.10	Updates to Medical, addition of CCP & Finance and winter Objectives
1.0	Final Draft version - published

Introduction – Director of Operations

- The past two winters have been difficult across all parts of the health and care system, on a local, regional, national and international level.
- The Covid-19 pandemic has yet to reach an end point, and has had a significant impact on patients, staff and the population that SECAmb and the wider NHS serves.
- This plan summarises the approach to winter being taken by SECAmb as part of the annual planning cycle.
- We will continue to work with all partners to provide a coordinated, integrated emergency and urgent care service through aspects of delivery through the winter period.

SECAmb Winter Plan – Introduction

- The NHS continues to experience significant levels of demand. While the impact of Covid has currently decreased, there is uncertainty around the recovery element moving in to Winter 2022. The potential impact of Covid variants allied with winter diseases continues to provide obstacles to modelling the impact on call volume and staff absence.
- SECAmb has experienced a particularly challenging year, with operations being faced with a number of significant problems including heatwaves, drought, the ongoing impact of Covid and the operational requirements of the London Bridge response.
- This year's winter plan has been structured to include additional considerations such as:
  - Recognition that the UK is still at Covid Pandemic level 2 which means that COVID-19 is present in UK, but the number of cases and transmission is low,
  - Continuing significant patient flow issues across the south-east region that are directly contributing to handover challenges which in turn contributes to a reduction in availability of SECAmb resources to attend calls,
  - Workforce challenges due to much higher levels of abstraction continue to result in delayed responses to calls – both call answering and attendance to incidents requiring an on-scene assessment/conveyance.

Context - Preparation

- A review of last year's plans by all operational service lines and directorates, and lessons identified have been incorporated in the development of the year's plans. The plans also include Performance Cell predictions of demand and resourcing across the 111 and 999 services.
- The Trust Outbreak plan has been updated in line with national guidance
- The work to deliver improved rotas within Field Operations continues with the intention to ensure resource provision planning is more aligned to actual need, and therefore ensure a more sustained, better performing service resulting in optimal patient care.
- There is continuing recruitment at pace for Emergency Medical Advisors & Health Advisors across the 999 Emergency Operations Centres and the 111 Service Line – this is being done in line with plans & trajectories agreed with commissioners, and in-line with the national intentions linked to the Integrated Routing Platform in 999 and the 111 Single Virtual Contact Centre strategies.
- Further considerations needs to be given to the potential impact and response approach during periods of adverse weather planning.

What are we seeing locally

- Increased call rate to both 999 and 111 services.
- Resultant extended periods of time at SMP 4.
- Impact on wider health resulting is long delays at ED, with an associated loss of hours available for service delivery.
- Poor overall performance against ARP targets, reflecting the national picture.
- Staff continuing to utilise their annual leave (max annual leave) in an attempt to rest and recuperate.
- Elevated levels of sickness absence.
- High levels of duplicate call rates.
- Increased requirement for system engagement.
- Impact on specialist resources (HART, SORT, CCP, PP). HART/ SORT information is now part of a national daily report, and the trust is required to take actions to mitigate any shortfalls.

System Surge and Winter Planning Factors

- Continued participation in Local Health Resilience Partnerships (LHRPs), working with health provider partners across all counties to develop shared plans for the continuation of care delivery in all circumstances.
- Continued participation in county-based Local Resilience Forums (LRFs) winter preparedness programmes – each forum holds an annual summit delivering integrated planning across health and non-health organisations
- Participation in local, regional, and national exercises:
- Local, e.g. contingencies associated with acute trust concerns above/beyond current delivery challenges
- Regional, e.g. contingency planning for utilities outages
- National, e.g. attendance at the Winter Preparation Event – Winter Preparedness: Reducing Risk and Sharing Good Practice (London, 28/09/22)
- Risks:
  - Potential industrial action across health and other agencies/services
  - Fragility of the provider networks, particularly in social care and the impact on patient flow in health
  - Potential worsening socio-economic pressures resulting in an increase in levels of vulnerability in the community
  - Increased scrutiny and reporting requirements at a regional level
  - Lack of consistent, sustainable system approaches through to resolution for individual provider issues

Specific Winter Objectives

Objective 1 – Demonstrate increased partnership working across Health and other Local Resilience Forum Partners

- Ensure engagement and sharing of information with Health and LRF Partners during the winter period.
- Weekly operational situation reports circulated to partners

Objective 2 – Improve SECAmb situational awareness of escalating issues both regional and system-wide

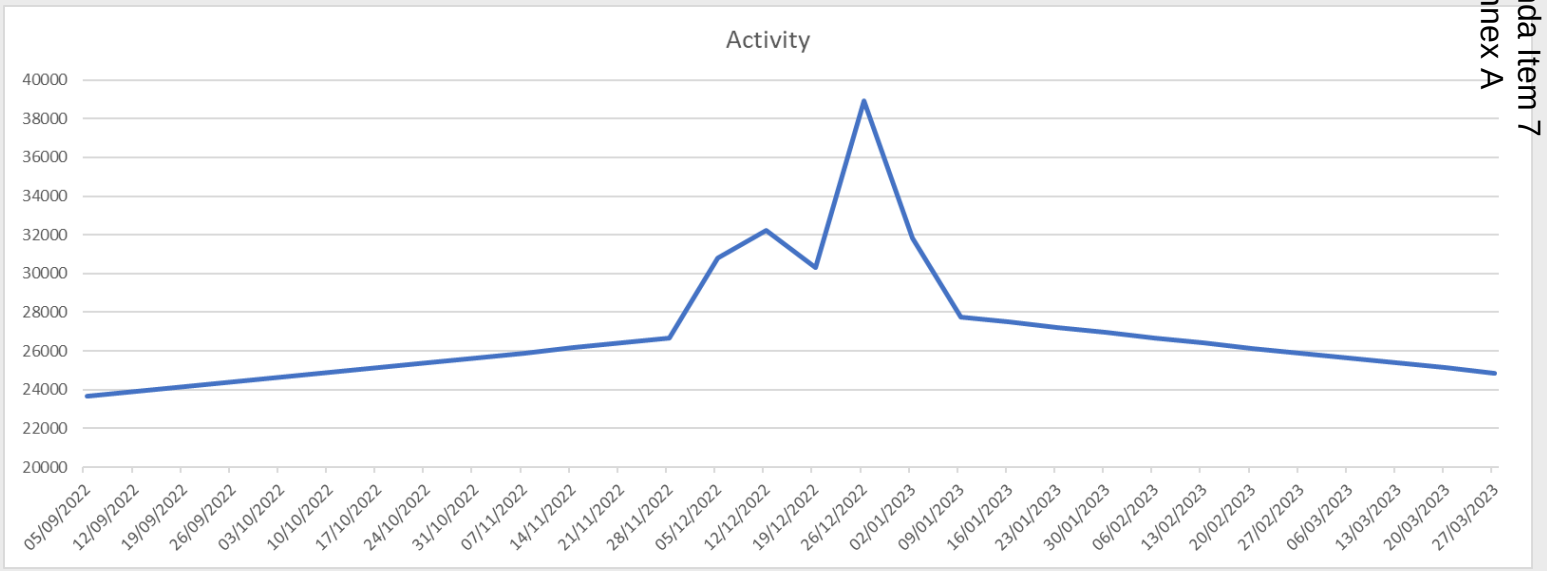
- Engagement with battle rhythms across all ICBs and regional groups, e.g. Winter Board, ROC etc

Objective 3 – To prepare for the impact of Covid variants, Influenza and other winter

- The seasonal influenza vaccination programme starts in autumn 2022, in house.
- Staff are being directed to services where they can receive their covid booster vaccine.

Forecast 111 scenario

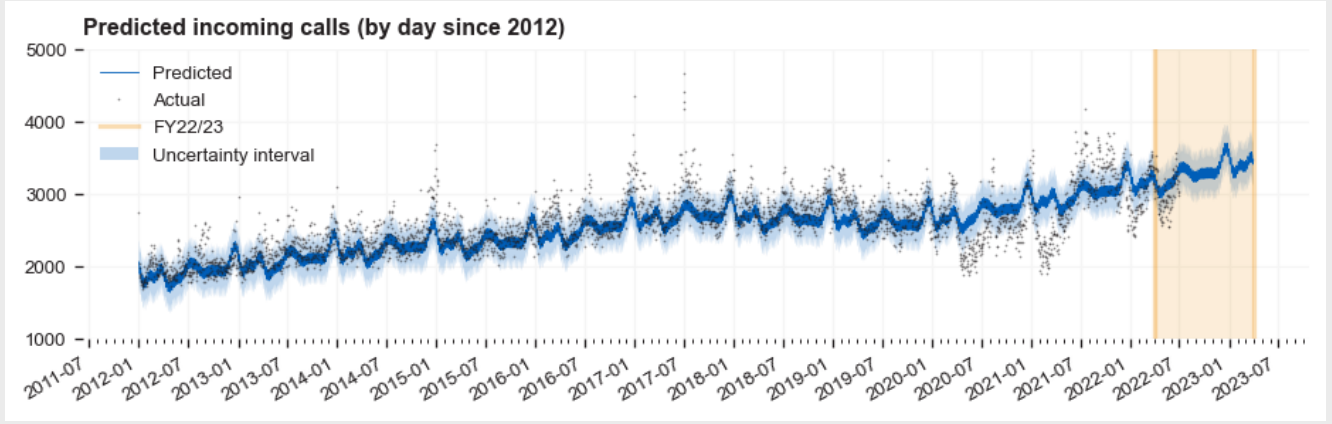
- Call activity is planned with increasing granularity as the service approaches the winter period.
- The forecasts and staffing requirements are calculated at fifteen-minute intervals and utilise a complex workforce planning tool.
- The forecasts consider key metrics such as Average Handling Time (AHT), call profiles, and staff shrinkage.
- Staff planning operates on a rolling 12-week window.

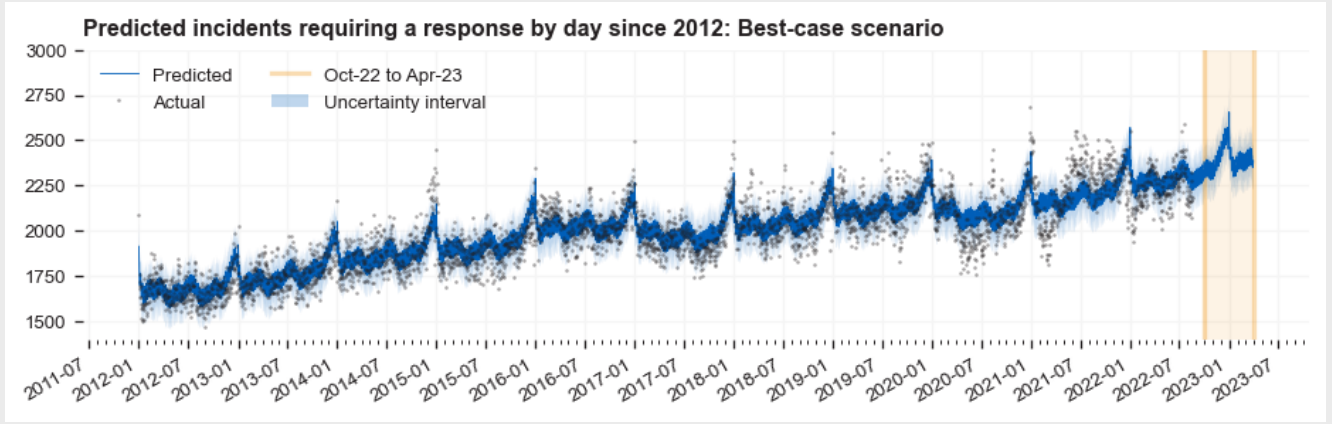


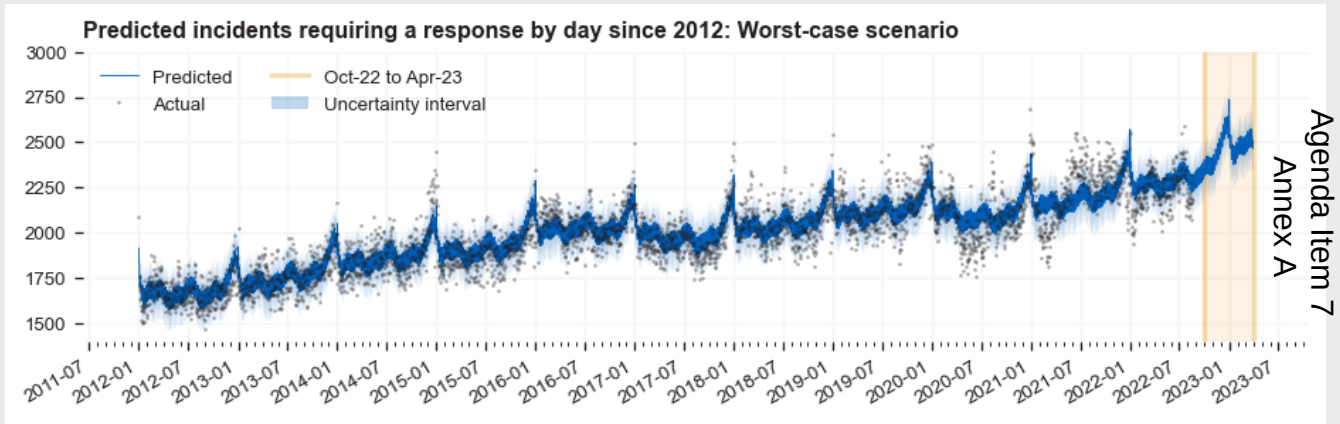
- The above weekly activity forecast is based on current revised forecasts of 1.46m and a cross between new and old (pre and during COVID) activity patterns

Forecast 999 scenarios

- Once COVID-19 lockdowns are accounted for, emergency call volume at our EOCs continues to increase each year. For FY 22/23 a 21-25% increase in emergency call volume from 2019 is anticipated.
- Since 2017, the introduction of ARP, and new ways of working in our EOCs have increased the hear & treat rate, slowing the rise in incidents requiring a response.
- However, increased incident cycle times, worsening hospital handover performance and recruitment challenges mean that the ability to meet demand still poses a significant operational challenge.





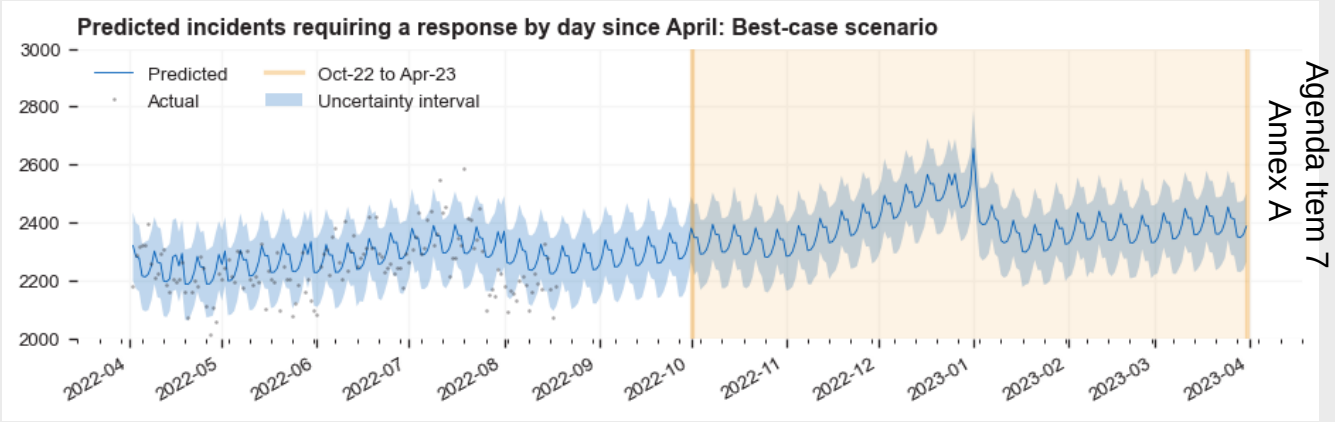


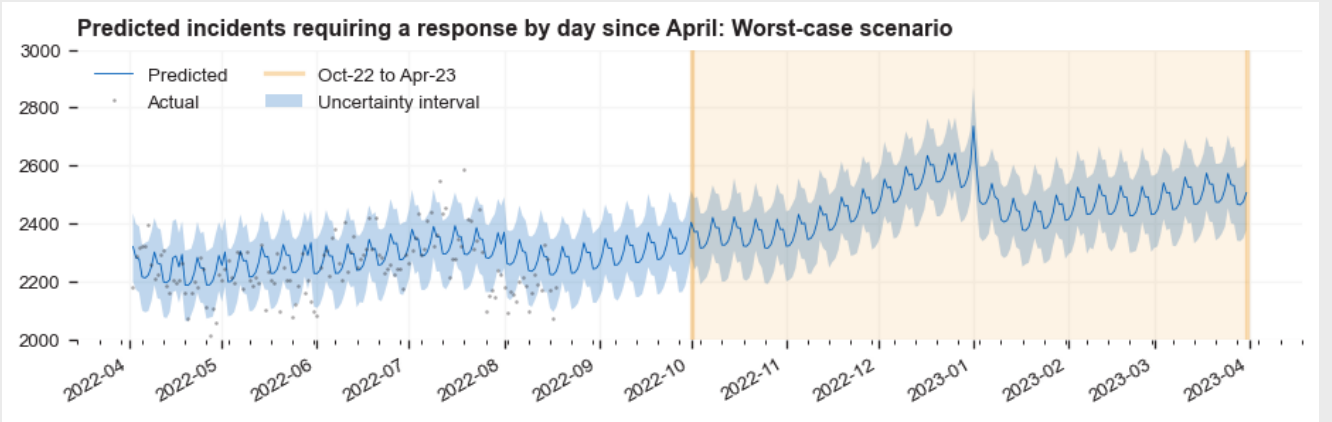
Forecast 999 scenarios

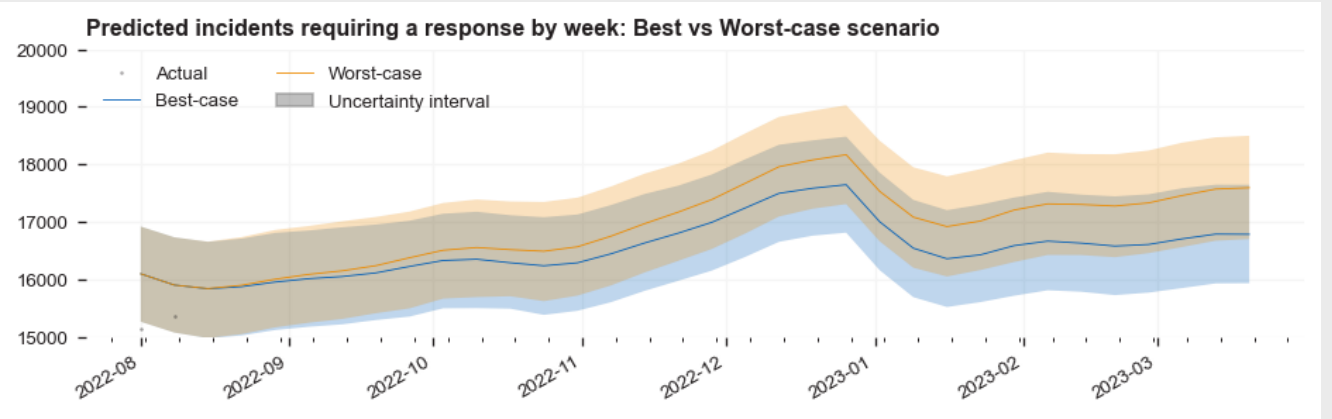
Two potential scenarios are provided for winter planning

- **Best-case** assumes that job cycle time components including hospital handover and wrap-up times remain relatively stable, and that this winter is mild
- **Worst-case** models a rising-tide of service demand as winter progresses, eventually leading to a 5% increase in demand over the best-case

	Best-case IRR	Best-case lower limit	Best-case upper limit	**Worst-case IRR**	Worst-case lower limit	Worst-case upper limit
Aug 2022	70,472	66,749	74,144	70,518	66,792	74,193
Sep 2022	68,848	65,254	72,440	69,284	65,667	72,899
Oct 2022	72,268	68,568	75,918	73,215	69,467	76,913
Nov 2022	71,021	67,443	74,623	72,436	68,786	76,109
Dec 2022	77,104	73,389	80,811	79,162	75,348	82,967
Jan 2023	73,685	69,958	77,460	76,156	72,303	80,057
Feb 2023	66,471	63,048	69,884	69,137	65,577	72,687
Mar 2023	74,014	70,247	77,844	77,468	73,525	81,477







SECAmb ICS Escalation frameworks

- SECAmb has always worked closely with system partners to ensure the smooth flow of information, in order to effectively ensure appropriate patient care.
- In order to enhance this collaboration, SECAmb has instituted a series of escalation measures to work alongside the Surge Management Plan (SMP). These include weekly meetings, weekend reports and enhanced reporting for pressure periods.
- The Surge Management Plan is currently in the process of being enhanced and rigorously tested to ensure that it meets the national requirements. This will include an effective methodology for alerting systems of the current Surge level and capacity.
- There is an intention to enhance the current Incident Command Centre (ICC) capacity, ensuring that effective measures are established to escalate issues as they arise.
- The SMP is utilised by Tactical and Strategic commanders to manage the overall clinical risk to patients across the SECAmb region.
- SECAmb is currently working with SH ICB on the cascade method for appropriate escalation to the wider health system.

REAP / Regional escalation

- SECAmb will continue to assess the Resource Escalatory Action Plan (REAP) position on a weekly basis, and utilise the process effectively to manage escalation.
- REAP actions will be reviewed for effectiveness in line with the established process.
- The daily National Ambulance Coordination Centre (NACC) report will continue, with an outline of all of the key factors impacting on service delivery.
- Any extraordinary actions (Critical Incident, Major Incident or BCI Declarations) will be escalated through the appropriate local channels as well as to the NACC.
- SECAmb will continue to work with surrounding Ambulance trusts on requirements for Mutual Aid, border working and the impact of health systems outside of the local area.(i.e. Hospitals in Hampshire & the IOW, London and the Berkshire, Oxfordshire & Buckinghamshire area).
- Regional ambulance meetings will continue, reviewing the current situation, and establishing the wider picture to allow for appropriate mutual aid requests and utilisation of resources.

Incident response levels and escalation triggers

National NHS Incident Level 2

- Continue with Business as usual response
- Manage SMP through usual process
- Ensure that contractual requirements are established and reported on as required
- Likely that Covid infection rate growth and impact will be within manageable boundaries

National NHS Incident Level 3

- Escalation of reporting mechanisms in line with national requirements
- SMP and REAP will increase in line with impact on health sector
- ICC will move to an effective management process to ensure that reports are furnished in a timely fashion

National NHS Incident Level 4

- Local Resilience Forums will move to Major Incident status, and SECAmb will
- move to reflect that
- ICC will move to reflect the reporting requirements (i.e. 0800 – 2200)
- SMP and REAP will move to reflect growing impact on healthcare sector

SECAmb High level actions

Command Structure

- Continue with 24/7 strategic command.
- Ensure robust command structures in place.
- Exercise Metis 2 – Exercise to be run in November to tabletop the plan.
- Mitigation plans in place for specialist resourcing and potential impact of high levels of absence.
- Operational plans in place with contingencies.
- Tactical Hubs manage daily actions and partnership working with systems.

SECAmb High level actions (2)

Resourcing

- Targeted Incentivised overtime.
- Annual Leave management process from December – January.
- Additional PAP.
- Use of CFRs in innovative approaches.
- Collaborative working with other Emergency Services.
- Voluntary Services agreements.
- Fleet and logistics to maximise staffing during peak periods.
- Servicing/MOTs of vehicles will be anticipated to avoid key times

SECAmb High level actions – (3)

Staff Welfare

- Continued trust welfare hub provision.
- Additional staff welfare vehicles to be considered.
- Optimising breaks on shift.
- Continued recruitment against agreed trajectories for call handling and field operational staff.

Capacity Management

- Revalidation of Cat 3 and 4 calls received by 111/999.
- Communications plan.

SECAmb High level actions – (4)

System Management

- Enhanced system calls on a weekly basis.
- Cascade exercise as part of Exercise Metis 2.
- Weekly reports on SECAmb status.
- Continued concentration on hospital handovers.

Adverse Weather

- Work with LRF partners on combined response to adverse weather.
- Work with partners to ensure prioritised access to 4x4 vehicles

Assurance and monitoring

Strategic monitoring

- Weekly Reports to the system.
- Issues of escalation reviewed at weekly system calls.

Triggers for Escalation

- Critical risk escalation as required.
- Significant variation in demand profile or additional concurrent risks raised as required (System wide calls).
- In addition, any major patient safety incidents will be highlighted.

Sign off, Check and Challenge

- Individual department plans (Operations and support directorates) to be signed off by EMB.
- EPRR team to provide expert advice and support where needed and to ensure appropriate resilience and reporting mechanisms are robust.

Appendices

REAP Level Overview

	999 DEMAND	OPERATIONAL RESOURCING	ABSTRACTIONS	EOC	PERFORMANCE	HOSPITAL HANDOVER	FLEET AVAILABILITY	EXTERNAL FACTORS
REAP 1 Steady State	Up to 10% above commissioned activity levels	Within 5% of commissioned resource levels to meet demand	Ops up to 5% above planned level EOC up to 5% above planned level	Call answering 90th centile within 10 seconds	Achieving all ARP commissioned targets in C1, C2, C3, with a variance of up to 5%*	Handover delays up to 20 minutes	Within 5% of required levels	Considerations: - Extremes of weather - Industrial action - Mass gathering events/concerts - Internal system failures - External infrastructure compromise - Health system pressures and impacts/ intelligence - Infection control concerns - Supply Chain - PPE requirements
REAP 2 Moderate Pressure	Between 10% and 15% above commissioned activity levels	Between 5% and 10% of commissioned resource levels	Ops up to 10% above planned level EOC up to 10% above planned level	Call answering 90th centile 10-20 seconds	Outside all ARP commissioned targets in C1, C2, C3 by between 5% and 10%*	Handover delays between 20 and 30 minutes OR 5% over 60 minutes	Loss of between 5% and 10% of required levels	
REAP 3 Major Pressure	Between 15% and 20% above commissioned activity levels	Between 10% and 15% of commissioned resource levels to meet demand	Ops up to 15% above planned level EOC up to 15% above planned level	Call answering 90th centile 20-30 seconds	Outside all ARP commissioned targets in C1, C2, C3 by between by between 10% and 25%*	Handover delays between 30 and 45 minutes OR 10% over 60 minutes	Loss of between 10% and 15% of required levels	
REAP 4 Extreme Pressure	>20% above commissioned levels	>15% of commissioned resource levels to meet demand	Ops over 15% above planned level EOC over 15% above planned level	Call answering 90th centile above 30 seconds	Outside all ARP commissioned targets in C1, C2, C3 by between on C1, C2, C3 by >25%*	Handover delays between 45 and 60 minutes OR 20% over 60 minutes	Loss in excess of 15% against required levels	

SMP (Surge Management Plan) Overview

	Triggers	Period in trigger to escalate	Period below trigger to de-escalate	Minimum implementation authority
SMP1	Business as usual - Ability for the Trust to dispatch & respond to meet patient needs as identified within the Ambulance Response Programme (ARP)	n/a	n/a	n/a
SMP2	Any of the triggers below: 2 x Category 1 unassigned for >7 Minutes or 8 x Category 2 unassigned for >9 Minutes or 20 x Category 3 unassigned for >60 Minutes or 20 x Category 4 unassigned for >120 Minutes or 20 x HCP 1/2/4 unassigned for (>45/>60/>180 Minutes) or A combined total of 30 from any of the above triggers	30 min	60 min	EOC Operational Commander
SMP3	Any of the triggers below: 5 x Category 1 unassigned for >7 Minutes or 15 x Category 2 unassigned for >9 Minutes or 35 x Category 3 unassigned for >60 Minutes or 35 x Category 4 unassigned for >120 Minutes or 35 x HCP 1/2/4 unassigned for (>45/>60/>180 Minutes) or A combined total of 45 from any of the above triggers	60 min	90 min	EOC Tactical Commander
SMP4	Any of the triggers below: 10 x Category 1 unassigned for >7 Minutes or 30 x Category 2 unassigned for >9 Minutes or 60 x Category 3 unassigned for >60 Minutes or 60 x Category 4 unassigned for >120 Minutes or 60 x HCP 1/2/4 unassigned for (>45/>60/>180 Minutes) or A combined total of 80 from any of the above triggers	60 min	120 min	Strategic Commander

Central Scheduling & Private Ambulance Providers (PAPs)

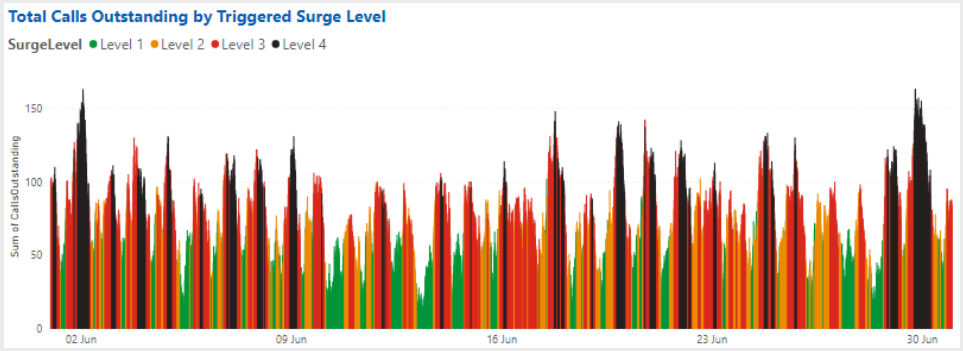
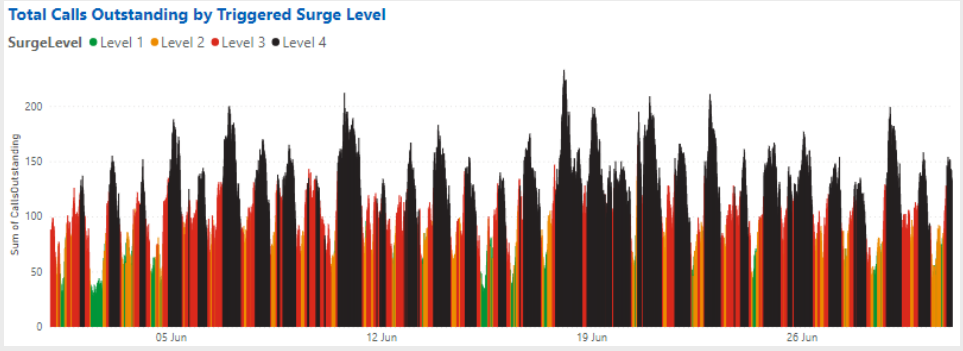
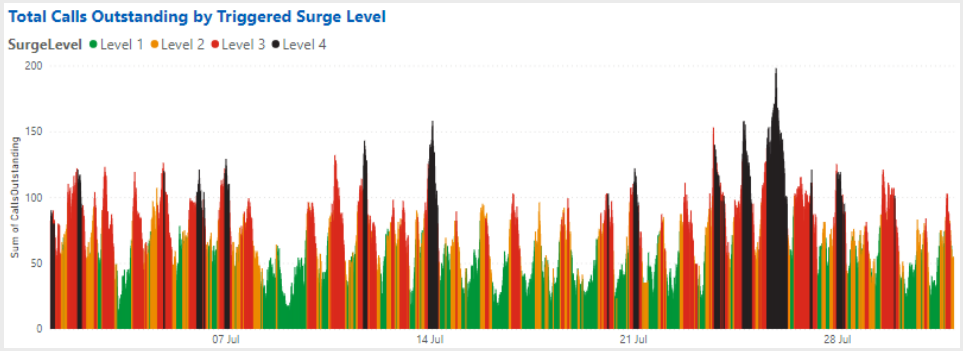
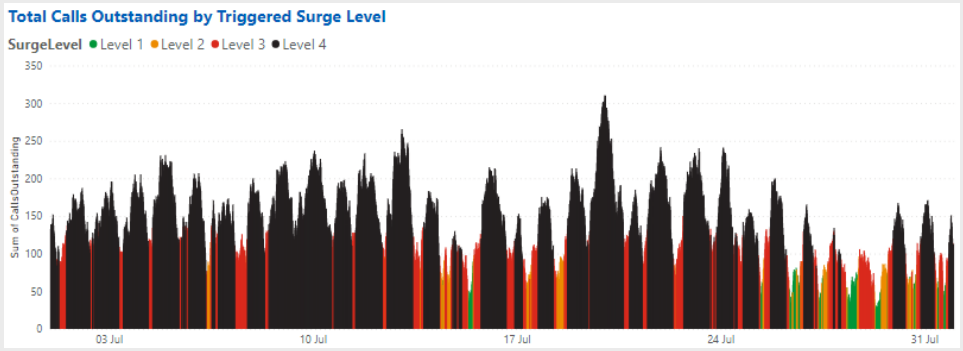
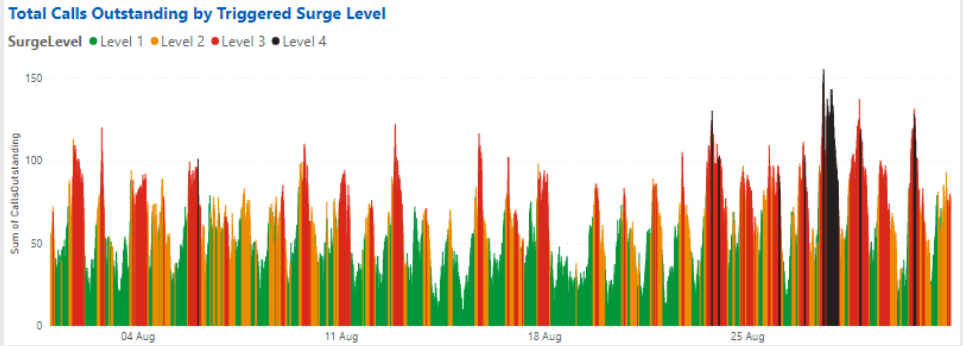
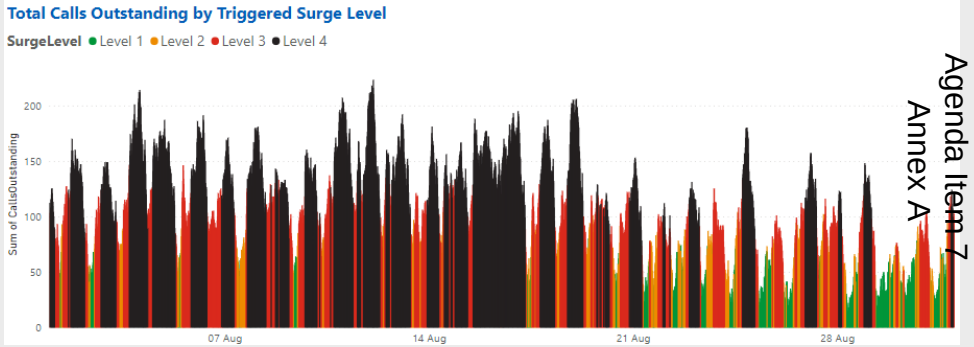
Central Scheduling

- Support OU scheduling teams enabling planning consistency and good abstraction management.
- Engagement with Senior Ops Team, utilise Tiresias/GRS to identify dates/times of highest risk, using rolling look forward, targeting overtime hours to best effect (weekly situational awareness meetings).
- Oversight of overtime incentive planning & implementation (if offered).

PAPs

- Contracted hrs uplift from Q4 2021/22 retained for 2022/23 (150 WTE).
- Contract secured with PAPs for the next 2yrs.
- Focus on providers compliance with contracted hours (monthly contract reviews).
- Obtain ad-hoc additional hours from providers as required.
- Roll-out of iPads to PAPs improve efficiency & safety (subject to business case approval).

Appendix X_1 – Historic Surge 2019 vs 2022

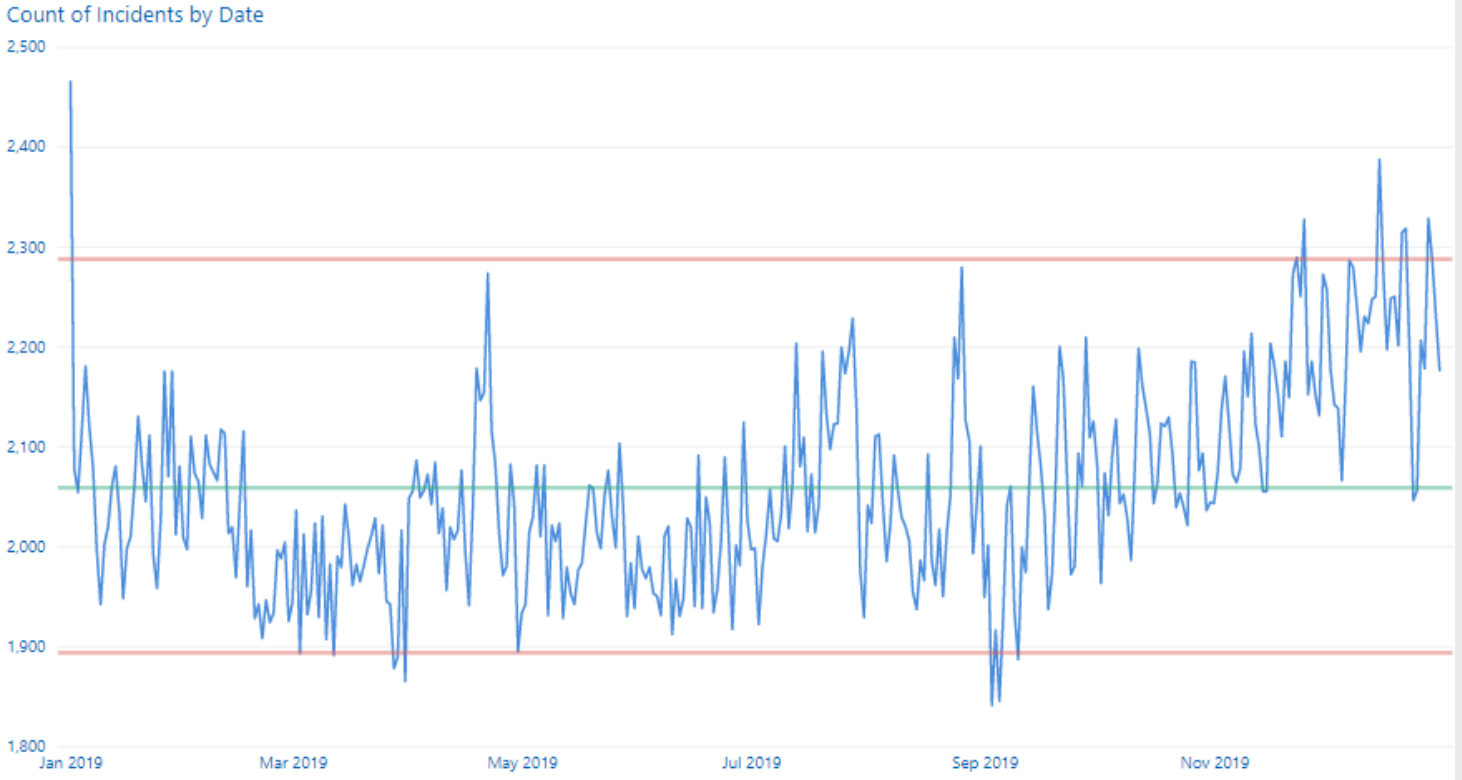
2019		2022
	June	
	July	
	August	

Appendix X_2 – 12-month Activity Dashboard 2019

706,502 Count of Incidents with response (ST/SC)	**239,258** ST Incidents
751,915 Count of Incidents	**467,244** SC Incidents
2,060 Average incidents per day	**45,413** HT Incidents
62,831 Average incidents per Average month	

ST = See and Treat
SC= See and Convey
HT = Hear and Treat

EOC	Count of Incidents	Count of C1 Incidents	Count of C2 Incidents	Count of C3 Incidents	Count of C4 Incidents
West	373955	21826	193118	118876	3122
East	377434	23669	208621	106210	2892
	526	21	407	72	
Total	**751915**	**45516**	**402146**	**225158**	**6014**



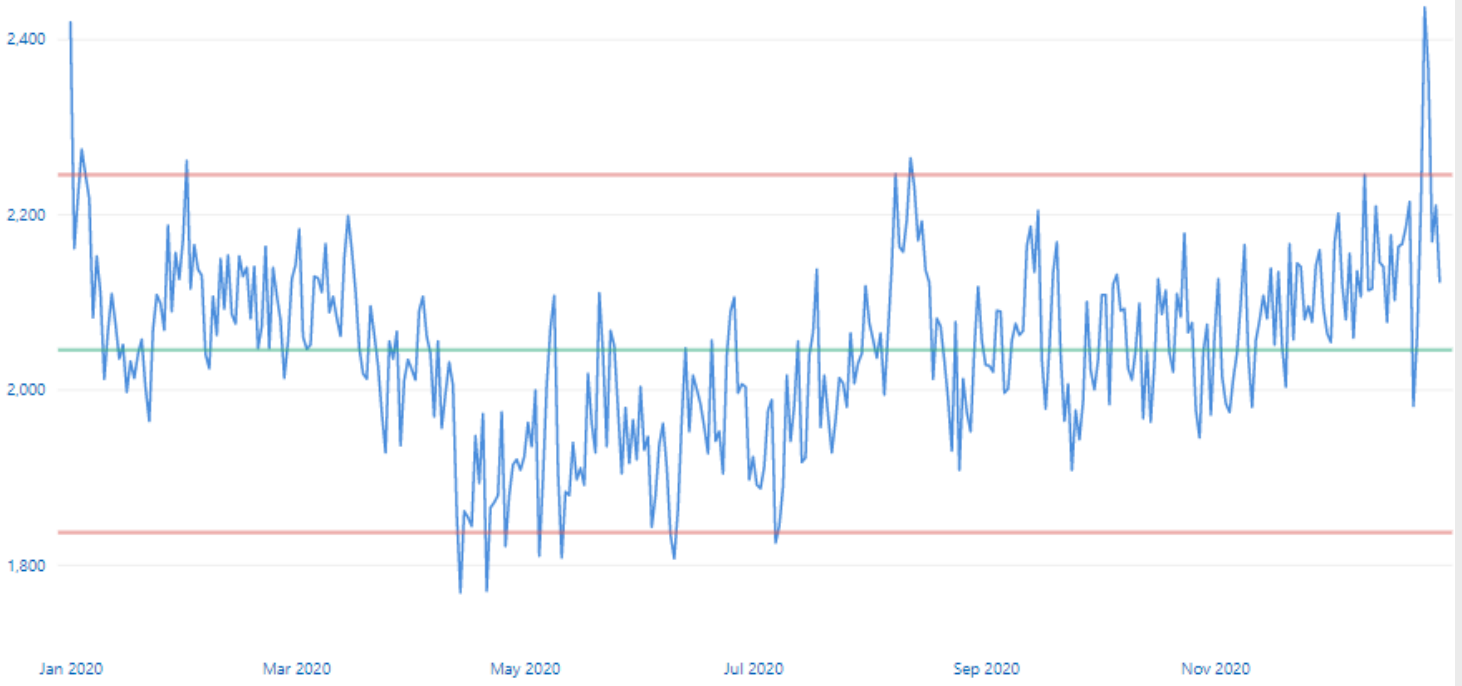
Appendix X_3 – 12-month Activity Dashboard 2020

701,681 Count of Incidents with response (ST/SC)	**264,747** ST Incidents
753,160 Count of Incidents	**436,934** SC Incidents
2,058 Average incidents per day	**51,479** HT Incidents
62,763 Average incidents per Average month	

ST = See and Treat
SC= See and Convey
HT = Hear and Treat

EOC	Count of Incidents	Count of C1 Incidents	Count of C2 Incidents	Count of C3 Incidents	Count of C4 Incidents
West	371808	22404	177959	128596	2355
East	376672	24401	195731	115452	2325
	4680	23	95	35	1
Total	**753160**	**46828**	**373785**	**244083**	**4681**

Count of Incidents by Date

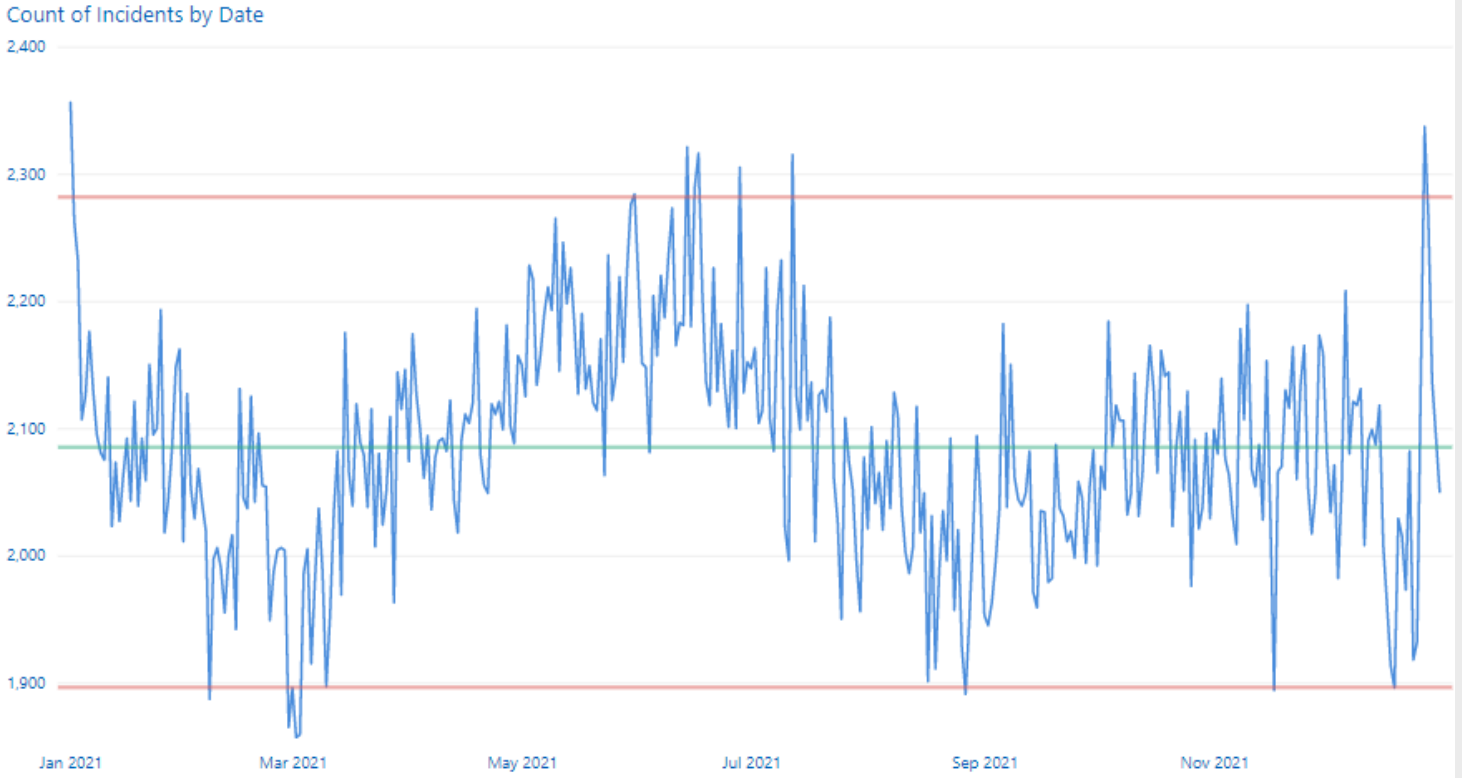


Appendix X_4 – 12-month Activity Dashboard 2021

695,562 Count of Incidents with response (ST/SC)	**246,651** ST Incidents
761,191 Count of Incidents	**448,911** SC Incidents
2,085 Average incidents per day	**65,629** HT Incidents
63,606 Average incidents per Average month	

ST = See and Treat
SC= See and Convey
HT = Hear and Treat

EOC	Count of Incidents	Count of C1 Incidents	Count of C2 Incidents	Count of C3 Incidents	Count of C4 Incidents
West	379095	26136	200674	102972	2120
East	381962	27986	213213	92848	1923
	134	20	42	7	
Total	**761191**	**54142**	**413929**	**195827**	**4043**

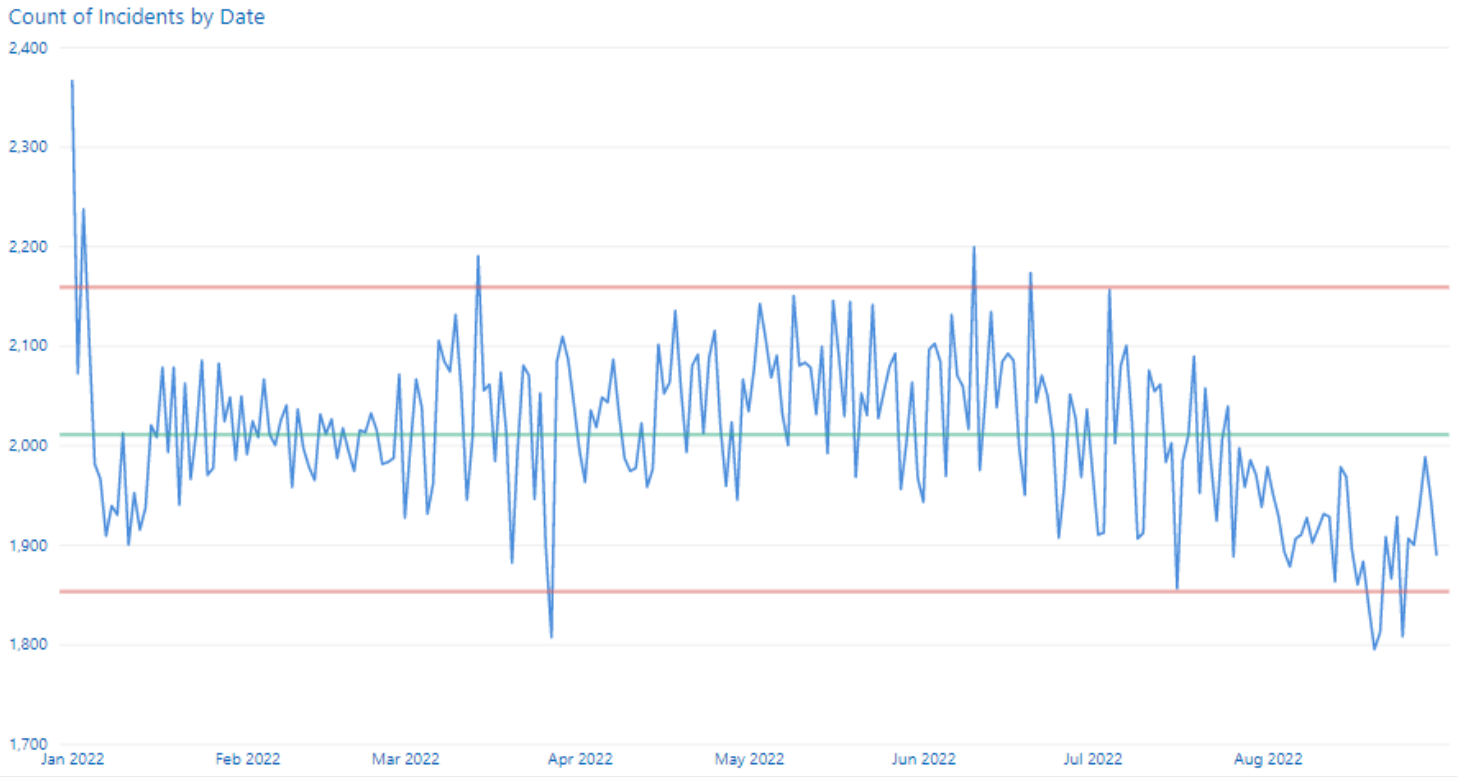


Appendix X_5 – 9-month Activity Dashboard 2022

440,658 Count of Incidents with response (ST/SC)	**155,306** ST Incidents
488,637 Count of Incidents	**285,352** SC Incidents
2,011 Average incidents per day	**47,979** HT Incidents
61,331 Average incidents per Average month	

ST = See and Treat
SC= See and Convey
HT = Hear and Treat

EOC	Count of Incidents	Count of C1 Incidents	Count of C2 Incidents	Count of C3 Incidents	Count of C4 Incidents
West	242043	17493	125216	63471	1628
East	246532	19277	135178	57828	1591
	62	14	24	5	
Total	**488637**	**36784**	**260418**	**121304**	**3219**

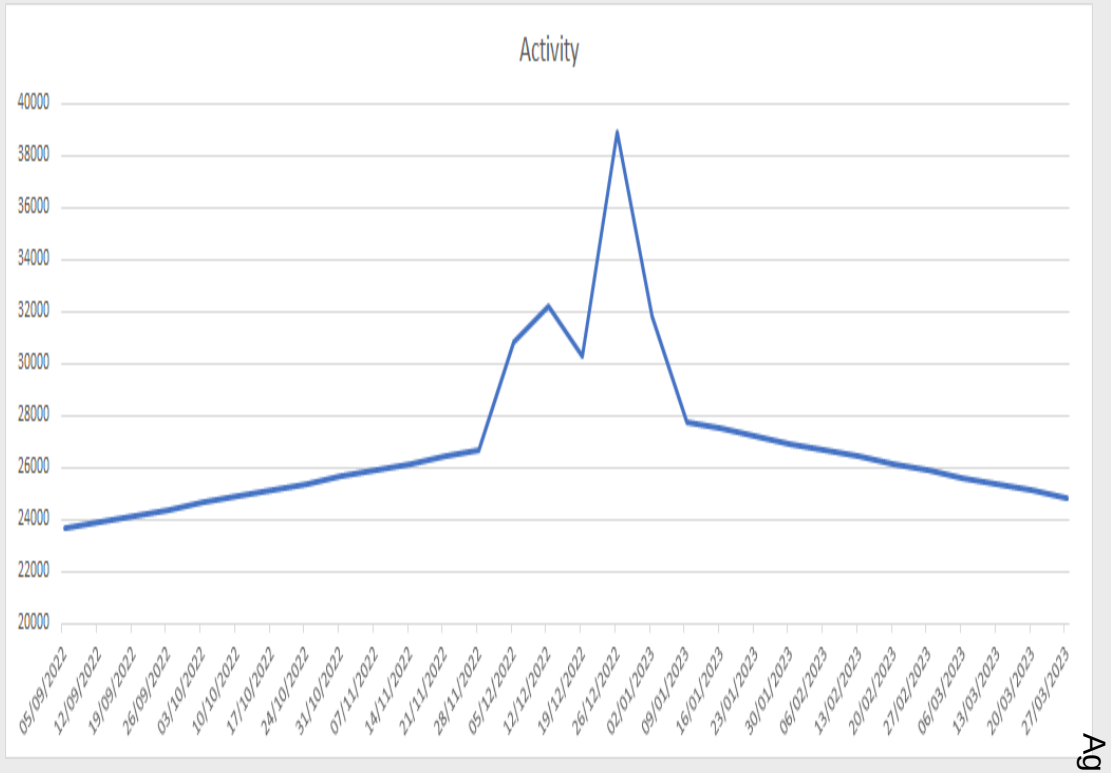


Dispatch Desks

South East Coast Ambulance Service
NHS Foundation Trust

Forecast most likely 111 scenario

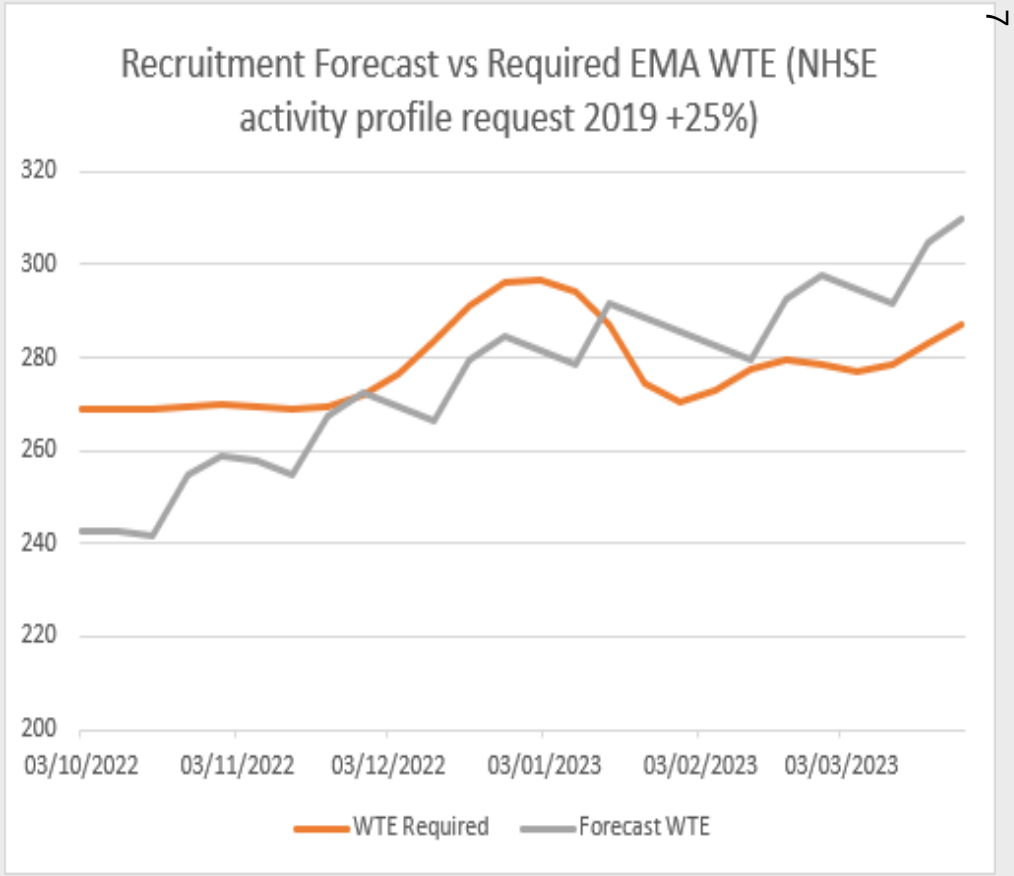
- The service's call planning and forecasts are reviewed daily, with staffing requirements calculated at fifteen-minute intervals, utilising a complex workforce planning tool.
- The forecasts consider key metrics such as Average Handling Time (AHT), call profiles and staff shrinkage.
- Staff planning operates on a rolling 12-week window.
- The winter of 21-22 was adversely impacted by COVID-19 with calls fluctuating dependent on lockdown status and other NHS E commissioned service capacity. However, the service anticipates a more typical activity profile in 22-23, with a significant spike across the festive period.
- The service will continue to focus on mitigating risk across the wider healthcare economy, with the validation of ED and ambulance dispositions being vital, along with facilitating Direct Appointment Booking (DAB), enabling patients to get the right care, from the most appropriate provider in a timely way.



South East Coast Ambulance Service
NHS Foundation Trust

Forecast for EMAs for likely 999 scenario

- The Trust has been asked to model expected 999 activity on the pre-COVID 2019 activity, with an additional 25% added.
- There is a significant recruitment plan to increase the number of Emergency Medical Advisors (EMAs) to answer the rise in 999 calls.
- A recruitment drive to ensure more dispatchers is also in progress, to provide resilience when the service is under pressure.
- The increase in clinical staffing in the Emergency Operations Centre (EOC) also continues, with a clear focus on Hear & Treat to mitigate clinical risk, whilst maintaining patient safety.



Dispatch Desk: Ashford - ICP

- Continued pressure across the system.
- System partners working to capacity and concerns over system resilience in the event of increased patient numbers with seasonal respiratory conditions including RSV and Flu.
- The east Kent ICP has been undertaking demand modelling and workforce modelling to understand gaps and risks, as well as opportunities.
- Community and social care working to maintain discharge capability to support acute beds.
- Working with DoS leads to review endpoints/pathways for 111, 999, and primary care.
- Reviewing available pathways and access, including maximising utilisation of community based UTCs.
- Workforce being risk assessed as a constraint to managing increasing levels of activity and maintaining patient safety.
- System review on patient ‘redirection’ to appropriate endpoints when arriving at ED.
- 111 being viewed as a key component in system resilience through the managing of unheralded activity.

Dispatch Desk: Ashford – Local Oversight

- Continued system pressure with volume of patients accessing acute sites for ED or UTC.
- Hospital staffing levels at times contributing to the slowness in responding to patients at the acute sites and restricting flow through the hospital and discharge, compounded by community capacity to receive patients.
- Knock on effect on department capacity (ED) generating delays in patient handover and crew turnaround.
- Investment into the structure of EDs at both QEQM and WHH to improve access and capacity.
- Re-profiling of community UTCs on the DoS to redirect at point of call to community UTCs opposed to the co-located UTCs. Reducing pressure at acute sites.
- Collaborative working with community frailty teams to reduce 999 calls and conveyance, especially from nursing and care homes.
- Ongoing potential for disruption from Operations Fennel and Brock, dependent on EU freight movement,
- Calls from police/coastguard due to volume of arrivals by boat along the South Kent coast – referred back to border force as specific private service commissioned for this activity.

Dispatch Desk: Ashford – Local Mitigation

- Demand – PP HUB running 24/7 to support clinical decision making and remote treatment – majority of Ashford PPs have received PAKs training.
- Workforce – ensure sickness management, abstractions, annual leave are carefully managed to ensure adequate resource cover.
- External Events – ensure adequate consumables available if disruption of road network – increase stock
- Capacity at Ashford MRC.
- External Events - Standard Operating Procedure escalated to EMB to ensure clear operating procedures to limit impact of attendances to migrants on resourcing from Ashford OU.

Dispatch Desk: Brighton ICP

- Continued pressure across the system.
- System partners working to capacity and concerns over system resilience in the event of increased patient numbers with seasonal respiratory conditions including RSV and Flu.
- System review on patient ‘redirection’ to appropriate alternative to ED i.e. local UTC or other alternative pathway
- Community and social care working to maintain discharge capability to support acute beds.
- Increased local liaison between OU teams and systems representatives regarding ongoing issues
- (impact of site redevelopments, available pathway provision).
- Dedicated alternative pathway project to review patient experience to access appropriate/specialist care avoiding ED
- Handover delay project to identify flow issues and improve local relationships.

Dispatch Desk: Brighton What are we seeing locally

- Continued system pressure with volume of patients accessing acute sites for ED or UTC.
- Collaborative working with commissioners and non acutes to reduce 999 calls and conveyance.
- Reduction in community bed availability affection discharge rates and outflow from acute sites.
- Hospital staffing levels at times contributing to the slowness in responding to patients at the acute sites and restricting flow through the hospital and discharge, compounded by community capacity to receive patients.
- Knock on effect on department capacity (ED) generating delays in patient handover and crew turnaround.
- Improvement of local, UTC, provision to reduce ED attendance.
- Delayed handover processes used proactively within ED

Dispatch Desk: Brighton

- Daily attendance at local system calls (OTL / Duty Manager) to support early identification and resolution of developing issues.
- Maximising PP HUB staffing to support clinical decision making and remote treatment – uplift in PAKs training throughout October / November for PPs within OU.
- Alt duties staff (1) supporting welfare calls backs locally.
- Increased scheduling capacity (alt duties) to support demand planning/frontline resourcing.
- Workforce – ensure sickness management, abstractions, annual leave are carefully managed to ensure adequate resource cover.
- Reduction in attendance/involvement in events planning within OU. Organisers encouraged to share plans via SPOC address.
- Dedicated HALO provision at RSCH (subject to funding and staffing plan) to support flow and ED pressures.
- Maximising management provision to support local demand pressures.

Dispatch Desk: Chertsey ICP

- North West Surrey Integrated Care Partnership.
- Population Covering : Weybridge, Chertsey, Woking, West Byfleet, Shepperton, Staines.
- ED’s: Ashford and St Peters NHS Trust.
- Minor Injury Unit : Woking MIU.
- Urgent Treatment Centre: Ashford & St Peters.

Dispatch Desk: Chertsey ICP

- Bi-Weekly Local Hospital Handover meetings. ASPH Matron & Service Delivery Managers meets with SECAmb OM & Nominated OTL.
- A&E delivery board for North West Surrey ICP Attended by SECAmb OUM and Senior managers of ASPH.
- Local push for admission avoidance pathways within the OU. Service finder reports to support usage of pathways and frontline crews accessing them.
- Agreed escalation plans for on the day handover delays managed by Duty OTL & Site Manager.

Dispatch Desk: Dartford & Paddock Wood (ICS)

- Continued pressure across the system.
- System partners working to capacity and concerns over system resilience in the event of increased patient numbers with seasonal respiratory conditions including RSV and Flu.
- Community and social care working to maintain discharge capability to support acute beds.
- Working with DoS leads to review endpoints/pathways for 111, 999, and primary care.
- Reviewing available pathways and access, including maximising utilisation of community based UTCs.
- Workforce being risk assessed as a constraint to managing increasing levels of activity and maintaining patient safety.
- System review on patient 'redirection' to appropriate endpoints when arriving at ED.
- 111 being viewed as a key component in system resilience through the managing of unheralded activity.
- National and ICS programmes around admission avoidance:
  - Virtual Wards
  - Urgent Community Response (UCR) – 2 Hour Response
  - Urgent Treatment Centres (UTC)
  - Mental Health (MH) - Health Care Professional by pass number (to directly access MH clinicians)
  - Same Day Emergency Care (SDEC) – direct access to specialist services for Ambulance/Primary Care/UCR

Dispatch Desk: Dartford & Paddock Wood Local Oversight – Health and Care Place (HaCP)

- Continued system pressure causing capacity issues at acute sites resulting in hospital handover delays despite a reduction in conveyance numbers – MTW and DVH both see fewer 60min breaches than other acute sites in Kent and Medway. There is the potential for delays to become more frequent over winter months if we see a peak in ED attendances/admissions coupled with poor discharge profile. Crews and local managers are well-versed in delayed handover procedures. Continue to build on already established good working relationships with acute trust to ensure a shared understand of risk.
- Regular liaison meetings in place focusing on risks/incidents, flow, handover delays, quality and patient safety.
- Working with speciality leads to create criteria for direct admission in SDEC including surgical, medical and frailty direct admission.
- Re-profiling of community UTCs on the DoS to redirect at point of call to community UTCs opposed to the co-located UTCs. Reducing pressure at acute sites.
- Working in close partnership with ICB to maximise referrals to Mental Health Crisis Team/Safe Haven to reduce ED conveyances for patients presenting with primary mental health presentation
- Home Treatment Service and Virtual Wards
- Concerns regarding system resilience in the event of increased patient numbers. Particular challenges expected if we see a peak in seasonal respiratory conditions including RSV and Flu.

Dispatch Desk: Dartford & Paddock Wood Local Oversight – Health and Care Place (HaCP)

- Continual review and update of all available local pathways including maximising utilisation of community based UTCs. Creation of specific West Kent pathways documents for all crews.
- Creation of new rotas to better match resource availability to demand
- Continued challenge with under supply in unit hours due to current vacancy rate. Risk of further compromise as sickness levels increase during winter months.
- Inexperienced workforce due to ongoing recruitment of newly qualified paramedics.

Dispatch Desk: Dartford & Paddock Wood – Health and Care Place (HaCP)

- Working with Kent Community Healthcare NHS FT (KCHFT) to review pathways:
  - Home Treatment Service
  - Urgent Community Response – 2 hour response
  - Overnight referrals
  - Consultant Geriatrician led workshops for HaCP (West Kent) clinicians inc. Ambulance
- Working with both MTW and DVH to improve direct access and tirage on arrival at hospital for ambulance:
  - Same Day Emergency Care – Frailty
  - Rapid Access Points – in ED to improve handover
- Urgent Treatment Centre (Sevenoaks):
  - Review of acceptance criteria for ambulance crews to match new standards
- Urgent Treatment Centre (co-located):
  - Review of direct acceptance from ambulance crews

Dispatch Desk: Dartford & Paddock Wood – Health and Care Place (HaCP)

- Paramedic Practitioner Hub:
  - Specialist paramedic advice and access to patient records via the Kent and Medway Care Record (KMCR)
- HaCP specific meetings:
  - Admission Avoidance
  - Winter Planning
  - Urgent Care Delivery Board
  - Integrated Care Commissioning – reviewing the pathways between West Kent and East Sussex
- Pathways:
  - Review of all local available pathways, with testing to check criteria and access
- 100 – day challenge
  - Working with collaboratively with community provider (KCHFT) in identifying patient cohorts that are appropriate for UCT to avoid conveyance

Dispatch Desk: Dartford & Paddock Wood - Local Mitigation

- To ensure local scheduling team prioritise cover of local Urgent Care Hub to support clinical decision making and remote treatment –All local Paramedic Practitioners being encouraged to compete PaCCS training to increase capability to support the clinical review of pending 999 incidents and encourage non ambulance dispositions (hear and treat).
- Operational Team Leaders to provide DCA cover during self-roster weeks and C1 cover when undertaking administrative duties. Operational managers completing regular DCA shifts (minimum 2 shifts per month).
- Continued promotion of overtime and introduction of localised incentives to better match resource availability to shortfall in hour provision
- Continued utilisation of Private Ambulance Providers. Regular review of performance against set KPI's including shift fulfilment, out of service, and job cycle time
- Engagement with Fire and Rescue and Community First Responder teams to align resource availability to demand profile.
- Ensure sickness management, abstractions, annual leave are carefully managed to ensure adequate resource cover
- Ensure Frequent caller policy is being followed and regular review of frequent callers within Dispatch Desk

Dispatch Desk: Dartford & Paddock Wood - Local Mitigation

- Weekly monitoring of operational hours
- On day management of operational hours, hospital wrap up and protracted on scene
- Ensure resilience of operational command cover and ensure adequate staff trained
- Weekly and daily management of abstractions.
- Continued focus on staff welfare (e.g. through drop in sessions with management, mental health practitioners, chaplaincy) to reduce workplace associated stress and sickness.
- Consistent application of sickness management procedures to support the return of staff to the workplace.
- Maintain high standards of IPC compliance to prevent avoidable transmission of infection.
- Proactive support to Band 5 NQPs to promote an on-time transition to Band 6 status.
- Recruitment to vacancies (predominantly NQP) with OTLs and OMs assisting with preceptorship to alleviate pressure on Band 6 staff.
- Work underway to reduce job-cycle-time (on scene and pin to clear) through one-to-one coaching with OTLs.
- Ensure Planned Non-Emergency Transport, ‘NET’ provision to allow a response to HCP booked journeys or those lower acuity emergency responses where a ‘NET’ response is suitable allowing for earlier conveyance increasing the likelihood of earlier discharge

Dispatch Desks: Gatwick & Redhill ICP

- Local Leadership Team having regular engagement with Hospital Leadership teams – East Surrey and Epsom.
- Collaborative working in trying to reduce A&E conveyances.
- Participating in workshops to look at Urgent Treatment Centre's and Same Day Emergency Care options in the local area.
- AEDB attendance when meetings planned.

Dispatch Desks: Gatwick & Redhill What are we seeing locally

- Banstead project complete with Banstead MRC fully operational.
- Lack of suitable facilitated ACRPs putting pressure on Gatwick and Banstead stations at peak times for meal breaks.
- Crews travelling long distances to support adjoining OU's.
- New rotas planned for implementation before Christmas 2022.
- Challenged operational hours due to high abstractions (Sickness/Secondments/Alternative duties).
- High levels of OU leadership absence due to long term sickness requiring secondments to cover key roles.
- Development OTLs supporting team across OU.
- Changes in Churchill contract are causing issues with lack of MRO / VPP staff and KPI compliance.

Dispatch Desks: Gatwick & Redhill Actions to mitigate

- Overtime being targeted to key times.
- NET vehicles being covered 7 days per week when possible.
- Planning shifts earlier in day to try to meet new demand profiles.
- Daily system calls being joined by leadership team.
- OTLs attending A&E regularly and attending bed meetings when hospital system pressured.
- Leadership team focussing on staff welfare issues and supporting when absent from work.
- Ensuring use of service finder and IBIS is optimised to ensure patients receive the right care in the right place.

Dispatch Desk: Guildford Context – Each ICB

- Guildford Operating Unit serves two ICBs
  - Guildford & Waverley ICB – Incorporating Royal Surrey Hospital – A 520 bed facility with Trauma Unit Status.
  - Absorbs 38% of the OU's See and Convey patients.
  - Accountable for 1518 Lost Hours Last Financial Year.
  - 440 Handovers >60 Minutes LFY.
- North East Hampshire and Farnham ICB – Incorporating Frimley Park Hospital – A 938 bed facility with Trauma Unit status and the regional heart attack centre.
  - Absorbs 58% of the OU's See and Convey patients.
  - Accountable for 771 Lost Hours Last Financial Year.
  - 224 Handovers >60 Minutes LFY
  - SECAmb Hear & Treat 9% / See & Treat 31% for whole Operating Unit Area

Dispatch Desk: Guildford What are we seeing locally

- Guildford OU is successful in matching the pattern of demand to operational hours.
- Still short against what would be needed to deliver ARP performance.
- Scheduling team work well to provide DCA's in keeping with requirement and add shifts over rota to achieve.
- C1 performance is within Trust averages in urban areas. Poor in more rural areas.
- C2 performance is better than Trust average.
- C3 performance is poorer than Trust average.
- Staffing is currently at budgeted levels.
- Delays at hospital account for high use of OTL time and lost hours, and subsequent lost performance, but significantly improved over previous year

Dispatch Desk: Guildford Actions to Mitigate

- Demand & Capacity
- We use innovative methods to supply to meet demand. Schedulers regularly utilise social media, What's App, E-Mail and networks to provide operational hours.
- PAP team have been engaged to increase supply for winter.
- Sickness management policy has been revisited and is robustly complied with.
- Workforce & Welfare
- Full audit of all estate has been undertaken to ensure it is fit for winter.
- Sufficient provisions at all sites such as salt, shovels etc.
- Building maintenance requested to ensure fit for purpose.
- External Events
- Hallowe'en, Bonfire Night, Christmas & New Year all present unique challenges.
- Reduction of available A/Leave for Christmas Week.
- Specific scheduling profiles for key event days.

Dispatch Desks: Hastings & Polegate

- Continued pressure across the system.
- System partners working to capacity and concerns over system resilience in the event of increased patient numbers with seasonal respiratory conditions including RSV and Flu.
- Community and social care working to maintain discharge capability to support acute beds.
- Working with DoS leads to review endpoints/pathways for 111, 999, and primary care.
- Reviewing available pathways and access, including maximising utilisation of community based UTCs.
- Utilising PP colleagues to work alongside hospital partners to improve direct admissions
- Workforce being risk assessed as a constraint to managing increasing levels of activity and maintaining patient safety.
- System review on patient ‘redirection’ to appropriate endpoints when arriving at ED.
- 111 being viewed as a key component in system resilience through the managing of unheralded activity.

Dispatch Desks: Hastings & Polegate - What are we seeing locally

- Continued system pressure with volume of patients accessing acute sites for ED or UTC.
- Hospital Handover issues, Hospital staffing levels at times contributing to the problem, lack of flow through the Hospital and poor discharge rates.
- Knock on effect on department capacity (ED) generating delays in patient handover and crew turnaround.
- Investment into the structure of EDs at both EDGH and Conquest to improve access and capacity.
- Re-profiling of community UTCs on the DoS to redirect at point of call to community UTCs opposed to the co-located UTCs. Reducing pressure at acute sites.
- Collaborative working with community frailty teams to reduce 999 calls and conveyance, especially from nursing and care homes.
- Increasing pathway availability such as SDEC
- Several events being held across OU – engagement to continue with safety advisory groups
- Frequent callers continuing to call into 999 and ensure frequent caller management policy to be followed to prevent attendance and conveyance where safe to do so.

Dispatch Desks: Hastings & Polegate Actions to mitigate

Demand

- To ensure Urgent Care Hub is fully covered to support clinical decision making and remote treatment – Continue to ensure all new PPs receive PACCS training.
- All response capable managers and OTLs to be booked on and have oversight of the surge on day.

Workforce

- Ensure sickness management, abstractions, annual leave are carefully managed to ensure adequate resource cover.
- On going recruitment plan to increase staff levels.
- Rota change to meet demand.

Exit flow

- Continued daily liaison meetings with ESHT to ensure plans are being followed and escalation delays are being managed correctly. Appointed Hospital Liaison OTL to regularly brief the station leadership team.
- Pathway engagement and data sharing with our external partners to reduce friction and ensure timely movement of patients between services to maintain system flow.
- Ensure resilience of operational command cover and ensure adequate staff trained
- Weekly and daily management of abstractions.

Dispatch Desks: Hastings & Polegate Actions to mitigate

External Events

- Local event management plans to be reviewed and SAG meetings to continue
- On day management of operational hours, hospital wrap up and protracted on scene

Demand

- Ensure Frequent caller policy is being followed and regular review of frequent callers within Dispatch Desk

Capacity

- Weekly monitoring of operational hours

Dispatch Desks: Hastings & Polegate Lessons identified

- Monitor and maintain compliance with IPC standards, absence management policy, welfare policy in order to optimise staffing levels, staff welfare and reduce lost hours.
- Work with supply chain and logistics partners to ensure stock of vital items.
- Staff identified to carry out Fiat assessments in order mitigate seatbelt/seat position issues.
- Identification of suitably trained and qualified staff who can fulfil operational/tactical command function in the event of short term absence.

Dispatch Desk: Medway ICP

- Continued pressure across the system.
- System partners working to capacity and concerns over system resilience in the event of increased patient numbers with seasonal respiratory conditions including RSV and Flu.
- Medway Council are experiencing signification concerns around amount of care packages available, with multiple care organisations ‘handing back’ packages.
- Community and social care working to maintain discharge capability to support acute beds.
- Working with DoS leads to review endpoints/pathways for 111, 999, and primary care.
- Reviewing available pathways and access, including maximising utilisation of community based UTCs.
- Workforce being risk assessed as a constraint to managing increasing levels of activity and maintaining patient safety.
- System review on patient ‘redirection’ to appropriate endpoints when arriving at ED via HARIS model. SECAmb supporting various recommendations such as direct frailty access for Ambulance.
- 111 being viewed as a key component in system resilience through the managing of unheralded activity.
- Swale UTC operational since 1st November 2021. Ongoing work stream to drive ambulance attendance.
- Medway & Swale Falls Car still running as an extended trial, S&T rates 65%. No current substantive funding.

Dispatch Desk: Medway Local Oversight

- Continued system pressure with volume of patients accessing acute sites for ED or UTC.
- Hospital staffing levels at times contributing to the slowness in responding to patients at the acute sites and restricting flow through the hospital and discharge, compounded by community capacity to receive patients.
- Knock on effect on department capacity (ED) generating delays in patient handover and crew turnaround.
- Investment into Frailty SDEC and Winter monies for staffing additional two wards at MFT.
- Re-profiling of community UTCs on the DoS to redirect at point of call to community UTCs opposed to the
- Co-located UTCs. Reducing pressure at acute sites.
- Collaborative working with community frailty teams to reduce 999 calls and conveyance, especially from nursing and care homes including looking at a winter hub.

Dispatch Desk: Medway Local Mitigation

- Demand – PP HUB running 24/7 to support clinical decision making and remote treatment – majority of North Kent PPs have received PAKs training.
- Workforce – ensure sickness management, abstractions, annual leave are carefully managed to ensure adequate resource cover.
- Increase NET / VAS provision to support SRV working and transport.
- Introduction of localised overtime incentives targeted to shortfalls in resourcing within the OU rather than trust wide.
- Early and effective communication around alterations to road networks particularly M2 Jct 5 closure (Sept' 22-Jan' 23) to mitigate any unnecessary delays to patients.

Dispatch Desk: Paddock Wood

- See Dartford Dispatch Desk

Dispatch Desk: Tangmere & Worthing Context

- The ICP has strong engagement across stakeholders, Primary care, Commissioning, community trusts, social care, Acute hospital and Ambulance providers.
- The system has seen a significant annual increase of ambulance handover delays at Worthing and St Richards EDs, more consistently arising at St Richards ED
- The majority of the ICP is rural/semi-rural, with Worthing and Chichester being the main centres of population/towns.
- Operational collaboration and joint grip with an opportunity for senior escalation is maintained via a daily system call where all stakeholders are present.
- The system has some more developed single point of access for admission avoidance and integration of care provision- via ‘One call’.
- Some aspects of the system are more embryonic, such as Frailty intervention and provision.

Dispatch Desk – Tangmere - What are we seeing locally

- There are a number of challenges split broadly into 3 areas;
- Staffing provision: Recruitment challenges across ambulance, the acute and social care are a barrier in being able to meet demand in line with the constitutional standards.
- Demand: Current demand outstrips resource provision and capacity. The area has an older population, there is consequently a lot of issues surrounding more frail, complex and comorbid patients.
- Acute Hospital Flow: The local acutes, Worthing and St Richards hospital have experienced more challenges recently with flow, seeing an increase in the amount of ambulance hours lost awaiting handover. This in part is hospital capacity, ED capacity but a key contributor is a number of medically ready for discharge
- Average transport (to both acute sites) and Average hours lost
- Local system work to maximise UCR pathways

Dispatch Desk: Tangmere Actions to mitigate

Mitigation Action	Benefits Realisation
•OTL attendance at ED safety Huddles •Senior OU representation at Daily System calls and Daily 'OPEX' calls	Ensures a common operating picture and shared situational awareness, allowing real time update and dynamic mitigations/escalations. Allows oversight also of any extra-ordinary external events/impacts
•Refreshing the use of Alternative pathway utilisation via the 'one call' service and using 'service finder'. •PP and OU pathways leads working with newly in post community matrons. •Launch of UCR 'champions' locally	Supporting the use of the most appropriate resource and demand reduction at source.
•Increasing utilisation of virtual response/Hear and Treat via our paramedic practitioner hubs using the PACS software system	Reducing demand on DCA deployment by providing the most appropriate clinical response (which may be virtual response). Most appropriate use of limited staffing/resource availability allowing us to get patients more quickly.
•Planned Non-Emergency Transport, 'NET' provision to allow a response to HCP booked journeys or those lower acuity emergency responses where a 'NET' response is suitable.	Reducing demand on DCA deployment by providing the most appropriate clinical response (which may be virtual response). Most appropriate use of limited staffing/resource availability allowing us to get patients more quickly.
•Local Workforce and Wellbeing actions including drop in sessions with Consultant MH Nurse to supplement the SECAmb wide Wellbeing hub	Supporting Workforce to stay healthy and promote wellbeing, as a secondary impact reducing absence.

Dispatch Desk: Tangmere

Domain Area	Purpose
Demand	To ensure that levels of demand across the system have been credibly modelled to ensure resources and capacity are effectively deployed – what are you doing to manage surges in demand?
Capacity	To ensure systems understand available capacity across the pathway and how this can be optimised most efficiently – what are you doing locally to increase capacity
Workforce	To ensure that levels of workforce are understood and are sufficient to meet the expected levels of demand and capacity – Welfare / workforce management?
Exit Flow	To ensure that interfaces between sections of the care pathway are optimised to reduce friction and ensure timely movement of patients between services to maintain system flow – are there any specialist pathways that you are working on to assist in winter?
External Events	To ensure that systems have considered factors external to themselves and the effect these may have on healthcare outcomes – are there any external events that may impact on this?

Dispatch Desk: Tangmere Lessons identified

- Regular and Open Discussions with System Stakeholders are vital in anticipating emerging challenges and allowing timely action to take place.

Dispatch Desk: Thanet Context – ICB

- Continued pressure across the system.
- System partners working to capacity and concerns over system resilience in the event of increased patient numbers with seasonal respiratory conditions including RSV and Flu.
- The East Kent ICB has been undertaking demand modelling and workforce modelling to understand gaps and risks, as well as opportunities.
- Community and social care working to maintain discharge capability to support acute beds.
- Working with DoS leads to review endpoints/pathways for 111, 999, and primary care.
- Reviewing available pathways and access, including maximising utilisation of community based UTCs.
- Workforce being risk assessed as a constraint to managing increasing levels of activity and maintaining patient safety.
- System review on patient ‘redirection’ to appropriate endpoints when arriving at ED.
- 111 being viewed as a key component in system resilience through the managing of unheralded activity.

Dispatch Desk: Thanet What are we seeing locally

- Continued system pressure with volume of patients accessing acute sites for ED or UTC.
- Hospital Handover issues, Hospital staffing levels at times contributing to the problem, lack of flow through the Hospital and poor discharge rates.
- Knock on effect on department capacity (ED) generating delays in patient handover and crew turnaround.
- Investment into the structure of EDs at both QEQM and WHH to improve access and capacity.
- Re-profiling of community UTCs on the DoS to redirect at point of call to community UTCs opposed to the co-located UTCs. Reducing pressure at acute sites.
- Collaborative working with community frailty teams to reduce 999 calls and conveyance, especially from nursing and care homes.
- Potential for disruption due road network disruption in neighbouring OU which will cause knock on delays to road infrastructure from Operations Fennel and Brock, and potential delays in accessing WHH, QEQM and other sites.
- Several events being held across OU – engagement to continue with safety advisory groups.
- Frequent callers continuing to call into 999 and ensure frequent caller management policy to be followed to prevent attendance and conveyance where safe to do so.

Dispatch Desk: Thanet Actions to mitigate

Demand

- To ensure Urgent Care Hub is fully covered to support clinical decision making and remote treatment – Continue to ensure all new Thanet PPs receive PACCS training.
- All response capable managers and OTLs to be booked on and have oversight of the surge on day.

Workforce

- Ensure sickness management, abstractions, annual leave are carefully managed to ensure adequate resource cover.
- On going recruitment plan to increase staff levels.
- Rota change to meet demand.

Exit flow

- Continued weekly liaison meetings with EKHUFT to ensure plans are being followed and escalation delays are being managed correctly. Appointed Hospital Liaison OTL to regularly brief the station leadership team.
- Pathway engagement and data sharing with our external partners to reduce friction and ensure timely movement of patients between services to maintain system flow.

Dispatch Desk: Thanet Actions to mitigate

External Events

- Ensure adequate consumables available if disruption of road network – increase stock capacity at Thanet MRC.
- Local event management plans to be reviewed and SAG meetings to continue

Demand

- Ensure Frequent caller policy is being followed and regular review of frequent callers within Dispatch Desk

Capacity

- Weekly monitoring of operational hours
- On day management of operational hours, hospital wrap up and protracted on scene
- Ensure resilience of operational command cover and ensure adequate staff trained
- Weekly and daily management of abstractions.

Community First Responders Context

- 335 Community First Responders 285 Active
- Positive C1 performance average of 15 seconds to the positive each month
- Leadership Team engagement through Team B
- Active list of 4x4 trained CFRs to support during inclement weather (List with operational support) (Own vehicles)
- Two CFR falls proof of concept schemes to support fallers in Gatwick, Polegate and Hastings area
- C1 CFR Drivers to assist with vehicle movements (Signed off by Driver Training)
- Number of CFRs trained for Make Ready support, if required

Community First Responders What are we seeing across the Trust?

- Increased number of CFRs from last year
- Increased number of calls attended by CFRs making a clear tangible impact on C1 calls
- Improved utilisation of CFRs within the EOC, however could still be improved by improved tasking and technology
- Improved booking on could be encouraged if fuel expenses raised for CFRs. This does impact on volunteering
- Improved communications between Trust and volunteers
- Increasing opportunities for CFRs

Community First Responders Actions to Mitigate

- Use of Everbridge to target busy areas, however, becoming BAU for CFRs with SMP 4 messaging increasing complacency
- Daily operations call and SMP calls attended by CFR Leadership Team to ensure effective communication and use of CFRs for the wider operations Team
- Looking at buddying up CFRs to volunteer in pairs to encourage evening and night time cover over the winter months
- Improved utilisation of falls CFRs

Directorate Plans: Finance & IT

- Neither Finance nor I.T have identified anything significant outside of their current BC Plans, to affect Winter Plans.
- Finance will mobilise the Business Case Group to consider urgent requests for resources on an ad hoc basis
- The virement process is available to realign existing budget where required and Finance will expedite such requests
- The Finance Department is considering reducing the frequency of budget meetings to two-monthly to free up operational management time during the winter period

Directorate Plans: Human Resources

Staff Welfare

- Continued trust welfare hub provision.
- Additional staff welfare vehicles and trollies to be activated during REAP 4 escalation, BCI and Critical Incidents and Major Incidents declared.
- Optimising breaks on shift.
- Continued recruitment against agreed trajectories for call handling and field operational staff.

Directorate Plans: Medical

For Medicines:

1. Work closely with recruitment to ensure vacancies are recruited as soon as possible.
2. Move teams from corporate areas to support medicines packing at the Medicines Distribution Centre (MDC).
3. Use the Trust approved incentive scheme to support the MDC with the packing of medicines pouches.

Directorate Plans: Medical

Information

- This briefing relates to the Medical Directorate with the exception of the Critical Care OU, the administrators and clinicians that work to support frontline Operational staff.
- This brief covers normal winter pressures coupled with potential additional pressures of new variants of COVID-19, seasonal and holiday activities, adverse weather, spontaneous serious incidents and other disruptions.

Intent

- To provide a high-quality support service to the Trust throughout the winter months.
- SECAmb provides access to a range of wellbeing services through the Wellbeing Hub.
- Regular 121s with team members and appropriate levels of supervision are key to ensuring that all members feel supported in the workplace.

Directorate Plans: Medical

Method

- The Medical Directorate comprises of the following teams:
  - Senior Medical Leadership Team (SMLT)
  - Urgent & Emergency Care including Professional Standards, Practice Development, End of Life Care & Frequent Caller leadership)
  - Critical Care Operating Unit
  - Clinical Education
  - Clinical Audit, Health Records & EOC Practice Development
  - Research
  - Medicines Governance

Administration

- Our approach will include:
  - Continuing to work agilely as per Trust guidance
  - Supporting the Trust at times of escalation with clinical support both frontline and in our contact centres
  - Supporting through remote clinical working (PaCCs)
  - Continuing to lead on Clinical Governance, ensuring that the Trust continues to follow the Trust governance process for any changes to clinical practice
  - Using our Urgent & Emergency Care teams to maintain an oversight of National policy that could affect the way our staff work (e.g., EOLC & Frequent Caller guidance)
  - Provide Strategic Clinical Advisor on-call function to the Trust

Directorate Plans: Medical

Risks

- This period presents a higher-than-normal risk profile due to most teams working remotely and the potential additional pressures of new variants of COVID-19, seasonal and holiday activities and adverse weather for those teams not working remotely.

- Staff availability and sickness absence may pose a potential risk, this will be managed through the Trust processes already in place.
- Our risks for the central teams is mitigated by the majority of staff working remotely, this is balanced by the need to maintain good communication with all our teams.
- The MDC staff must be included in the critical staff planning due to the nature of the business area and the limited resource trained to work in this area.

- Delivery of the Key Skills programme could potentially be at risk

- Delivery of the workforce pipeline, tied in to the issues ongoing at Crawley College

- Medicines Governance, the packing of medicines pouches (Paddock Wood MDC) and issue of Controlled Drugs is a critical business area and must be resourced to meet demand.

Directorate Plans – Medical

Initiatives

- The central teams will continue to work remotely and follow National and Trust guidance.
- As required and in periods of escalation all teams will be expected to support the Trust, this could be providing Loggist duties when required or supporting in the Medicines Governance area.
- Support the potential introduction of an n Inter Facility Transfer/HCP Desk (resource to be identified)
- Increase the number of PaCCs trained staff

Communication

- The SMLT meets alternate weekdays to ensure any areas for escalation are raised in a timely manner. This enables updates from the central team to be cascaded through normal reporting channels.
- Each team meets weekly/bi-weekly to ensure that our staff whilst most are working remotely are supported and feel part of the team.
- All staff are invited to the bi-weekly 1600 calls and attend the webinars as required.
- Provide Strategic Clinical Advice to the Trust through an on call rota of senior clinicians

Directorate Plans – Medical

Humanitarian

- SECAmb provides access to a range of wellbeing services through the Wellbeing Hub.
- Regular 121s with team members and appropriate levels of supervision are key to ensuring that all members feel supported in the workplace.

Distribution

- SMLT
- EPRR Team

Directorate Plans – Medical (CCP)

Information

- This briefing relates to the geographical area covered by the Critical Care OU. The OU covers all areas of the trust including Kent, Surrey, Sussex and a small area of North Hampshire.
- The OU also works closely with partner agencies from a number of different NHS trusts (including but not exclusively, the regional trauma networks) but also with the local air ambulance charity, 'Air Ambulance - Kent Surrey & Sussex'.
- This brief covers normal winter pressures coupled with potential additional pressures of COVID-19 variants, seasonal and holiday activities, adverse weather, spontaneous serious incidents and other disruptions.

Intent

- To provide a high quality, pre-hospital critical care service to the population we serve. Our service is there to meet the anticipated demand for high acuity patients and mitigate the associated risks. Our OU is led in accordance with the vision and values of SECAmb.

Directorate Plans – Medical (CCP)

Method

- To ensure that patient safety is at the centre of our actions.
- We have a predefined structure of 10 Critical Care Paramedics working at 10 geographically spread bases, both day and night. They are supported by a Critical Care Desk (CCD) which is staffed by a team of 3 over a 24 hour period - that is a day, a link and a night. For operational oversight the OU have an Operational Manager on call 24 hours a day and they are supported by the trusts strategic medical advisor. For senior clinical advice we also have access to a medical consultant 24 hours a day, often referred to as ‘Top Cover’.
- Staff welfare will remain a key priority through the winter and proactive measures will ensure our staff have adequate breaks within the constraints of anticipated operational demand. With an ongoing pandemic, staff safety is paramount and we will maintain a continuous supply of personal protective equipment in line with PHE / NHS guidelines.
- Due to the often high risk medical interventions carried out by the CCP cohort we have a governance and skills assurance time within the rota, 4 x 10 hour days planned every 7 weeks. This ‘non-clinical’ time can be adjusted to support at periods of high demand in line with the existing escalation plan aligned to REAP. This will be reviewed throughout the winter, however skills assurance time must be protected.

Directorate Plans – Medical (CCP)

Administration

- Our approach will include:
- Our dedicated scheduler will be proactive in rota planning to maintain, where possible 10 teams and an appropriately staffed Critical Care Desk both day and night.

- Staff abstraction will be an ongoing challenge, continuing to support Key Skills delivery. Leave will be planned in advance and in accordance with the annual leave policy.
- Utilise bank staff as required.

- All response capable managers (RCMs) will be booked on the CAD when on duty.

Risks

- This period presents a much higher than normal risk profile due to normal winter pressures coupled with potential additional pressures of COVID-19, seasonal and holiday activities, adverse weather, spontaneous serious incidents and other disruptions. Staff availability and sickness absence will be a specific risk during this period particularly given that the CCP workforce is comparably small and specialist.

- We also have an ongoing issue with our current fleet. The vehicles used by the OU are 7 years old and reliability is often an issue. The capacity for spare vehicles is also inconsistent. This situation is expected to worsen with adverse weather. The fleet issue is acknowledged as a Trust issue. A new fleet of SRVs have now been ordered, however there is not a confirmed delivery date. **This risk does not have any current mitigation**

Directorate Plans – Medical (CCP)

Risks

- It is expected that hospital turnaround times are likely to increase however, many of the patient's attended by a CCP will be pre-alerted and it would not seem unreasonable to suggest the impact to the OU will be limited.
- Disruption of medicines and consumables supplies which will lead to limitations in CCP capability.
- Abstraction for Key Skills delivery represents an ongoing risk to operational cover. There is no increased establishment or budget to support this so mitigation is based solely on uptake of overtime at financial risk.

Initiatives

- SECAmb will work with partner agencies to improve operational effectiveness and efficiency especially during times of SURGE. This will include:

- Additional cover with our RCMs
- The CCD and on duty CCPs will continue to monitor the CAD to identify cases where clinical risk is identified due to response delays or clinical skill mix.
- The CCD will work in partnership with the HEMS desk to ensure a timely response to our high acuity case load.
- CCPs will be auto dispatched via the CAD to C1 calls

Directorate Plans – Medical (CCP)

Initiatives

- CCPs can be considered to provide thrombolysis to patients suffering STEMI where transportation to hospital within an acceptable time frame is not possible.
- CCCPs to undertake PACCS training where available to increase the availability of senior clinicians supporting virtual response.
- Support skills assurance, debriefing and supervision of the wider clinical workforce.
- Work proactively with Logistics and Medicines teams to proactively identify threats to supply and find suitable alternatives.

Communication

- SECAmb will maintain a rhythm of daily conference and escalation calls to set the strategic and tactical plan for local implementation. The CCP leadership team will maintain a presence on these daily calls and communicate with our teams as appropriate.
- The Leadership team deliver a weekly brief to all our CCPs and this is expected to continue throughout the winter.
- The Duty Manager is available 24/7 to cascade urgent messages.

Directorate Plans – Medical (CCP)

Humanitarian

SECAmb will seek to respond to all calls on a timely bases utilising the triage and assessment tools available. This will be enhanced by the provision of a critical care desk which will aim to identify patients with critical medical need at the earliest possible opportunity. Patient safety will be at the centre of the Critical Care OU.

- We will also place significant emphasis on staff support and welfare. Support will be given via the following:
  - Easy access to support service e.g. counselling and chaplaincy.
  - To maintain the 24 hour on call OM rota.
  - Duty Team Leader cover.
- To maintain elements of governance time to support case discussion and welfare discussions.

Distribution

- CCOU Leadership Team
- Medical SLT
- EPRR Team
- Top Cover Consultant group
- AAKSS leadership team

Directorate Plans – Nursing & Quality

- The seasonal influenza vaccination programme will commence in autumn 2022. This is being delivered in-house as in previous years.
- SECAmb is not delivering covid booster vaccinations but staff are being directed to alternative services where they can receive their vaccine.
- Nursing & Quality have not identified anything significant outside of their current BC Plans, to affect Winter Plans.

Directorate Plans: P&BD - Logistics

The Logistics Department are responsible for ensuring that all Trust locations have the availability of medical consumables, medical paperwork and sundry items to ensure that the Operational vehicles can be maintained to the required stock levels for effective patient treatment and care. There are a number of measures which can be taken by the Logistics Support Department to ensure that stock levels are pre-positioned and maintained to ensure maximum availability, particularly in the lead up to and through Q3 & Q4, and may factor in the following:

- Medical equipment servicing is not planned during the Q3/Q4 period. We are on plan for the lifepak servicing Which will give us re-assurance through winter pressures of all lifepak devises being serviced
- There are also x2 of all kit held at all make ready sites as spares also stock holding held with the MES team for extra resilience.
- Medical consumables stock is uplifted to account for the increase in demand all stores hold up to 3 weeks' worth of medical consumables
- We hold 4x4 resilience boxes for winter pressures with winter survival (tow ropes, sat navs, blue lights and meal boxes)

We maintain our visits to each Station/MRC up to and over the Christmas period

The Logistics Support Department will support and work alongside the Make Ready and Vehicle Preparation Programme (VPP) to ensure efficient turnaround of equipment and consumable requests required to support the vehicles within the system

Directorate Plans: P&BD - Fleet Resource Planning

Fleet services are responsible for ensuring that the Trust's vehicles are available to operations when required to meet their peak demand. However, this must be based on an effective working relationship between operational managers and vehicle maintenance staff. This will ensure that vehicles are presented for scheduled maintenance and MOTs when requested without affecting performance and that vehicle utilisation is maximised by robust monitoring and implementation of driving standards and vehicle damage.

There are a number of measures for the Fleet Department to take to ensure that vehicle availability is maximised and particularly through Q3 and Q4; these include:

- All MOTs being rescheduled to avoid November and December
- Damage repairs will be 'bundled' to be undertaken in batches (unless it requires to be done for safety / road worthiness)
- All decommissioning of old vehicles will be slowed down so we can utilise these additional resources where possible
- The Fleet Department has an escalatory Plan which ensure that additional maintenance capacity can be applied during periods of higher demand
- The Fleet Department will support and work alongside the Make Ready and Vehicle Preparation Programme (VPP) to ensure efficient turnaround of vehicles within the system maximising vehicles available to Ops

Directorate Plans: P&BD Trust 4x4 Capability

- At times of severe weather during the winter period or access via difficult terrain, the Trust needs to be able to deploy four-wheel drive (4x4) resources to provide access to patients and retrieval to road-based resources
- The Trust operates a variety of vehicles with 4x4 capability across its geography and a range of operational staff across the organisation are trained to drive these vehicles
- All the Trust's ambulances/response cars have all-weather tyres fitted in readiness for adverse weather conditions
- The Trust also maintains a contract with an external company to hire in additional 4x4 vehicles to support with staff movement
- These will be deployed under the direction of Tactical Commanders in preparation for or during any adverse weather

Classification: Official

Publication approval reference: B1160

2022/23 priorities and operational planning guidance

24 December 2021

Dear colleague

Thank you to you and your teams for your continued extraordinary efforts for all our patients.

At the end of January, we will mark two years since paramedics from Yorkshire Ambulance Service and hospital teams in Hull and Newcastle started to treat this country's first patients with COVID-19, and earlier this month we marked the anniversary of the first COVID-19 vaccine dose – and the milestone of 100 million doses – delivered in the biggest and fastest vaccination programme in NHS history.

The last two years have been the most challenging in the history of the NHS, and staff across the service – and many thousands of volunteers – have stepped up time and time again:

- expanding and flexing services to meet the changing demands of the pandemic
- developing and rolling out new treatments, new services and new pathways to respond to the needs of patients with COVID-19 and those without
- pulling out all the stops to recover services that have been disrupted.

At the time of writing, we are again operating within a Level 4 National Incident in response to the emergence of the Omicron variant. Teams from across the NHS and our partners are:

- significantly increasing vaccination capacity to provide the maximum level of immunity for the maximum number of people
- rolling out new antiviral and monoclonal antibody treatments through COVID medicines delivery units
- preparing for a potentially significant increase in those requiring life-saving care.

This concrete and rapid action in the face of uncertainty has characterised the NHS response to the pandemic. We face that uncertainty again now – in terms of the potential impact of Omicron over the coming weeks and months and the development of the pandemic as we look ahead to 2022/23. Despite this, the clear message I have had from colleagues across the NHS is that it is important to provide certainty and clarity where we can by now setting out the priorities and financial arrangements for the whole of 2022/23, recognising that they will have to be kept under review.

The objectives set out in this document are based on a scenario where COVID-19 returns to a low level and we are able to make significant progress in the first part of next year as we continue to rise to the challenge of restoring services and reducing the COVID backlogs.

Building on the excellent progress seen during 2021/22, this means significantly increasing the number of people we can diagnose, treat and care for in a timely way. This will depend on us doing things differently, accelerating partnership working through integrated care systems (ICSs) to make the most effective use of the resources available to us across health and social care, and ensure reducing inequalities in access is embedded in our approach. As part of this, and when the context allows it, we will need to find ways to eliminate the loss in non-COVID output caused by the pandemic.

Securing a sustainable recovery will depend on a continued focus on the health, wellbeing and safety of our staff. ICSs will also need to look beyond the immediate operational priorities and drive the shift to managing the health of populations by targeting interventions at those groups most at risk and focusing on prevention as well as treatment. Thank you for the significant progress that has been made in preparing for the proposed establishment of statutory Integrated Care Systems. To allow sufficient time for the remaining parliamentary stages, a new target date of 1 July 2022 has been agreed for statutory arrangements to take effect and ICBs to be legally and operationally established.

Our ability to fully realise the objectives set out in this document is linked to the ongoing level of healthcare demand from COVID-19. Given the immediate priorities and anticipated pressures, we are not expecting you or your teams to engage with specific planning asks now. The planning timetable will be extended to the end of April 2022, and we will keep this under review.

On behalf of myself and the whole NHS leadership team I want to thank you for the way you are continuing to support staff, put patients first and rise to the challenges we face.

With best wishes

Amanda Pritchard
NHS Chief Executive

Introduction

In 2022/23 we will continue to rise to the challenges of restoring services, meeting the new care demands and reducing the care backlogs that are a direct consequence of the pandemic. While the future pattern of COVID-19 transmission and the resulting demands on the NHS remain uncertain, we know we need to continue to increase our capacity and resilience to deliver safe, high quality services that meet the full range of people's health and care needs. We will:

- accelerate plans to grow the substantive workforce and work differently as we keep our focus on the health, wellbeing and safety of our staff
- use what we have learnt through the pandemic to rapidly and consistently adopt new models of care that exploit the full potential of digital technologies
- work in partnership as systems to make the most effective use of the resources available to us across acute, community, primary and social care settings, to get above pre-pandemic levels of productivity as the context allows
- use the additional funding government has made available to us to increase our capacity and invest in our buildings and equipment to support staff to deliver safe, effective and efficient care.

Our goal is that these actions will support a significant increase in the number of people we are able to treat and care for in a timely way. Our ability to fully realise this goal is linked to the ongoing level of healthcare demand from COVID-19. The new Omicron variant reminds us that we will need to remain ready to rise to new vaccination challenges and significant increases in COVID-19 cases. We are not able to predict the timing or impact of new variants and must develop ambitious plans for what we can achieve for patients and local populations in a more favourable context. The objectives for 2022/23 set out in this document are therefore based on COVID-19 returning to a low level. We will keep these objectives under review as the pandemic evolves.

Effective partnership is critical to achieving the priorities set out in this document. After several years of local development, we have established 42 integrated care systems (ICSs) across England with four strategic purposes:

- improving outcomes in population health and healthcare
- tackling inequalities in outcomes, experience and access

- enhancing productivity and value for money
- supporting broader social and economic development.

To underpin these arrangements, the Health and Care Bill, which intends to put ICSs on a statutory footing and create integrated care boards (ICBs) as new NHS bodies, is currently being considered by Parliament.

To allow sufficient time for the remaining parliamentary stages, a new target date of 1 July 2022 has been agreed for new statutory arrangements to take effect and ICBs to be legally and operationally established. This replaces the previously stated target date of 1 April 2022. This new target date will provide some extra flexibility for systems preparing for the new statutory arrangements and managing the immediate priorities in the pandemic response, while maintaining our momentum towards more effective system working.

The establishment of statutory ICSs, and timing of this, remains subject to the passage of the Bill through Parliament. An implementation date of 1 July would mean the current statutory arrangements would remain in place until then, with the first quarter of 2022/23 serving as a continued preparatory period.

Joint working arrangements have been in place at system level for some time, and there has already been significant progress in preparing for the proposed establishment of statutory ICSs, including recruitment of designate ICB chairs and chief executives. Designate ICB leaders should continue to develop system-level plans for 2022/23 and prepare for the formal establishment of ICBs in line with the guidance previously set out by NHS England and NHS Improvement and the updated transition timeline (this is set out more fully in section J).

The NHS's financial arrangements for 2022/23 will continue to support a system-based approach to planning and delivery and will align to the new ICS boundaries agreed during 2021/22. We will shortly issue one-year revenue allocations for 2022/23 and three-year capital allocations to 2024/25. We intend to publish the remaining two-year revenue allocations to 2024/25 in the first half of 2022/23. It is in this context that we are asking systems to focus on the following priorities for 2022/23:

A. Invest in our workforce – with more people (for example, the additional roles in primary care, expansion of mental health and community services, and tackling

substantive gaps in acute care) and new ways of working, and by strengthening the compassionate and inclusive culture needed to deliver outstanding care.

B. Respond to COVID-19 ever more effectively – delivering the NHS COVID-19 vaccination programme and meeting the needs of patients with COVID-19.

C. Deliver significantly more elective care to tackle the elective backlog, reduce long waits and improve performance against cancer waiting times standards.

D. Improve the responsiveness of urgent and emergency care (UEC) and build community care capacity– keeping patients safe and offering the right care, at the right time, in the right setting. This needs to be supported by creating the equivalent of 5,000 additional beds, in particular through expansion of virtual ward models, and includes eliminating 12-hour waits in emergency departments (EDs) and minimising ambulance handover delays.

E. Improve timely access to primary care – maximising the impact of the investment in primary medical care and primary care networks (PCNs) to expand capacity, increase the number of appointments available and drive integrated working at neighbourhood and place level.

F. Improve mental health services and services for people with a learning disability and/or autistic people – maintaining continued growth in mental health investment to transform and expand community health services and improve access.

G. Continue to develop our approach to population health management, prevent ill-health and address health inequalities – using data and analytics to redesign care pathways and measure outcomes with a focus on improving access and health equity for underserved communities.

H. Exploit the potential of digital technologies to transform the delivery of care and patient outcomes – achieving a core level of digitisation in every service across systems.

I. Make the most effective use of our resources – moving back to and beyond pre-pandemic levels of productivity when the context allows this.

J. Establish ICBs and collaborative system working – working together with local authorities and other partners across their ICS to develop a five-year strategic plan for their system and places.

Across all these areas we will maintain our focus on preventing ill-health and tackling health inequalities by redoubling our efforts on the five priority areas for tackling health

inequalities set out in guidance in March 2021. ICSs will take a lead role in tackling health inequalities, building on the Core20PLUS5 approach introduced in 2021/22 to support the reduction of health inequalities experienced by adults, children and young people, at both the national and system level.

Improved data collection and reporting will drive a better understanding of local health inequalities in access to, experience of and outcomes from healthcare services, by informing the development of action plans to narrow the health inequalities gap. ICBs, once established, and trust board performance packs are therefore expected to be disaggregated by deprivation and ethnicity.

We will also continue to embed the response to climate change into core NHS business. Trusts and ICBs, once established, are expected to have a board-level Net Zero lead and a Green Plan, and are asked to deliver carbon reductions against this, throughout 2022/23.

ICS footprints represent the basis of strategic and operational plans for 2022/23 and beyond. Designate ICB leadership teams are asked to work with partners in their ICS to develop plans that reflect these priorities and are triangulated across activity, workforce and money. The immediate focus should remain on the priorities set out in Preparing the NHS for the potential impact of the Omicron variant and we have extended the planning timetable to reflect this.

A. Invest in our workforce – with more people and new ways of working, and by strengthening the compassionate and inclusive culture needed to deliver outstanding care

During the pandemic the focus has rightly been on the health, wellbeing and safety of our staff; this will continue. To support the restoration and recovery of services we need more people, working differently in a compassionate and inclusive culture where leaders at all levels inspire, empower and enable them to deliver high quality care in the most effective and efficient way.

We are therefore asking systems to accelerate work to transform and grow the substantive workforce and make the NHS a better place to work for all our staff. The actions to achieve this should be set out in whole system workforce plans that build on the progress made in delivering local people plans and reflect the ambitions to:

Look after our people:

- improve retention by delivering the NHS People Promise to improve the experience of our staff, through a focus on flexible working, early/mid/late career conversations and enabling staff to understand their pensions
- continue to support the health and wellbeing of our staff, including through effective health and wellbeing conversations and the mental health hubs
- improve attendance by addressing the root causes of non COVID-related sickness absence and, where appropriate, supporting staff to return to work.

Improve belonging in the NHS:

- improve the Black, Asian and minority ethnic disparity ratio, delivering the six high impact actions to overhaul recruitment and promotion practices
- implement plans to promote equality across all protected characteristics.

Work differently:

- accelerate the introduction of new roles, such as anaesthetic associates and first contact practitioners, and expanding advanced clinical practitioners
- develop the workforce required to deliver multidisciplinary care closer to home, including supporting the rollout of virtual wards and discharge to assess models
- ensure the highest level of attainment set out by the ‘meaningful use standards’ for e-job planning and e-rostering is met to optimise the capacity of the current workforce
- establish, or become part of, volunteer services such as the NHS cadets and NHS reservists.

Grow for the future:

- expand international recruitment through ongoing ethical recruitment of high quality nurses and midwifes

- leverage the role of NHS organisations as anchor institutions/networks to widen participation and create training and employment opportunities, including through expanding apprenticeships as a route into working in health and care
- make the most effective use of temporary staffing, including by expanding collaborative system banks and reducing reliance on high-cost agency staff
- ensure training of postgraduate doctors continues, with adequate time in the job plans of supervisors to maintain education and training pipelines
- ensure sufficient clinical placement capacity to enable students to qualify and register as close to their initial expected date as possible.

Health Education England (HEE) and NHS England and NHS Improvement regional teams will support systems to develop and deliver their workforce plans. We will support systems to deliver through:

- investment to expand the national nursing international recruitment programme and support to recruit more allied health professionals
- the national healthcare support worker (HCSW) recruitment and retention programme
- continued funding of mental health hubs to enable staff access to enhanced occupational health and wellbeing and psychological support
- a suite of national GP recruitment and retention initiatives to enable systems to support their PCNs to expand the GP workforce and make full use of the digital locum pool
- the Additional Roles Reimbursement Scheme (ARRS) to deliver 26,000 roles in primary care, to support the creation of multidisciplinary teams.

B. Respond to COVID-19 ever more effectively – delivering the NHS COVID vaccination programme and meeting the needs of patients with COVID-19

The NHS has been asked to offer every eligible adult over the age of 18 a booster vaccination by 31 December 2021 and the immediate next steps for deployment were set out in the recent letter to services. Delivery of the vaccine programme is expected

to remain a key priority as we look ahead to 2022/23 and systems are asked to plan to maintain the infrastructure that underpins our ability to respond as needed. We will set out further details as future requirements become clearer.

A number of new treatment options, including neutralising monoclonal antibodies and oral antivirals, are now available for non-hospitalised NHS patients at greater risk from COVID-19. These treatments are in addition to COVID-19 vaccines, which remain the most important intervention for protecting people from COVID-19 infection.

These new treatments, which reduce the risk of hospitalisation and death, are being rolled out initially for a targeted cohort of highest-risk patients and should continue to be prioritised. In parallel, the government has also launched a study to assess the efficacy of antivirals in the UK's predominately vaccinated population. Dependent on the results of that study, we will develop plans for wider access to antivirals from the spring.

The Office for National Statistics (ONS) estimates around one million people are living with post-COVID syndrome (long COVID) in England. The NHS in England has responded by establishing 90 specialist post-COVID clinics to assess, diagnose and help people recover from long COVID, as well as 14 paediatric hubs to provide expert advice to local services treating children and young people.

While good progress has been made, there is still wide local variation in referral rates, waiting times and access to the clinics across diverse demographic groups. Systems are asked to:

- increase the number of patients referred to post-COVID services and seen within six weeks of referral
- decrease the number of patients waiting longer than 15 weeks, to enable their timely placement on the appropriate management or rehabilitation pathway.

£90 million is being made available to support this work in 2022/23.

C. Deliver significantly more elective care to tackle the elective backlog, reduce long waits and improve performance against cancer waiting times standards

C1: Maximise elective activity and reduce long waits, taking full advantage of opportunities to transform the delivery of services

The pandemic has had a significant impact on the delivery of elective care and, as a result, on the lives of many patients who are waiting for treatment. Over the next three years, we will rise to the challenge of addressing the elective backlogs that have grown during the pandemic through a combination of expanding capacity, prioritising treatment and transforming delivery of services. Every system is required to develop an elective care recovery plan for 2022/23, setting out how the first full year of longer-term recovery plans will be achieved.

As in the COVID-19 wave last winter, it is crucial that we continue to deliver elective care and ensure that the highest clinical priority patients – including patients on cancer pathways and those with the longest waits – are prioritised. Once again, clinical leadership and judgement about prioritisation and risk will be essential. Wherever possible over winter, we need systems and providers to continue to separate services and to maintain maximum possible levels of inpatient, day case, outpatient and diagnostic activity, recognising the requirement to release staff to support the vaccination programme and respond to the potential increase in COVID-19 cases. This should include the independent sector as separate green pathway capacity.

The ongoing uncertainties and challenges of COVID-19 and demand make it particularly hard to predict how quickly we will be able to recover elective services, but we have set an ambitious goal to deliver around 30% more elective activity by 2024/25 than before the pandemic, after accounting for the impact of an improved care offer through system transformation, and specialist advice, including advice and guidance. We will continue to work to return to pre-pandemic performance as soon as possible with an ambition in 2022/23 for systems to deliver over 10% more elective activity than before the pandemic and reduce long waits. Treatment should continue to be prioritised based on clinical urgency and steps should be taken to address health

inequalities. Systems should make use of alternative providers if people have been waiting a long time for treatment. Systems are asked to:

- eliminate waits of over 104 weeks as a priority and maintain this position through 2022/23 (except where patients choose to wait longer)
- reduce waits of over 78 weeks and conduct three-monthly reviews for this cohort of patients, extending the three-monthly reviews to patients waiting over 52 weeks from 1 July 2022
- develop plans that support an overall reduction in 52-week waits where possible
- accelerate the progress we have already made towards a more personalised approach to follow-up care in hospitals or clinics, reducing outpatient follow-ups by a minimum of 25% against 2019/20 activity levels by March 2023 and going further where possible. We will agree specific targets with systems through the planning process.

Our ability to fully deliver on the objectives is linked to the ongoing level of healthcare demand from COVID-19 and will depend on:

- holding elective activity through the winter
- systems eliminating the loss in productivity caused by the operating constraints resulting from the pandemic.

A more personalised approach to outpatient follow-up appointments will ensure people who require a follow-up appointment receive one in a timely manner – protecting clinical time for the most value adding activity. The opportunity to reduce outpatient follow-ups will differ by trust and specialty and local planning should inform how the ambition will be delivered across the system, supported through a combination of:

- patient initiated follow-up (PIFU) – expanding the uptake of PIFU to all major outpatient specialties, moving or discharging 5% of outpatient attendances to PIFU pathways by March 2023
- effective discharge, particularly of those patients for whom clinical interventions have been exhausted
- more streamlined diagnostic pathways
- referral optimisation, including through use of specialist advice services to enhance patient pathways – delivering 16 specialist advice requests, including

advice and guidance (A&G), per 100 outpatient first attendances by March 2023.

Systems are asked to plan how the redeployment of the released capacity (including staff) is used to increase elective clock-stops or reduce clock-starts proactively.

£2.3 billion of elective recovery funding has been allocated to systems to support the recovery of elective services in 2022/23. We will set out further details in additional guidance.

£1.5 billion of capital above that funded within core envelopes has been made available to the NHS over three years to support new surgical hubs, increased bed capacity and equipment to help elective services recover. Systems are asked to demonstrate how their capital proposals support a material quantified increase in elective activity, eg through schemes that enable the separation of elective and non-elective activity, the setting up or expansion of elective hub sites, day case units or increased bed capacity. Further detail on these requirements and the process will be set out in additional guidance.

Systems are asked to rapidly draw up delivery plans across elective inpatient, outpatient and diagnostic services for adults and children (including specialised services) for April 2022 to March 2023. These plans should set out how:

- systems will meet the ambitions set out above, reflecting the additional revenue and capital funding being made available. We will set out further details in additional guidance
- services will be organised and delivered to maximise productivity opportunities and secure the best possible outcomes for patients
- local independent sector capacity is incorporated as a core element to deliver improved outcomes for patients and reduce waiting times sustainably
- the updated UK Health Security Agency (UKHSA) guidance will be implemented, ensuring safety concerns are appropriately balanced.
- systems will ensure inclusive recovery and reduce health inequalities where they are identified
- elective care, UEC, social care and mental health will be managed in a way that ensures elective recovery can be protected and any disruptions minimised.

C2: Complete recovery and improve performance against cancer waiting times standards

The number of patients seen following an urgent suspected cancer referral has remained at a record high since March 2021. However, backlogs remain for those who have been referred for treatment, and we would have expected at least 36,000 more patients to have come forward to start treatment during the pandemic than have done so. Systems should therefore, as a priority, complete any outstanding work on the post-pandemic cancer recovery objectives set out in the 2021/22 H2 planning guidance, to:

- return the number of people waiting for longer than 62 days to the level in February 2020 (based on the national average in February 2020)
- meet the increased level of referrals and treatment required to reduce the shortfall in number of first treatments.

Priority actions should centre on ensuring there is sufficient diagnostic and treatment capacity to meet recovering levels of demand, with a particular focus on the three cancers making up two-thirds of the national backlog (lower GI, prostate and skin), including:

- provision of sufficient commissioned capacity so that every urgent suspected lower GI cancer referral is accompanied by a faecal immunochemical test (FIT) result
- delivery of the optimal timed pathway for prostate cancer, including ensuring mpMRI prior to biopsy to eliminate the need for biopsy wherever possible
- making teledermatology available as an option for clinicians in all providers receiving urgent cancer referrals.

Systems are asked to work with Cancer Alliances to develop and implement a plan to:

- improve performance against all cancer standards, with a focus on the 62-day urgent referral to first treatment standard, the 28-day faster diagnosis standard and the 31-day decision-to-treat to first treatment standard
- make progress against the ambition in the NHS Long Term Plan to diagnose more people with cancer at an earlier stage, with a particular focus on disadvantaged areas where rates of early diagnosis are lower.

Delivery of these plans is expected to support:

- Timely presentation and effective primary care pathways including:
  - working with PCNs to support implementation of cancer early diagnosis as set out in the Network Contract Directed Enhanced Service (DES)
  - running local campaigns to complement national advertising to raise public awareness of cancer symptoms and encourage timely presentation.
- Faster diagnosis, including:
  - extending coverage of non-specific symptom pathways – with at least 75% population coverage by March 2023
  - ensuring at least 65% of urgent cancer referrals for suspected prostate, colorectal, lung, oesophago-gastric, gynaecology and head and neck cancer meet timed pathway milestones.
- Targeted case finding and surveillance, including:
  - maximising the uptake of targeted lung health checks (TLHC) and the effective delivery of follow-up low dose CT scans, to meet trajectories agreed with the national team. From 2022/23, all Cancer Alliances will have at least one TLHC project
  - ensuring that every person diagnosed with colorectal and endometrial cancer is tested for Lynch syndrome (with cascade testing offered to family members), and patients who qualify for liver surveillance under National Institute for Health and Care Excellence (NICE) guidance are identified and invited to surveillance.

The national cancer team will provide data and guidance to Cancer Alliances to support the development of their plans. Plans will form the basis of Cancer Alliance funding agreements.

ICBs and Cancer Alliances are also asked to work with trusts to:

- ensure they have fully operational and sustainable patient stratified follow-up (PSFU) pathways for breast, prostate, colorectal and one other cancer by the end of the first quarter of 2022/23; and for two further cancers (one of which should be endometrial cancer) by March 2023
- for systems participating in colon capsule endoscopy and cytosponge projects, deliver agreed levels of activity

- increase the recruitment and retention of clinical nurse specialists, cancer support workers and pathway navigators, and promote take up of clinical training opportunities for the cancer workforce.

Maintaining and restoring cancer screening programmes is critical to our efforts to fully restore cancer services. For breast cancer screening in particular, any systems that have not restored compliance with the three-year cycle by the end of March 2022 are expected to have done so by the end of June 2022.

C3: Diagnostics

Recovery of the highest possible diagnostic activity volumes is critical to providing responsive, high quality services and supporting elective recovery and early cancer diagnosis. This will be supported by the timely implementation of new community diagnostic centres (CDCs). Systems are asked to:

- increase diagnostic activity to a minimum of 120% of pre-pandemic levels across 2022/23 to support these ambitions and meet local need
- develop investment plans that lay the foundations for further expansion of capacity through CDCs in 2023/24 and 2024/25.

Three-year capital funding allocations will be included in system envelopes for this purpose. National investment through HEE is planned to facilitate training and supply of the workforce to support these goals. Systems will be able to access dedicated revenue funding to support set up and running of CDCs, subject to the necessary business case approvals. Revenue will be allocated to align with the programmes of work or agreed capital business cases.

Systems are asked to utilise targeted capital allocations to:

- increase the number of endoscopy rooms, levelling up to a guide level of 3.5 rooms per 100,000 population over 50 years of age. Systems should consider using this funding to locate endoscopy services in CDCs and supplement available CDC funding allocations, seeking to co-locate endoscopy and imaging services where possible. Funding will also be available to units that have yet to meet Joint Advisory Group (JAG) on Gastrointestinal Endoscopy Endoscopy accreditation to upgrade their services

- invest in CT capacity to support expansion the Target Lung Health Checks programme from 2023/24, with target coverage to be agreed between Cancer Alliances and the National Cancer Programme team. Cancer Alliances will receive this targeted funding on the basis of their remaining unscreened population and existing CT capacity and should coordinate with ICSs.
- develop additional digitally connected imaging capacity and ensure that acute sites have a minimum of two CT scanners
- procure new breast screening units to deliver the 36-month cycle.

Operational capital resources should continue to be used to reduce the backlog of diagnostic equipment replacement over 10 years old.

Pathology and imaging networks are asked to complete the delivery of their diagnostic digital roadmaps as part of their digital investment plans. National funding will be provided that is broadly consistent with these roadmaps, taking account of progress to date. Refreshed roadmaps need to include specific plans setting out how pathology and imaging networks and CDCs will with their systems support artificial intelligence (AI) research and innovation, and the scalable and sustainable integration of AI-driven diagnostics. The implementation of digital diagnostic investments is expected to deliver at least a 10% improvement in productivity by 2024/25, in line with the best early adopters.

Systems should ensure that pathology networks reach, as a minimum, the ‘maturing’ status for delivery of pathology services on the pathology network maturity framework by 2024/25. They should also meet the requirements of all national data collections for diagnostic services and support the work to scope creation of endoscopy and clinical physiology networks.

Programme funding of £21 million is available to support pathology and imaging networks to deliver on these priorities in 2022/23 alongside the implementation of CDCs.

C4 Deliver improvements in maternity care

Systems working through local maternity systems (LMSs) are asked to continue to work towards delivering a range of transformation objectives to make maternity and neonatal care safer, more personalised and more equitable. ICSs should undertake

formal, structured and systematic oversight of how their LMS delivers its functions and there should be a direct line of sight to the LMS board.

Providers are asked to continue to embed and deliver the seven immediate and essential actions identified in the interim Ockenden report, along with any future learning shared in the second Ockenden report and East Kent review (when published). LMSs should continue to oversee quality in line with Implementing a revised perinatal quality surveillance model.

LMSs are asked to support providers to prioritise reopening any services suspended due to the pandemic, ensuring women can take somebody with them to all maternity appointments and supporting work to increase vaccination against COVID-19 in pregnancy. LMSs should implement local maternity equity and equality action plans in line with Equity and equality: Guidance for local maternity systems.

LMSs are also asked to continue to work with providers to implement local plans to deliver Better Births, the report of the national maternity review, including:

- delivering local plans for midwifery continuity of carer (MCoC) in line with Delivering midwifery continuity of carer at full scale, prioritising MCoC so that most Black, Asian and mixed ethnicity women and most women from the most deprived areas receive it once the building blocks are in place
- offering every woman a personalised care and support plan in line with the Personalised care and support planning guidance
- fully implement Saving Babies' Lives. Providers should have a preterm birth clinic and act so that at least 85% of women who are expected to give birth at less than 27 weeks' gestation are able to do so in a hospital with appropriate on-site neonatal care.

Funding of c£93 million to support the implementation of Ockenden actions through investment in workforce will go into baselines from 2022/23. Programme funding will also be made available to support the delivery of the Better Births priorities.

D. Improve the responsiveness of urgent and emergency care and build community care capacity– keeping patients safe and offering the right care, at the right time, in the right setting

Sustaining UEC performance has been very challenging due to the pandemic. We need to continue reforms to community and urgent and emergency care to deliver safe, high quality care by preventing inappropriate attendance at EDs, improving timely admission to hospital for ED patients, reducing length of stay and restoring ambulance response times. An essential requirement is to increase the capacity of the NHS by the equivalent of at least 5,000 G&A beds and return, as a minimum, to pre-pandemic levels of bed availability through a combination of:

- national funding for the further development of virtual wards (including hospital at home)
- system capital plans to increase physical bed capacity as part of elective recovery plans
- re-establishing bed capacity consistent with latest UKHSA IPC guidance.

D1: Urgent and emergency care

The urgent and emergency care system continues to be under significant pressure ahead of what is expected to be an extremely challenging winter. These pressures are exacerbated by delayed ambulance handovers and ambulance response times. A longer term improvement approach is required for the full recovery of urgent and emergency care services. Expected performance levels in 2022/23 therefore represent a first step towards recovery.

Systems are therefore asked to:

- reduce 12-hour waits in EDs towards zero and no more than 2%
- improve against all Ambulance Response Standards, with plans to achieve Category 1 and Category 2 mean and 90th percentile standards

- minimise handover delays between ambulance and hospital, allowing crews to get back on the road and contribute to achieving the ambulance response standards. This includes:
  - eliminating handover delays of over 60 minutes
  - ensuring 95% of handovers take place within 30 minutes
  - ensuring 65% of handovers take place within 15 minutes
- ensure stability of services and have planned contingency in advance of next winter.

Systems are asked to build on the work already commenced, as indicated in the UEC 10 Point Action Recovery Plan. This should incorporate:

- Increasing capacity within NHS 111 to ensure the service is the credible first option for patients, enabling their referral to the most appropriate care setting, including:
  - call handling capacity to meet growing demand
  - clinical capacity within the clinical assessment service to support decision-making, with >15% of calls received having clinical input
  - ensuring there is a full range of available options in the Directory of Services to meet local need
  - adopting the new regional/national route calling technology.
- Expanding urgent treatment centre (UTC) provision and increasingly moving to a model where UTCs act as the front door of ED, to enable emergency medicine specialists to focus on higher acuity need within the ED.

Systems are asked to put in place integrated health and care plans for children and young people's services that include a focus on urgent care; building on learning from pilots placing paediatric staff within NHS 111 services; better connections between paediatric health services; joining up children's services across the NHS and local authorities; improving transitions to adult services; and supporting young people with physical and mental health needs within acute and urgent care settings.

Systems are asked to consistently submit timely Emergency Care Data Set (ECDS) data, now seven days a week.

D2: Transform and build community services capacity to deliver more care at home and improve hospital discharge

The transformation of out-of-hospital services is a key element of the NHS recovery. National funding, alongside additional growth within core allocations for community services funding, will support systems to increase overall capacity of community services to provide care for more patients at home and address waiting lists, develop and expand new models of community care and support timely hospital discharge.

Community care models

Virtual wards

The NHS has already had considerable success in implementing virtual wards, including Hospital at Home services. Over 53 virtual wards are already providing over 2,500 ‘beds’ nationwide, enabled by technology. In addition to managing patients with COVID, they also support patients with acute respiratory infections, urinary tract infections (UTIs), chronic obstructive pulmonary disease (COPD) and complex presentations, such as those who are frail as well as having a specific medical need.

The scope for virtual wards is far greater. Given the significant pressure on acute beds we must now aim for their full implementation as rapidly as possible. We are therefore asking systems to develop detailed plans to maximise the rollout of virtual wards to deliver care for patients who would otherwise have to be treated in hospital, by enabling earlier supported discharge and providing alternatives to admission. These plans should be developed across systems and provider collaboratives, rather than individual institutions, based on partnership between secondary, community, primary and mental health services. Systems should also consider partnerships with the independent sector where this will help grow capacity.

By December 2023, we expect systems to have completed the comprehensive development of virtual wards towards a national ambition of 40–50 virtual wards per 100,000 population. Successful implementation will require systems to:

- maximise their overall bed capacity to include virtual wards
- prevent virtual wards becoming a new community-based safety netting service; they should only be used for patients who would otherwise be admitted to an NHS acute hospital bed or to facilitate early discharge
- maintain the most efficient safe staffing and caseload model

- manage length of stay in virtual wards through establishing clear criteria to admit and reside for services
- fully exploit remote monitoring technology and wider digital platforms to deliver effective and efficient care.

Up to £200 million will be available in 2022/23 and up to £250 million in 2023/24 (subject to progress of systems) to support the implementation of these plans. We expect plans to cover two years. The scale of funding awarded in 2022/23 will depend on credible ambition for delivery of virtual wards by December 2022 to provide capacity for next winter. Systems will want to consider approaches that address patients with lower intensity and higher intensity needs (ie Hospital at Home services). We will set out further guidance on the virtual ward model, the support available and the funding criteria.

Urgent community response

By April 2022 all parts of England will be covered by 2 hour urgent community response services and over 2022-23 providers and systems will be required to:

- Maintain full geographic rollout and continue to grow services to reach more people extending operating hours where demand necessitates and at a minimum operating 8am to 8pm, 7 days a week in line with national guidance
- Improve outcomes through reaching patients in crisis in under 2 hours where clinically appropriate. Providers will be required to achieve, and ideally exceed in the majority of cases, the minimum threshold of reaching 70% of 2 hour crisis response demand within 2 hours from the end of Q3.
- Increase the number of referrals from all key routes, with a focus on UEC, 111 and 999, and increase care contacts
- Improve capacity in post urgent community response services to support flow and patient outcomes including avoiding deterioration into crisis again or unnecessary admission
- Ensure workforce plans support increasing capacity and development of skills and competencies in line with service development
- Improve data quality and completeness in the Community Services Dataset (CSDS) as this will be the key method to monitor outcomes, system performance and capacity growth

Anticipatory care

Anticipatory care (AC) is a Long-Term Plan commitment focused on provision of proactive care in the community for multimorbid and frail individuals who would benefit most from integrated evidence-based care. ICSs should design, plan for and commission AC for their system. Systems need to work with health and care providers to develop a plan for delivering AC from 2023/24 by Q3 2022, in line with forthcoming national operating model for AC.

Enhanced Health in Care Homes

Ensure consistent and comprehensive coverage of Enhanced Health in Care Homes in line with the national framework.

Community service waiting lists

Systems must develop and agree a plan for reduction of community service waiting lists and ensure compliance of national sitrep reporting. Specifically, systems are asked to:

- develop a trajectory for reducing their community service waiting lists
- significantly reduce the number of patients waiting for community services
- prioritise patients on waiting lists
- consider transforming service pathways and models to improve effectiveness and productivity.

Hospital discharge

As outlined in the H2 2021/22 planning guidance, the additional funding for the Hospital Discharge Programme will end in March 2022. As part of preparing the NHS for the potential impact of the Omicron variant and other winter pressures, we have asked systems to work together with local authorities and partners, including hospices and care homes, to release the maximum number of beds, as a minimum this should be equivalent to half of current delayed discharges. Systems should seek to sustain the improvement in delayed discharges in 2022/23 working with local authority partners and supported by the Better Care Fund and the investment in virtual wards.

Digital

Digital tools and timely, accurate information are key to delivering on these aims and systems are asked to:

- identify digital priorities to support the delivery of out-of-hospital models of care through the development of system digital investment plans, ensuring community health services providers are supported to develop robust digital strategies to support improvements in care delivery
- ensure providers of community health services, including ICS-commissioned independent providers, can access the Local Care Shared Record as a priority in 2022/23, to enable urgent care response and virtual wards
- deliver radical improvements in quality and availability against national data requirements and clinical standards, including the priority areas of urgent care response and musculoskeletal (MSK).

E. Improve timely access to primary care – expanding capacity and increasing the number of appointments available

The NHS Long Term Plan commits to increasing investment in primary medical and community services (PMCS) by £4.5 billion real terms investment growth by 2023/24. We expect systems to maximise the impact of their investment in primary medical care and PCNs with the aim of driving and supporting integrated working at neighbourhood and place level. Systems are asked to look for opportunities to support integration between community services and PCNs, given they are an integral part of solutions to key system challenges that require a whole system response, including elective recovery and supporting more people in their own homes and local communities. Systems should also consider how community pharmacy can play a greater role in local plans as part of these integrated approaches.

Expanding the primary care workforce remains a top priority to increase capacity. Systems are expected to:

- support their PCNs to have in place their share of the 20,500 FTE PCN roles by the end of 2022/23 (in line with the target of 26,000 by the end of 2023/24) and

to work to implement shared employment models, drawing on more than £1 billion of Additional Roles Reimbursement Scheme (ARRS) funding across system development funding (SDF) and allocations

- expand the number of GPs towards the 6,000 FTE target, with consistent local delivery of national GP recruitment and retention initiatives, thereby continuing to make progress towards delivering 50 million more appointments in general practice by 2024.

In line with the principles outlined in the October 2021 plan, systems are asked to support the continued delivery of good quality access to general practice through increasing and optimising capacity, addressing variation and spreading good practice. Every opportunity to secure universal participation in the Community Pharmacist Consultation Service should be taken. Systems should drive the transfer of lower acuity care from both general practice and NHS 111 under this scheme, supported by a new investment and impact fund indicator for PCNs which incentivises contributions to a minimum of two million appointments in 2022/23. Performance at the rate of the best early implementers of 50 referrals a week would move more than 15 million appointments out of general practice. Systems will need to implement revised arrangements for enhanced access delivered through PCNs from October 2022.

Systems are asked to support practices and PCNs to ensure the commitment that every patient has the right to be offered digital-first primary care by 2023/24 is delivered. By ‘digital-first primary care’ we mean a full primary care service that patients can access easily and consistently online, that enables them to quickly reach the right service for their needs (whether in person or remotely), that is integrated with the wider health system, and that enables clinicians to provide efficient and appropriate care.

2022/23 will see the implementation of GP contract changes, including those to the DES. In addition to the five services already being delivered by PCNs, from April 2022 there will be a phased introduction of two new services – anticipatory care and personalised care – and an expanded focus on cardiovascular disease (CVD) diagnosis and prevention.

Systems are asked to support their PCNs to work closely with local communities to address health inequalities. Practices should continue the critical job of catching up on the backlog of care for their registered patients who have ongoing conditions, to

ensure the best outcomes for them and to avoid acute episodes or exacerbations that may otherwise result in avoidable hospital admissions or even premature mortality.

Systems are asked to take every opportunity to use community pharmacy to support this; for example, in the delivery of care processes such as blood pressure measurement under new contract arrangements. This will drive detection of hypertension across our communities, address backlogs in care and deliver longer-term transformation in integrated local primary care approaches. Systems should also optimise use of pharmacy services around smoking cessation on hospital discharge, the expanded new medicines service and the discharge medicines service.

For dental services, the focus is on maximising clinically appropriate activity in the face of ongoing IPC measures, and targeting capacity to meet urgent care demand, minimise deterioration in oral health and reduce health inequalities.

Subject to the passage of the Health and Care Bill, ICBs will become the delegated commissioners for primary medical services and, in some cases, also dental, community pharmacy and optometry services, during 2022/23 – the target date now being 1 July 2022. Once established, ICBs should develop plans, working with NHS England regional commissioning teams to take on effective delegated dental, community pharmacy and optometry commissioning functions from 2023/24.

F. Grow and improve mental health services and services for people with a learning disability and/or autistic people

F1: Expand and improve mental health services

The complexity of needs for those requiring mental health services has risen because of the pandemic. In addition to a pre-existing treatment gap within mental health, this is increasing pressures within community services, mental health UEC and inpatient pathways across all ages. To address these pressures and continue to make progress against the NHS Long Term Plan ambitions, systems are asked to:

- Continue to expand and improve their mental health crisis care provision for all ages. This includes improving the operation of all age 24/7 crisis lines, crisis resolution home treatment teams and mental health liaison services in acute

hospitals. Systems are also asked to increase the provision of alternatives to A&E and admission, and improve the ambulance mental health response. Over the next three years £150 million targeted national capital funding will be made available to support improvements in mental health UEC, including mental health ambulances, extending Section 136 suites, safe spaces in or near A&E.

- Ensure admissions are intervention-focused, therapeutic and supported by a multidisciplinary team, utilising the expansion of mental health provider collaboratives across the whole mental health pathway where systems plan such developments. These collaboratives will support systems to transform services and reduce reliance on hospital-based care delivered away from people's local area.
- Continue the expansion and transformation of mental health services, as set out in the NHS Mental Health Implementation Plan 2019/20–2023/24, to improve the quality of mental healthcare across all ages. The mental health LTP ambitions tool will support systems to understand their delivery requirements for expanding access, as well as the Mental Health Delivery Plan 2022/23.
- Continue to grow and expand specialist care and treatment for infants, children and young people by increasing the support provided through specialist perinatal teams for infants and their parents up to 24 months and through continuing to expand access to children and young people’s mental health services.
- Subject to confirmation, encourage participation in the first phase of the national Quality Improvement programme to support implementation of the Mental Health Act reforms.

We ask that systems maintain a focus on improving equalities across all programmes, noting the actions and resources identified in the Advancing Mental Health Equalities Strategy.

Delivery of the Mental Health Investment Standard (MHIS) remains a mandatory minimum requirement, ensuring appropriate investment of baseline funding and SDF to deliver the mental health NHS Long Term Plan objectives by 2023/24. Where SDF funding supports ongoing services, these will continue to be funded beyond 2023/24. This will support the continued expansion and transformation of the mental health workforce. For this:

- systems are asked to develop a mental health workforce plan to 2023/24 in collaboration with mental health providers, HEE and partners in the voluntary, community and social enterprise (VCSE) and education sectors
- PCNs and mental health trusts are asked to continue to use the mental health practitioner ARRS roles to improve the care and treatment for adults, children and young people in line with NHS Long Term Plan ambitions.

Capital funding made available through system allocations is expected to support urgent patient safety projects for mental health trusts, such as those that address ligature points and other infrastructure concerns that pose immediate risks to patients. Funding to eradicate mental health dormitories will continue in 2022/23 and 2023/24.

Systems are asked to work with the Mental Health Provider Collaboratives to produce a clear plan of requirements for CYPMH general adolescent and psychiatric intensive care in-patient beds to meet the health needs of their population, strengthen local services and eliminate out of area placements for the most vulnerable young people. These bed plans should be an integral part of the overall plan for CYP mental health services to ensure a local, whole patient pathway for patients with mental health, learning disability and/or autism needs. The plans should be complete by the end of Q1 2022/23 and should be funded through system operational capital. Investing in this way is expected to reduce operating costs as a direct result of improving access to local services and reducing out of area patient flows. Further guidance on the development of these plans will be issued before the start of 2022/23.

All NHS commissioned services must flow data to the national datasets and relevant bespoke collections. Provision for this must be included and agreed in commissioning arrangements planned for 2021/22, as part of this process.

F2: Meeting the needs of people with a learning disability and autistic people

The pandemic has highlighted and exacerbated the significant health inequalities experienced by people with a learning disability and autistic people. As we recover from the pandemic, we must ensure that people with a learning disability and autistic people are not further disadvantaged in fair access to healthcare. As digital healthcare develops, this means making sure there are reasonable adjustments and tailored responses, including consideration of the ongoing need for face-to-face appointments. Systems are asked to:

- Increase the rate of annual health checks for people aged 14 and over on a GP learning disability register towards the 75% ambition in 2023/24. Every annual health check should be accompanied by a health action plan to identify actions to improve the person's health.
- Continue to improve the accuracy of GP learning disability registers so that the identification and coding of patients is complete, and particularly for under-represented groups such as children and young people and people from ethnic minority groups.
- Maintain a strong commitment to reducing reliance on inpatient care for both adults and children with a learning disability and/or who are autistic, consistent with the ambition set out in the NHS Long Term Plan, and to develop community services to support admission avoidance and timely discharge.
- Build on the investment made in 2021/22 to develop a range of care and diagnostic services for autistic people delivered by multidisciplinary teams. This includes access to community mental health services; support for autistic children and young people and their families; and access to the right support and housing. Systems should adopt best practice to improve local diagnostic pathways to minimise waiting times for diagnosis, improve patient experience and ensure that there is accurate and complete reporting of diagnostic data.
- Implement the actions coming out of Learning Disability Mortality Reviews (LeDeRs), including following deaths of people who are autistic, to tackle the inequalities experienced by people with a learning disability; these have been exacerbated by the pandemic.

Service development funding support of £75 million is being made available in 2022/23 to achieve the above ambitions.

G. Continue to develop our approach to population health management, prevent ill-health and address health inequalities

Working alongside local authorities and other partners we will continue to develop our approach to population health management and prevention so that people can play a more proactive role in promoting good health. ICSs will drive the shift to population

health, targeting interventions at those groups most at risk, supporting health prevention as well as treatment. ICSs will take a lead role in tackling health inequalities by building on the Core20PLUS5 approach introduced in 2021/22.

The safe and effective use of patient data is key to this. Systems are asked to develop plans by June 2022 to put in place the systems, skills and data safeguards that will act as the foundation for this. By April 2023, every system should have in place the technical capability required for population health management, with longitudinal linked data available to enable population segmentation and risk stratification, using data and analytics to redesign care pathways and measure outcomes with a focus on improving access and health equity for underserved communities. Systems are encouraged to work together to share data and analytic capabilities.

To support this, we will:

- continue to operate national data platforms for key, individually identified clinical data driven national programmes (eg the COVID pass, vaccine registries)
- provide a clear set of technical requirements and standards.

We are asking systems to develop robust plans for the prevention of ill-health, led by a nominated senior responsible officer (SRO). These plans should reflect the primary and secondary prevention deliverables as outlined in the NHS Long Term Plan, and the key local priorities agreed by the ICS. Plans should set out how system allocations will be deployed to:

- Support the rollout of tobacco dependence treatment services in all inpatient and maternity settings, in line with agreed trajectories and utilising £42 million of SDF funding.
- Improve uptake of lifestyle services, the Diabetes Prevention Programme, Low Calorie Diets, the new Digital Weight Management Programme and digitally supported self-management services.
- Restore diagnosis, monitoring and management of hypertension, atrial fibrillation and high cholesterol and diabetes, as well as asthma and COPD registers and spirometry checks for adults and children, to pre-pandemic levels in 2022/23, as per the Quality and Outcomes Framework (QOF), Integrated Investment Fund and Direct Enhanced Service targets.

- Progress against the NHS Long Term Plan high impact actions to support respiratory, stroke and cardiac care, implementing new models of care and rehabilitation, including remote and digital models, and increasing respiratory, hypertension, atrial fibrillation and high cholesterol detection and monitoring/control to pre-pandemic levels. This should include how systems plan to implement national procurements and population health agreements such as those in place for inclisiran and direct oral anticoagulants (DOACs). NHS England's new DOAC framework agreement will make treatment more affordable, allowing the NHS to provide DOACs to 610,000 additional patients. Uptake of DOAC treatment at this level will help prevent an estimated 21,700 strokes and save 5,400 lives over the next three years
- Reduce antibiotic use in primary and secondary care through early identification and treatment of bacterial infections, and support reduced lengths of hospital stays by ensuring that intravenous antibiotics are only used for as long as clinically necessary, with a switch to oral antibiotics as soon as appropriate.

There is strong evidence that people from socio-economically deprived populations and certain ethnic minority groups experience poorer health than the rest of the population, so it is particularly important to focus preventative services on these groups. Smoking is the single largest driver of health disparities between the most and least affluent quintiles. Obesity is the next biggest preventable risk factor and obesity in children has seen a major increase during the pandemic, especially in the least well off.

Systems are also asked to:

- renew their focus on reducing inequalities in access to and outcomes from NHS public health screening and immunisation services
- continue to adopt culturally competent approaches to increasing vaccination uptake in groups that have a lower than overall average uptake as of March 2022
- continue to deliver on the personalised care commitments set out in the NHS Long Term Plan – social prescribing referrals, personal health budgets, and personalised care and support plans are key enablers of population health and prevention.

H. Exploit the potential of digital technologies to transform the delivery of care and patient outcomes

During the pandemic digital technologies transformed the delivery of care. The opportunity now is for the health and care sector to build on this and use the potential of digital to help the NHS address both its long-term challenges and the immediate task of recovering from the pandemic. In practice this means better outcomes for patients, better experience for staff and more effective population health management.

We will support health and care systems to 'level-up' their digital maturity, and ensure they have a core level of infrastructure, digitisation and skills.

A core level of digitisation in every service within a system is essential. Acute, community, mental health and ambulance providers are required to meet a core level of digitisation by March 2025, in line with the NHS Long Term Plan commitment. By March 2022, systems should develop plans that set out their first year's priorities for achieving a core level of digitisation across all these settings (as set out by the Frontline Digitisation minimum viable product, which will be published by 31 December).

Costed three-year digital investment plans should be finalised by June 2022 in line with What Good Looks Like (WGLL). We will fund systems to establish dedicated teams to support the development and delivery of their plans, which should:

- include provisions for robust cyber security across the system. We will continue to provide and further enhance centralised cyber security capabilities systems; however, local organisations are responsible for managing their own cyber risk
- reflect ambitions to consolidate purchasing and deployment of digital capabilities, such as electronic patient records and workforce management systems, at system level where possible
- set out the steps being taken locally to support digital inclusion
- consider how digital services can support the NHS Net Zero Agenda.

Capital will be available to systems for three years from 2022/23, to support digitisation of acute, mental health, ambulance and community services. £250 million will initially

be allocated to systems for 2022/23 while they develop their digital investment plans. This funding will be directed towards those services and settings that are the least digitally mature.

A digitised, interoperable and connected health and care system is a key enabler of delivering more effective, integrated care. Systems are asked to ensure that:

- by March 2023, all systems within a Shared Care Record collaborative can exchange information across the whole collaborative, with a view to national exchange by March 2024. Standards will be published to support this
- local authorities with social service responsibilities within their footprint are connected to their local Shared Care Record solution by March 2023, and that all social care providers can connect within six months of them having an operational digital social care record system
- suppliers comply with interoperability standards as these are finalised by April 2022
- general practice promotes the NHS App and NHS.UK to reach 60% adult registration by March 2023
- plans are developed to support skilling up the workforce to maximise the opportunities of digital solutions.

The ambition is for the NHS e-Referral Service (e-RS) to become an any-to-any health sector triage, referral and booking system by 2025. This will support two-way digital advice and guidance between clinical teams, ensuring patients are managed safely, and the referral is triaged and processed according to clinical priority. We will support systems with adoption as this functionality is made available to support triage, bookings and referrals. Mental health and other additional services are being evaluated for inclusion in 2022/23.

I. Make the most effective use of our resources

The 2021 Spending Review (SR21) provided the NHS with a three-year revenue and capital settlement covering 2022/23 to 2024/25. The government committed to spend an additional £8 billion to support tackling the elective backlog over the next three

years, from 2022/23 to 2024/25. This allows us to prioritise £2.3 billion in 2022/23 to support elective recovery.

SR21 also confirmed that the NHS will receive total capital resources of £23.8 billion over the next three years, including £4.2 billion of funding to support the building of 40 new hospitals and to upgrade more than 70 hospitals; £2.3 billion to transform diagnostic services; £2.1 billion for innovative use of digital technology; and £1.5 billion to support elective recovery.

We will shortly issue one-year revenue allocations to 2022/23 and three-year capital allocations to 2024/25. We intend to publish the remaining two-year revenue allocations to 2024/25 in the first half of 2022/23.

I1: Use of resources

With this funding, the NHS is expected to fully restore core services and make significant in-roads into the elective backlog and NHS Long Term Plan commitments. The SR21 settlement assumes the NHS takes out cost and delivers significant additional efficiencies, on top of the NHS Long Term Plan requirements, to address the excess costs driven by the pandemic response, moving back to and beyond pre-pandemic levels of productivity when the context allows this.

The scale of the efficiency requirement will be sustained throughout the SR21 period and systems should ensure they develop plans that deliver the necessary exit run-rate position to support delivery of future requirements.

We will continue to provide tools, information and support to help systems work together to deliver cost improvement plans that maximise efficiency and productivity opportunities, and reduce unwarranted variation. We will set out additional information on the support programmes available in additional guidance.

I2: Financial framework

The COVID-19 pandemic necessitated simplified finance and contracting arrangements that supported systems to dedicate maximum focus to responding to immediate operational challenges. To support the next phase of service restoration, the financial and contracting frameworks need to evolve to enable systems to take the appropriate funding decisions for their populations.

The future financial framework will continue to support system collaboration with a focus on financial discipline and management of NHS resources within system financial balance. Partner organisations should work together to deliver the new duties on ICBs and trusts.

Advice and guidance on the establishment of ICB financial management and governance arrangements is available as part of the ongoing support offer for ICB establishment. Regional teams are working with clinical commissioning groups (CCGs) and designate ICB board appointees to ensure that ICBs are ready to operate as statutory bodies from 1 July 2022, subject to the passage of legislation. ICBs and the boards of their constituent partners must be clear on the lines of financial accountability in managing NHS resources. This includes meeting core principles for managing public money, statutory responsibilities and other national expectations.

The 2022/23 financial and contracting arrangements are summarised as:

- A glidepath from current system revenue envelopes to fair share allocations. ICB revenue allocations will be based on current system funding envelopes, which continue to include the funding previously provided to support financial sustainability. In addition to a general efficiency requirement, we will apply a convergence adjustment to bring systems gradually towards their fair share of NHS resources. This will mean a tougher ask for systems consuming more than their relative need.
- Increased clarity and certainty over capital allocations, with multi-year operational capital allocations set at ICB level, building on the approach taken in the last two years, and greater transparency over the allocation of national capital programmes.
- A collective local accountability and responsibility for delivering system and ICB financial balance. The Health and Care Bill includes provisions which are designed to ensure that ICBs and trusts are collectively held responsible for their use of revenue and capital resources. Each ICB and its partner trusts will have a financial objective to deliver a financially balanced system, namely a duty on breakeven.
- A return to signed contracts and local ownership for payment flows under simplified rules. To restore the link between commissioning and funding flows, commissioners and trusts will have local ownership for setting payment values on simplified terms, supported by additional guidance from NHS England and

NHS Improvement. While written contracts between commissioners and all providers (NHS and non-NHS) will be needed to cover the whole of the 2022/23 financial year, systems and organisations should continue to take a partnership approach to establishing payment terms and contract management such that focus on delivery of operational and financial priorities can be maximised. We are separately publishing an updated draft of the NHS Standard Contract for 2022/23 for consultation; the final version of the contract, to be used in practice, will be published in February 2022.

- A commitment to support systems to tackle the elective backlog and deliver the NHS Long Term Plan. Additional revenue and capital funding will be provided to systems to support elective recovery, with access to additional revenue where systems exceed target levels. Provider elective activity plans will be funded as per the aligned payment and incentive approach, with payment linked to the actual level of activity delivered. ICBs will continue to be required to deliver the MHIS, as well as to meet other national investment expectations. We will set these out in additional guidance.
- A continued focus on integration of services to support the transition for future delegations. For those services that continue to be commissioned by NHS England in 2022/23, mechanisms to strengthen joint working with ICBs will be established.

J. Establish ICBs and collaborative system working

The establishment of ICBs, and everything that follows regarding the process and timing for this, remains subject to the passage of the Health and Care Bill through Parliament.

The continued development of ICSs during 2022/23 will help to accelerate local health and care service transformation and improve patient outcomes. As stated in the introduction to this document, a new target date of 1 July 2022 has been agreed for new statutory arrangements for ICSs to take effect and ICBs to be legally and operationally established. National and local plans for ICS implementation will now be adjusted to reflect this timescale, with an extended preparatory phase from 1 April 2022 up to the point of commencement of the new statutory arrangements. During this period:

- CCGs will remain in place as statutory organisations. They will retain all existing duties and functions and will conduct their business (collaboratively in cases where there are multiple CCGs within an ICS footprint) through existing governing bodies.
- CCG leaders will work closely with designate ICB leaders in key decisions that will affect the future ICB, notably commissioning and contracting.
- NHS England and NHS Improvement will retain all direct commissioning responsibilities not already delegated to CCGs.

During Q4 2021/22, NHS England and NHS Improvement will consult a small number of CCGs on changes to their boundaries, to align with the ICS boundary changes decided by the Secretary of State in July 2021. Those CCG boundary changes coming into effect from 1 April 2022 would support the smooth transition from CCGs to ICBs at the implementation date. Arrangements for people affected will be discussed directly with the relevant CCG and designate ICB leaders.

We do not plan to implement any further CCG mergers before the establishment of ICBs.

Next steps

CCG leaders and designate ICB leaders should continue with preparations for the closure of CCGs and the establishment of ICBs, working toward the new target date. NHS England and NHS Improvement will support CCG and designate ICB leaders to reset their implementation plans, to ensure the safe transfer of people, property (in its widest sense) and liabilities from CCGs to ICBs from their establishment. The national programme team will work closely with colleagues in systems and in regional teams to identify what support is needed to manage the new timetable.

We will work with national partners, including trade unions, to communicate the changed target date and any implications for the transfer process. Systems should also ensure they have clear and effective plans for local communications and engagement with the public, staff, trade unions and other stakeholders.

ICB designate chairs and chief executives should continue to progress recruitment to their designate leadership teams, adjusting their timelines as necessary while managing immediate operational demands. Current/planned recruitment activities for designate leadership roles should continue where this is the local preference, but

formal transition to the future leadership arrangements should now be planned for the new target date of 1 July 2022.

Regional teams will work with CCG leaders to agree arrangements that ensure that:

- CCGs remains legally constituted and able to operate effectively, working in partnership with the designate ICB leadership
- individuals' roles and circumstances are clear during the extended preparatory phase.

The employment commitment arrangements for other affected staff and the talent-based approach to people transition previously set out will be extended to reflect the new target date.

The requirements for ICB Readiness to Operate and System Development Plan submissions currently due in mid-February 2022 will be revised to reflect the extended preparatory period. Further details of these plans along with specific implications for financial, people or legal arrangements during the extended preparatory period will be developed with systems and set out in January 2022.

Designate ICB leaders, CCG accountable officers and NHS England and NHS Improvement regional teams will be asked to agree ways of working for 2022/23 before the end of March 2022. This will include agreeing how they will work together to support ongoing system development during Q1, including the establishment of statutory ICSs and the oversight and quality governance arrangements in their system.

Planning during 2022/23

The Health and Care Bill before Parliament will require each ICB to publish a five-year system plan before April each year. This plan must take account of the strategy produced by the integrated care partnership (ICP), and the joint strategic needs assessments and joint health and wellbeing strategies produced by the relevant health and wellbeing board(s).

We expect to require ICBs' refreshed five-year system plans in March 2023. This will give each ICB and its local authority partners sufficient time to agree a strategy for the ICP that has broad support, and to develop a plan to support its implementation, including the development of place based integration. ICBs will undertake preparatory work through 2022/23 to ensure that their five-year system plans:

- match the ambition for their ICS, including delivering specific objectives under the four purposes to:
  - improve outcomes in population health and healthcare
  - tackle inequalities in outcomes, experience and access
  - enhance productivity and value for money
  - support broader social and economic development
- reflect the national priorities and ambitions for the NHS
- take account of the responsibilities that they will be taking on for commissioning services that are currently directly commissioned by NHS England, such as primary care and some specialised services.

Plan submission

The planning timetable will be extended to the end of April 2022, with draft plans due in mid-March. We will keep this under review and publish further guidance setting out the requirements for plan submission.

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Publishing approval reference: PAR1160

Classification: Official
Publication reference: PR1929

NHS England

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- NHS Foundation Trust and NHS Trust:
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  - Chairs

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12 August 2022

cc.
- Regional Directors

Dear colleagues

Next steps in increasing capacity and operational resilience in urgent and emergency care ahead of winter

This week the NHS reached its first key ambition on recovering services, focusing on patients who had been waiting more than 104 weeks. We delivered this important milestone despite having to contend with further waves of COVID-19, including more than a quarter of our COVID-19 inpatients occurring since publishing the Elective Recovery Plan, an unprecedented heatwave, and other significant pressures. It shows once again that when we prioritise, invest, and innovate, the NHS can, acting as a national service, deliver for patients.

Urgent and Emergency Care is currently under significant pressure. Staff have faced one of their busiest summers ever with record numbers of A&E attendances and the most urgent ambulance call outs, all alongside another wave of COVID-19. Thanks to the professionalism and commitment of those staff, the NHS continues to provide care to over 100,000 urgent and emergency care patients each week. Despite their best efforts, these pressures have meant that there have been too many occasions when staff have not been able to provide timely access for our patients in the way they would have wanted.

Our immediate response has been to focus on ambulance performance, and the linked issue of speeding up discharge. We have provided extra funding to ambulance services, offered intensive support to those trusts most challenged by ambulance delays, and rolled out virtual wards across the country, enabling patients who would otherwise be in hospital to receive support at home.

And we have begun planning for the coming winter earlier than usual, recognising pressure on the NHS is likely to be substantial, particularly in UEC, making the most of the opportunity created by the formation of ICBs to maximise the benefits of system working.

In addition to maintaining progress on 2022/23 operational priorities and building on the significant successes in delivering our Elective Recovery plan, with a strong focus on 62 day cancer backlogs and elective long waits, today we are setting out the next steps in our plans to rapidly increase capacity and resilience ahead of winter, building on the operational plans we have worked on together.

Core objectives and key actions for operational resilience

Our collective core objectives and actions are to:

1) **Prepare for variants of COVID-19 and respiratory challenges**, including an integrated COVID-19 and flu vaccination programme.
2) **Increase capacity outside acute trusts**, including the scaling up of additional roles in primary care and releasing annual funding to support mental health through the winter.
3) **Increase resilience in NHS 111 and 999 services**, through increasing the number of call handlers to 4.8k in 111 and 2.5k in 999.
4) **Target Category 2 response times and ambulance handover delays**, including improved utilisation of urgent community response and rapid response services, the new digital intelligent routing platform, and direct support to the most challenged trusts.
5) **Reduce crowding in A&E departments and target the longest waits in ED**, through improving use of the NHS directory of services, and increasing provision of same day emergency care and acute frailty services.
6) **Reduce hospital occupancy**, through increasing capacity by the equivalent of at least 7,000 general and acute beds, through a mix of new physical beds, virtual wards, and improvements elsewhere in the pathway.
7) **Ensure timely discharge**, across acute, mental health, and community settings, by working with social care partners and implementing the 10 best practice interventions through the ‘100 day challenge’.
8) **Provide better support for people at home**, including the scaling up of virtual wards and additional support for High Intensity Users with complex needs.

This letter and the appendix sets out the important actions, developed in partnership with you, to help deliver these core objectives, as well as how NHS England will support you. Taking these actions should help manage pressure across the pathway, supporting improved flow for patients in emergency departments.

Clearly, expanding capacity is dependent on both sufficient workforce and workforce wellbeing. This is why it is important that the plans have been built from the bottom up, with ICBs responsible for developing plans that are based on realistic assumptions, including how many staff can be recruited and at what speed. We will fully fund the recent pay award nationally, avoiding the need to cut frontline services for winter.

Similarly, ICBs have been clear with us that much of the pressure on urgent and emergency care is driven by the current, significant, growing strain in social care. Too many patients are spending longer in hospital than they need to, creating pressure along the entire pathway. We will continue to work with the Government, and national local government partners, to help, as far as possible, address these issues. At a local level, the creation of ICSs offers an opportunity for all partners in a local system to work together to deliver local solutions. This includes making best use of the Better Care Fund, building on the work you are doing locally to map local demand and capacity.

Performance and accountability: A new approach to working together

This plan is underpinned by a new approach to how organisations in the NHS work together – the Health and Care Act 2022 has enshrined Integrated Care Systems in law. Although this winter presents significant challenges, it is an opportunity to show how these new ways of working can make a real difference to patients and join up the entire urgent and emergency care pathway in ways we've been unable to do before. The plan empowers system leaders to do this in a number of critical areas, and where you can go further, please do so.

System working also means a new approach to accountability. ICBs are accountable for ensuring that their system providers and other partners deliver their agreed role in their local plans and work together effectively for the benefit of the populations they serve. ICBs are responsible for initial problem solving and intervention should providers fail, or be unable, to deliver their agreed role. Intervention support can be provided from NHS England regional teams as required, drawing on the expertise of our national level urgent and emergency care team as needed.

That line of accountability does mean that we will want to continue to work with you to stress test your plans and to 'check and challenge' progress in delivering them. We will expect that you work with us to report on local performance and collaboratively, but quickly, tackle problems where they occur.

On performance metrics, the overall objective remains the provision of safe and effective care. Until the adoption of the Clinically-led Review of Standards is agreed with the Government, current standards remain for emergency department performance and flow. Likewise, objectives set out in Planning Guidance, which includes reducing 12 hour waits and increased clinical input in 111, remain. These should continue to be used to understand flow through your emergency departments.

Working with ICBs we have identified the following six specific metrics, key to the provision of safe and effective urgent and emergency care, that NHS England and ICBs will use to monitor performance in each system through the Board Assurance Framework:

- 111 call abandonment.
- Mean 999 call answering times.
- Category 2 ambulance response times.
- Average hours lost to ambulance handover delays per day.
- Adult general and acute type 1 bed occupancy (adjusted for void beds).
- Percentage of beds occupied by patients who no longer meet the criteria to reside.

We will work with you through the Assurance Framework to develop local performance trajectories to sit alongside these measures.

The work on elective care and the 100 day discharge challenge demonstrates the value of using an improvement approach based on data, easy to access best practice guidance, as well as senior clinical and executive peer review in spreading solutions focused on those facing the greatest challenges. We will launch new improvement offers to support ambulance handover and response times in the coming weeks.

To support ICBs, we will provide you with a Board Assurance Framework to monitor progress monthly against the combined System Capacity Plans, Actions and Good Practice basics and improvement priorities developed with colleagues over time. This is aimed at supporting and ensuring trusts continue to implement best practice. Each BAF will be unique to each ICS to reflect the specific capacity gaps that you have identified.

While these plans represent substantial work to increase capacity and improve operational resilience, clearly epidemiological modelling suggests reasonable worst-case scenarios for Covid-19 which would require a more significant set of actions. We will work with you to develop plans for these scenarios.

Thank you to you and your teams across the NHS for your continued hard work. While there is no doubt that we are going to experience challenges over the winter, when the NHS unites as it has over the past two and half years of the pandemic and works closely with wider partners, we know we can best serve patients, support our teams and maintain the momentum of the NHS's recovery from the pandemic.

Yours sincerely,

Amanda Pritchard
NHS Chief Executive

Julian Kelly
Chief Financial Officer
NHS England

Sir David Sloman
Chief Operating Officer
NHS England

Appendix – Actions: Further details on increasing capacity and operational resilience in urgent and emergency care ahead of winter

Each ICB plan has been discussed, and agreed, with the relevant NHS England region and a series of specific actions have been agreed between NHS England and each ICB in the following areas:

1. **New variants of COVID-19 and respiratory challenges**

SPI-M scenarios for COVID-19, combined with scenarios for flu, suggest that even in optimistic scenarios, high numbers of beds may be needed for respiratory patients during winter. Resulting IPC requirements will make bed management complex, especially if bed occupancy remains high. We will do further work with you in the coming months on stress-testing planning for the operational response to realistic worst-case scenarios. We are working with local areas to:

- Deliver an integrated COVID-19 booster and flu vaccination programme to minimise hospital admissions from both viruses.
- Implement UKHSA's IPC guidance in a proportionate way and develop strategies to minimise the impact of 'void' beds.

2. **Demand and capacity**

A lack of capacity across the NHS has an impact on all areas of the system. It is essential that ambulance and NHS 111 services have the necessary capacity in place and that access to primary care, community health services and mental health services for urgent patients is sufficient to ensure patients do not need to present to emergency services. We are working with local areas to:

- Open additional beds across England, to match the additional capacity identified by ICSs to be able to deliver against expected winter demand. This should create the equivalent of 7,000 additional general and acute beds, through a mix of new physical beds, scaling up virtual wards, and improvements in discharge and flow.
- Increase the number of NHS 111 call handlers to 4,800 and the number of NHS 999 call handlers to 2,500.
- Increase provision of High Intensity User services.
- Support good working relationships with the independent sector, building on the success so far, and facilitating patient choice.

In community care:

- Increase two-hour Urgent Community Response provision by maximising referrals from the ambulance service and other providers, aiming to maintain and improve the current standard of responding to 70% of call outs within two hours.
- Increase the number of virtual wards to create an additional 2,500 virtual beds.

In primary care:

- We will maximise recruitment of new staff in primary care across the winter, including care co-ordinators and social prescribing link workers.
- ICBs to actively support and engage with PCNs to work with each other and other providers to develop collaborative models to manage seasonal preparedness and

specific winter pressures (such as oximetry monitoring for COVID-19 patients) alongside the digital development of primary care.

In mental health, cancer, and elective care:

- Share mental health best practice between systems and work with the VCS and LA sector to alleviate capacity constraints.
- Releasing £10m of annual funding to support MH through the winter, in addition to continued planned growth in community and crisis provision.
- Maintain and increase elective capacity to eliminate waits of over 18 months, as per the Elective Recovery Plan, except for patients who choose to wait longer or require alternative plans due to clinical complexity.
- Reduce the number of people waiting more than 62 days from an urgent cancer referral back to pre-pandemic levels by March 2023.
- Ensure the preservation of the standard clinical pathway for CYP elective surgery, critically ill children, and emergency, general and specialist services.

3. Discharge

While challenges are often seen at the ‘front door’, we know that their root cause is often in the ability to discharge patients from, and flow through, hospitals. There is a significant number of patients spending longer in hospital than they need to, often due to a lack of availability of social care. While the provision of social care falls outside of the NHS’s remit, the health service must ensure patients not requiring onwards care are discharged as soon as they are ready and can access services they may need following a hospital stay. We are working with local areas to:

- Implement the 10 best practice interventions through the 100-day challenge.
- Encourage a shift towards home models of rehab for patients with less severe injuries or conditions.
- Maximise support available from the Seasonal Surge Support Programme, provided by VCS partners.

4. Ambulance service performance

While ensuring there is enough capacity for ambulances to respond to the most urgent calls and take patients to hospital is essential, it is also important to focus on what can be done to reduce avoidable ambulance activity, through treating patients at the scene. We are working with local areas to:

- Implement a digital intelligent routing platform and live analysis of 999 calls.
- Agree and implement good practice principles for the rapid release of queuing ambulances in response to unmet category two demand.
- Work with the most challenged trusts on ambulance handover delays to develop solutions, including expanding post-ED capacity.
- Increase the utilisation of rapid response vehicles, supported by non-paramedic staff, to respond to lower acuity calls.
- Model optimal fleet requirements and implement in line with identified need.
- Implement the ambulance auxiliary service which creates national surge capacity to enhance the response and support for ambulance trusts.

- Deploy mental health professionals in 999 operation centres and clinical assessment services and deliver education and training to the workforce.
- Increase the use of specialist vehicles to support mental health patients.

5. NHS 111 performance

The NHS 111 service can only work if it has sufficient clinical capacity to provide consultations if required and patients are able to be directed to the right service for their needs. We are working with local areas to:

- Improve call handling performance through the implementation of regional call management which will enable better integration between providers and ensure the entire NHS 111 capacity is used effectively.
- Continue pilot of national Paediatric Clinical Assessment Service and build on what we are learning.
- ICBs to update details of the 24/7 urgent mental health helplines for patients experiencing a mental health crisis, and ensure these services are promoted.

6. Preventing avoidable admissions

A full range of urgent care services should be available to ensure patients can access the right care in the right place. The Directory of Services should be used by staff to direct patients to the most appropriate place, while same-day emergency care, frailty and 'hot' outpatient services should also be available for patients requiring urgent specialist treatment but not necessarily via an ED. We are working with local areas to:

- Increase number and breadth of services profiled on the Directory of Services to ensure only patients with an emergency need are directed to A&E.
- Develop and protect capacity for same-day emergency care services so that operational hours are profiled against demand and surgical availability.
- Review non-emergency patient transport services so that patients not requiring an overnight hospital stay can be taken home when ready.
- Improve the provision of the Acute Frailty service, including the delivery of thorough assessments from multidisciplinary teams.
- Implement out of hospital home-based pathways, including virtual wards, to improve flow by reducing hospital attendances. Reduce unnecessary attendances for patients with mild illness through revised NHS @home pathways that incorporate broader acute respiratory infections.

7. Workforce

NHS staff have worked incredibly hard throughout the pandemic and both current and future pressures on the health services mean teams will remain stretched. The health and wellbeing of the workforce is crucial and interventions targeting recruitment and retention will be important in managing additional demand this winter. We are working with local areas to:

- Implement your recruitment and retention plans including staff sharing and bank arrangements.
- Utilise international support for UEC recovery, identifying shortages of key roles and skills and targeting recruitment as such.

- Implement the Wellbeing Practitioners' Pack.
- Develop roles for volunteers that reduce pressure on services and improve patient experience, such as community first responders and support in discharge.

8. Data and performance management

Making the full use of data at a local, regional, and national level will help inform operational decision-making and improve the delivery of services. We are working with local areas to:

- Ensure timely and accurate submission to the Emergency Care Data Set.
- Encourage use of the A&E Forecasting Tool.

9. Communications

We are undertaking the following actions to enable strong communications:

- Implement your winter communications strategy to support the public to minimise pressures on urgent and emergency services.
- Deliver the NHS 111 and GP Access strands of the Help Us Help You campaigns.

UEC Improvement Framework			
Key lines of enquiry (KLOEs)	**Implementation Questions**	**Implementation Answers**	**National guidance/ Best Practices (Links)**
111 Service (IUC) Ambition - Patients are signposted to the most appropriate service for their needs every time, all the time.			
IUC - 1. Are services within the Directory of Service correctly profiled and what is your assurance process to ensure the right patients are being directed to the right service? DoS returns the most appropriate, lowest acuity services, based on time of day, service capacity, and the patient's location. If alternative services to ED are available these should be given higher order and ED should be profiled last.			DoS Profiling Principles
IUC - 2. Are 111 services undertaking revalidation of primary care, urgent care, emergency department and ambulance dispositions?			Urgent Care Service Specification Integrated Urgent Care Service Specification addendum: NHS 111 First
IUC 3 - Does 111 service redirect patients to CPCS for community pharmacy needs via online and telephony and what are the total numbers redirected per month?			https://www.england.nhs.uk/primary-care/pharmacy/pharmacy-integration-fund/community-pharmacist-consultation-service/
IUC 4 - Can patients make a direct referral to 24/7 MH crisis via NHS 111 (national IVR option) and how many per month?			NB - Link to MH futures page

UEC Improvement Framework

Key lines of enquiry (KLOEs)	Implementation Questions	Implementation Answers	National guidance/ Best Practices (Links)
Ambulance (AMB) Ambition - Patients receive timely emergency and urgent ambulance care and conveyance, with minimal delays.			
AMB - 5. 999 call handling capacity with trajectory in place to achieve consistently a mean call response of less than 10 seconds.			https://www.england.nhs.uk/wp-content/uploads/2018/10/ambulance-response-programme-review.pdf
AMB - 6. Accessible system-wide capacity with activity to each per month, to reduce unnecessary ambulance conveyance to ED, including an updated Directory of Services for ambulance service referral to e.g. UCR; frailty services; mental health; SDEC and UTCs			planning-to-safetly-reduce-avoidable-conveyance-v4.0.pdf (england.nhs.uk) Reducing avoidable ambulance conveyance in England: Interventions and associated evidence Safely Reducing Avoidable Conveyance Programmes - aace.org.uk-
AMB - 7. Escalation processes to reduce excessive handover delays (>60) , including the use of Hospital Ambulance Liaison Officers (HALOs) and how are you assured that minimum care standards are provided to any patient delayed in an ambulance?'			Reducing_ambulance_handover_delays_-_key_lines_of_enquiry_v1.1.pdf (england.nhs.uk)
AMB - 8. Is current demand / opportunity for clinical capacity being met in EOCs to optimise Hear and Treat rates.			National framework for healthcare professional ambulance responses
AMB - 9. Outline activity per month to enhance current paramedic access to clinical advice to improve See and Treat and time on scene e.g. through Clinical Assessment Service; 'call before convey' and ED virtual consultation models.			Direct ambulance access to acute speciality criteria Final 25th January 2021 Version 1.0 - ECIST Network - FutureNHS Collaboration Platform
AMB - 10. Improve the integration of NEPTS as part of discharge planning to reduce the time spent 'waiting for transport'.			NEPTS Review
AMB - 11. Increase awareness of the Healthcare Travel Cost Scheme to support patient discharge.			NEPTS Review
AMB - 12. How does the NEPTS service in the local systems meet the requirements of the NEPTS Review?			NEPTS Review

UEC Improvement Framework

Key lines of enquiry (KLOEs)	Implementation Questions	Implementation Answers	National guidance/ Best Practices (Links)
Alternative Acute and Community Pathways/Services (AAP) - Alternative to ED attendance and hospital admission including direct access from Community and ED Ambition - Patients are treated in the right care setting, at the right time, by the right person. This includes access to alternative acute pathways and the appropiate voidance of attendance to the Emergency Department.			
AAP - 16. Complete a system exercise to ascertain available alternatives to ED attendance and admission eg Alternative to ED and hospital admission tool (AIED and AIA) and Missed Opportunities tool.			Improving referral pathways between Urgent & Emergency Services
AAP - 17. Agreed pathways available to support a safe reduction in ambulance conveyance to ED - improving access to the wider health & socail care service, including access to clinical advice. what are the pathways and what is the activity currently versus ambition activity.			planning-to-safetly-reduce-avoidable-conveyance-v4.0.pdf (england.nhs.uk) Reducing avoidable ambulance conveyance in England: Interventions and associated evidence Safely Reducing Avoidable Conveyance Programmes - aace.org.uk-
AAP - 18. All acute alternative pathways accept direct referrals from system wide healthcare professionals. What is the activity per month per service? And is the access criteria open and in line with the CQC Patient First ideology : the patient goes to the right care setting for their need and that ED should not be a default for assessment.			Improving referral pathways between Urgent & Emergency Services
AAP - 19. ED streamers and triage nurses empowered to stream to all hospital services (eg all SDECS, AMU, SAU, GAU, Ortho, ENT, Paeds etc) and with streaming activity to each of these areas a month outlined.			Improving referral pathways between Urgent & Emergency Services
AAP - 20. Regularly reviewed Directory of Service in place to support accurate service profiling and re-direction.			Directory of Services Profiling Principles Quick guide -Improving access to UTC using the directory of services
AAP - 21. SDEC Services with rapid diagnostic access are operational to meet patient demand profile.			SDEC -NHSE/I
AAP - 22. Acute Frailty Services are operational to meet patient demand profile.			Acute Frailty - NHSE/I Same Day Acute Frailty Services
AAP - 23. Hot clinic capacity is aligned to patient demand.			Principle and approach to deliver a personalised out-patient model
AAP - 24.Virtual wards are operational to support admission avoidance and LOS reduction and are led by a relevant specialist and delivered by the Community.			Virtual Wards - NHSE/I A guide to setting up technology-enabled virtual wards

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Annex C Ambulance Response Performance Metrics July – October 2022

Date		July			August			September			October		
Incident Response Level		England	SECAmb	SECAmb National Position	England	SECAmb	SECAmb National Position	England	SECAmb	SECAmb National Position	England	SECAmb	SECAmb National Position
Category 1	Mean	00:09:35	00:09:34	2nd	00:09:08	00:09:08	5th	00:09:19	00:09:38	6th	00:09:56	00:09:42	6th
	90th Centile	00:16:55	00:16:57	3rd	00:16:20	00:16:28	5th	00:16:38	00:17:20	7th	00:17:42	00:17:40	6th
Category 2	Mean	00:59:07	00:42:19	2nd	00:42:44	00:35:29	4th	00:47:59	00:38:47	4th	01:01:19	00:36:54	2nd
	90th Centile	02:11:47	01:29:08	3rd	01:33:20	01:13:30	4th	01:45:45	01:19:08	3rd	02:16:11	01:15:33	2nd
Category 3	Mean	03:17:06	03:36:26	7th	02:16:23	02:44:11	9th	02:42:28	03:01:00	8th	03:34:34	02:51:50	4th
	90th Centile	08:21:47	08:48:23	6th	05:41:13	06:49:13	9th	06:51:31	07:17:45	8th	08:49:35	06:52:54	4th
Category 4	Mean	04:02:57	05:25:09	11th	02:56:39	04:23:48	11th	03:12:34	04:11:33	11th	04:01:52	04:01:22	7th
	90th Centile	09:56:24	12:26:40	10th	07:27:56	11:14:23	10th	07:48:12	10:07:35	10th	09:54:11	09:22:58	7th

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West Sussex ARP Performance metrics – October 2022: Gatwick, Worthing, and Tangmere Dispatch Desks

	Target		AQI								
Category	Mean	90th Centile	Incidents	Mean	90th Centile	95th Centile	99th Centile	Incidents %	H&T %	S&T %	S&C %
C1	00:07:00	00:15:00	804	00:09:52	00:18:42	00:22:51	00:29:00	8.82%		36.19%	63.81%
C1T	00:19:00	00:30:00	513	00:11:58	00:23:08	00:23:23	00:28:42			36.19%	63.81%
C2	00:18:00	00:40:00	5729	00:37:33	01:20:40	01:43:14	02:38:15	62.82%		29.78%	70.22%
C3		02:00:00	2517	02:45:34	06:42:17	09:29:24	15:10:36	27.60%	0.20%	50.75%	49.05%
C4		03:00:00	70	03:23:10	08:49:58	09:56:31	12:44:31	0.77%		37.14%	62.86%
HCP 3			166	02:50:48	06:07:48	09:55:56	14:09:25				
HCP 4			136	03:29:23	08:06:27	10:37:35	14:46:08				
IFT 3			53	02:51:05	05:08:50	08:50:47	13:17:32				
IFT 4			21	03:25:38	08:32:44	08:34:12	08:43:19				
HCP 60				0:0:0	0:0:0	0:0:0	0:0:0				
HCP 120				0:0:0	0:0:0	0:0:0	0:0:0				
HCP 240				0:0:0	0:0:0	0:0:0	0:0:0				
ST	All Incidents		3371	32.09%							
SC	All Incidents		6110	58.16%							
HT	All Incidents		1024	9.75%							
Count of Incidents			10505								
Count of Incidents with a Response			9481								
999 Mean	Call Answer Target 00:05		77500	01:10							
999 90th	Call Answer Target 00:10			03:33							
Trust EOC 999 Abandoned Calls			4461	5.4%							
A0	EOC All Calls		13262								

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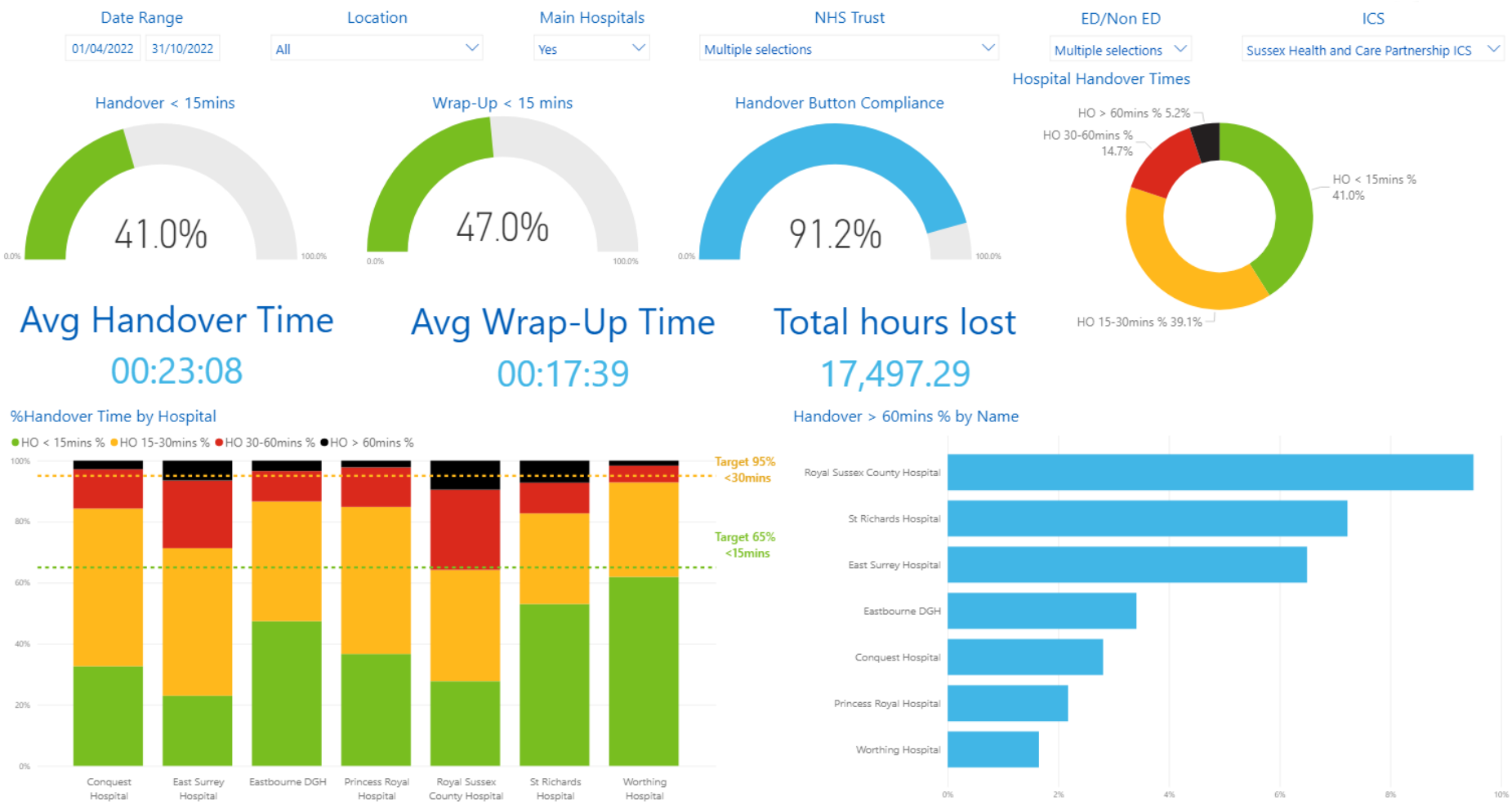
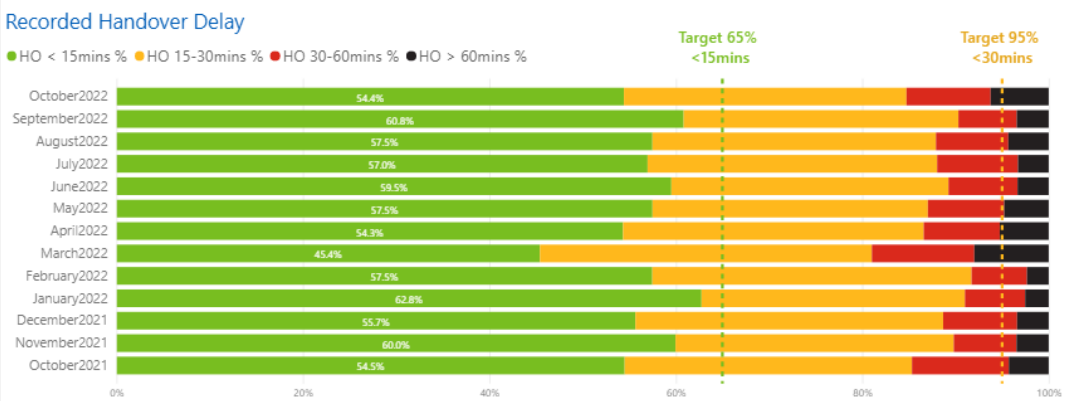
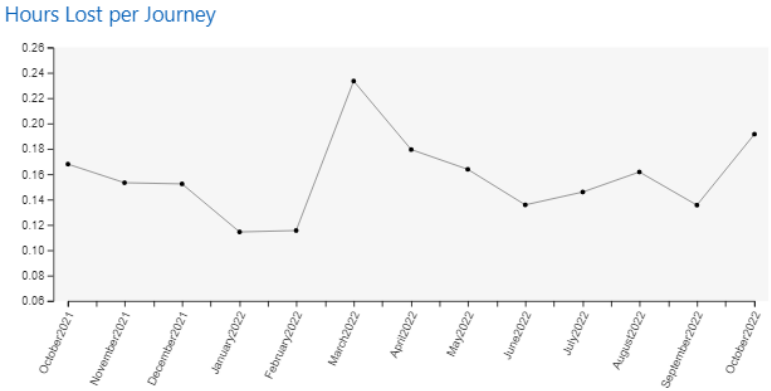
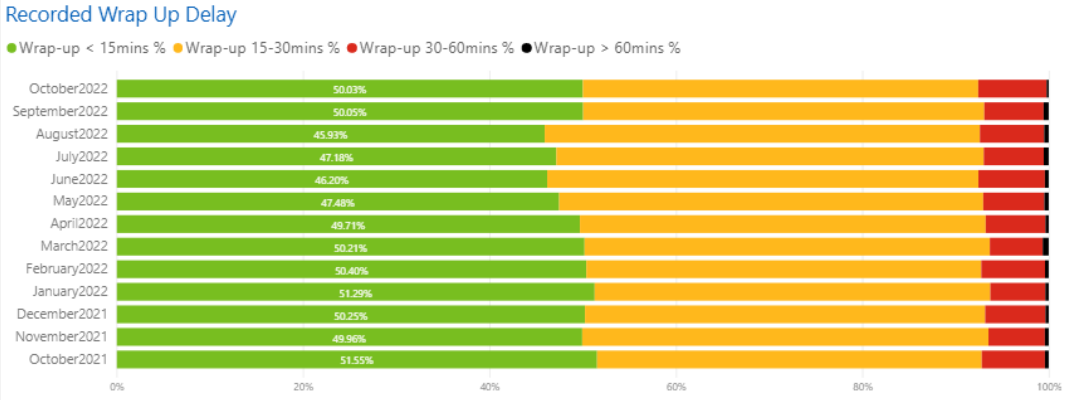
Ambulance Handover Performance – Sussex Health & Care Partnership ICS April 22 – October 22

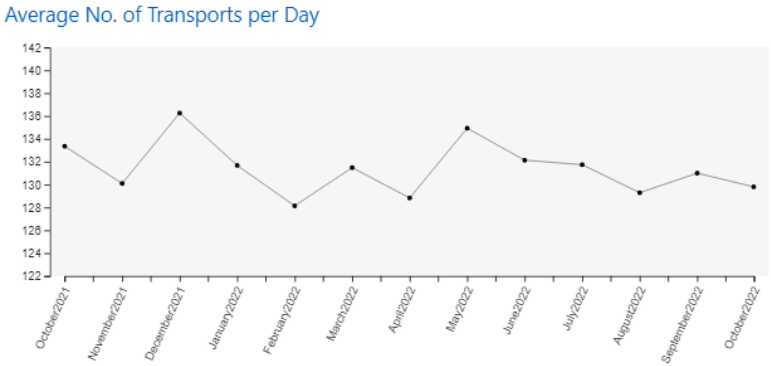


Ambulance Handover Performance – West Sussex, University Hospitals Trust West October 21 – October 22





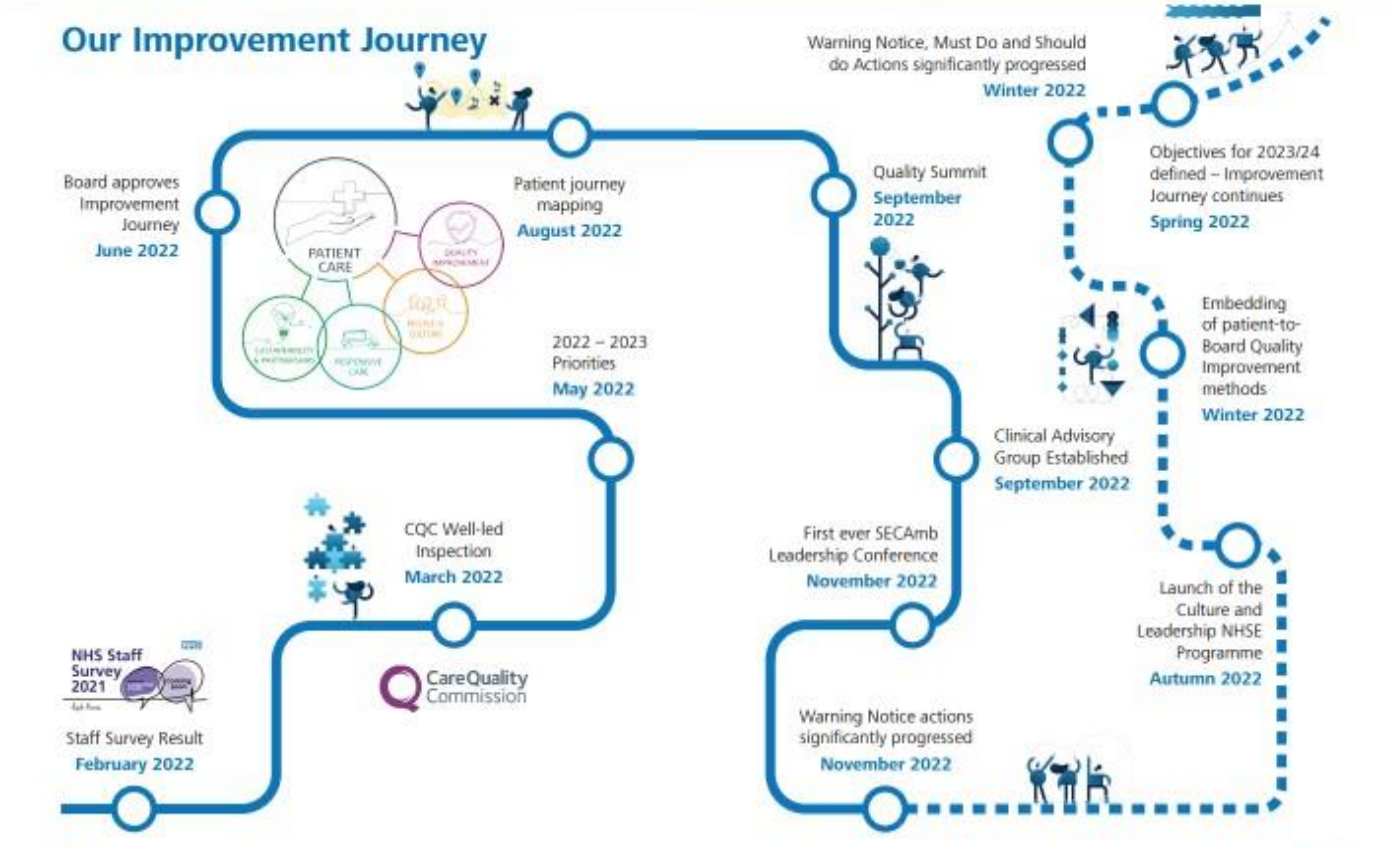




Worthing – best performing handover performance in West Sussex. Urgent Treatment Centre 999 access is via a non-direct ED pathway, however this enables single queue visibility. Emergency Floor access review versus SDEC criteria required.

St. Richards – handover process good but discharge flow blocking exit. Escalation process includes boarding & peer review.

CQC and Improvement Journey (1)



CQC and Improvement Journey (2)

QUALITY IMPROVEMENT

- Better learning from incidents to improve what we do
- Future proofing our medicines management approach
- Creating a better system to identify and share risks and take action in response
- Listening more to our patients & acting on their feedback

RESPONSIVE CARE

- Keeping people safe across the whole patient journey
- Using on-scene time effectively
- Safely enhancing virtual responses to appropriate patients
- Developing smarter dispatch processes
- Making sure we have the right resources in the right place to meet patient need
- Ensuring fleet and estates are right sized and fit for purpose

PEOPLE & CULTURE

- Recruiting the colleagues we need to provide the right service to our patients and ensuring they feel supported to remain with us
- Demonstrating our values every day, with zero tolerance to poor behaviours
- Ensuring our colleagues have the right channels to raise concerns, including FTSU and that action is taken when they do
- Changing how we listen to and engage with our colleagues to improve how we work together

SUSTAINABILITY & PARTNERSHIPS

- Focussing as much resource as possible on front-line care
- Progressing our plans to significantly reduce our carbon footprint
- Growing our voice within the wider NHS system to support improved patient pathways, reduce handover delays and develop new partnerships
- Developing a five-year plan to deliver sustainable, quality care which gives us a clear way forwards

Glossary of Terms

Glossary of Terms

West Sussex Health & Adult Select Committee - Preparation for Winter Pressures 2022/2023

SECAmb Report

ARP	Ambulance Response Programme
BLT	Blue Light Triage (Mental Health on-scene convergence model)
CQC	Care Quality Commission
CQUIN	Commissioning for Quality & Innovation Framework
C1	Category 1 Level Response (Response Standard 7 mins)
C2	Category 2 Level Response (Response Standard 18 mins)
C3	Category 3 Level Response (Response Standard 120 mins)
C4	Category 4 Level Response (Response Standard 180 mins)
CQUIN	Commissioning for Quality & Innovation Framework
DoS	Directory of Services
ED	Emergency Department
EOC	Emergency Operations Centre
HART	Hazardous Area Response Team
H&T	Hear & Treat (Hear and Refer?
ICS	Integrated Care System/s
ICB	Integrated Care Board/s
IUC	Integrated Urgent Care
ITK	Interoperability Toolkit
KMS	Kent & Medway and Sussex
MHP	Mental Health Practitioner
NHSE	NHS England
OPEL	Operational Performance Escalation Levels
PaCCS	NHS Digital Pathways Clinical Consultation Support System
PCNs	Primary Care Networks
PDL	Practice Development Lead
PP	Paramedic Practitioner
PPG	Practice Plus Group
REAP	Resource Escalation Action Plan
ROC	Regional Operations Centre
SDEC	Same Day Emergency Care
SMP	Surge Management Plan
SVCC	Single Virtual Contact Centre
T111	Think 111 First
UCR	Urgent Community Response
UEC	Urgent Emergency Care
VW	Virtual Ward

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