Notice of Meeting

Adults and Health Select Committee

Date & time	Place	Contact	Chief Executive
Wednesday, 5 October 2022 at 10.00 am	Council Chamber, Woodhatch Place	Omid Nouri, Scrutiny Officer Tel 07977 595 687 omid.nouri@surreycc.gov.uk	Joanna Killian We're on Twitter: @SCCdemocracy

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This meeting will be held in public. If you would like to attend and you have any special requirements, please contact Omid Nouri, Scrutiny Officer on 07977 595 687.

Elected Members

Nick Darby, Robert Evans, Chris Farr, Angela Goodwin (Vice-Chairman), Trefor Hogg, Rebecca Jennings-Evans, Frank Kelly, Riasat Khan (Vice-Chairman), David Lewis, Ernest Mallett MBE, Carla Morson, Bernie Muir (Chairman) and Buddhi Weerasinghe

Independent Representatives:

Borough Councillor Neil Houston (Elmbridge Borough Council), District Councillor Charlotte Swann (Tandridge District Council) and Borough Councillor Abby King (Runnymede Borough Council)

TERMS OF REFERENCE

- Statutory health scrutiny
- Adult Social Care (including safeguarding)
- Health integration and devolution
- Review and scrutiny of all health services commissioned or delivered within Surrey
- Public Health
- Review delivery of the Health and Wellbeing Strategy
- Health and Wellbeing Board
- Future local delivery model and strategic commissioning

AGENDA

1 APOLOGIES FOR ABSENCE AND SUBSTITUTIONS

Purpose of the item: To report any apologies for absence and substitutions.

2 MINUTES OF THE PREVIOUS MEETING: 23 JUNE 2022 (Pages 5 - 30)

Purpose of the item: To agree the minutes of the previous meeting of the Adults and Health Select Committee as a true and accurate record of proceedings.

3 DECLARATIONS OF INTEREST

Purpose of the item: All Members present are required to declare, at this point in the meeting or as soon as possible thereafter:

I. Any disclosable pecuniary interests and / or

II. Other interests arising under the Code of Conduct in respect of any item(s) of business being considered at this meeting.

NOTES:

- Members are reminded that they must not participate in any item where they have a disclosable pecuniary interest.
- As well as an interest of the Member, this includes any interest, of which the Member is aware, that relates to the Member's spouse or civil partner (or any person with whom the Member is living as a spouse or civil partner).
- Members with a significant personal interest may participate in the discussion and vote on that matter unless that interest could be reasonably regarded as prejudicial.

4 QUESTIONS AND PETITIONS

Purpose of the item: To receive any questions or petitions.

NOTES:

1. The deadline for Members' questions is 12:00pm four working days before the meeting *(29 September 2022)***.**
2. The deadline for public questions is seven days before the meeting *(28 September 2022).*
3. The deadline for petitions was 14 days before the meeting, and no petitions have been received.

5 PREPARATION FOR WINTER PRESSURES

Purpose of the reports: For the Select Committee to receive reports on the measures put in place across the health system to mitigate against pressures during the 2022-23 winter period.

a SURREY HEARTLANDS (Pages 31 - 124)

b SOUTH EAST COAST AMBULANCE SERVICE (Pages 125 - 266)

c FRIMLEY HEALTH AND CARE (Pages 267 - 282)

6 ENABLING YOU WITH TECHNOLOGY - TRANSFORMATION PROGRAMME (Pages 283 - 292)

Purpose of the report: To update the Adults and Health Select Committee on the Enabling You with Technology (Technology Enabled Care) Transformation Programme.

7 MENTAL HEALTH IMPROVEMENT PROGRAMME

a MENTAL HEALTH IMPROVEMENT PROGRAMME: UPDATE ON PHASING OF SYSTEM PRIORITIES (Pages 293 - 298)

Purpose of the report: To provide an update to the Adults and Health Select Committee on progress since the June 2022 meeting.

b MENTAL HEALTH IMPROVEMENT PLAN TECHNOLOGY UPDATE (Pages 299 - 326)

Purpose of the report: To provide the Committee with an update on use of technology and digital tools in the Mental Health Improvement Plan.

8 RECOMMENDATIONS TRACKER AND FORWARD WORK PROGRAMME (Pages 327 - 358)

Purpose of the item: For the Select Committee to review the attached recommendations tracker and forward work programme, making suggestions for additions or amendments as appropriate.

9 DATE OF THE NEXT MEETING

The next public meeting of the Select Committee will be held on Wednesday, 2 November 2022.

Joanna Killian
Chief Executive
Published: Tuesday, 27 September 2022

MOBILE TECHNOLOGY AND FILMING – ACCEPTABLE USE

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Thank you for your co-operation

MINUTES of the meeting of the **ADULTS AND HEALTH SELECT COMMITTEE** held at 10.00 am on 23 June 2022 at Council Chamber, Woodhatch Place.

These minutes are subject to confirmation by the Committee at its meeting on Friday, 16 September 2022.

Elected Members:

*	Nick Darby
	Robert Evans
	Chris Farr
*	Angela Goodwin (Vice-Chairman)
*	Trefor Hogg
	Rebecca Jennings-Evans
*	Frank Kelly
*	Riasat Khan (Vice-Chairman)
*	David Lewis
*	Ernest Mallett MBE
*	Carla Morson
*	Bernie Muir (Chairman)
	Buddhi Weerasinghe

(*=present at the meeting)

19/22 APOLOGIES FOR ABSENCE AND SUBSTITUTIONS [Item 1]

Apologies were received from Robert Evans, Buddhi Weerasinghe, and Neil Houston. Neil Houston attended the meeting remotely. Jonathan Hulley substituted for Buddhi Weerasinghe.

20/22 MINUTES OF THE PREVIOUS MEETINGS: 3 MARCH 2022 [Item 2]

The minutes were agreed as a true record of the meeting.

21/22 DECLARATIONS OF INTEREST [Item 3]

Bernie Muir declared a personal interest that her son worked for Surrey Choices.

Trefor Hogg declared a personal interest as a community representative for Frimley Clinical Commissioning Group.

Frank Kelly declared a pecuniary interest as an employee of Surrey and Borders NHS Foundation Trust.

Nick Darby and Sinead Mooney declared a pecuniary interest as a governor for Surrey and Borders NHS Foundation Trust.

22/22 QUESTIONS AND PETITIONS [Item 4]

None received.

23/22 ALL-AGE AUTISM STRATEGY REVIEW [Item 5]

Witnesses:

Sinead Mooney – Cabinet Member for Adults and Health

Hayley Connor – Director for Commissioning (Children, Families and Lifelong Learning)
Steve Hook – Assistant Director for Learning Disabilities, Autism and Transition
Liz Williams – Joint Strategic Commissioning Convenor (Learning Disabilities and Autism)
Clare Burgess – Chief Executive of Surrey Coalition of Disabled People

Key points raised during the discussion:

1. The Assistant Director explained that the strategy was signed off in September 2021 and the report provided an update of the progress to date. During the development of the strategy there had been consultation with the autistic community. Resources of £500,000 had been allocated from the Better Care Fund and additional funding had been secured from NHS England for specific projects. Some projects could be delivered in the first year, whereas others would take longer to deliver.

2. The Chairman asked about co-operation with other partners involved in the strategy. The Assistant Director responded that the foundation of the strategy was based around co-production. The Council would continue to consult with the autistic community throughout the implementation of the strategy. A governance model that included partners was crucial, with senior level officer responsibility and input from those with lived experience. The implementation of the strategy was held across the system and the Implementation Board would monitor gaps.

3. A Member queried the accessibility of the information produced for autistic services. The Assistant Director explained that there were minimum standards that the Council had to reach, such as easy read benchmarks. The Council checked with groups like ATLAS to make sure that the information produced was relevant and easy to understand. The Learning Disabilities and Autism (LD&A) Partnership Board included communication officers with specific expertise.

4. In response to a question on the amount and the timescale of funding from the Better Care Fund, the Assistant Director responded that the funding had been used to recruit to key posts and develop an information strategy and a training programme. Although there was an annual bidding process, officers were confident that they would attract ongoing funding due to the profile and impact of the project. Each partner involved had committed their own resources to deliver on aspects of the strategy that they were responsible for. Successful bids had been made to the NHS, such as funding to improve sensory environments for individuals with autism.

5. A Member asked about the collaboration with other partners to increase awareness and understanding of autism in Surrey. The Director stated that the commissioning function had been integrated with Surrey Heartlands. Raising awareness and understanding of autism was a big element of the consultation and a focus of the first year of the strategy was autism friendly communities and schools. The national and regional autism strategies provided opportunities to learn from others and the autism community brought ideas, such as children and young people suggesting the change in the use of language. The Member highlighted the importance of ethnicity and autism. The Director agreed that equality, diversity and inclusion (EDI) needed to run through the strategy.

6. A Member enquired about work to raise awareness of autism amongst members of the black, Asian, and minority ethnic (BAME) and Gypsy, Roma, Traveller (GRT) communities. There was a GRT strategic group which the Council would link up with. It was known that there were differences in terms of seeking help and identification of autism in these communities. One reason could be access, as navigating the services was raised as an issue in the consultation process. The Assistant Director added that there were challenges as an employer to ensure it had sufficient experience of working with the BAME community. The Adult Social Care Service had tried to recruit a representative workforce and 34% of the staff in the LD&A and transition team were from BAME backgrounds. The Cabinet Member informed the Members that they would take the strategy back to the EDI Lead Officer in the Council. The Chairman suggested that the Committee had an informal briefing on this topic.

7. A Member asked about the impact of the coronavirus pandemic on the implementation of the strategy. The Director responded

that the strategy was developed at the height of the pandemic, and they switched to using remote options and moved away from hosting large events based on feedback. Diagnoses of autism were delayed as a result of the pandemic but the Director expected this to change as circumstances changed.

8. Responding to a question on the decision process for school placements for autistic children, the Director explained that there was a clear decision-making phase, and the Education Health and Care Plans (EHCPs) planning process was clearly set out. The decisions had not changed throughout the development of the strategy. A child's EHCP was reviewed, and decisions were made in consultation with schools and parents.

9. The Chairman asked about the Personalised Resilience and Engagement Programme (PREP) and employment for those with LD&A. The Director explained that culture change was vital and the commitment to co-design had already illustrated a change in culture. PREP was an example of a scheme of evidence based relational models that had been established. The scheme helped children and young people to understand their settings and helped the Council to understand what provision needed to be made available. The Joint Strategic Commissioning Convenor (Convenor) added that the strategy had an employment workstream which linked into other initiatives, such as the No One Left Behind Schools and Employment Network. *Naturally Talented Me* was an online CV platform which added pictures and other formats to a traditional CV, which members of the autistic community preferred using. It was also important to understand the skills that were needed in the labour market. The Assistant Director added that people in receipt of Adult Social Care (ASC) in employment in Surrey was around 19.5%, which was in the top quartile nationally. The Council's broader workforce strategy included work with the Surrey Care Association and Surrey Heartlands. They had secured a workforce innovation fund of £6 million which would help to increase the care workforce. The aim was to increase employment of those in marginal groups. The CEO of Catalyst who headed the Voluntary Community and Social Enterprise as part of the strategy.

10. The Chairman queried how the Council was working with Chambers of Commerce to support autistic people get into employment and how this was monitored. The Assistant Director explained that Chambers of Commerce were engaged with the strategy and the Council was also working closely with the Department of Work and Pensions (DWP) and Jobcentre Plus.

Three specially trained staff had been employed by Jobcentre Plus to support people with autism getting into work. The Council had made a bid with Surrey Choices to the DWP, which funded a project called Employment Works for Everyone, and helped 16 autistic people gain employment. The Chairman questioned whether Surrey Choices' employment scheme could be widened to the cohort who were not receive statutorily recognised but required support. The Assistant Director responded that there were plans for Surrey Choices projects for those who were not eligible for care and support and a supported internship and apprenticeship programme for young people with an EHCP.

11. A Member asked about support for transition into adulthood, specifically management of relationship changes. The Assistant Director agreed this was complicated for young people with additional needs. A Preparing for Adulthood Transformation Board, which the Cabinet Member sat on, had been developed to address some of the issues that developed during this period. The number of young people with EHCPs that would qualify for ASC was about 10%. It was important to provide additional support for those who would not qualify.

12. A Member questioned the flexibility of the system to support changes as individuals grew and transitioned. The Assistant Director explained that this was recognised by the Council and that they were trying to make the system more flexible. As part of the strategy, a series of support mechanisms would be developed to support people with autism in their homes when experiencing crisis. The Convenor added that there was a support register lead by clinicians that monitored individuals' risk factors, in relation to admission, and this would soon be a digital register. Additionally, a piece of work was starting shortly in which a doctor would undertake scoping work with people with lived experience to understand their experience of crises to support the development of a crisis element of a pathway.

13. In response to a question on current diagnosis waiting times, the Convenor explained that there were around 2,200 adults waiting for an assessment, three times as many referrals compared to 2019. Those currently being seen for a diagnosis were referred in 2018 and 2019. A workshop was held to understand the capacity and capability required to help reduce waiting times and meet the rising demand. The capacity in the team was for 36 diagnostics a month and they were receiving over 100 referrals a month. The Council had received funding from NHS England to test ways to support people prior to a diagnosis, as

60% of those waiting for an autism diagnosis would receive one. The funding would separate individuals into three groups: those who would definitely receive a diagnosis, those who may or may not receive a diagnosis, and those who would definitely not receive a diagnosis. This would allow the Council to signpost those who would not receive a diagnosis to other support. The Director stated that people were waiting too long and the backlog in Children's Services had been known for some time. Surrey and Borders Partnership NHS Trust (SABP) commissioned external diagnosis support to help with the backlog which stood at approximately 1,500 children waiting for a neurodevelopmental assessment. Assessments took more than 6 months and the waiting list time had been reduced at certain points in time. The Mindworks neurodevelopmental pathway had not been transformed at the rate that the Council would have liked. However, children coming onto the pathway were linked up to a third sector provider who would offer both group and individual work, as well as working in schools.

14. A Member sought assurance that the waiting times would reduce, and the Chairman asked about the barriers with the neurodevelopmental pathway. The Director responded that it was hoped that they would have developed multi-disciplinary hubs that would provide holistic support at an earlier stage. Mindworks had invested more in family support for those pre-diagnosis, but due to demand and workforce issues there were issues with the development of the pathway. This was a national issue. The Assistant Director assured the Members that the Council was committed to working with colleagues at SABP. Currently, a diagnosis was perceived as a gateway into services. The Council were working with schools to support young people with autism prior to a diagnosis.

15. A Member asked whether the referral rates for children and young people were similar to the rates for adults. The Director shared that there was rising demand. For example, last year there was capacity to complete ten assessments a week, but there was demand for 18 a week, which is why additional support had been commissioned but challenges to recruitment and transforming the Service remained.

16. The CEO of Surrey Coalition of Disabled People sought assurance that those already on the waiting list, who were unlikely to receive a diagnosis, would not be removed. The Director confirmed that there were no intentions to remove anyone from the waiting list. The CEO raised the issue of the NHS not recognising diagnoses (such as, Attention Deficit

Hyperactivity Disorder) from the private sector. The Convenor explained that if an individual received a diagnosis from the private sector, they would have to get any prescribed medication at a continual basis from the private sector and fund it themselves. There was no short cut to get into the NHS and receive your medication through the NHS. The Convenor would double check that this information was completely accurate. The Director would provide an answer from a children and young people's perspective following the meeting.

17. In response to questions on further independent living accommodation and autism training for housing officers, the Assistant Director explained that they were continuing to look at accommodation options for those with autism. There were a number of independent living schemes in development across three sites across Surrey to support those with learning disabilities and autism. As part of the autism friendly community in Redhill, work had been undertaken with housing officers at the borough council to improve access. A training programme for housing departments in district and borough councils. A Member asked about the timeframe for this work. The Assistant Director explained that the work was underway through the pathway around independent living. Concepts were being trialled on a small scale and then plans to roll them would be explored.

18. The Chairman asked whether the training was mandatory and who received it. The Assistant Director confirmed that the training was mandatory for specialist services across Adults and Children's. If partners signed up to the strategy, they had to complete the training too.

19. A Member questioned the support provided for those who experienced a death of a family member who supported them with accommodation. The Assistant Director recognised that many autistic people who did not qualify for ASC support, relied on their carers and families. There was an ageing population of family carers and thus, there was a Carers Strategy in place to identify that cohort of people and prioritising that cohort to move into independent living.

Actions/requests for further information:

1. The Director of Commissioning (CFLL) to provide additional information on annual reviews of EHC Plans.

2. The Director of Commissioning (CFLL) to provide an answer regarding private diagnoses not being recognised by the NHS from a Children's Services perspective.

Recommendations:

The Adults and Health Select Committee makes the following recommendations:

1. For Learning Disabilities and Autism Leads at Surrey County Council and other partners involved in the strategy to raise further awareness of Autism amongst elements of the BAME/GRT community. To have an informal meeting on progress toward this in a future informal Adults and Health Select Committee meeting.
2. For Learning Disabilities and Autism Leads at Surrey County Council to closely work with Surrey Heartlands and Frimley ICSs to ensure that knowledge and consideration of autism is emphasised in EDI training and as well as in EDI principles surrounding staff recruitment and work practices.
3. For Learning Disabilities and Autism Leads at Surrey County Council and other partners involved in the strategy to adopt a meaningful co-production approach, a shared vision, resourcing and prompt timelines to implement the strategy, given that the success of the strategy will largely rest on being able to collaborate effectively with other partners.
4. Bring this item back to the Adults and Health Select Committee in an informal session, with specific updates on the ***work with Employability*** as well as the ***preparations for the Adulthood Board Activities***.

24/22 ADULT SOCIAL CARE COMPLAINTS - OCTOBER 2021 TO MARCH 2022 [Item 6]

Witnesses:

Sinead Mooney – Cabinet Member for Adults and Health

Liz Bruce – Joint Executive Director for Adult Social Care and Integrated Commissioning (Surrey County Council and Surrey Heartlands ICS)
Liz Uliasz – Deputy Director for Adult Social Care
Kathryn Pyper – Senior Programme Manager (ASC)
Clare Burgess – CEO of Surrey Coalition of Disabled People
Maria Millwood – Board Director (Healthwatch Surrey)

Key points raised during the discussion:

1. A Member asked whether there was any explanation as to why the number of complaints were higher in north-west Surrey and Surrey Heath. The Deputy Director explained that they had merged into one area now creating a large patch with higher caseloads. The staff were now better at managing complaints, due to a cultural shift around learning from them.

2. A Member queried whether the officers were satisfied that it was easy to complain. The Deputy Director responded that they were satisfied. They had been working with staff to encourage people to complain and reassuring residents who had doubts about complaining. The website was accessible, and the Council had been using GPs to help to encourage people to complain as well. The Member queried the publicity of learnings from complaints. The Deputy Director explained that in the Council's response to a complaint, they shared what they have done differently as a result of the complaint and an annual report was published with learnings from complaints. The Joint Executive Director added that as of May 2022, there were over 20,000 cases open on the system. This was positive as it illustrated the engagement of service users.

3. The CEO of Surrey Coalition of Disabled People asked about the involvement of people with lived experiences in the learning space training. The Senior Programme Manager responded that they would welcome that.

4. The Board Director welcomed the section of the report on equality, diversity and inclusion. Healthwatch Surrey met with ASC on a quarterly basis to provide them with user feedback. Healthwatch had undertaken a piece of work on care within the home, through the Giving Carers a Voice contract.

5. A Member asked about plans for more in-depth complaints training for front-line staff. The Deputy Director explained that complaints training was offered, and staff were expected to attend it. Staff had mandatory training related to their job role which would be monitored by their line manager. The Senior Programme Manager explained that the learning space training consisted of monthly 60-minute sessions, with each session looking at a specific theme. The Cabinet Member added that the section on Ombudsman complaints was the most challenging to read but it was important to learn from those case studies.

6. In response to a question on preventing complaints from going to the Ombudsman, the Deputy Director explained that sometimes complaints needed to go to the Ombudsman for an objective view. However, early resolution and talking to residents helped to stop the complaint process at the beginning.

7. A Member asked about the involvement of other agencies in the complaints process. The Deputy Director responded that the relevant agency would always be contacted if they were included in a complaint and a joint response would be produced.

8. The Chairman asked about the progress regarding the Council's customer relationship management (CRM) system. The Deputy Director explained that they had a CRM system which would be replaced over the next few years. There were plans to develop the digital front door to record issues of concerns more effectively. The Joint Executive Director has reached out to the Executive Director of Customer and Communities to look into this. The Chairman stressed the need to have issues of concern flagged up on the new system.

Recommendations:
The Adults and Health Select Committee recommends:

1. That a thorough review is undertaken by Adult Social Care Leads at Surrey County Council, with the assistance of relevant corporate system providers, of the current CRM system in place to make it as user-friendly as possible, and to harness all the functions within the CRM system.

2. For Adult Social Care Leads at Surrey County Council to review what is being considered, and the parameters being used, in the process of acquiring a new CRM system.

3. That a follow-up informal session is held to address/investigate how Issues of Concern are recorded and dealt with, as opposed to formal complaints.

4. For Adult Social Care Leads at Surrey County Council to look into investigating training available from the Ombudsman to learn from cases upheld.

Ernest Mallet left the meeting at 12:33pm.

The meeting paused at 12:33pm and reconvened at 1pm.

25/22 MENTAL HEALTH IMPROVEMENT PROGRAMME (MHIP) STOCKTAKE AFTER 12 MONTHS [Item 7]

Witnesses:

Sinead Mooney – Cabinet Member for Adults and Health

Joanna Killian – Chief Executive of Surrey County Council
Liz Bruce – Joint Executive Director for Adult Social Care and Integrated Commissioning (Surrey County Council and Surrey Heartlands ICS)
Liz Uliasz – Deputy Director for Adult Social Care
Liz Williams – Joint Strategic Commissioning Convenor (LD&A)
Kate Barker – Joint Strategic Commissioning Convenor (CFLL)
Graham Wareham – Chief Executive of Surrey and Borders Partnership
Professor Helen Rostill – Deputy Chief Executive of Surrey and Borders Partnership and Director of Therapies
Sally Heath – Director of Business and Innovation (Surrey and Borders Partnership)
Patrick Wolter – CEO of Mary Frances Trust
Clare Burgess – CEO of Surrey Coalition of Disabled People

Key points raised during the discussion:

Frank Kelly left the meeting for this item.

1. The officers gave a presentation to the Members (Annex 1). The Deputy Director explained that the cost-of-living crisis and the war in Ukraine was impacting on residents' mental health. Service users' voices were the focus of the work and recommendations and a whole system response was required.

2. The Director of Business and Innovation shared that the General Practice integrated Mental Health Service (GPimhs) programme had been rolled out to 18 out of 25 sites, with planned for last 7 to go live by end of 2023. GPimhs is currently offering around 20,000 appointments per quarter As a result, there had been a reduction in routine referrals and bounce back. A one team pilot had been developed and early findings had shown reduced waiting times for psychologist services, improved working relationships, and early identification of social care needs. SABP had commissioned a piece of work to understand the resource and capacity across the system and a number of opportunities around resourcing and contracting mechanisms had been identified.

3. The CEO of Mary Frances Trust added that they had a system wide campaign to address the impact of the pandemic, led by a joint mental health communication group. It aimed to reduce the stigma and tackle health inequalities. By diverting five people it would offset the cost of the campaign.

4. The Deputy Chief Executive of SABP emphasised the scale and complexity of the transformation programme. There was significant commitment from all senior stakeholders, but it had not translated into prioritisation, capacity and clarity of purpose. The governance had been fragmented and the right level of expertise was required to drive forward the programme. There was an agreement to share human resources, however, some partners were unable to provide the resource required to continue to deliver the programme. The impact of the pandemic was not declining for mental health and a vision had been lacking as well. The Chief Executive of SABP added that there was a lack of accountability which had now been addressed by the development of the Mental Health System Delivery Board which would govern the programme.

5. The Chairman questioned the clarity of decision-makers. The Chief Executive of SABP confirmed that there was clarity now. The system had an integrated commissioning function and the new Mental Health System Delivery Board included all the decision-makers. The Chairman additionally asked whether the shared vision and commitment from partners continued. The Chief Executive confirmed that all partners were committed to the vision. However, it was challenging times with pressure from the Treasury for the NHS to balance its books and the continued impact of the pandemic.

6. The Chairman asked whether key organisations were lobbying government for investment on the basis that it would produce savings in the long-term. The Chief Executive of SABP agreed that early intervention was required in the form of an integrated model within neighbourhoods. This would provide wider benefits for other institutions and society, however, these were hard to measure benefits. They had been talking to the national team at the NHS about investment. The Deputy Chief Executive added that for every £1 spent, it created a £3 return. System development funding had largely focused on higher end needs. There was a consultation on the ten-year Mental Health Plan that was ending in July 2022. The Chairman noted the funding formula which disadvantaged Surrey. The Joint Executive Director explained that all partners would be contributing to the call for evidence for the ten-year Plan to

show that the formula needed to change to acknowledge the importance of early intervention.

7. A Member asked about the progress made to date in light of the impact of the pandemic on mental health services. The Chief Executive of SABP explained that they had significantly increased capacity in the most intensive services, such as purchasing an additional 30 independent sector beds. The surge and complexity of need was so great that they were not enough qualified practitioners. They were working to find new roles and to train staff but this would take time. The Deputy Director shared that there were individuals who had never previously had mental health issues, who were now needing to be detained. The Chief Executive of the Council added that the impact was coming through its contact centre as well. There was a specialist welfare support line who were facing challenging calls. The support offered to the Council workforce has been increased. School leaders welcomed wraparound teams which had been added to school communities. The Deputy Chief Executive of SABP shared that SABP had established a staff wellbeing hub called *Here for You*, open to staff of all system partners, which had 17,000 visits thus far.

8. The Chairman raised cultural change, the Chief Executive of the Council explained that at the Council they spoke about good mental health for everyone, with a culture that valued being able to talk to each other so that individuals could spot when their colleagues were losing their good mental health. From a leadership perspective, mental health was a dimension of every conversation. There was more to do to tackle this issue earlier, especially for children and young people where the demand was high. The Deputy Chief Executive of SABP added that it started with early years and families. Honest conversations were needed to help to move forward. Comments from third sector colleagues in the task group report illustrated a commitment to come together in an alliance which demonstrated a shift.

9. A Member asked about the work to raise awareness of mental health services. The CEO of Mary Frances Trust explained that there was a 'time to change' campaign funded by public health and delivered by third sector organisations to reach out to as many people as possible from a variety of backgrounds. The CEO of Surrey Coalition of Disabled People added that there was a programme called 'tech to community connect' which gave someone who was facing digital exclusion a device and matched with a tech angel who provided support. One of

the target groups was those experiencing mental ill health. They were shown how to use their device to access therapies, social groups, or stay connected with another person. It was also important to continue to communicate in other ways than just digitally.

10. The Chairman referenced the use of technology in service solutions. The Deputy Chief Executive of SABP explained that the pandemic accelerated the rate of digital technology which meant that a lot of services were being provided online. Services were being brought back in person as the pandemic has reduced. A digital roadmap was being developed and embedded into Surrey Heartlands digital and data strategy plan. The Joint Commissioning Convenor (CFLL) added that the mental health digital road map was very active. It had been co-designed and had 20 recommendations; they were working on the costing of the solutions. The Deputy Director also added that through digital enabled care, more residents were staying in their home and being supported with technology.

11. In response to a question on overcoming barriers for the black, Asian, and minority ethnic (BAME) and Gypsy, Roma, Traveller (GRT) communities, the CEO of Surrey Coalition of Disabled Peopled explained that the Independent Mental Health Network worked with Surrey Minority Ethnic Forum to conduct research into minority ethnic communities. This produced a summary report with recommendations to the system and progress had been good.

12. The Chairman asked about the work with businesses in Surrey. The Chief Executive of the Council explained that they were adopting a workforce strategy across Surrey Heartlands and ASC around getting more people into the workforce that would not normally consider a career, such as, those with neurodevelopmental issues. The Joint Executive Director explained that they had made links with economic growth colleagues about developing a diverse and flexible workforce. The Joint Commissioning Convenor (LD&A) added that there were bidding to extend the individual placement scheme, which supported those enduring mental ill health. . Employment was a key part of the recovery journey and SABP were working with Chambers of Commerce to support workplace mental health.

13. A Member enquired about the inability of IT systems to speak to each other. The Chief Executive of SABP explained that that was a problem and Surrey Heartlands had engaged in an

upgrade for technology and they would link into the Council. The Surrey Office of Data Analytics were looking to understand where the greatest need was.

14. A Member asked about Camerados public living room project. The CEO of Surrey Coalition of Disabled People explained that it was an international movement concerned with people's wellbeing, with the message that people needed other people and purpose to live a happy life. The public living room concept which they would like to enable communities within surrey to establish in various locations. Funding would need to be secured first.

15. The Chairman queried how far the progress was from the original programme. The Chief Executive of SABP explained that they had prioritised a number of projects which did have funding attached. There was not enough capacity to deliver all of the projects concurrently. There was a financial recovery plan for the ICS and a new board had been established to bring together all of the projects. Other pieces of work had been identified but did not have clear timelines of when they could be achieved. The Chief Executive recognised that there was a gap. The Chairman questioned the speed and urgency of the delivery board. The Joint Executive Director explained that there was one system improvement plan and terms of reference and membership were roughly agreed. There was a set of shared actions and metrics and a shared commissioning strategy needed to be delivered. The Chief Executive added that the new plan included the same 19 recommendations sequenced through time. The Board's role was to work out how to achieve that and there would be deliverables along the way. There was a significant funding challenge and there might be the need to lobby government. The Chairman queried the lack of key data that should underpin decisions, having requested this information over a number of years. It was agreed that they would make this information available as a matter of urgency.

Recommendations:

The Adults and Health Select Committee recommends:

1. For Surrey Heartlands CCG, Surrey and Borders Partnership NHS Foundation Trust, and Surrey County Council to continue to campaign for a change in the National Allocation Formula that would accurately reflect some of the mental health issues faced by Surrey Residents.

2. For Surrey Heartlands CCG, Surrey and Borders Partnership NHS Foundation Trust, and Mental Health leads in Surrey County Council to provide a future update and report to the Adults and Health Select Committee on the technology being sought, and the progress being made in rolling out technological systems to improve Mental Health Services in Surrey.

3. For Surrey Heartlands CCG, Surrey and Borders Partnership NHS Foundation Trust, and Mental Health leads in Surrey County Council to provide a future update and report to the Adults and Health Select Committee on how existing and additional funding will be effectively used to deliver on the Mental Health Improvement Programme, and to provide a timeline as to when the plan is expected to be delivered on.

26/22 RECOMMENDATIONS TRACKER AND FORWARD WORK PROGRAMME [Item 8]

Key points raised during the discussion:

None.

27/22 DATE OF THE NEXT MEETING [Item 9]

The Select Committee noted that its next meeting would be held on Wednesday, 5 October 2022.

Meeting ended at: 3.04 pm

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Chairman

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Delivering the 19 improvement Recommendations

Annex 1

The delivery of the 19 recommendations has taken place against a backlog of significant pressures and transformation in mental health, both in Surrey and nationally

THE MENTAL HEALTH IMPROVEMENT PLAN AIMS:

- Address the recommendations contained within the Surrey Heartlands Mental Health review.
- Bring partner organisations together (Voluntary, Community and Social Enterprise (VCSE), lived experience/carers, statutory, health, communities) to deliver the required improvements.
- Ensure that user voice and lived experience is central to project definition and delivery.
- Support the rationalisation of the governance mechanisms around the delivery and reporting of Mental Health improvement to eliminate duplication of activity.
- Initiate and mobilise new improvement activities within the Mental Health system.
- Track and monitor the delivery of benefits and risks.
- Review the resourcing model for emotional wellbeing and mental health in Surrey.

OUR JOURNEY

March 2019

Adult and Health Select Committee formally established the cross party Mental Health Task Group

October 2020

Recommendations presented to the Cabinet.

November 2020

Mental Health Summit hosted with a "call for action". Agreement to set up an independently chaired Mental Health Partnership Board

June 2021

19 recommendations approved and programme of work commenced. System wide workshop shaped priorities

Dec 2021

Second Mental health summit hosted focussing on progress made and hearing from service users

June 2022

Reset and stocktake on progress made. Senior re-commitment agreed

July 2022

New Executive MH System Delivery Group to commence

Addressing recommendation 3: Focus on resilience, early support and helping people understand and access it:

What

- GPimhs/MHICS roll out commenced in 2018
- Embeds new integrated mental health teams within Primary Care Networks, creating new roles and bringing together the NHS, Social Care and the third sector.
- First port of call for GP's to seek support for managing people in their local population with significant mental health needs.

Aims

- Improving patient journey of accessing mental health services and removing barriers to access
- Easy-in and easy-out access to evidence based interventions where required.

Findings

- Of the GPIMHS established in 11 PCNS, it has supported over 9000 patients that would previously been unable to access Mental Health services to access support. There are plans for further roll out and extending this to 25 PCNS by the end of 2023 with 9 new sites are rolling out in 2021/22.

Early findings of the model show that in PCNs where Gpimhs/MHICS is present (compared to PCNs where it is not):

- Number of routine referrals from GPs to SPA reduce by 6%
- Number of routine referrals from GPs to CMHRS reduce by 24%
- Number of SPA referrals back to GP reduce by 28%

Addressing recommendation 5: Focus on better joined up work at the local community level

What

New one team in Epsom pilot as part of community transformation testing streamlined and effective referral processes for people stepping up to- and down from- specialist interventions in secondary care

Aims

The 'One Team' approach is to integrate GPimhs/MHICS with Community Mental Health Recovery Services (CMHRSs) and Community Mental Health Teams for Older People (CMHTOPs), around their local PCN population.

Findings

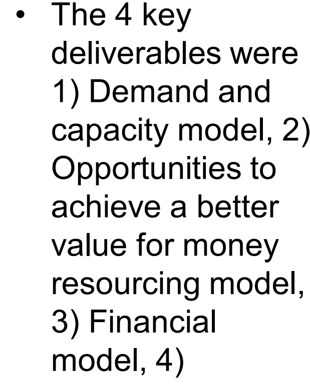
1. *Accelerate access to care pathways* – reduced CMHRS caseload by 20%; cut 'Step Up' wait times in half; reduced wait times for psychological therapies by 25%; 3 out of 4 people stepped down within 6 days
2. *Identify unmet needs, offer a wider range of interventions and ensure smooth transition between care pathways* - 20% increase in social care needs identified and met, multiple services or interventions were identified to support the individual and their family, - reflecting the multiple determinants of health; tracking data on reduction of re-referrals and bounce
3. *Enhance patient outcomes through interdisciplinary 'One Team' working* –There is a real sense of services working together to offer the best possible outcome for the client (care wrapping around the client – partnership working)"

Addressing recommendation 7: Focus on the resource and capacity needed to deliver

What

- CF were commissioned to complete a review of resourcing, impact and value for money assessment of the emotional wellbeing and mental health services delivered across Surrey.

Aims



Findings

A report can be provided of the full findings. The review highlighted six resourcing opportunities:

1. Avoid the use of high acuity care settings through the expansion of early intervention and prevention.
2. Reduce barriers to specialist intervention earlier in the care pathway, to avoid deterioration and consequently need for intensive treatment and bed-based care.
3. Expedite the discharge of medically fit for discharge patients and improve mental health inpatient flow.
4. Integrate physical and mental health MDTs so that patients get holistic inpatient care in acute hospitals, thereby reducing lengths of stay for acute and mental health inpatient units.
5. Reduce the need for high-cost agency and bank staff by improving the recruitment and retention of the permanent workforce.
6. Create digital systems and integrated datasets

Addressing recommendation 13: Communication, Resilience & Preventative Strategy

What

- Major system-wide mental health campaign designed to help address the impact of Covid-19
- Led by a joint mental health communications group (SABP, SCC, SH and FH ICS, Public Health, Police, VCSE and others)
- Diverting just 5 people away from an inpatient admission would offset the cost of the campaign

Aims

- Raise awareness and reduce stigma
- Drive an increase in numbers seeking self-help and lower level support and reduce demand on more acute services
- Reduce stigma
- Tackle health inequalities

Impact

- Mailer QR code has been scanned more than 300 times and mailer contributed to a 29% increase in claims to Surrey crisis fund
- 14,922 visits to mental wellbeing web page (up from 4,091)
- 100% increase in traffic to Mindworks Surrey
- Increase in people accessing Talking Therapies – 11% increase in number of people receiving Talking Therapies
- 20% increase in new referrals to Community Connections & 52% increase in number of clients supported by Community Connections

Addressing recommendation 17: Review Capacity of Mental Health Crisis and Inpatient Services

What

The In-Reach pilot is a multi-agency service between SABP and the 3 Community Connections Lead Providers Catalyst, Mary Francis Trust & Richmond Fellowship. The pilot was mobilised to support discharge from inpatient wards.

Aims

The services aims to support individuals and their families through the transition from the ward back into the community and to prevent re-admissions.

Findings

Between June 21 and January 22:

74 people were supported and of these only **5** were re-admitted

13% had discharges earlier than planned and **18%** as planned

Clients gave an average score of **8.3 out of 10** for how beneficial the support of their In-Reach worker was in helping them in their transition home

92% of clients felt the support of In-Reach reduced the likelihood of them returning to hospital

Staff gave an average score for **8.3 out of 10** for how satisfied respondents were with the support that the service offered

Staff gave a score of **9 out of 10** for how likely are you to consider referring to the In-Reach service when discharging patients

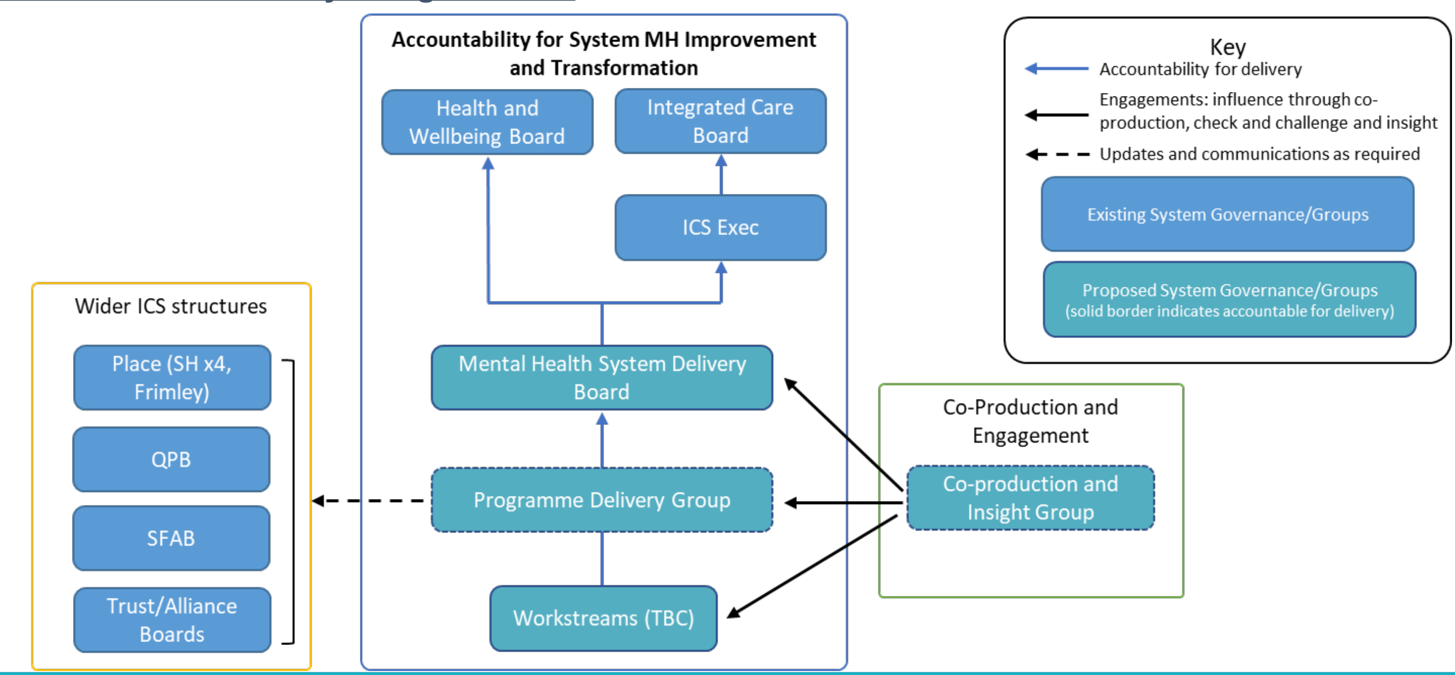
Key Delivery Challenges

- There has been commitment at the highest levels but this has not translated into clarity of purpose or the transformation capacity to deliver the change
- There has been a lack of clarity on system governance making it difficult to agree priorities and move at pace
- Despite initial allocation of shared human resources from across the system these have gradually fallen away to leave the Programme Director and part-time SABP project officer
- Scale of transformation required to deliver the improvement plan against other competing priorities and pressures, including responding to the Covid pandemic, delivering the NHS Long Term Plan, and delivering priority 2 of the Surrey Health and Wellbeing Strategy
- There has been a lack of a shared longer term strategy and vision for emotional wellbeing and mental health in Surrey which has resulted in misalignment of objectives and priorities which the MHIP has tried to navigate through

Governance and Next Steps

Governance has been a challenge to the delivery of the programme and has not resulted in clear prioritisation or phasing of the work. As a result, senior systems leaders met on 23rd May 2022 to reaffirm commitment to the programme and to simplifying of the governance structure. It has been proposed that:

New proposed Governance currently being finalised



Item 5a

ADULTS AND HEALTH SELECT COMMITTEE

SURREY
COUNTY COUNCIL

Wednesday, 5 October 2022

Surrey Heartlands ICS - Managing UEC Surge

Purpose of report:

This report is to inform the committee of the impact of UEC Surge 2022/23 on the Surrey Heartlands system, including reference to previous winter pressures; and to describe the whole system measures being put in place to promote resilience throughout the upcoming winter period.

1. Introduction

1.1 With the introduction of the Health and Care Act 2022, the formal NHS and Social Care landscape has changed with the establishment of 42 ICSs across England. Each Integrated Care System has two statutory elements, an Integrated Care Partnership (sometimes known as an ICP) and an NHS Integrated Care Board (sometimes referred to as an ICB) – in Surrey Heartlands our ICB is known as NHS Surrey Heartlands.

1.2 The outstanding dedication, skill and commitment of all our Surrey Heartlands health and care workers, going above and beyond to rapidly respond to the flexing needs of the pandemic has in turn help to strengthen our ICS partnership as teams and partners come together to create one system.

1.3 During this period of recovery and moving back into 'business as usual' for both Elective and Emergency care (whilst maintaining a very strong focus on wait times for our patients), both Ashford and St Peter's and Royal Surrey NHS Foundation Trusts launched, on 16th May 2022, a new electronic patient record system – known as Surrey Safe Care, setting the scene for joined up care across the county, with SaSH upgrading their system in September. The system consists of a series of software applications that bring together and digitalise clinical and administrative data to replace paper-based records. The system, provided by Cerner Corporation UK, will improve processes and increase safety, efficiency and experience for patients.

2. Report Summary

Please refer to the attached full report: Surrey Heartlands – Managing UEC Surge.

2.1 As the attached report demonstrates, not only was the winter of 2021/22 very challenging, with these pressures continuing throughout the 2022 spring and summer periods.

2.2 **Primary Care**: the total for the last full financial year (2021/22) of combined appointments and online contacts is **7.7m.** The previous year (2020/21) is at **6.6m** which is an increase of 18% (These numbers doesn't take into account the delivery of the Covid-19 vaccinations). Surrey Heartlands has one of the highest online utilisation rates across England resulting in **2.5m** online contacts/requests made during 2021/22. Our face-to-face consultations, whilst they dropped significantly during the first wave of Covid, have since recovered, and are higher than pre-pandemic levels.

2.3 **Primary Care Winter preparedness** - Primary Care has planned its approach on any announcement of Winter Access funding to mitigate against winter pressures as set out below:

- Practice Level Additional Appointment Capacity
- Fuller Stocktake implementation of urgent care demand hubs
- At scale back office
- Cloud Based Telephony
- General Practice Community Pharmacy Consultation Services
- OPEL – absence reporting

2.4 Primary Care also has new duties from April 2022, Surrey Heartlands became the delegated authority for Pharmacy, Optometry & Dentistry (POD). With the triple aim in mind of better health for everyone, better care for all patients and efficient use of NHS resources, the opportunities offered to locally commissioning these services include the following include:

- Patient benefits: Joined up care, increased focus on prevention, early intervention, right care, right time, right place, holistic, multi-disciplinary approach to care and better step down care
- Equity: directly tackling health inequalities, reducing and removing organisational constraints and barriers and tackling variation
- Better value: improved management of patient demand, protecting and building workforce resilience, improved budgetary management

2.5 **NHS 111**: Patient activity has been consistently above planned levels nationally across the majority of the 2021/22 period, peaking at times in Surrey specifically, to around 30% above usual levels. Call arrival patterns at times have been sporadic and do not align to the usual historic trends, making resource profiling difficult to predict. Since 2022, activity appears to be making a return to normal levels although as we approach the winter months, it is uncertain if this will continue.

2.6 **NHS 111 winter preparedness**: in order to mitigate against the performance and operational issues, an action plan has been drawn up which aims to address the wider issues such as workforce and recruitment; with work continuing in relation to strengthening existing capacity across Health Advisor / Clinical advisors / Clinical Assessment Service staffing; along with plans put in place to mitigate against any forecasted shortfall. The operational ability to create daily flex to meet demand is being developed.

2.7 **Community Services** have developed a transformation programme to build the infrastructure will bring together the 'sum of the parts' to offer coordinated and comprehensive community urgent care. The Urgent Community Response (UCR) service aims to support people within their home environment, reducing conveyance to ED. The Surrey Heartlands' Urgent Community Response (UCR) service which is committed to maintaining geographical coverage and delivering 2-hour response services from 8am-8pm every day.

2.8 **Community Service winter preparedness:** in supporting the system to deliver Urgent Care out of the acute environment; key workstreams are focusing on streamlining ambulance referrals into UCR, aligning the service provision with NHS 111 pathways and responding to people who experience a fall in a community setting and do not require Acute intervention.

2.9 **Virtual Wards** support patients, who would otherwise be in hospital, to receive the acute care, remote monitoring and treatment they need in their own home or usual place of residence. Surrey Heartlands is mobilising 172 'beds' by the end of December 2022, increasing towards a national ambition of 40–50 virtual beds per 100,000 population by March 2024.

2.10 **Virtual Wards winter preparedness** – the deployment of these wards is increasing ahead of winter and pathways into the virtual wards are being simplified and communicated across partners organisations. Access to the virtual wards will be via UCR in the community and part of the step-down provision available following an acute admission.

2.11 **Ambulance attendances to ED** - when focusing on the winter months (November to March), the overall attendance figures (all types) have decreased by 5.4% when comparing 2021/22 with 2019/20. Whilst the combined winter month figures show a decrease in ambulance attendances; there was an

increase of 4.2% increase in March 2022. This trend of increased activity has continued into the summer months 2022.

2.12 **Ambulance Handovers**: the number of handovers within 15 minutes have decreased; with the corresponding number of over 15 and over 60-minute handovers increasing, particularly since April 2022, again this is due to increased pressures within the system. The main reasons for the delay in handovers are availability of staffing; ambulances arriving in 'batches' for example 4 or 5 ambulances arriving at once and high occupancy within each of the Acutes.

2.13 **ED attendances** of Surrey Heartlands residents attending the acute hospitals experienced a +7.0% growth when comparing 2019/20 to 2021/22; this is significantly higher than the national growth of -0.0%.

2.14 **ED 4-hour performance**: all four Acute hospitals had more challenged performance when comparing 2019/20 winter months to 2021/22. The NHSE national average from November 2019 to March 2020, when compared to November 2021 to March 2022, has significantly fallen from 72% to 61%. However, whilst work continues to improve ED wait times, it is noted that Surrey Heartlands is generally performing better than the NHSE national average.

A&E 4 Hour Performance (Type 1)						
Provider	Nov-19 to Mar-20		Nov-20 to Mar-21		Nov-21 to Mar-22	
	Performance	Variance to NHSE	Performance	Variance to NHSE	Performance	Variance to NHSE
ASPH	75%	+3%	74%	-2%	66%	+5%
ESTH	80%	+8%	86%	+10%	79%	+18%
RSFT	81%	+10%	88%	+13%	69%	+8%
SASH	84%	+13%	91%	+16%	74%	+13%
NHSE	**72%**		**75%**		**61%**	

2.15 **ED winter preparedness** – provision of a streaming and re-direction service; people attending the EDs will be supported by a healthcare professional in answering questions in relation to their health and from the information given, the patients will be 'streamed' to the right service within the hospital or re-directed to more appropriate primary and community services.

2.16 **Non-elective admissions and length of stay over 21 days** - Surrey Heartlands experienced an overall increase in Non-elective (NEL) admissions, with maximum numbers experienced from April 2019 to February 2020; since lockdowns eased the number of admissions steadily increased and are now predominantly over 8,000 per month across Surrey Heartlands ICS. With regard to length of stay over 21 days, during the period from April 2019 to April 2022, numbers were at the highest in March 2020; however, numbers fell dramatically in April and May 2020. Since September 2021 numbers of patients staying hospital over 21 days has again increased.

2.17 **Length of stay – winter preparedness:** The main areas of focus throughout the winter 2022/23 and spring 2023 will be:

- To 'discharge to recover and assess' patients for longer term support.

- For patients whose needs are too great to return to their own home suitable alternative arrangements will be provided

- To discharge plan early - all Surrey Heartlands patients in hospital are receiving a daily clinically led review.

- Community hospital discharges are expected to increase which will help with acute discharge flow.

- Trusted Assessments – This is an area Surrey Heartlands providers will be focusing on. The approach once in place and working well, will support care homes with timelier assessments.

- Virtual wards provision as described above.

2.18 **Care Homes: winter preparedness.** A number of initiatives have been put in Place to support care homes this winter, these include:

- Surrey County Council and health partners are now agreeing a discharge model and funding arrangements for September 2022 onwards in line with the Hospital discharge and community support guidance published in March 2022.

- Surrey Heartlands promotes collaborative working between health, social care, the voluntary and community sector, and care home partners to enhance the health and wellbeing of residents living in a care home and to support care home staff and providers.

- There are supportive meetings and networks in situ that has developed a shared work programme across all Surrey Heartlands. Individual Places have set their strategic priorities which all include reducing unplanned hospital admissions and enhancing training for staff.

- Practice Plus Group run a Star line which is a telephony menu option for providing rapid access to additional clinical support for Care Homes and Paramedics.

- By enabling Primary Care Networks, Surrey Heartlands will have designated teams co - located within neighbourhoods, to extend models of personalised care, embed enhanced health in care homes and develop a consistent set of diagnostic tests.

- Provision of co-ordinating vaccination programmes, screening and health checks in accordance with national standards.

- Surrey Heartlands ICB have agreed with PPG the delivery of an additional 'On Call' GP to support outbreaks of flu within care homes from 26th November 2022 to 31st March 2023. The provision will be in place for the out of hours' arrangements for the administration of anti-viral medication should there be an outbreak of influenza within a Care Home.

2.19 **Mental Health**: All Acute Trusts in Surrey Heartlands are supported by 24/7 Psychiatric Liaison Services. These services work efficiently and effectively to have consistently responded to approximately 900 referrals per month. This service is complemented by the Crisis Support Services for Children and Young People.

2.20 **Mental Health winter preparedness**: The following areas of delivery will support patients this winter:-

- All Community Services will operate as normal over the winter period and attention is always paid to ensuring that leave is managed to ensure sufficient staff for any working day. The Safe Havens (operated in partnership between voluntary sector partners and SABP) are open every day of the year and Home Treatment Teams operate 24/7 365 days a year, along with the Single Point of Access.

- SABP and Community Connections are piloting a 'Recovery & Connect' service within Elmbridge, Guildford and Tandridge CMHRSs over the Autumn and Winter 2022.

- Richmond Fellowship employment advisors are already embedded within CMHRSs to support people with mental health needs into employment and/or to help them remain in employment.

- The GP Integrated Mental Health service (GPimhs) provides an integrated mental health team working within Primary Care. It is currently live in 15 PCNs across Surrey Heartlands and due to be rolled out across all sites by December 2022, giving extra resilience for the winter period.

- As part of the Surrey mental health transformation, work is ongoing to test and spread a 'One Team' approach in Epsom by integrating CMHRS alongside Primary Care, Social Care, and wider VCSE services.

- Plans are in place with a care provider to create a Crisis House (in partnership with Home Treatment Team services).

2.21 **Paediatric emergency admissions** continue to reflect seasonal variances of respiratory illnesses and remain high. During periods of peak activity, hospitals may request mutual aid from other hospitals, although these actions are only taken in extremis.

2.22 **Covid / Flu Vaccinations**: Surrey Heartlands has maintained a strong position with C-19 vaccination delivery providing over 2.2 million vaccines since the C-19 pandemic started. Our operating model structure has been revisited to ensure delivery is through a financially viable model, with a sustainable workforce and optimisation of NHS/Local Authority estate. As of 3rd March 2022, Surrey Heartlands had delivered ~590k Flu vaccinations within the 2021/22 Seasonal Flu Vaccinations campaign

2.23 **Covid/ Flu winter preparedness**: Based on JCVI guidance, the Autumn Covid Booster Campaign commences on the 5th September 2022 with cohorts 1-9 being asked to come forward at staggered intervals. Housebound, Care Home Residents and Care Home Staff cohorts will be prioritised as per national guidance. The Flu Vaccination programme will also commence in September 2022. High vaccination levels within the community directly supports lower admissions due to complications resulting from covid and flu.

2.24 **Elective recovery:** Surrey Heartlands continues to maintain a very strong emphasis on wait times for our patients; services have been working on delivering the Recovery Plan; this work is now transitioning to 'business as usual' whilst remaining focused on ensuring those who are most clinically in need receive the health interventions that they require as soon as possible

2.25 **Surge Planning (includes winter 2021/22)** - Surrey Heartland ICS are undertaking a number of programmes of work to continue to build resilience within our urgent care services and prepare for extended periods of surge in demand, this includes the winter period.

2.26 **Surge Planning – winter preparedness:**

- Paediatrics Transfer service for ICS: Capacity funding bid to provide system Paediatrics transfer service for winter 22/23

- SCAS PTS additional resource for all acutes: Provider discharge resource for patient transports

- Paediatric and Care Home Virtual Facetime: Limiting requirement for face-to-face interventions to increase capacity.

- WSP Modelling: Triangulate system modelling with statistical modelling across the whole Southeast Region.

- Increase in UTC capacity: To aid in redirection and streaming away from ED and reduce admission rate

- Case Management Digital solution: To improve discharge processes - part of the Royal Surrey transformation programme.

- Transport Flow Manager: To support flow - part of the Royal Surrey transformation programme.

- Enhance Paediatric services at SASH increasing capacity: To provide additional capacity, redirection and interventions for Paediatrics due to current limited capacity

- Community Front Door Expansion/Admission Avoidance: Community front door service in reach to ED “pulling” patients out of the acute providing wrap around care in the persons place of residence. Proposal will strengthen and expand MDT - 7 days / extended hours

- Consultant support to Paramedics/ Ambulance crew: On-call Consultant input available by phone/video conferencing to aid crew decision making

- Enhance active complex case management in the community: Reducing risk of going into hospital/ supporting step down from acute linking to Virtual Ward

- Strengthening proactive care coordination across all neighbourhoods: Consultant support and in reach to PCN and Care homes for both crisis support and proactive case management

2.27 **The Surrey Heartlands Seasonal Urgent Care and Escalation Communications Plan** supports targeted messaging out to the wider community particularly in relation to how the person may seek help and support

without needing to attend ED; messages are also tailored to each areas system escalation alerting the public to how busy their local hospital is and have been reviewed in light of the pandemic to ensure consistency of messaging.

3. Governance

3.1 As a mature Integrated Care System (ICS), Surrey Heartlands has developed strong partnerships across all areas of UEC delivery through introducing a three-year UEC strategy and forming an ICS UEC committee to oversee its delivery and monitor our performance.

3.2 The Urgent and Emergency Care (UEC) Committee has created four delivery groups, which report directly to the Committee, and focus on Same Day Urgent Care within both the Acute Hospitals and the Community, Integrated Urgent Care (as part of NHS 111), Focusing on Discharge; along with working with GPs in identifying those at high risk of needing urgent hospitalisation and putting in plans to prevent or reduce admissions. The actions and deliverables from these groups will together support the delivery of reduced numbers of people waiting longer than 4 hrs in ED.

3.3 The Surrey Heartlands ICS main vehicles responsible for the delivery of urgent care across the area are the Place based Local Accident & Emergency Delivery Boards (LAEDBs) of Northwest Surrey, East Surrey and Guildford & Waverley, along with the Surrey Downs Urgent Care Forum – which links to the Sutton and Kingston Place based LAEDB's. Through these groups each of the systems put in place their plans, with some schemes being established across Surrey Heartlands to ensure that the systems were well prepared to manage sustained surge pressures.

4. Recommendations:

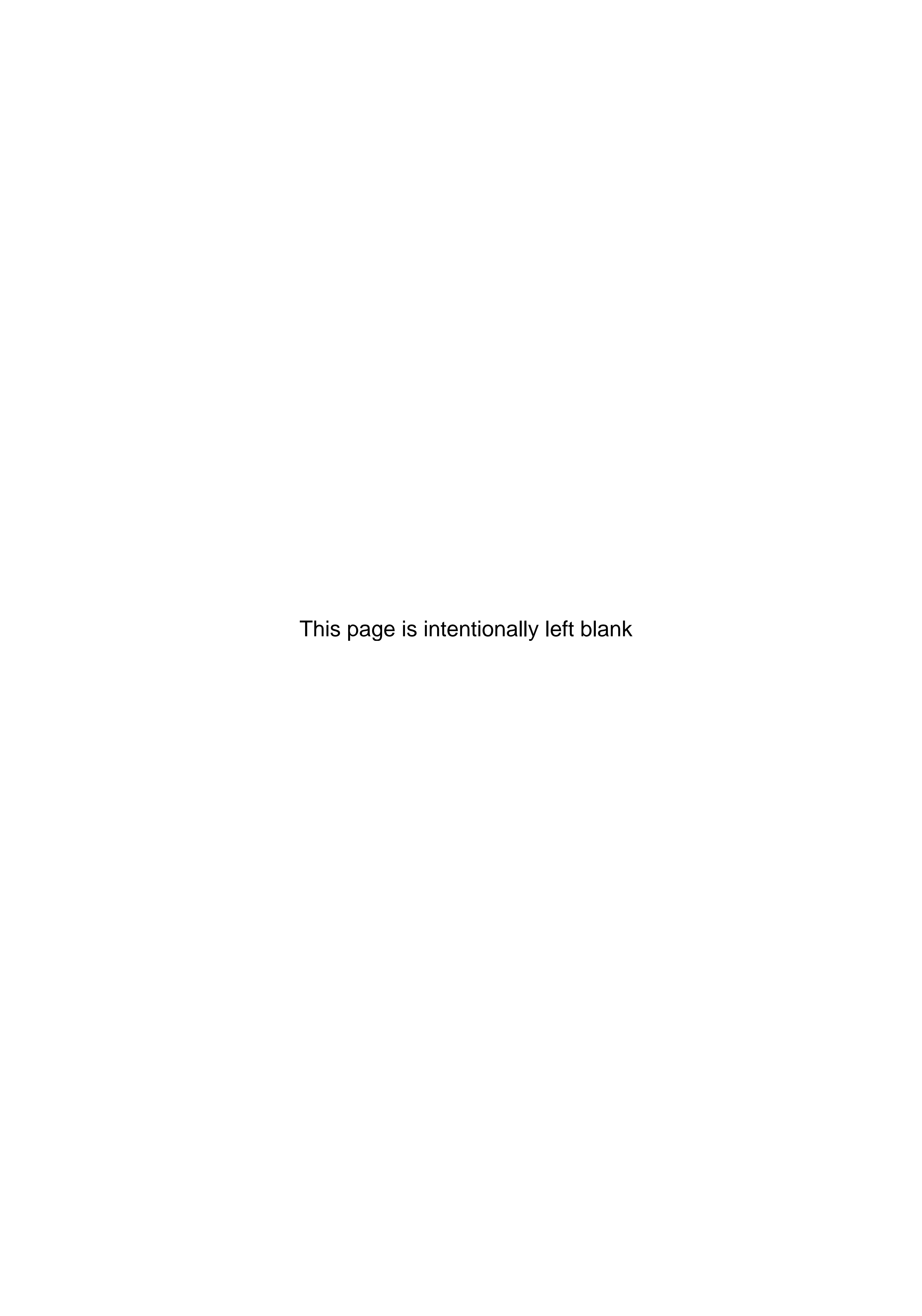
4.1 The Committee is requested to note the preparations for Surges in UEC demand during 2022/23 as set out in this paper.

Report contact: Dr Charlotte Canniff

Joint Chief Medical Officer

Surrey Heartlands Integrated Care System

Contact details - email: c.canniff@nhs.net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Surrey Heartlands ICS - Managing UEC Surge

September 2022
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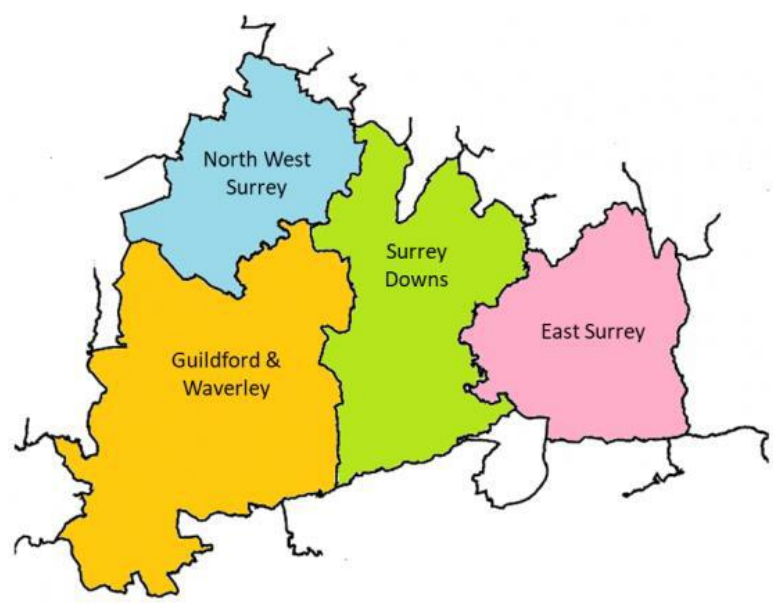
1. Introduction

1.1 The COVID-19 pandemic has had, and continues to place, an enormous challenge, not only in the number of people being admitted with Covid – but also the very high demand for all services across Primary Care; Community Services; Adult Social Care and our Emergency Services. In Surrey Heartlands, our focus remains on reducing elective and non-elective wait times; the quality of our services; reducing health inequalities and the well-being of our staff.

1.2 Surrey Heartlands ICS serves over 1,000,000 people within the areas of East Surrey, Guildford and Waverley, Northwest Surrey and Surrey Downs and accounts for around three quarters of the overall Surrey population. Surrey Heartlands shares many of the same challenges as other areas in the UK – an ageing population, increasing demand on services for vulnerable children and the significant pressure on public finances.

1.3 There are 106 practices working within 24 primary care networks (PCNs); 4 acute hospital sites; 11 community hospital sites; 2 community service partners; 1 mental health partner including 3 inpatient units and 33 community sites; 1 upper tier local authority (Surrey County Council) operating adult & children's social services; 9 District/Borough Councils all working together in the newly formed statutory Integrated Care System. This report sets out an outline of the impact of 2021/22 winter pressures, along with the whole system measures put in place which provide mitigation and promote resilience throughout the upcoming winter season 2022/23.



1.4 This paper was written at the beginning of September 2022 and represents the situation at that point in time.

2. ICB restructuring/reconfiguration

2.1 The Health and Care Act 2022 has established 42 ICSs across England. Each Integrated Care System has two statutory elements, an Integrated Care Partnership (sometimes known as an ICP) and an NHS Integrated Care Board (sometimes referred to as an ICB) – in Surrey Heartlands our ICB is known as NHS Surrey Heartlands. The purpose of the ICB is:

- Improve outcomes in population health and healthcare
- Tackle inequalitiues in outcomes, experience and access
- Support broader social and economic development
- Enhance productively and value for money.

2.2 The Integrated Care Partnership is a statutory committee jointly formed between the NHS Integrated Care Board and all upper-tier local authorities that fall within the ICS area (in Surrey this is Surrey County Council). This committee brings together a broad alliance of partners concerned with improving the care, health and wellbeing of the population, with membership determined locally.

2.3 The Integrated Care Board is a statutory NHS organisation responsible for developing a plan for meeting the health needs of the population, managing the local NHS budget and arranging for the provision of health services in the ICS area. With the creation of Integrated Care Board, the previous Clinical Commissioning Groups (CCGs) have been abolished, with the majority of their statutory duties taken on by the new ICB.

2.4 Integrated Care System are made up of Place based partnerships: these partnerships will lead the detailed design and delivery of integrated services at a more local level. These partnerships involve the local NHS, local councils, community and voluntary organisations and other community partners with a role in supporting the health and wellbeing of the population, working closely with local people and communities.

2.5 Provider collaboratives is another feature of the ICS as they bring NHS partners together to achieve the benefits of working at scale across multiple places and one or more ICSs, to improve quality, efficiency and outcomes and address

unwarranted variation and inequalities in access and experience across different providers.

2.6 The Voluntary, Community and Social Enterprise (VCSE) sector is a key strategic partner in helping local systems shape, improve and deliver services. The sector also has a crucial role in developing and implementing plans to tackle the wider determinants of health – factors that play a key role in the root causes of poor health, such as pollution, poverty, education and housing.

2.7 The outstanding dedication, skill and commitment of all our Surrey Heartlands health and care workers, going above and beyond to rapidly respond to the flexing needs of the pandemic has in turn helped to strengthen our ICS partnership by removing the more traditional 'silo' working in favour of coming together as partners within one system. An example of this is that hospitals and community services are able to identify areas where system assistance is required and be confident that if partners can offer help, they will do so via mutual aid.

2.8 This strength of partnership, as part of what is now a formal arrangement led by the Integrated Care Board, will also assist with winter planning across Surrey Heartlands as we continue to bring together all our resources across health and social care to the benefit of the community through periods of increased demand.

2.9 **Surrey Heartlands ICS five health and care priorities:** As part of coming together as an ICB and building on the joint working already achieved as a mature ICS: the ICB have agreed that all partners will focus on five main objectives. Known as the 'Critical Five' these priorities will also help us recover waiting lists following the Covid-19 pandemic and support people to access the health and care they need. The first three objectives described below link directly into the delivery of the Fuller Stocktake (please see 2.10).

- Keeping people well – doing more to promote prevention and stepping in earlier to prevent people's health deteriorating; and, when people do deteriorate, making sure they understand how and where to get the urgent help they need.

- Safe and effective discharge – helping patients, their carers and families understand and safely navigate the options available to them from a much more joined up and improved community care environment.
- High-risk care management – making sure those who are most vulnerable receive the care they need in a coordinated and planned way.
- Effective hospital management – making best use of hospital resources to support patients safely and efficiently from the point of admission to discharge; this is also about delivering high quality care based on the 'Get it Right First Time' principles (a national programme designed to improve patient treatment and care through in-depth reviews of services and analysis of data/evidence).
- Surrey Heartlands-wide efficiencies – system-wide programmes that ensure we are working in the most efficient way - whilst maintaining high quality care - across areas such as diagnostics, clinical networks, more efficient use of our workforce, digital innovation, corporate and clinical support services, financial management and how we use our estates and facilities.

2.10 **The Fuller Stocktake:** In November 2021, NHS Surrey Heartlands Chief Executive, Professor Claire Fuller, was asked by NHS England Chief Executive, Amanda Pritchard, to lead a review into integrated primary care – looking at what's working well, why it's working well and how the NHS can accelerate the implementation of integrated primary care (including general practice, community pharmacy, dentistry and optometry) across systems.

2.11 The result of the review was 'The Fuller Stocktake' which was published by NHS England on 26th May 2022, the recommendations from which will form a key part of our strategy going forward.

2.12 As part of the review, the team engaged with almost 1,000 people through workstreams, roundtables and one-to-one meetings, alongside over 12,000 individual visits to a dedicated engagement platform, and a real consensus emerged. What is not working in primary care is access and continuity, with frustrations shared by both patients and staff alike. What also emerged was a consensus on what the NHS and partners can do differently:

- Integrated neighbourhood ‘teams of teams’, need to evolve from primary care networks to work collaboratively to improve the health and wellbeing of the local population.
- Streamlined access to urgent, same-day care and advice from an expanded multi-disciplinary team, using data and digital technology to enable patients to quickly find the right support.
- Ensuring those who would most benefit from continuity of care in general practice (such as those with long term conditions) can access more proactive, personalised support from a named clinician.
- Taking a more active role in creating healthy communities and prevention by working with communities, making more effective use of data and developing closer working relationships with local authorities and the voluntary sector.

2.13 The formal establishment of Integrated Care Systems could not be timelier as a vehicle for collaboration, and this report clearly signals the need for primary care voice and leadership to be at the heart of local and national priorities. Finally, the report sets out a requirement for additional support from Government and NHS England, targeted most of all at fixing workforce supply, estates, and digital infrastructure.

2.14 Looking ahead, in Surrey Heartlands we will start to work with teams and partners to reshape our programmes of work to align to the emerging themes as well as our new Critical Five objectives. Our first three priorities – keeping people well through improved interventions and prevention; safe and effective discharge supported by an improved integrated community care environment; and high-risk care management, wrapping care around the most vulnerable – are all about delivery at place, and integrated neighbourhood teams will play a key role in how we do this.

3. Surrey Safe Care

3.1 During this period of recovery and moving back into ‘business as usual’ for both Elective and Emergency care, whilst maintaining a very strong focus on wait times for our patients, both Ashford and St Peter’s and Royal Surrey NHS Foundation Trusts launched, on 16th May 2022, a new electronic patient record system – known as Surrey Safe Care, setting the scene for joined up care across the county.

3.2 The system consists of a series of software applications that bring together and digitalise clinical and administrative data to replace paper-based records. The system, provided by Cerner Corporation UK, will improve processes and increase safety, efficiency and experience for patients.

3.3 Together, the two Trusts serve a population of approximately 800,000 people across six sites and a wider population of 1.3m for cancer services.

3.4 A shared system will bring a number of benefits for patients and the teams. Healthcare professionals from both organisations will gain immediate access to information about patients' care and treatments irrespective of where it was received, resulting in a more coordinated approach to effective and consistent care.

3.5 In addition to this, clinicians will be able to use the platform to make informed, data-driven decisions while ensuring patient confidentiality is safeguarded through the strongest national and international security measures for handling information.

3.6 Implementing an effective Electronic Patient Record like the Surrey Safe Care allows the Surrey Heartlands ICS Acute Hospital partners to meet the policy direction of provider digitisation guidance from NHS England and Improvement. This states that electronic patient records are essential "to support the recovery and sustainability of the NHS and care" whilst also contributing to the wider levelling up of delivery. The Surrey Safe Care programme targets £28.8m of financial benefits (to be delivered over 10 years), alongside safety benefits identified. These benefits will need managing in order to realise, with support needed to both define and clarify the mechanisms for the financial savings.

Benefit ID	**Title**	**Ten-year total £m**
B001	Average Length of Stay/ Admissions	5.463
B002	Locum & Agency spend	6.533
B005	Medicines Management	2.934
B006	Harm Free Care	8.218
B007	Physician Documentation	2.448
B008	Order Communications	0.73
B009	Nursing Documentation	2.477
Target opportunities		**£28.8m**

3.7 The implementation of Surrey Safe Care involved a major, digitally enabled transformational change and a huge volume of work has gone into getting the two Trusts prepared for the launch.

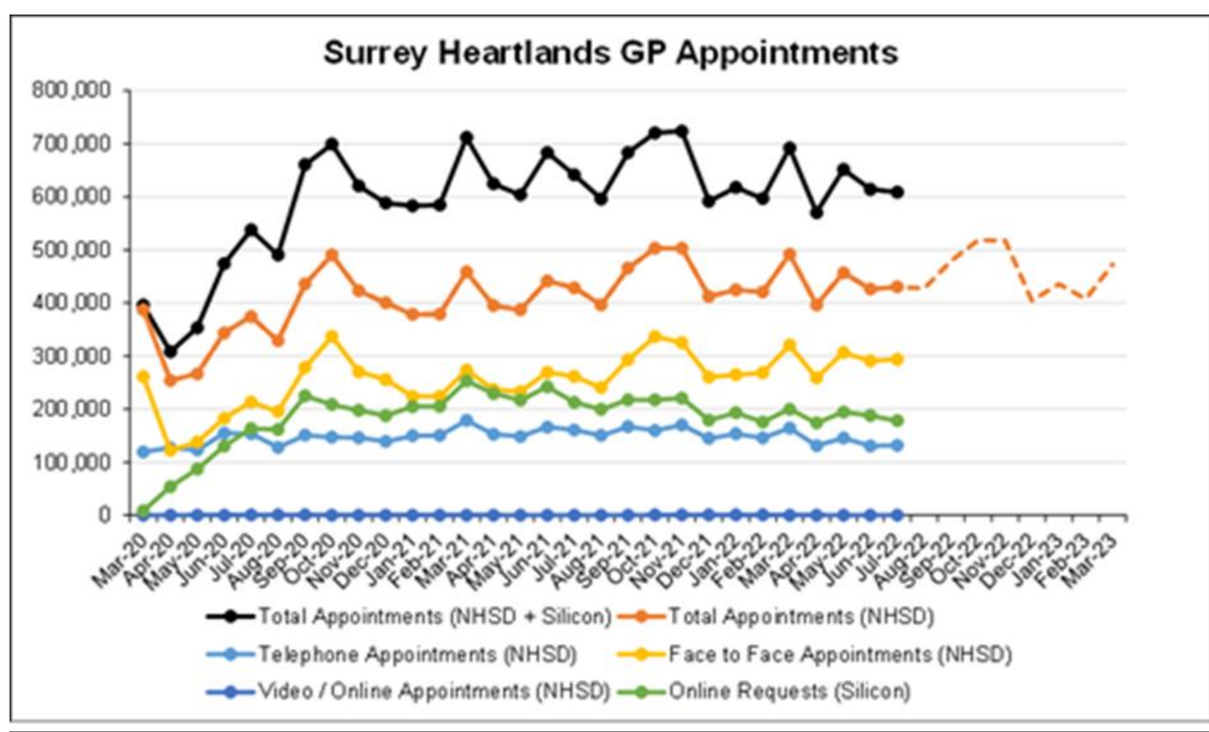
3.8 Whilst recognising the long-term benefits for patients and staff of a fully electronic patient record, it will be some weeks before we are able to provide fully validated data that reflects our system-wide position.

3.9 Please note that this report only includes validated data.

PART A – Managing UEC Surge

4. Primary Care Surge Preparedness

4.1 **Current Position**: The chart below shows data from NHS Digital (publicly available) and Silicon Practice (Surrey Heartlands main online consulting provider) from March 2020 to June 2022. It outlines the total appointments and then breaks this down further into the 'mode' (telephone, online, video) and shows the number seen face to face.



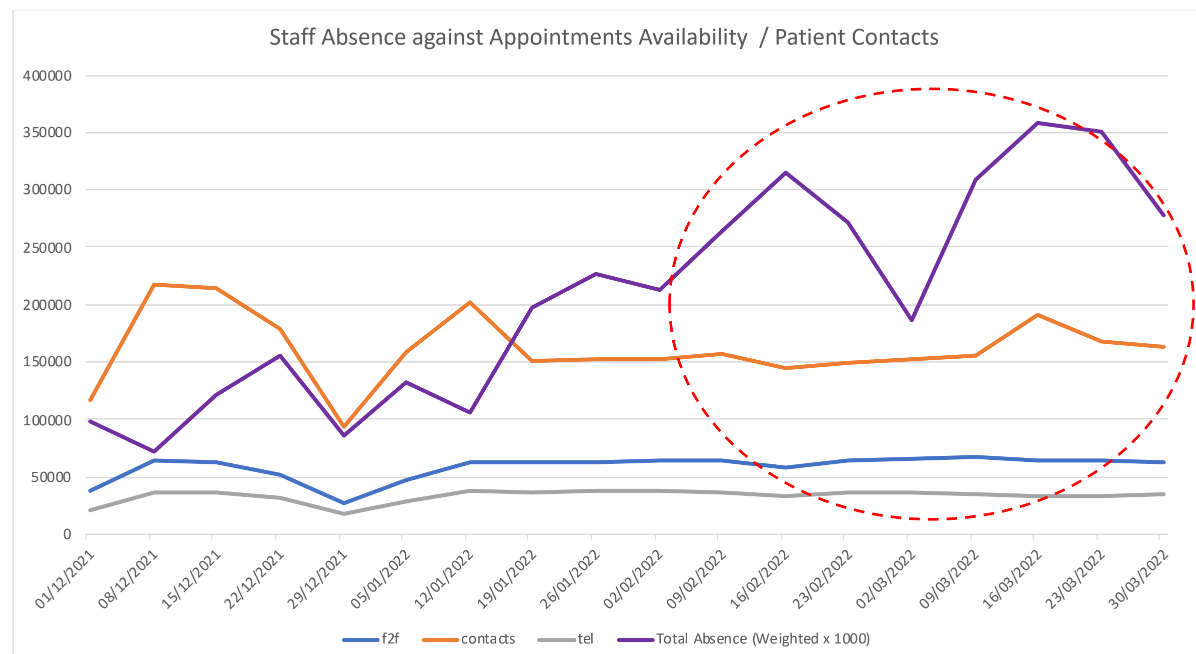
Financial Year	Total Appointments (NHSD)	Online Requests (Silicon)	Combined (NHSD + Silicon)
Fy-2018/19	4,940,790		
Fy-2019/20	4,919,930		
Fy-2020/21	4,535,146	2,078,077	6,613,223
Fy-2021/22	5,271,585	2,505,850	7,777,435
Fy-2022/23 Est.	*5,375,166*		

**NHS Digital outlines the data caveats associated with this data here: Appointments in General Practice - NHS Digital **

4.11 These charts outline that the total for the last full financial year (2021/22) of combined appointments and online contacts is **7.7m.** The previous year (2020/21) is at **6.6m,** which is an increase of 18% (these numbers do not take into account the delivery of the Covid-19 vaccinations).

4.12 It is important to note that Surrey Heartlands has one of the highest online utilisation rates across England resulting in **2.5m** online contacts/requests made during 2021/22. Our face-to-face consultations, whilst they dropped significantly during the first wave of Covid, have since recovered, and are higher than pre-pandemic levels.

4.2 **Staff Absences:** Coupled with overall increase in demand, General Practice has also seen a significant number of absences at the start of 2022 illustrated by the graph below. This shows that staff absences across General Practice increased by c.185% during the early part of 2022 and shown in the purple line in the chart below.



4.21 Winter Plan 2021/2022 – Winter Access Funding (WAF) had a positive impact on appointment availability generating additional capacity in the system by creating additional sessions, provided by portfolio GPs, to ensure appointment availability remained constant throughout times of absences and additional pressure.

4.22 Without the WAF, the working assumption would be that activity would decrease to mirror the emerging workforce challenges related to COVID absences. The ICS completed a robust evaluation process on the impact of the WAF and have worked the learning into our model for 2022/23.

4.3 **Achieving workforce expansion targets to support demand:** As at June-22 in Surrey Heartlands GP Practice Workforce there are a total of:

- 524 Full Time Equivalent (FTE) GPs (excluding GPs in Training Grade): This increases to 608.5 FTE GPs including those in training grade.
- 220.7 FTE Nurses
- 181.1 FTE Direct Patient Care Staff (DPC)
- 1,153.4 FTE Admin or Non-Clinical staff

4.31 Across Surrey Heartlands, the average number of GP FTEs per 100,000 population is 46, which is just above the England average of 45. For Nurses, the Surrey Heartlands figure is 20, which is lower than the England average of 27.

4.32 For Direct Patient Care staff, Surrey Heartlands has an average of 16 FTE per 100,000 population which is lower than the England average of 25 FTE. Admin and Non-Clinical staff average per 100,000 population is also lower in Surrey Heartlands at 102 FTE, whereas the England average is 118 FTE (Data Sources: NHSD General Practice Interactive Dashboard June 2022, NHSD GPW Bulletin Tables, Primary Care Data publication June 2022. Note: Practice level data only and excludes PCN workforce).

4.33 The challenges, including an ageing Admin and Nursing workforce, are being mitigated by working with PCN Educator teams, Surrey Training Hub and practices with succession plans being developed which includes increasing student nurse placements in Primary Care.

4.34 Surrey Heartlands will be focusing on maximising the full use of the additional funding that is going into General Practice workforce supply (Additional Role Reimbursement Scheme -ARRS) as set out in the Long-Term Plan. ARRS roles include Pharmacy Technicians, Social Prescribing Link Workers, Health and Wellbeing Coaches, Care Co-ordinators, Physician Associates, First Contact Physiotherapists and Dieticians.

4.35 Surrey Heartlands total additional roles recruited by 2024 will be 535 FTE. We are on trajectory and as at August 2022, **300 FTE** roles have been recruited to and are working across our Practices.

4.36 A flexible multi-disciplinary staff bank has been created which extends beyond GPs to include all primary care staff allowing easy deployment of staff to meet reconfigured demand. This will become the 'go to' staff bank for General Practice to share their own workforce and gain access to a wider GP pool of bank staff.

4.37 As of July 2022, 155 GPs have registered and completed the onboarding process for Lantum, the flexible GP locum pool for Surrey Heartlands. 83 Surrey Heartlands Practices have signed up to use the Lantum platform to help fill available locum opportunities. The uptake of the flexible locum pool has resulted in 1264 hours of clinical work being completed by registered GPs sourced through Lantum.

4.4 **Winter Preparedness:** There has been no confirmation of Winter Access Funding from a national perspective yet, however Surrey Heartlands has been preparing its approach on announcement of funding as set out below:

- **Practice Level Additional Appointment Capacity**
  - Each practice is offered up to an additional 15 sessions from October to March
  - This would potentially provide the system with up to 240 additional appointments per practice per week, if every additional session is utilised (based on 15 min appointments over a 4-hour session)

- **Fuller Stocktake implementation of urgent care demand hubs**
  - Each place is working with its Primary Care Networks to ensure overflow hubs are in place
  - This means that when a practice is at capacity on the day demand can be moved to other available resources such as a Walk-in-centre

- **At scale back office**
  - Menu of areas have been worked on to provide at scale delivery of some back-office functions such as administrative support to code hospital letters into clinical notes

- **Cloud Based Telephony**
  - Surrey Heartlands has been supporting all 104 Practices to move to Cloud Based Telephony since Autumn 2021. Currently 56/104 (53%) practices have moved and the remaining 48 will be transferred by March 2023.
  - The modernisation of these systems means that we move from analogue systems that limit the number of incoming/outgoing calls that can happen at any one time, to unlimited 'lines' available to patients wanting to contact the practice.
  - Patients can also be alerted to where they are in the queue and request a call back option if they don't want to wait. This will result in less drop calls and less patients abandoning their attempts to contact primary care.

- **General Practice Community Pharmacy Consultation Services (CPCS)**
  - CPCS will support practices in ensuring that patients are directed to the best area when requesting care, at the first point of contact.
  - Surrey Heartlands has been supporting practices in getting enabled and trained to refer patients to community pharmacy when appropriate
  - Currently 24/25 PCNs are active, with 75 practices actively sending referrals. As at 08/09/2022 there have been 2822 referrals sent to Community Pharmacy from General Practice.

- **OPEL – absence reporting**
  - Reporting staff absences to ensure we have a clear picture of any practices that may need additional support offered

4.5 **New Duties:** From April 2022, Surrey Heartlands became the delegated authority for Pharmacy, Optometry & Dentistry (POD). With the triple aim in mind of better health for everyone, better care for all patients and efficient use

of NHS resources, the opportunities offered to locally commissioning these services include the following include:

- Patient benefits: Joined up care, increased focus on prevention, early intervention, right care, right time, right place, holistic, multi-disciplinary approach to care and better step down care

- Equity: directly tackling health inequalities, reducing and removing organisational constraints and barriers and tackling variation

- Better value: improved management of patient demand, protecting and building workforce resilience, improved budgetary management

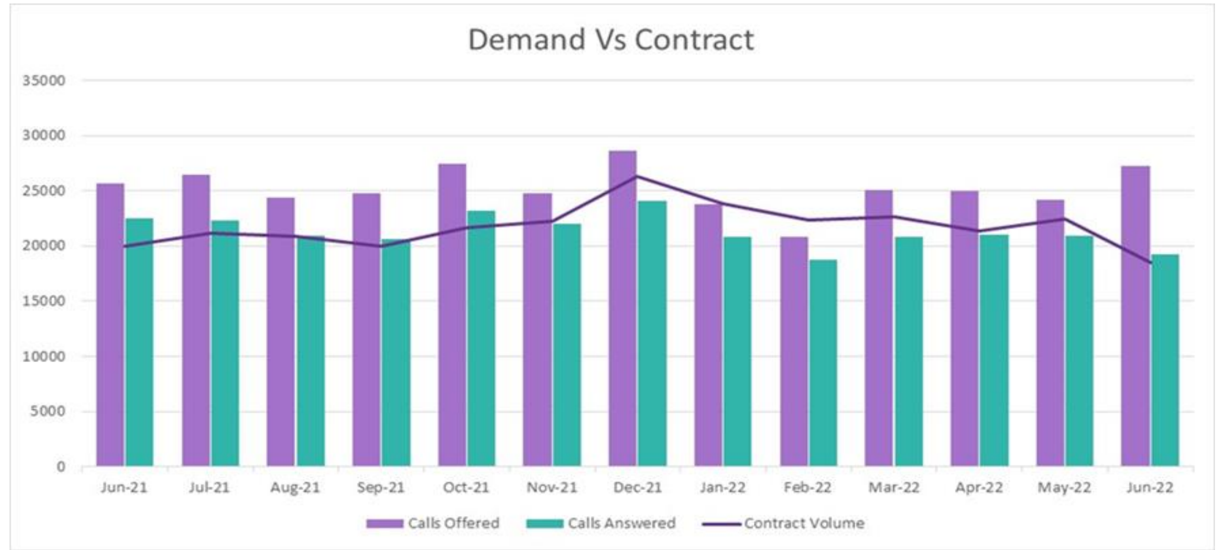
4.51 The above would be achieved by strengthening links with PCNs, Population Health Management and Public Health; fully aligning and localising approaches, advice and communications relating to staying well, through all primary care providers, particularly promoting the wider services offered by Community Pharmacies; along with developing local initiatives to improve patient access and experience.

5. NHS 111 / Integrated Urgent Care Single Virtual Contact Centre

5.1 Practice Plus Group (PPG - previously Care UK) provides Surrey Integrated Urgent Care (IUC) services which is currently operating within year 4 of a 5-year contract. The Integrated Urgent Care Centre covers NHS 111 call answering, Clinical Assessment Services (CAS) and GP Out of Hours provision (including clinical contacts, base visits and home visiting).

5.2 Patient activity in NHS 111 has been consistently above planned levels nationally across the majority of the 2021/22 period, peaking at times in Surrey specifically, to around 30% above usual levels. Call arrival patterns at times have been sporadic and do not align to the usual historic trends, making resource profiling difficult to predict.

5.3 The initial increase has been due to a number of reasons such as the easing of lockdown measures, seasonal surges in Covid and in response to the national 'Think 111 First' directive and media campaigns. Since 2022, activity appears to be making a return to normal levels although as we approach the winter months, it is uncertain if this will continue (Please see graph below).



5.4 'Think 111 First' was a national programme with the primary objective of reducing waiting times in ED by offering 'bookable' appointments within the ED department or other areas of the Acute hospital should these be required; more often it is envisaged that the person will be offered support via other community services. Across Surrey Heartlands, these appointments can now be booked via the NHS 111 service. Prior to booking advice and guidance will be provided as the person may be able to receive support from their Pharmacy or advice from the NHS 111 clinical team.

5.5 As with other national IUC Providers, PPG hold a challenged rota fill across all areas of IUC as per other service providers, coupled with monthly instances of national contingency which is unplanned and occurs when other services across the country are unable to meet demand. The new Single Virtual Contact Centre model will, in part, start to address this issue through the smoothing out of NHS 111 call taking across the Southeast region. NHS 111 capacity continues impact directly on KPI achievement across all Integrated Urgent Care providers. NHS England focus has prioritised improvements in NHS 111 access standards

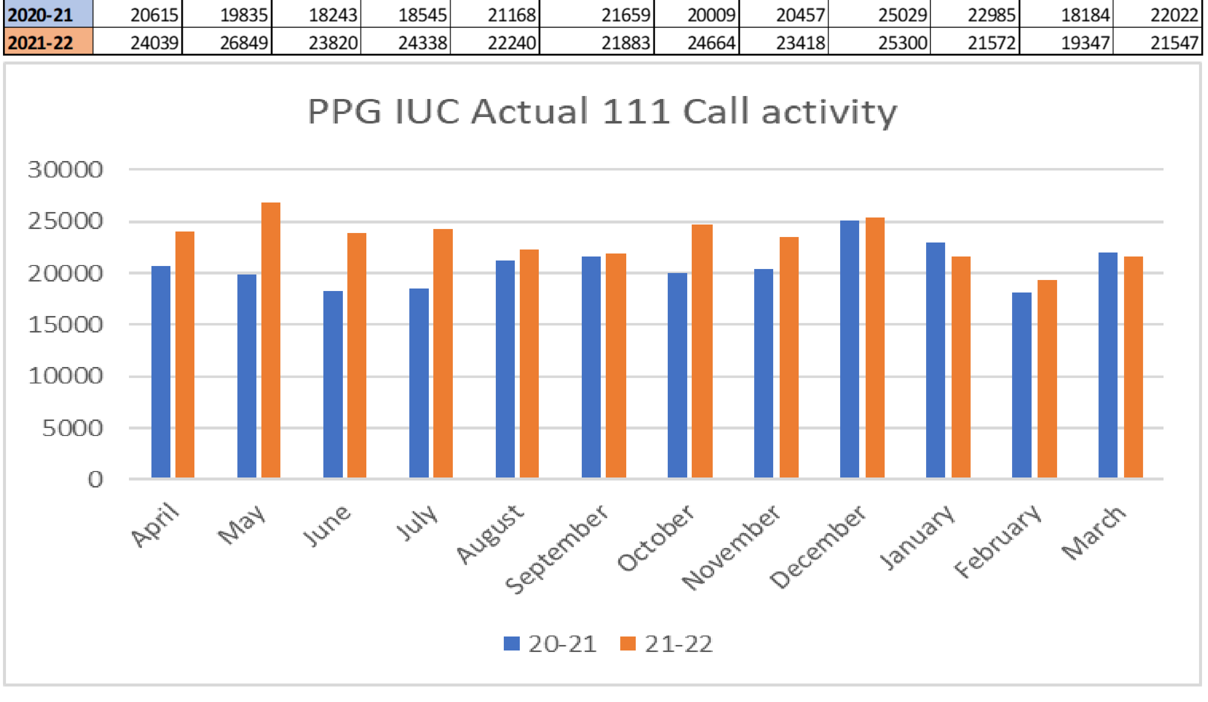
e.g. call answering and call abandonment, with central non-recurrent Service Development Funding being made available in year to support recovery in these areas and supplement staff recruitment and retention.

5.6 **NHS 111 winter preparedness**: in order to mitigate against the performance and operational issues, an action plan has been drawn up which aims to address the wider issues such as workforce and recruitment; with work continuing in relation to strengthening existing capacity across Health Advisor / Clinical advisors / Clinical Assessment Service staffing; along with plans put in place to mitigate against any forecasted shortfall. The operational ability to create daily flex to meet demand is being developed.

5.7 It is anticipated that this will positively impact on a wide range of KPIs which are built around response times, clinical assessment and validation and ability to call priority category patients back in a timely way.

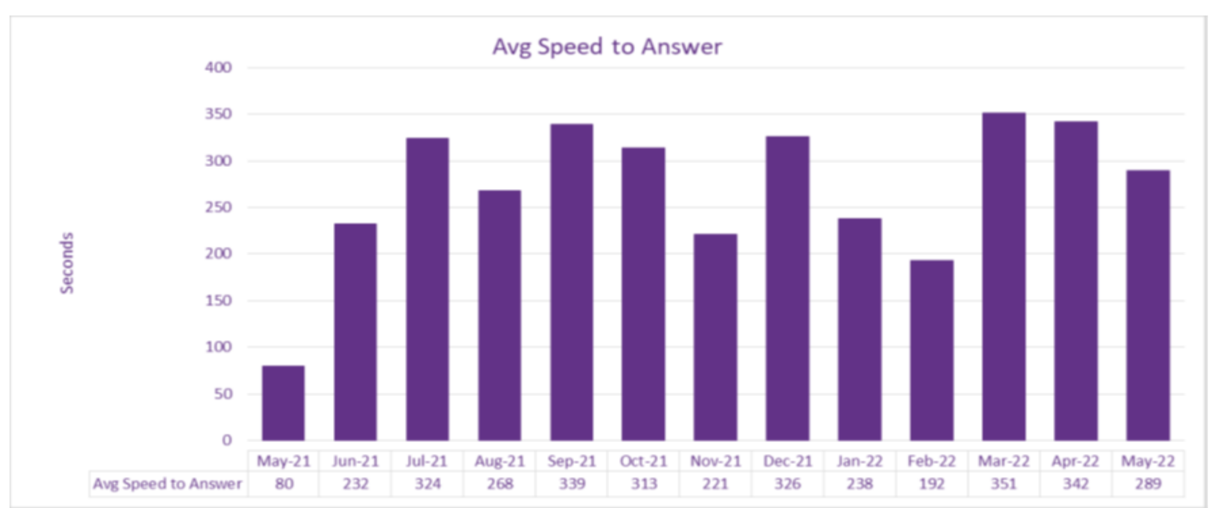
5.8 As the graph on the next page describes, activity has moved to a similar position for 2022 to 2021.

	April	May	June	July	August	September	October	Novembe	December	January	February	March
2020-21	20615	19835	18243	18545	21168	21659	20009	20457	25029	22985	18184	22022
2021-22	24039	26849	23820	24338	22240	21883	24664	23418	25300	21572	19347	21547

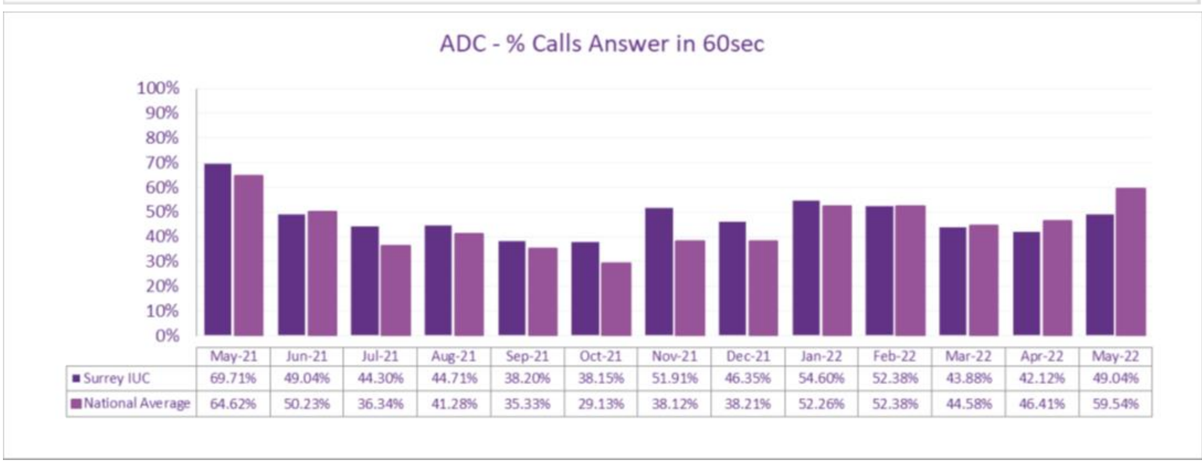


5.9 The NHS 111 service was previously required to answer 95% of calls within 60 seconds, as the information below shows, this Key Performance Indicator (KPI) is still reported but this has moved to the new KPI of Average Speed to Answer <= 20 seconds from 1st April 2022.

5.10 In terms of the KPI, the impact of higher demand and challenge to recruitment and retention are negatively impacting on their ability to achieve the required standards. As mentioned in the above paragraph, commissioners are working alongside PPG to track and monitor progress against RAP milestones and outcomes.



	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22
Avg Speed to Answer	80	232	324	268	339	313	221	326	238	192	351	342	289



	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22
Surrey IUC	69.71%	49.04%	44.30%	44.71%	38.20%	38.15%	51.91%	46.35%	54.60%	52.38%	43.88%	42.12%	49.04%
National Average	64.62%	50.23%	36.34%	41.28%	35.33%	29.13%	38.12%	38.21%	52.26%	52.38%	44.58%	46.41%	59.54%

5.11 As per the Integrated Urgent Care Commissioning Framework 2021, NHS England requires that NHS 111 call handling is delivered on a regional footprint

through the networking of services (Regional Call Networking (RCN)). In order to fully realise the efficiency gains associated with moving to a regional NHS 111 networked model, the intention is to have one single system across the country, partitioned into each area, known as the Single Virtual Contact Centre (SVCC).

5.12 For Surrey Heartlands, calls received through the SVCC platform will be considered as Southeast regional calls that can be assessed equally across any of the Providers that sit within the geography. Regional performance metrics have been introduced to focus on the proportion of calls abandoned (≤3%) and the average speed to answer calls (<20 seconds).

5.13 A single Coordinating / Lead ICS for NHS 111 in the Southeast has been agreed upon. NHS Surrey Heartlands has accepted this responsibility for the region and on behalf of Hampshire & Isle of Wight, Kent, Sussex, Frimley and Buckinghamshire, Oxfordshire and Berkshire West, supported by a collaborative, coordinating commissioning arrangement with all ICS and regional teams.

5.14 The ambition of the RCN & SVCC models is to better manage NHS 111 call handling, to prevent long call waits and aborted calls which has the unintended potential consequence of a patient self-presenting to an Emergency Department or calling 999. The aim is to ensure that patients across the region receive equity of service and receive the most appropriate care for their needs as close to home as possible.

5.15 The southeast region SVCC is planned to go 'live' in September 2022, this will follow an emulation exercise, a process of assurance against readiness and an evaluation against clinical call safety.

6. Community Services Transformation

6.1 As a system, work is underway to transform the services outside of hospital and across our communities in response to the continuous increase in demand; during the past few months Surrey Heartlands ICS have initiated an ambitious programme that aims to bring together different parts of the system to develop

a joint and co-ordinated approach to strengthen community provision. Our five focus areas include:

- Urgent community response
- Core community services
- Integrated community-based services
- Care homes and domiciliary care
- Prevention and independent living

6.2 Surrey Heartlands is using population health data to build the services around the identified needs of those who are most at risk due to complex or unstable health and social care status, whilst building the infrastructures to eliminate unheralded demand across the system. This will ensure people are empowered and supported in the management of their health needs. Unheralded attendances are where patients self-present at hospital and, in some cases, their needs would be better met by other services.

6.3 The transformation programme to build the infrastructure will bring together the 'sum of the parts' to offer coordinated and comprehensive urgent care. The ambition is to demonstrate incremental reductions in unheralded attendance, reduction in ambulance conveyance of category 3 and 4; using digital technology support assists people to expedite their recovery in their own homes. Working across neighbourhoods, the multi organisational relationships required to simplify pathways, reduce duplication and eliminate gaps have been established, which is building the capacity to deliver more care at home and improve hospital discharge.

6.4 Reimagining Intermediate Care: When a person deteriorates at home, or indeed someone at lower risk runs into difficulty, a timely and comprehensive response is required to ensure the person can remain safely at home. Surrey Heartlands have set out a model of intermediate care that encompasses a clear, simple access point with specific redirection pathways for NHS111, 999 and hospital ED Departments and that can mobilise the full range of health, wellbeing and care interventions necessary to keep someone safe and supported at home.

6.5 The Urgent Community Response (UCR) service development aims to support people to manage changes in their health and social care needs, within their home environment. This reduces conveyance to and admission from ED,

reducing use of hospital bed capacity. The Surrey Heartlands' Urgent Community Response (UCR) service which is committed to maintaining geographical coverage and delivering 2-hour response services from 8am-8pm every day. **Winter preparedness:** in supporting the system to deliver Urgent Care out of the acute environment; key workstreams are focusing on streamlining ambulance referrals into UCR, aligning the service provision with NHS 111 pathways and responding to people who experience a fall in a community setting and do not require Acute intervention.

6.6 Virtual Wards support patients, who would otherwise be in hospital, to receive the acute care, remote monitoring and treatment they need in their own home or usual place of residence. Surrey Heartlands is mobilising 172 'beds' by the end of December 2022, increasing towards a national ambition of 40–50 virtual beds per 100,000 population by March 2024. **Winter preparedness:** the deployment of these wards is increasing ahead of winter and pathways into the vitual wards are being simplified and communicated across partners organisations. Access to the vitual wards will be via UCR in the community and part of the step-down provision available following an acute admission. This care will be delivered by a multi disciplinary team who will identify the personalised health and care needs of each individual to provide wrap around services, with monitoring in place for a period of seven to ten days.

7. Streaming and Redirection

7.1 Surrey Heartlands ambition to reduce wait times across Urgent and Emergency Care services is supported by providing a streaming and re-direction service; this means that people attending the EDs will be supported by a healthcare professional in answering questions in relation to their health and from the information given, the patients will be 'streamed' to the right service within the hospital or re-directed to more appropriate primary and community services; the primary aim of this service is to take pressure away from the emergency departments and reduce wait times for our patients.

7.2 Data collected through mobilising the NHS Digital streaming and redirection tool at the front door of the Acute Hospitals in July 2021, showed us that activity levels have returned to pre COVID levels and suggested that up to 70.8% of people who continue to attend the Surrey Heartlands EDs could be seen elsewhere e.g. within an Urgent Treatment Centre or Minor Injuries Unit.

Therefore the 2022/23 priorities seek to build on this by introducing digital integrated capability at the front door to support streaming and redirection, with greater focus on optimising alternative services and ensuring that wherever people access healthcare that they receive the same offer across Urgent Care Services.

7.3 A streaming and redirection tool has been implemented across Surrey Heartlands at the front door of the ED's. The overarching project objective is to implement a strategic Surrey Heartlands UEC scheduling service for booked and unheralded activity to significantly reduce the administrative burden on clerical staff and provide clinical teams with the ability to either stream (onsite) and redirection (off site) to the most appropriate service for the patient's needs.

- **Phase 1:** Replacing the scheduling service used to provide Urgent & Emergency (UEC) direct appointment booking and implement a booking schedule where direct booking is not currently possible due to care connect compatibility. This phase has been implemented in three of the four acutes, with project plans for ASPH to go live mid-September.

- **Phase 2:** Integrate the new booking system of the NHS111 Provider scheduler into Trust UEC systems to eliminate administrative overhead and risk of transcribing patient details and referral documentation. This phase has been slightly delayed due to the Surrey Safe Care Project (please see section 3) in three of the four hospitals, with Epsom Hospital planned for for mid-September.

- **Phase 3:** "Any to Many" scheduling to support integration with the ED Streaming Service, internal referrals, onward referrals, to book appointments into multiple UEC schedules, including Urgent Treatment Centres, Same Day Emergency Care, Minor Injuries Unit, Walk in Centre, Community Pharmacy Consultation Service, Primary Care, and integration with Surrey Care Records. The streaming and redirection internal referral in Epsom General Hospital will go live in September, closely followed by the Royal Surrey Hospital. Referral to the Community Pharmacy Consultation Service (CPCS) will be available at both Epsom and Royal Surrey Hospitals by the end of September. SASH 'Go Live' for internal redirection will be mid-September, again followed closely by

the CPCS redirection. Streaming & Redirection internal referral at ASPH is aimed for mid-October. Integration with Surrey Care Record into the acutes EPR systems is aimed for mid-September.

8. '999' Ambulance Response

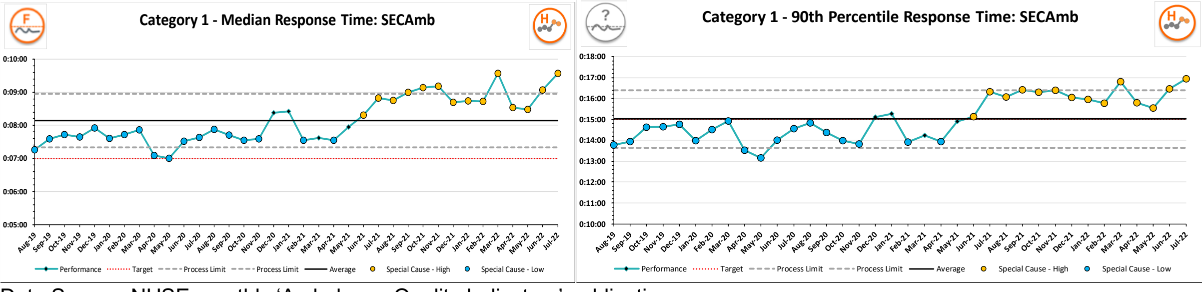
8.1 From 2017, Ambulance Trusts around the country have been using the following response time measures into their reporting, the main purpose of these standards is to ensure that the sickest patients get the fastest response and that all patients get the right response, first time. Response times (how quickly a response reaches the patient) are measured from the time the 999 call is connected to the Emergency Operation Centres. These targets are set nationally and apply to all ambulance services in England and Wales.

There are 4 levels of response:

Category	Response	Average response time
Category 1	For calls to people with immediately life-threatening and time critical injuries and illnesses.	These will be responded to in a mean average time of seven minutes and at least 9 out of 10 times before 15 minutes (the 90th percentile).
Category 2	For emergency calls. Stroke patients will fall into this category and will get to hospital or a specialist stroke unit quicker because we can send the most appropriate vehicle first time.	These will be responded to in a mean average time of 18 minutes and at least 9 out of 10 times before 40 minutes (the 90th percentile).
Category 3	For urgent calls. In some instances, patients in this category may be treated by ambulance staff in their own home. These types of calls will be responded to at least 9 out of 10 times before 120 minutes.	These types of calls will be responded to at least 9 out of 10 times before 120 minutes (the 90th percentile).

Category 4	For less urgent calls. In some instances, patients may be given advice over the telephone or referred to another service such as a GP or pharmacist.	These less urgent calls will be responded to at least 9 out of 10 times before 180 minutes (the 90th percentile).

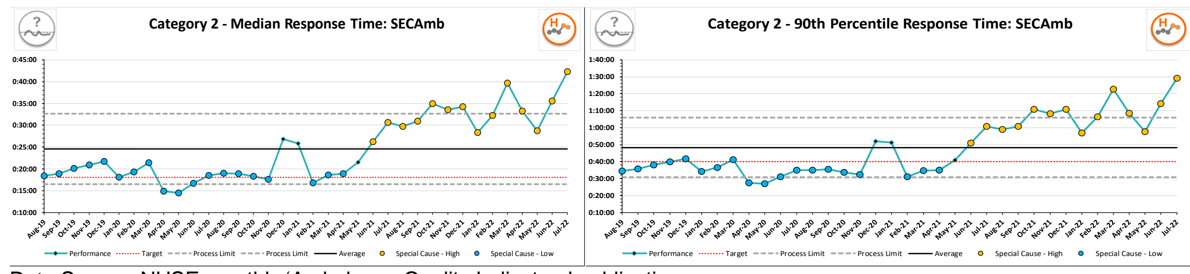
8.2 Performance against the required standards: SECAmb are commissioned to provide '999' services across Kent, Surrey, Sussex; along with the Surrey Heath, Northeast Hants and Farnham element of Frimley ICB. The graphs below outline performance from December 2019 to June 2020. The use of the 90% percentile target system is to assist in measuring performance across all ambulance trusts. Please note that the combined figures below cover all three counties.



Data Source: NHSE monthly 'Ambulance Quality Indicators' publications.

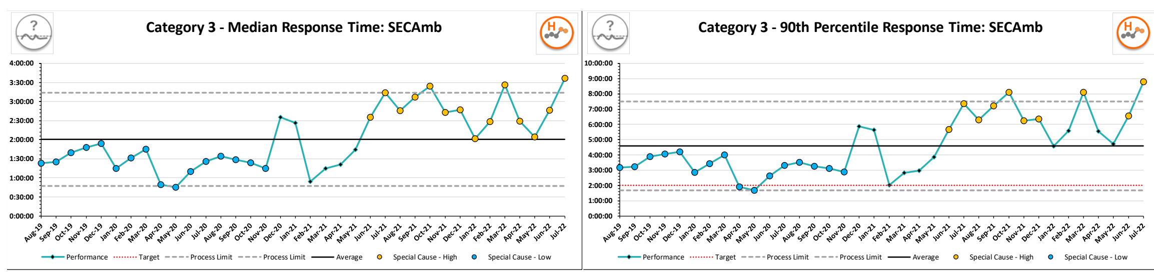
8.3 The graphs above show that when taking an average response time – between August 2019 to July 2022 the ambulance service did not meet the 7 - minute target; more recently the response time is between 8 and 10 minutes from June 2021. When considered on the 90% percentile – Cat 1 response times have been above the required target since June 2021.

8.4 The graphs below describe the Cat 2 response times; the target (as an average) of being on scene within 18 minutes was not being met from August 2019 to April 2020 when response times generally improved until April 2021. Since then, wait times have increased due to high demand and reduced staffing levels as a result of Covid and vacancies. When considering the 90% percentile; the ambulance service has largely met the target of response within a maximum of 40 minutes until June 2021.

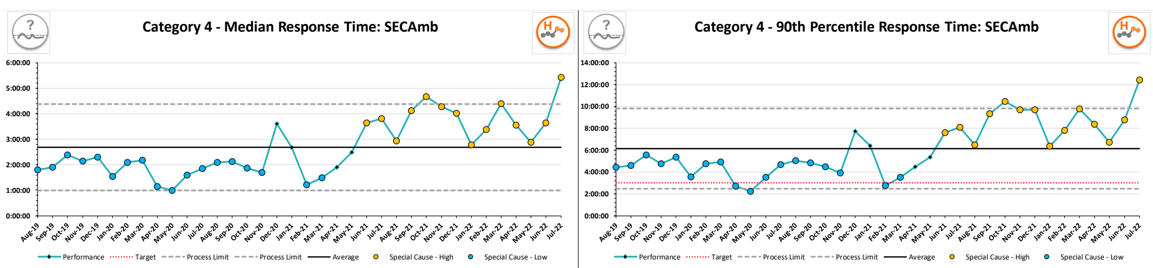


Data Source: NHSE monthly 'Ambulance Quality Indicators' publications.

8.5 Category 3 requires a response in 120 minutes, the graphs below show a similar picture to above as ambulances are diverted to the most vulnerable with life-threatening and time critical conditions. The Category 4 response time target is 180 minutes – as depicted in the graphs below, the ambulance service has experienced difficulty in meeting these targets during the period from June 2021 to July 2022.



Data Source: NHSE monthly 'Ambulance Quality Indicators' publications.



Data Source: NHSE monthly 'Ambulance Quality Indicators' publications.

8.6 SECAmb have put in place a comprehensive Improvement Plan following recent CQC inspections. This plan not only responds to the requirements of CQC, but also outlines the fundamental 4 key priority areas which will drive transformation across the organisation and deliver ongoing performance improvement. SECAmb and ICB partners are collaboratively working together through structured governance, to focus on reducing demand, improving access to alternative care provision and strenghtening the interfacing

dependancies across other services within the SECAmb footprint e.g. Mental Health.

8.7 Reducing demand: SECAmb have enhanced the Trusts ability to undertake predictive modelling and forecasting in order to implement the necessary profiling and skill mix to meet the response time standards. 2022/23 targets have been developed to demonstrate a reduction in demand for on-scene attendance by increasing the number of people supported through 'Hear and Treat'. This will have a direct impact on Category 3 and Category 4 activity, freeing up resource to respond to the higher acuity time critical patient calls.

8.8 SECAmb will look to continue to build upon Emergency Medical Advisor (EMA) resourcing which has demonstrated improvements in recruitment and training, which are now coming to fruition. New staff are undergoing mentoring, with shifts scheduled at times where EMA resourcing is particularly challenged. NHS 111- ambulance validation and referral rates are consistently strong, minimising dispatch to incidents where appropriate.

8.9 Efficiency & Utilisation: Focus has been placed on both virtual operational response and physical operational response; the intention is to stabilise available resource capacity on a 24/7 period basis, ensuring safe staffing levels and operational capability to respond to demand changes.

8.10 Increasing Capacity: SECAmb have a comprehensive workforce transformation plan in place which focusses on:

- shared visibility of the workforce plan, safe staffing levels, demand changes and forward trajectories
- wellbeing and welfare initiatives to provide staff support and sickness absence management
- retention to focus on why people leave, succession planning and career progression
- organisational development planning for current and future years
- wider system demand on paramedic workforce
- to support delivery at pace.

8.11 For field operations, SECAmb will prioritise recruitment of staff and will recruit critical care paramedics to establishment. In addition, the Trust has committed to continue with the increased Private Ambulance Provision secured over the 2021/22 winter period and has planned to achieve an overtime rate of 7.6% over the year, inclusive of bank staff. SECAmb will focus on delivery of Key Skills training to catch up from 2 years of freeze during the pandemic. Coupled with SECAmb's Clinical Education Strategy, which will build on the work commenced in 2019 to provide the very highest level of education and training to current and future SECAmb staff, this approach will bolster available operational resources with a view to creating further capacity required to respond to Category 1 and Category 2 patient calls.

8.12 Nationally, ambulance trusts and their staff continue to remain under severe pressure, with the majority of Ambulance Trusts operating at their highest level described as REAP (Resource Escalation Action Plan) Level 4.

8.13 The findings of the CQC inspection undertaken in February 2022, which considered in particular management and leadership, as well as the Emergency Operations Centres (EOCs) and NHS 111 service, has now been published. The Trust received an overall rating on well-led as 'inadequate' with recommendations made that SECAmb is placed in the Recovery Support Programme. During the inspection CQC identified a requirement for further checks, which have been on-going throughout August and the Trusts overall rating suspended until these are completed. The initial report outlines a series of 'Must' and 'Should' actions which have been compiled into an action plan and with oversight of this across various system fourms, including regional Recovery Support Programme.

8.14 There are a number of programmes on-going:

- Incident and harm governance improvement plan: Serious Incidents - initial process mapping completed, future state in development with engagement from Quality Leads within the ICB and other systems to aid development.

- Patient Experience Group: Restarted and chaired by the Executive for Quality & Nursing. Attendance and engagement from external partners.

- Medicines Management Deep-Dive: From the 7 actions produced by the medicines deep dive, there has been development of a business case to support one of these actions. Further work expected to underpin all outputs from this deep dive.

- Quality Dashboard: Work being undertaken to structure which metrics are applicable to quality dashboard in line with the improvement journey.

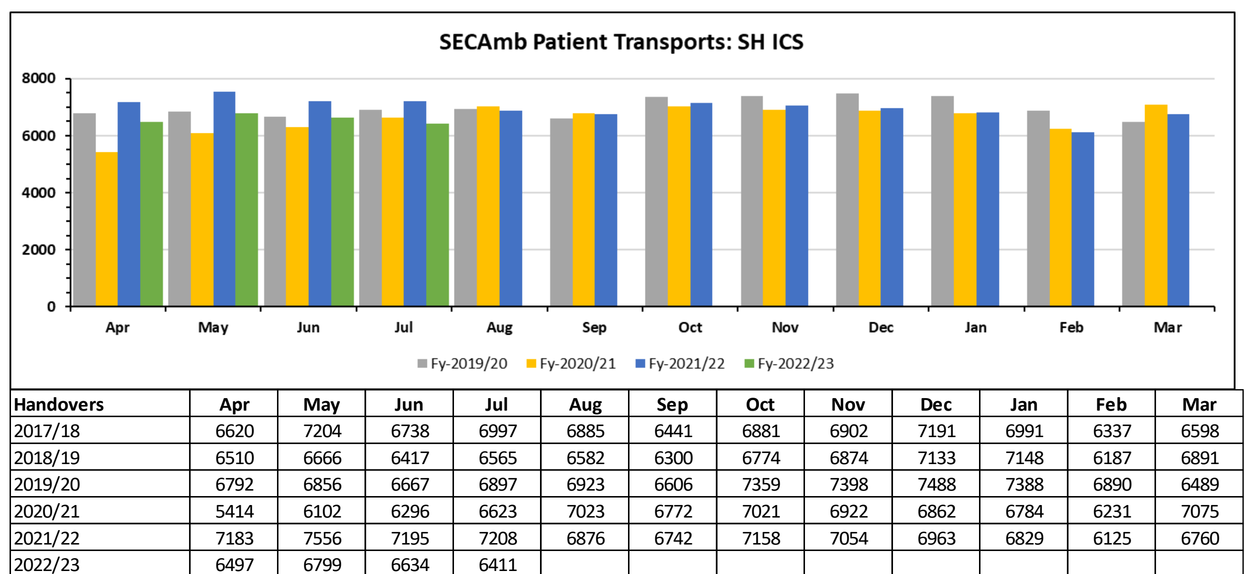
- Quality Governance: New Quality Governance Group launched in July 2022. New Clinical Senate Group in development – that will report to Executive Management Board.

8.15 In addition, an important campaign – 'Until it Stops' – is being rolled out to address inappropriate behaviours and culture in order to implement long lasting changes across the organisation.

9. Ambulance Conveyances

9.1 Throughout 2021/22, ambulance conveyances were fairly static when compared to 2019/20, however wider attendance numbers (please see below) are now higher than pre-pandemic norms; highly congested ED's have a direct impact on the department's ability to complete ambulance handovers in a timely fashion, this may be due to staff available and actual physical cubicle or trolley space. This has led to an increase in over 60-minute handovers.

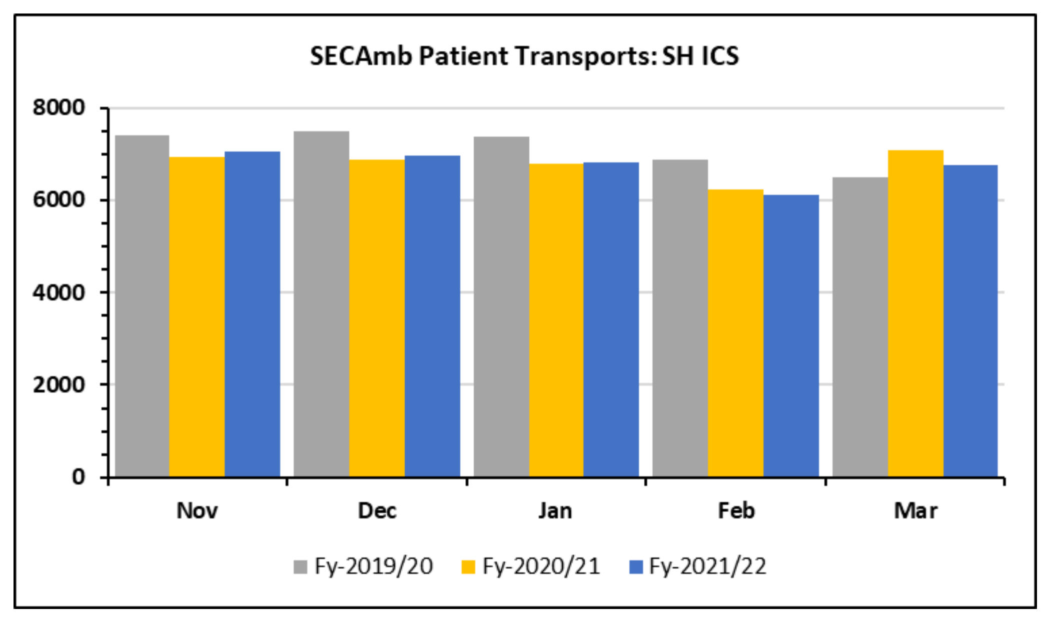
9.2 In respect of Ambulances attendances to ED, the graph below compares 2019/20, 2020/21, 2021/22 to July 2022.



Handovers	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2017/18	6620	7204	6738	6997	6885	6441	6881	6902	7191	6991	6337	6598
2018/19	6510	6666	6417	6565	6582	6300	6774	6874	7133	7148	6187	6891
2019/20	6792	6856	6667	6897	6923	6606	7359	7398	7488	7388	6890	6489
2020/21	5414	6102	6296	6623	7023	6772	7021	6922	6862	6784	6231	7075
2021/22	7183	7556	7195	7208	6876	6742	7158	7054	6963	6829	6125	6760
2022/23	6497	6799	6634	6411								

Data Source: SCW CSU SECAmb 999 Activity and Performance Reports
Data Source: SECAmb Contract Monitoring Reports

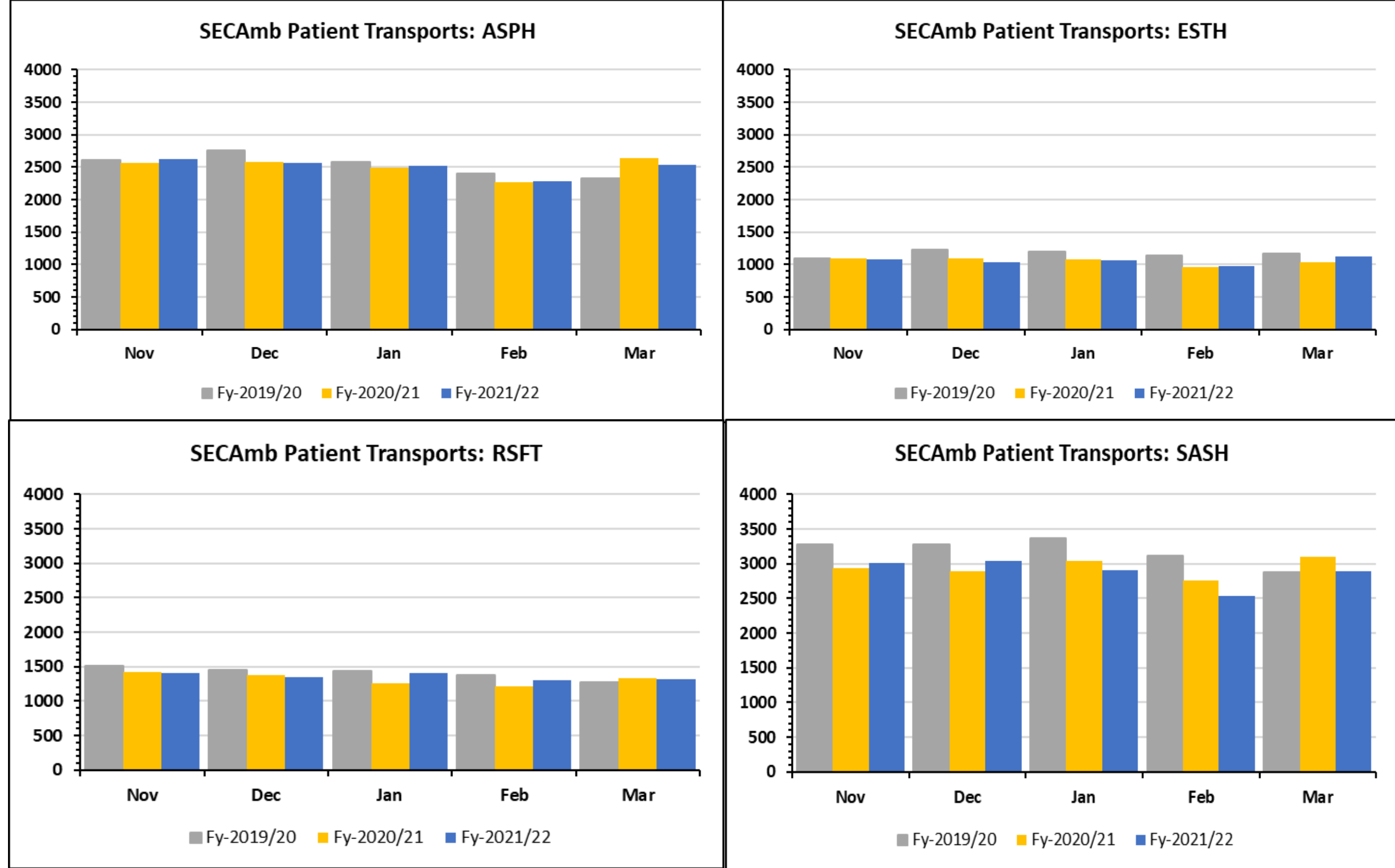
9.3 When focusing on the winter months, the overall attendance figures (all types) have decreased by 5.4% when 2021/22 is compared to 2019/20. Whilst the combined figures show a decrease in ambulance attendances; there was an increase of 4.2% increase in March 2022.



Handovers	Nov	Dec	Jan	Feb	Mar	Winter
2017/18	6902	7191	6991	6337	6598	**34019**
2018/19	6874	7133	7148	6187	6891	**34233**
2019/20	**7398**	**7488**	**7388**	**6890**	**6489**	**35653**
2020/21	6922	6862	6784	6231	7075	**33874**
2021/22	**7054**	**6963**	**6829**	**6125**	**6760**	**33731**
% Var	**-4.6%**	**-7.0%**	**-7.6%**	**-11.1%**	**+4.2%**	**-5.4%**

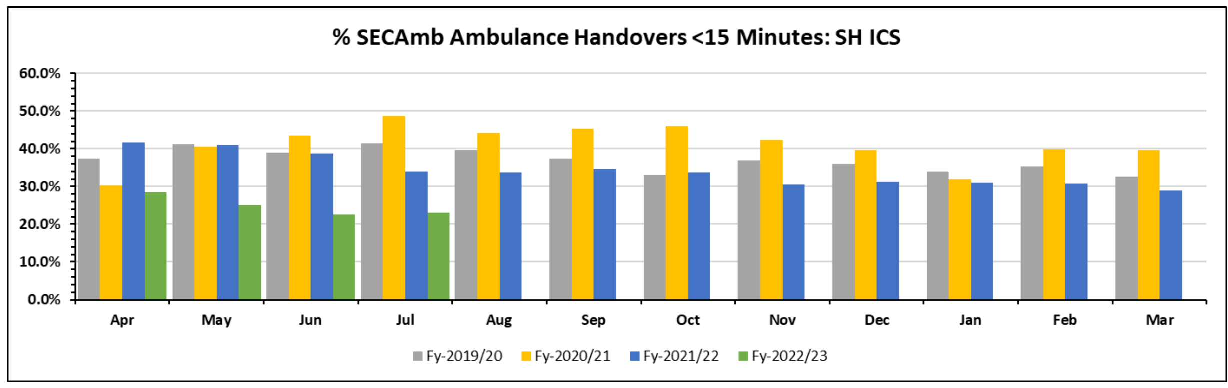
NB: % Variance is 2021/22 vs 2019/20.

9.4 The following graphs provide a Place based breakdown of the above information for each of the acute hospitals.



10. Ambulance Handovers

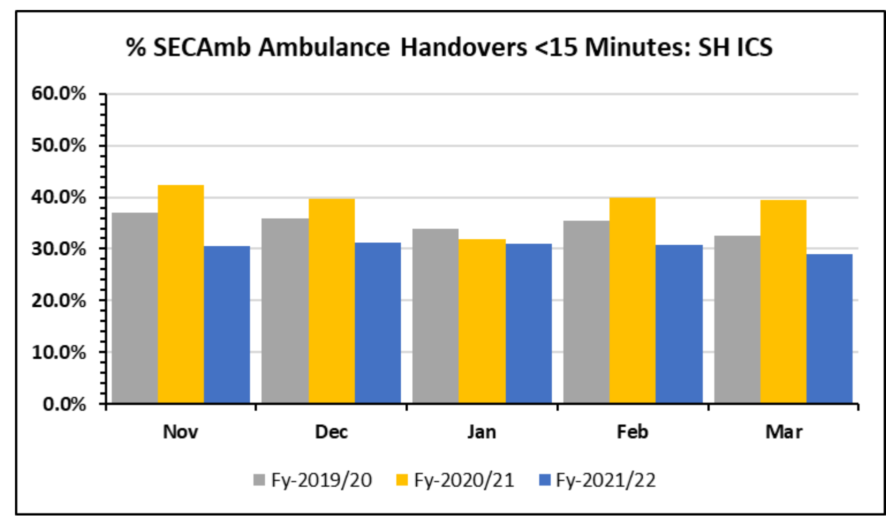
10.1 Whilst both the ambulance service and all the Acute hospitals continue to strive to increase numbers of handovers within 15-minutes (please see the graph below); with a proportion of these handovers just missing the 15-minute target by being recorded at 16 or 17 minutes; the more recent general picture is that the numbers of handovers taking place under 15-minute is now reducing; whilst the 30-minute and 60-minute handover times have increased; this is again due to overall demand and issues with wider system flow e.g. facilitating timely discharges.



% <15 Minutes	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2017/18	33.2%	28.9%	26.7%	26.3%	24.2%	32.3%	28.8%	25.3%	20.7%	20.7%	18.6%	25.2%
2018/19	35.6%	43.4%	40.0%	38.4%	47.4%	47.9%	46.6%	44.8%	35.6%	29.9%	35.2%	41.2%
2019/20	37.4%	41.2%	39.0%	41.4%	39.7%	37.3%	33.1%	37.0%	36.0%	34.0%	35.4%	32.5%
2020/21	30.4%	40.4%	43.6%	48.8%	44.2%	45.3%	45.9%	42.3%	39.7%	31.9%	39.8%	39.5%
2021/22	41.7%	41.0%	38.8%	33.9%	33.8%	34.5%	33.7%	30.5%	31.2%	31.0%	30.8%	28.9%
2022/23	28.6%	25.0%	22.7%	23.0%								

Data Source: SCW CSU SECAmb 999 Activity and Performance Reports
Data Source: SECAmb Contract Monitoring Reports

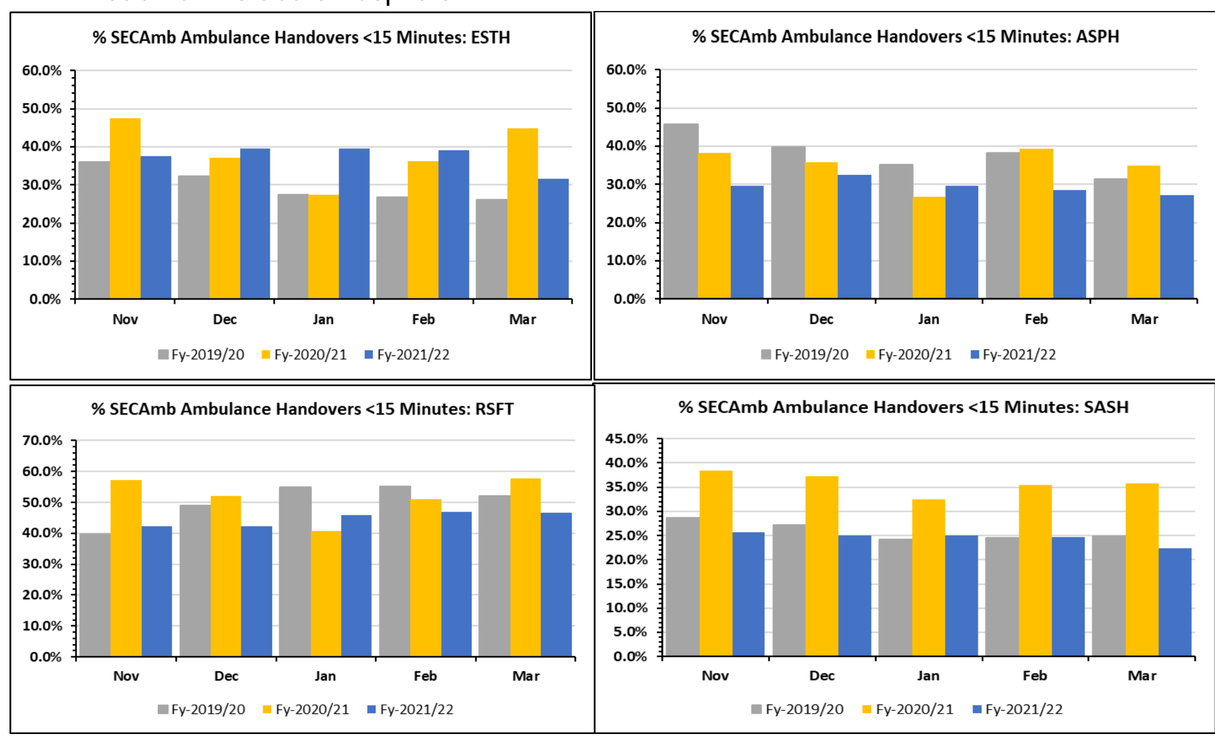
10.2 The figures below describe ambulance handovers achieved within 15 minutes of arrival to the Emergency Department during the winter months between November 2021 to March 2022 for the ICS as a whole and for each of the acute hospitals across Surrey Heartlands.



10.3 When comparing the data between 2-19/20 and 2021/22 winter period there is a -4.6% reduction in the number of hamdovers completed with 15 minutes (please refer to the table below).

% <15 Minutes	Nov	Dec	Jan	Feb	Mar	Winter
2017/18	25.3%	20.7%	20.7%	18.6%	25.2%	**22.1%**
2018/19	44.8%	35.6%	29.9%	35.2%	41.2%	**37.3%**
2019/20	37.0%	36.0%	34.0%	35.4%	32.5%	**35.0%**
2020/21	42.3%	39.7%	31.9%	39.8%	39.5%	**38.7%**
2021/22	30.5%	31.2%	31.0%	30.8%	28.9%	**30.5%**
21/22 vs 19/20	**-6.5%**	**-4.8%**	**-3.0%**	**-4.6%**	**-3.6%**	**-4.6%**

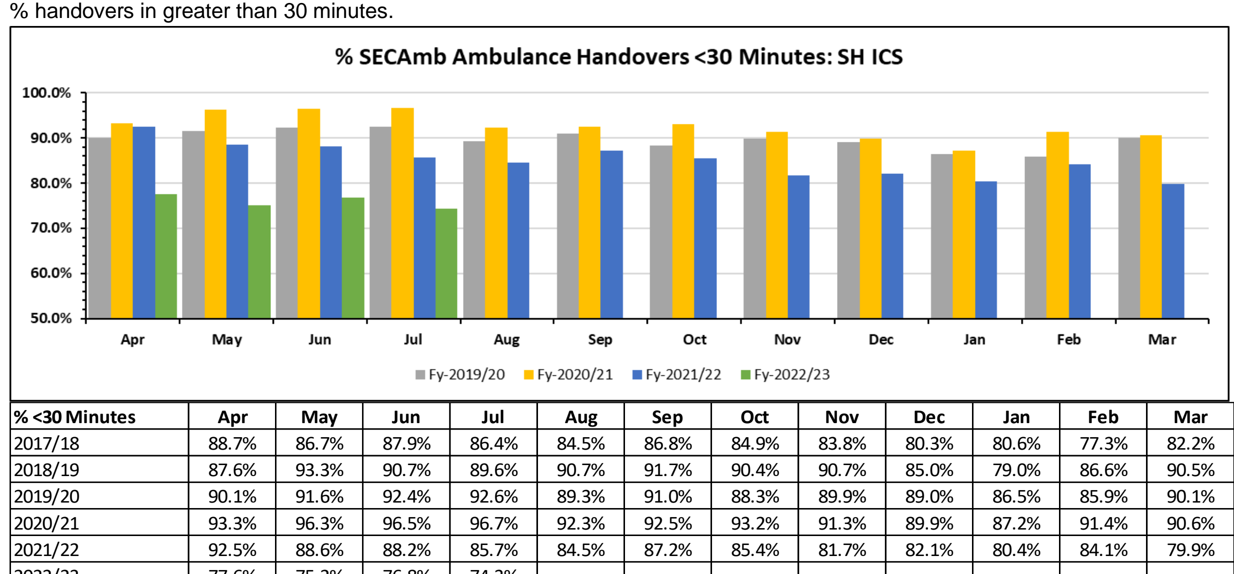
10.4 The following graphs provide a Place based breakdown of the above information for each of the acute hospitals.



10.5 The graphs below describes Ambulance handovers from April 2019 to July 2022; as numbers of handovers within 15 minutes have decreased; the corresponding number of over 15 and over 60-minute handovers have increased, particularly since April 2022; again this is due to increased pressures within the system, with the April 2022 to July 2022 figures being greater than the previous 5 years for the same period. Each hospitals figures are different, this is due to a number of reasons, for example, the size of the Emergency Department, the number of ambulances arriving each day and at

certain times of day, the availability of ward beds to receive admissions from the ED and levels of staffing.

% handovers in greater than 30 minutes.

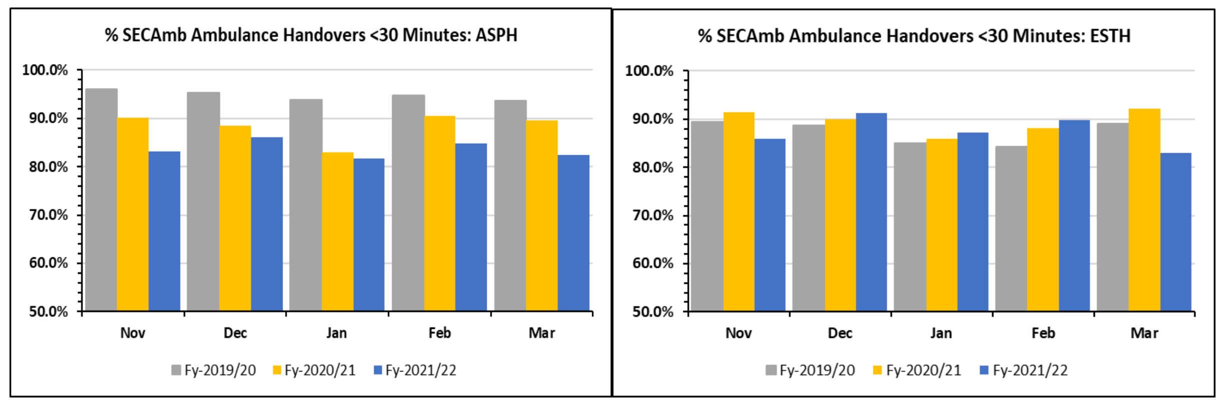


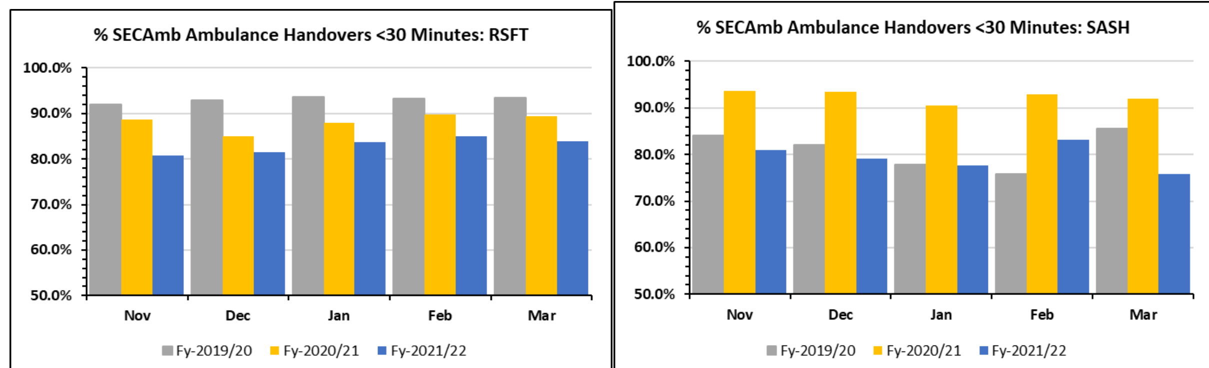
% <30 Minutes	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2017/18	88.7%	86.7%	87.9%	86.4%	84.5%	86.8%	84.9%	83.8%	80.3%	80.6%	77.3%	82.2%
2018/19	87.6%	93.3%	90.7%	89.6%	90.7%	91.7%	90.4%	90.7%	85.0%	79.0%	86.6%	90.5%
2019/20	90.1%	91.6%	92.4%	92.6%	89.3%	91.0%	88.3%	89.9%	89.0%	86.5%	85.9%	90.1%
2020/21	93.3%	96.3%	96.5%	96.7%	92.3%	92.5%	93.2%	91.3%	89.9%	87.2%	91.4%	90.6%
2021/22	92.5%	88.6%	88.2%	85.7%	84.5%	87.2%	85.4%	81.7%	82.1%	80.4%	84.1%	79.9%
2022/23	77.6%	75.2%	76.8%	74.3%								

Data Source: SCW CSU SECAmb 999 Activity and Performance Reports

Data Source: SECAmb Contract Monitoring Reports

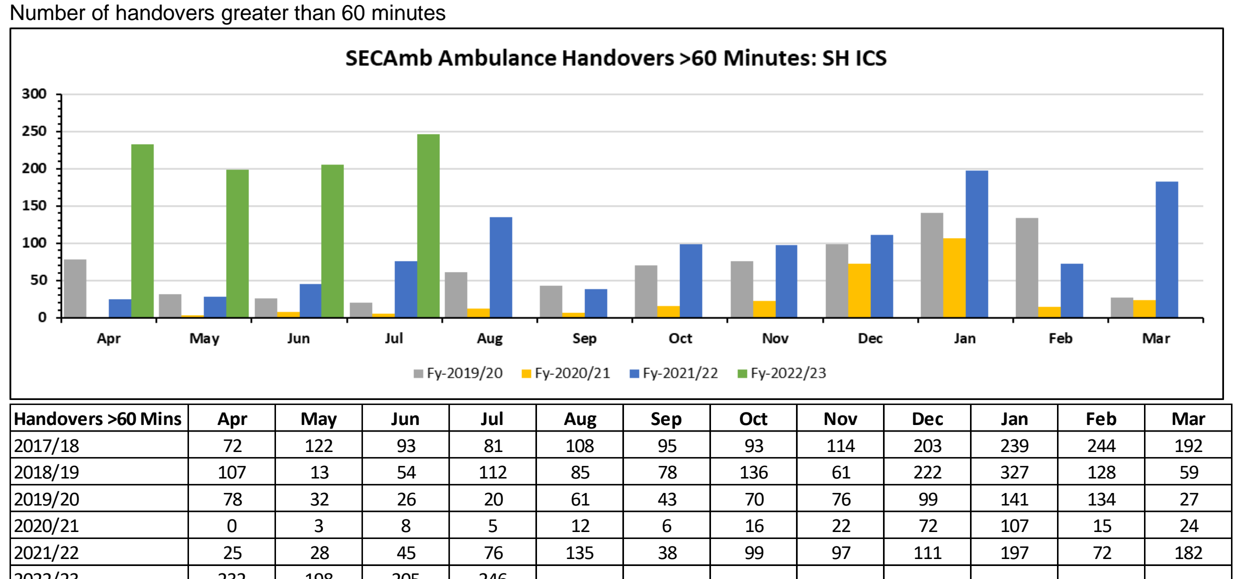
10.6 The following graphs provide a Place based breakdown of over 30 minutes handovers for the winter period (from November to March) for each of the acute hospitals.





10.7 The graphs below describe the over 60-minute Ambulance handovers from April 2019 to July 2022.

Number of handovers greater than 60 minutes



Handovers >60 Mins	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2017/18	72	122	93	81	108	95	93	114	203	239	244	192
2018/19	107	13	54	112	85	78	136	61	222	327	128	59
2019/20	78	32	26	20	61	43	70	76	99	141	134	27
2020/21	0	3	8	5	12	6	16	22	72	107	15	24
2021/22	25	28	45	76	135	38	99	97	111	197	72	182
2022/23	232	198	205	246								

Data Source: SCW CSU SECAmb 999 Activity and Performance Reports
Data Source: SECAmb Contract Monitoring Reports

10.8 The main reasons for the delay in handovers are:-

- Staffing – lower levels of staffing due to sickness means that staff are needing to care for the patients already in the ED, whilst receiving handovers for arriving patients. Each Acute proritises staffing the ED, with additional staff sourced from the Staffing Bank and from other wards. However, covering sickness is an ongoing challenge due to wider shortages of staff.

- Ambulances arriving in 'batches', for example 4 or 5 ambulances arriving at once, again requiring ED staff to be available to support handover. SECAmb do try to provide a more evenly spaced attendance of ambulances, however due to the needs of the community, this is not always possible.

- High occupancy within each of the Acutes – lack of bed availability at the time when each patient is ready to be transferred from ED to the ward causes a build up of patients in the ED waiting for beds. A main contributor to these ED waits is the wait times being experienced by patients who no longer need to receive care within an Acute Hospital environment. Delays in discharges are due to a number of factors including availability of domiciliary care and the care home provision at the point of discharge.

10.9 Improving handover times remains an important target as timely handovers provides a real benefit to the patient and the system as patients are able to be seen by ED staff quicker, with the Ambulance crew being able to leave the hospital and respond to the next call.

10.10 The main operational actions are:-

- All acutes have ambulance handover improvement plans

- All acutes now meeting with ambulance service on regular basis to discuss and improve handover

- All acutes reviewing best practice for ambulance handover

10.11 However, improvements are being constrained by the sustained pressure on ED, which is being heavily impacted by lack of flow through and critically out of the acute hospitals.

11. Emergency Department Attendances

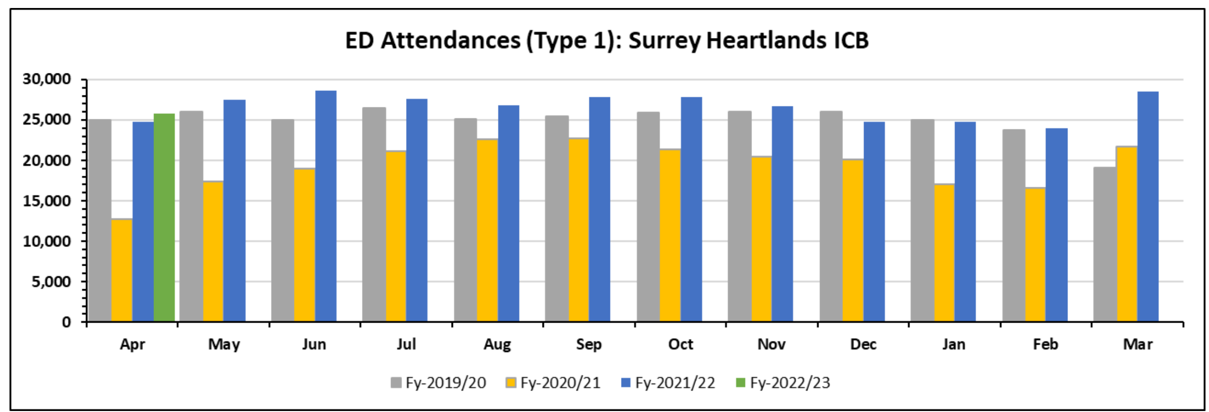
11.1 While some systems have experienced reductions in ED attendances, Surrey Heartlands continues to experience high pressure across all areas of UEC

delivery in both primary and secondary care. 2019 Model System data (pre-pandemic) showed that Surrey Heartlands ICS has the highest rate of ED attendances across all ICSs. As we continue to experience peaks in demand in relation to the pandemic and general growth in attendance, managing this activity continues to be impacted by workforce issues e.g. sickness and the need for staff to isolate, along with the required infection prevention and control measures; which in turn have constrained the capacity within the system to manage this demand.

11.2 Attendances are categorised into 'Types':

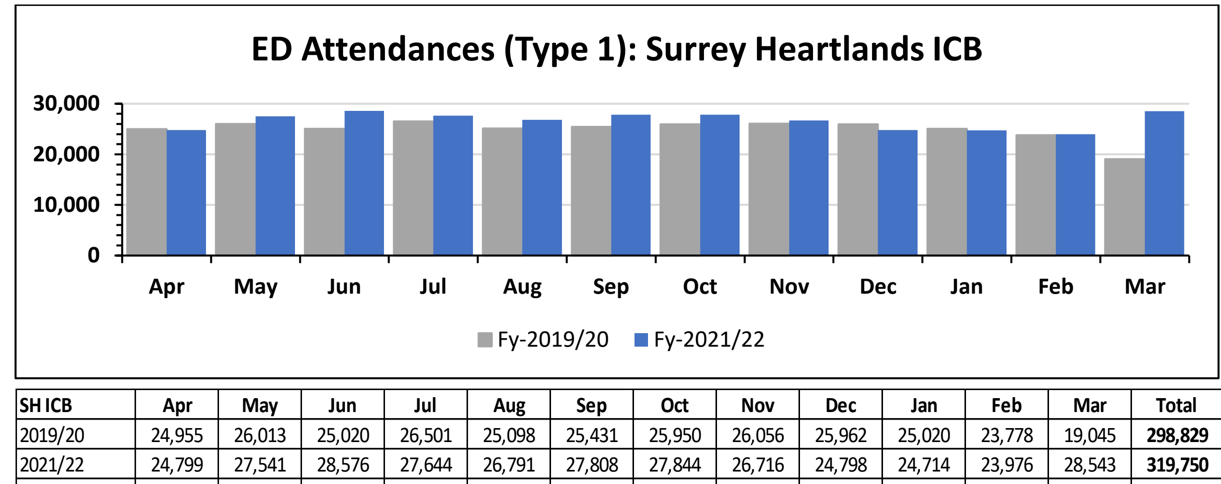
- Type 1 is attendance to an A&E department with a consultant led 24-hour service, full resuscitation facilities and designated accommodation for the reception of accident and emergency patients.
- Type 2 is attendance to an A&E department with a consultant led single specialty accident and emergency service (e.g. ophthalmology, dental) and with designated accommodation for the reception of patients.
- Type 3 and Type 4 are usually grouped together as this is attendance to an urgent treatment centres (UTC); minor injury units (MIUs) or walk-in centres (WiCs).

11.3 During the period from April 2019 to March 2020, the general trend has been one of growth in relation to attendances. The information below clearly describes how ED attendances markedly reduced in March/ April 2020 and January / February 2021 as lockdowns were introduced (marked in red in the table below).



SH ICB	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2017/18	23,067	25,207	24,029	24,650	23,228	24,042	25,252	24,592	24,733	23,362	22,245	25,501
2018/19	23,989	26,092	25,136	25,906	23,663	23,915	24,941	24,877	24,621	25,675	23,320	26,087
2019/20	24,955	26,013	25,020	26,501	25,098	25,431	25,950	26,056	25,962	25,020	23,778	19,045
2020/21	12,688	17,348	18,966	21,089	22,584	22,690	21,410	20,487	20,115	17,017	16,581	21,718
2021/22	24,799	27,541	28,576	27,644	26,791	27,808	27,844	26,716	24,798	24,714	23,976	28,543
2022/23	25,828											

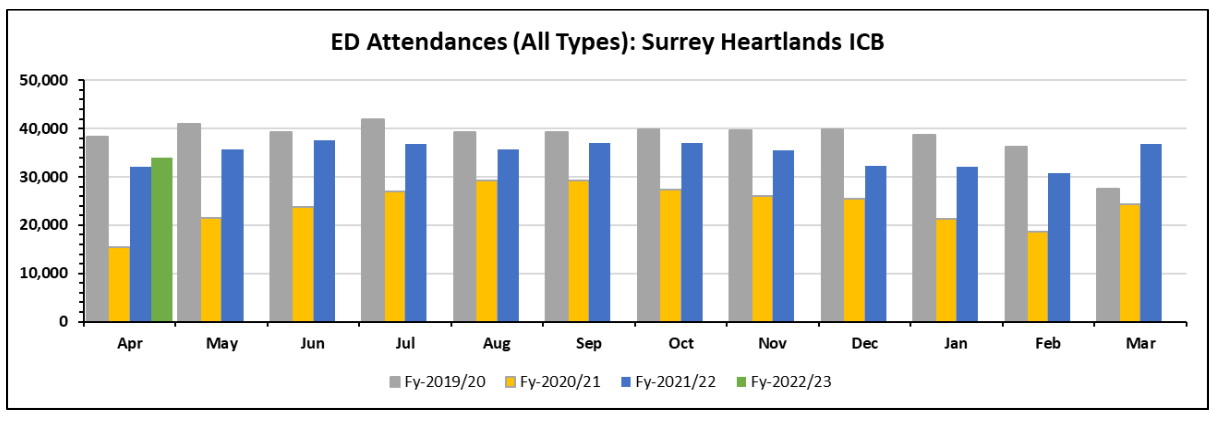
11.4 Due to the pandemic, the system experienced lower levels followed by spikes in activity; the graph below describes the changes in demand from 2019/20 (pre-pandemic) to 2021/22. The graph is complemented by the actual attendance figures which includes the percentage variation. The numbers described demonstrates a +7.0% growth when comparing 2019/20 to 2021/22; this is significantly higher than the national growth of -0.0%. The graphs above and below represent the numbers of Surrey Heartlands residents that have attended the Acutes Hospitals.



SH ICB	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total
2019/20	24,955	26,013	25,020	26,501	25,098	25,431	25,950	26,056	25,962	25,020	23,778	19,045	**298,829**
2021/22	24,799	27,541	28,576	27,644	26,791	27,808	27,844	26,716	24,798	24,714	23,976	28,543	**319,750**
Growth	**-0.6%**	**+5.9%**	**+14.2%**	**+4.3%**	**+6.7%**	**+9.3%**	**+7.3%**	**+2.5%**	**-4.5%**	**-1.2%**	**+0.8%**	**+49.9%**	**+7.0%**
Nat. Growth	**-6.9%**	**+0.1%**	**+6.1%**	**-1.6%**	**-0.7%**	**+1.7%**	**+0.9%**	**-3.9%**	**-10.9%**	**-8.3%**	**-4.8%**	**+37.6%**	**-0.0%**

Data Source: NHSE Joint Activity Report, dated 11th August 2022

11.5 The numbers of attendances have a major impact on wait times; the more congested the Emergency Department (ED) becomes, the greater the risk of 4 or even 12 hour waits. The ED attendances across Surrey Heartlands (shown above) highlights that our Emergency Departments have been under sustained pressure since April 2021; with this pressure continuing throughout the recent summer months. The graph and table below show both Type 1 and Type 3 attendances combined, again showing a period of growth when compared to 2019/20.

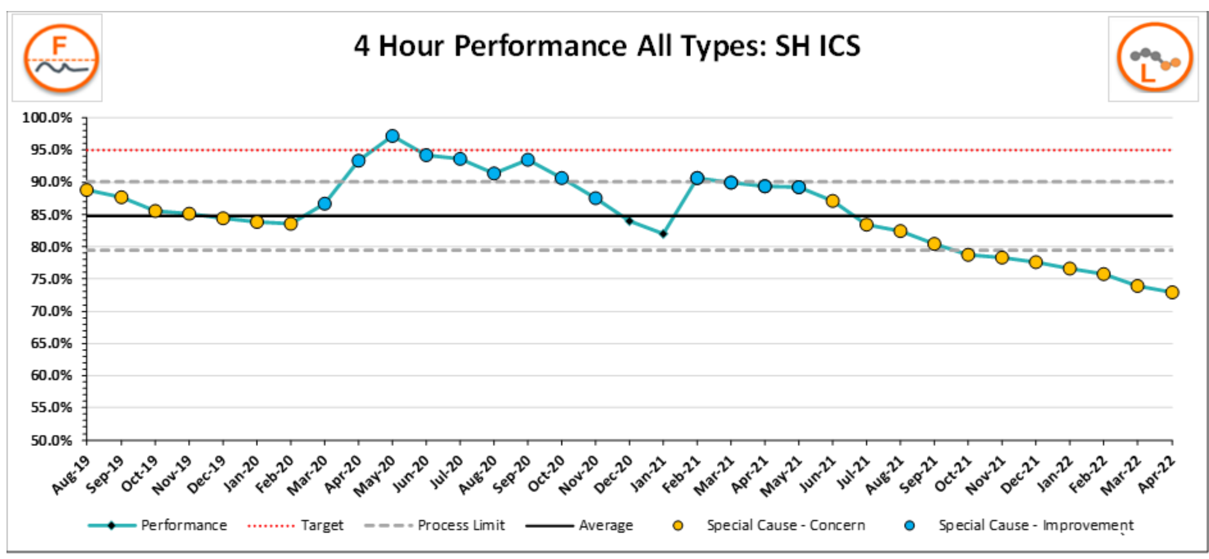


SH ICB	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2017/18	32,534	35,199	33,850	33,775	31,528	31,859	33,393	32,409	33,228	31,983	29,759	34,357
2018/19	32,361	34,857	33,621	34,638	32,445	32,255	33,331	33,091	33,099	33,566	31,835	35,197
2019/20	38,371	40,979	39,205	41,831	39,326	39,332	39,774	39,584	39,773	38,670	36,192	27,567
2020/21	15,459	21,410	23,703	26,991	29,318	29,231	27,352	26,012	25,468	21,273	18,612	24,346
2021/22	32,024	35,720	37,491	36,841	35,655	37,062	36,983	35,447	32,341	32,048	30,766	36,783
2022/23	33,908											

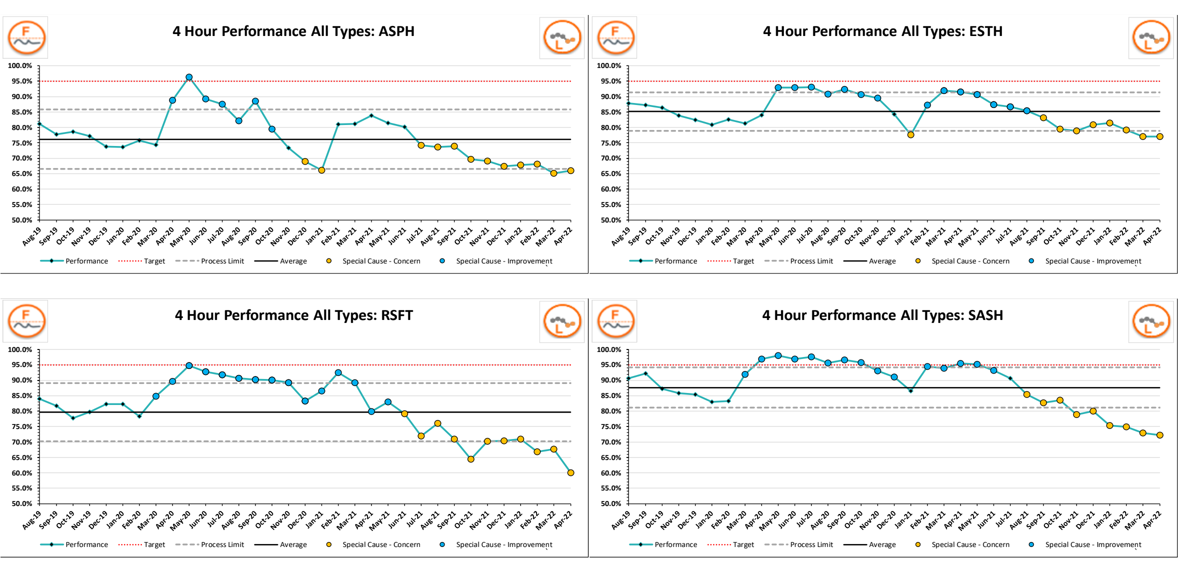
12. Performance of the 4-hour quality indicator

12.1 The following information describes the year-on-year performance from August 2019 to April 2022. Meeting of the four-hour quality care standard has, for each of the four Acute hospitals within Surrey, continued to be increasingly challenging, in line with the national picture. Since June 2021, performance has continued to deteriorate, primarily due to the increase in attendance numbers; increase in the number of people who no longer need to be cared for within an Acute hospital; staffing issues e.g. securing cover for short notice sick leave (with numbers having spiked recently due to Covid).

12.2 The graph below provides the combined Surrey Heartlands 4–hour (All Types) performance data from August 2019 to April 2022: this includes Ashford and St Peters NHS Foundation Trust (ASPH); Royal Surrey Foundation Trust (RSFT); Sussex and Surrey Hospital (SaSH) and Epsom General Hospital. The second set of graphs describe performance for the individual Acute Hospitals over the same period.



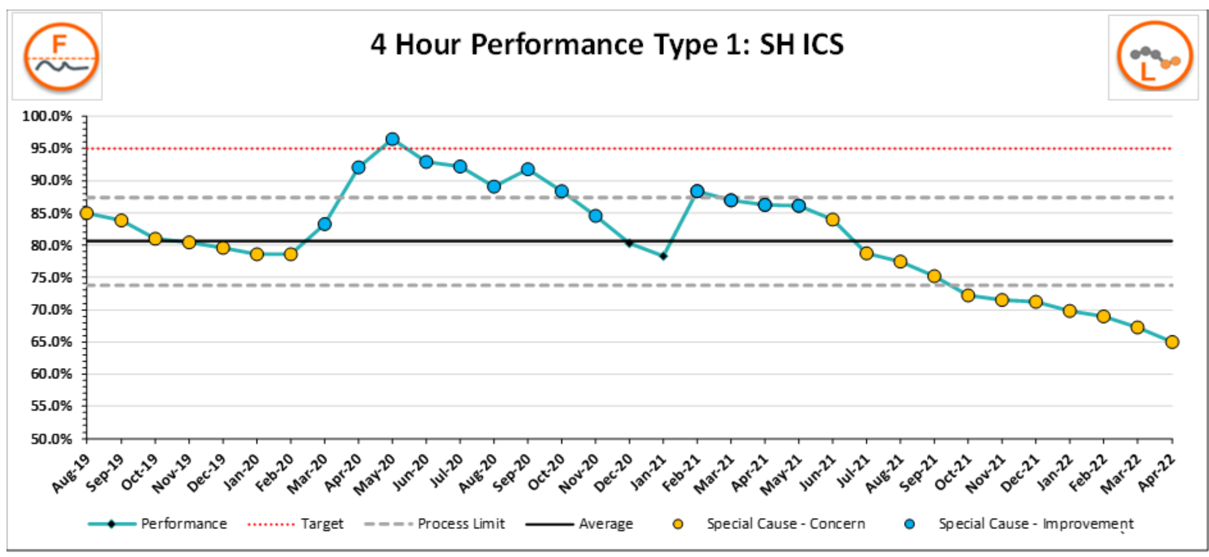
Acute Trusts (All Types A&E Performance):



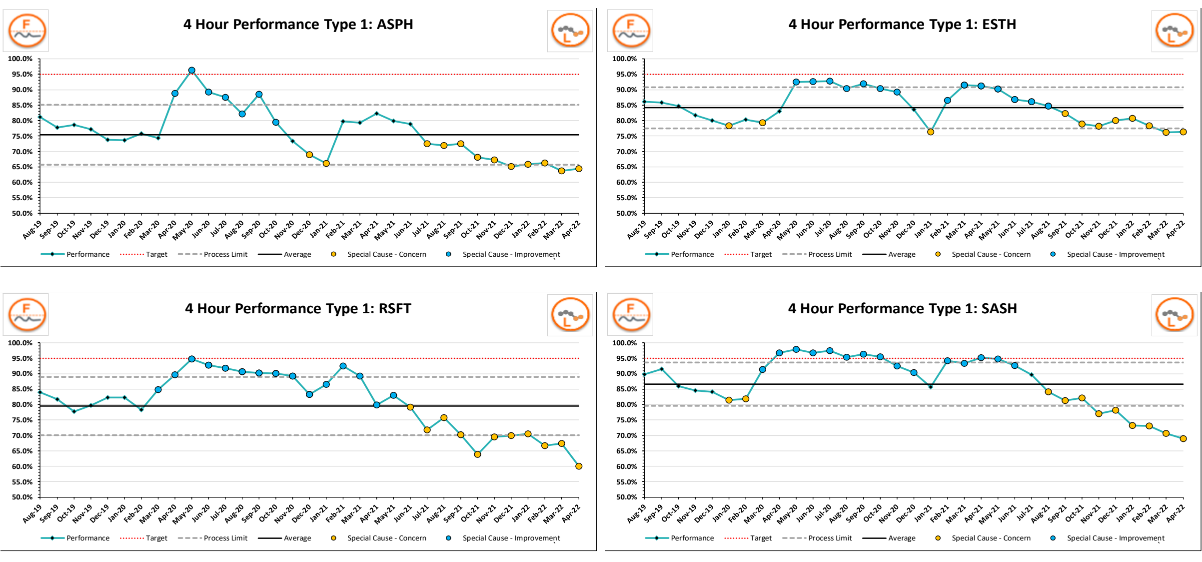
12.3 When considering Type 1 attendance (this is attendance to an ED department with a consultant led 24-hour service, full resuscitation facilities and designated accommodation for the reception of accident and emergency patients); the data reveals that performance improved during March 2020 to May 2021. The key driver of the improvement in the 4-hour performance indicator during this period was due to the reduction in attendances to ED. All ED attendances reduced

significantly at the commencement of the first and second waves of Covid and this has been noted on the graph as a special cause variation.

12.4 Type 1 performance drops significantly after June 2021 and has yet to recover (again shown at an ICS and individual Trust level).



Acute Trusts (Type 1 A&E Performance):



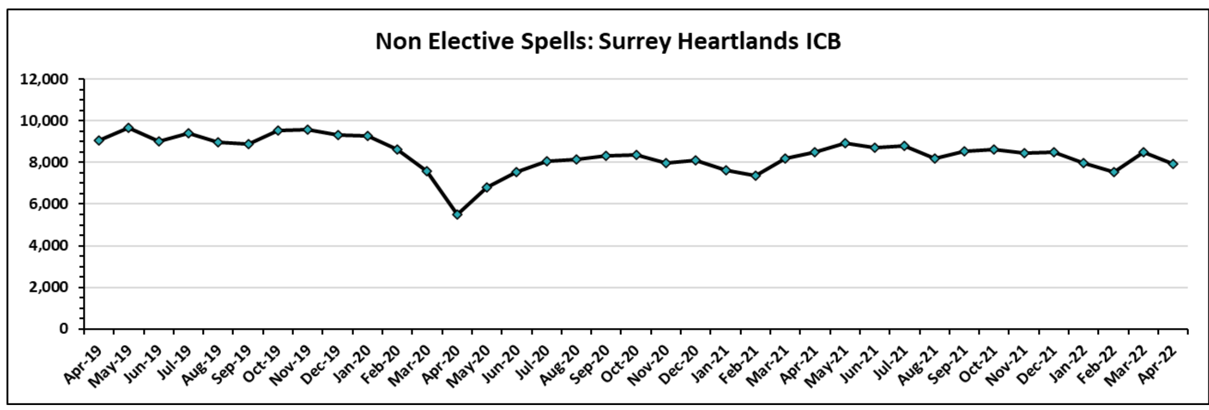
12.5 It should be noted that the graphs above show the combined ICS position, and this include attendances by residents who do not live in the Surrey Heartlands area.

12.6 The table below demonstrates that all four Acute hospitals had more challenged performance when comparing 2019/20 winter months to the same period in 2021/22. The NHSE national average from November 2019 to March 2020, when compared to November 2021 to March 2022 has significantly fallen from 72% to 61%. However, whilst work continues to improve ED wait times, it is noted that Surrey Heartlands is generally performing better than the NHSE national average.

A&E 4 Hour Performance (Type 1)						
Provider	Nov-19 to Mar-20		Nov-20 to Mar-21		Nov-21 to Mar-22	
	Performance	Variance to NHSE	Performance	Variance to NHSE	Performance	Variance to NHSE
ASPH	75%	+3%	74%	-2%	66%	+5%
ESTH	80%	+8%	86%	+10%	79%	+18%
RSFT	81%	+10%	88%	+13%	69%	+8%
SASH	84%	+13%	91%	+16%	74%	+13%
NHSE	**72%**		**75%**		**61%**	

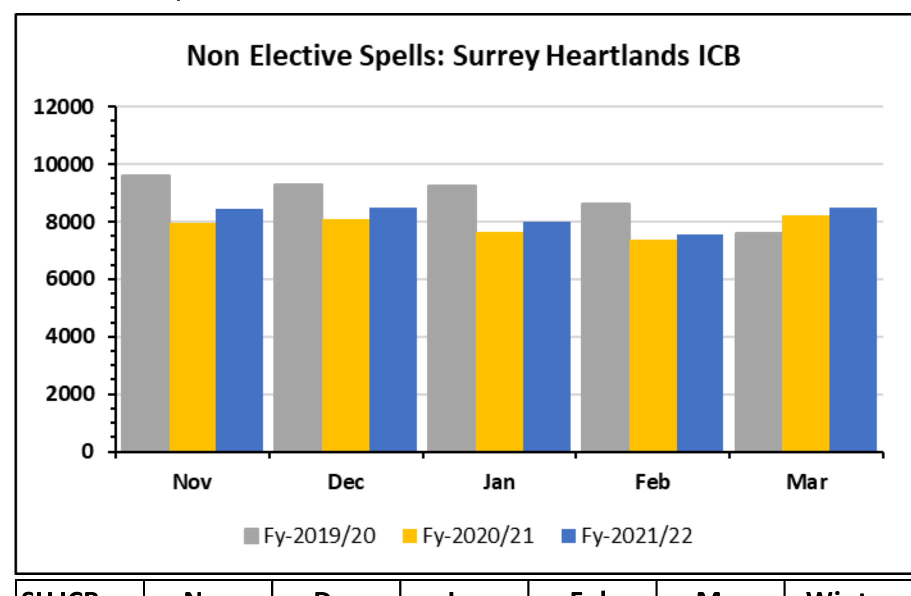
13. Non-elective Admissions

13.1 Surrey Heartlands experienced an overall increase in non-elective (NEL) admissions, with maximum numbers experienced from April 2019 to February 2020; since lockdowns eased the number of admissions steadily increased and are now predominantly over 8,000 per month across Surrey Heartlands ICS.

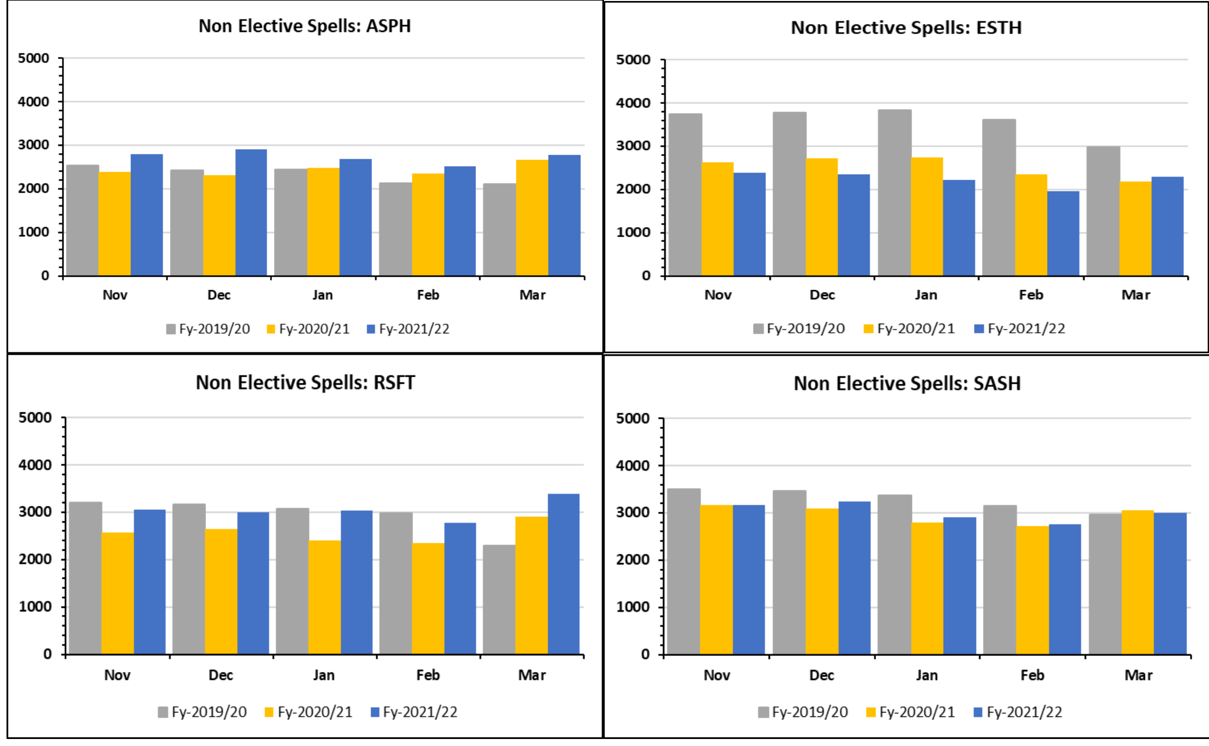


SH ICB	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2017/18	7,756	8,586	8,195	8,276	8,096	8,002	8,425	8,504	8,582	8,725	7,881	8,777
2018/19	7,791	8,390	8,164	8,281	8,088	8,017	8,564	8,906	8,740	8,945	8,115	9,148
2019/20	9,054	9,682	9,015	9,392	8,967	8,904	9,550	9,591	9,299	9,253	8,625	7,598
2020/21	5,512	6,798	7,534	8,076	8,165	8,322	8,370	7,975	8,084	7,636	7,361	8,201
2021/22	8,499	8,935	8,730	8,801	8,179	8,550	8,627	8,441	8,483	7,989	7,538	8,508
2022/23	7,914											

13.2 The following graphs provide an ICB view for the winter period (November to March), followed by an Acute Hospital breakdown of non elective admissions; overall non- elective admissions reduced.by 1.1% over the same period when 2021/22 is compared to 2019/20.

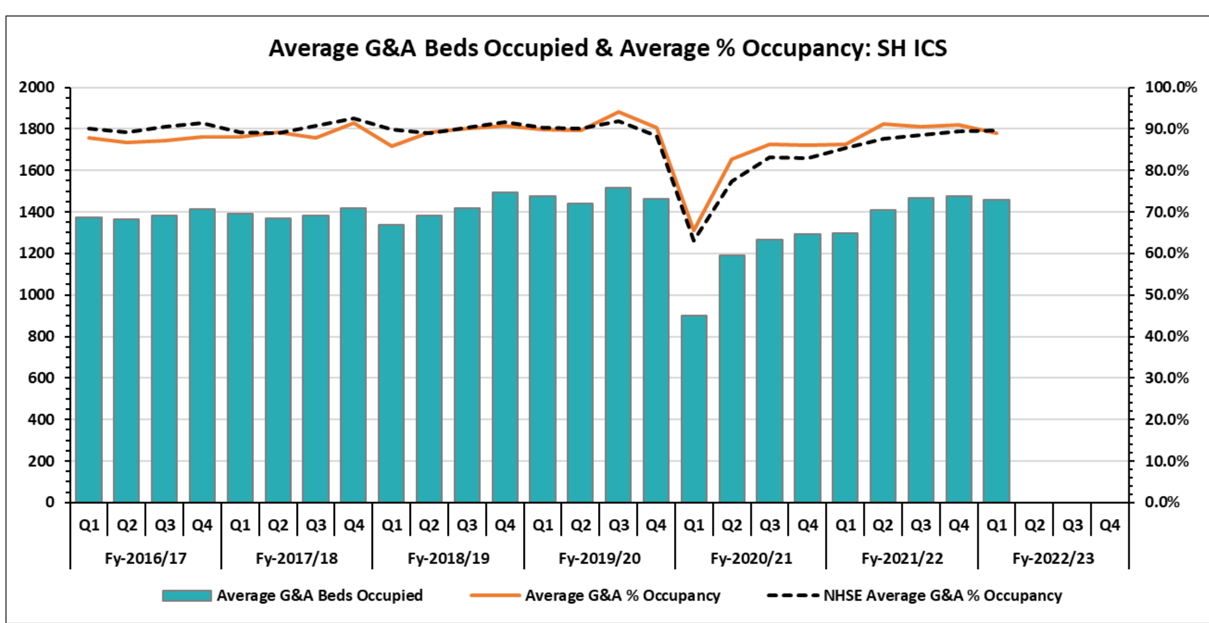


SH ICB	Nov	Dec	Jan	Feb	Mar	Winter
2017/18	8506	8585	8726	7890	8782	**42489**
2018/19	8907	8740	8945	8117	9146	**43855**
2019/20	**8954**	**8651**	**8658**	**8025**	**7108**	**41396**
2020/21	7975	8084	7636	7361	8201	**39257**
2021/22	**8441**	**8483**	**7989**	**7538**	**8508**	**40959**
% Var	**-5.7%**	**-1.9%**	**-7.7%**	**-6.1%**	**+19.7%**	**-1.1%**



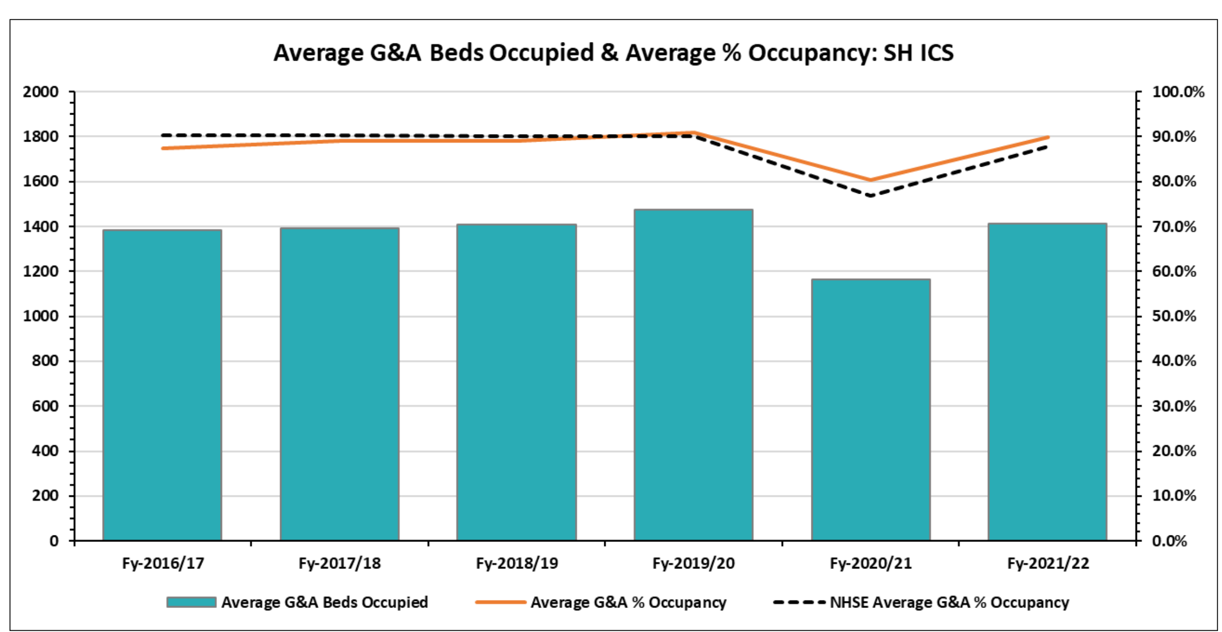
14. Acute Hospital Bed Occupancy

14.1 As described above Surrey Heartlands experienced a steady increase in non-elective (NEL) admissions since lockdowns eased. The graph below also illustrates these pressures; the first graph depicts beds occupied (per quarter) from quarter 4 in 2016/17 to quarter 1 2022/23; with a spike in bed occupancy each winter (quarters 3 and 4). It should be noted that the amber line demonstrates percentage of beds occupied, ideally this should be at 90% or under to enhance flow through ED and the wider hospital. However, the system has returned to pre-pandemic occupancy of over 90% since 2021 quarter 2.



Data Source: NHSE quarterly 'Bed Availability and Occupancy' publications (based on KH03 provider submissions).

14.2 This second graph demonstrates the year-on-year increase in bed occupancy from 2016/17 to 2021/22; with a decease during 2020/21 due to the pandemic and again shapely increasing during 2021/22.



Data Source: NHSE quarterly 'Bed Availability and Occupancy' publications (based on KH03 provider submissions).

14.3 The following graphs provide a breakdown of the occupancy levels for each of the Acutes; presented by quarter and as an annual percentage.

Average G&A Beds Occupied & Average % Occupancy: ASPH

Average G&A Beds Occupied & Average % Occupancy: ASPH

Average G&A Beds Occupied & Average % Occupancy: RSFT

Average G&A Beds Occupied & Average % Occupancy: RSFT

Average G&A Beds Occupied & Average % Occupancy: SASH

Average G&A Beds Occupied & Average % Occupancy: SASH

Average G&A Beds Occupied & Average % Occupancy: ESTH

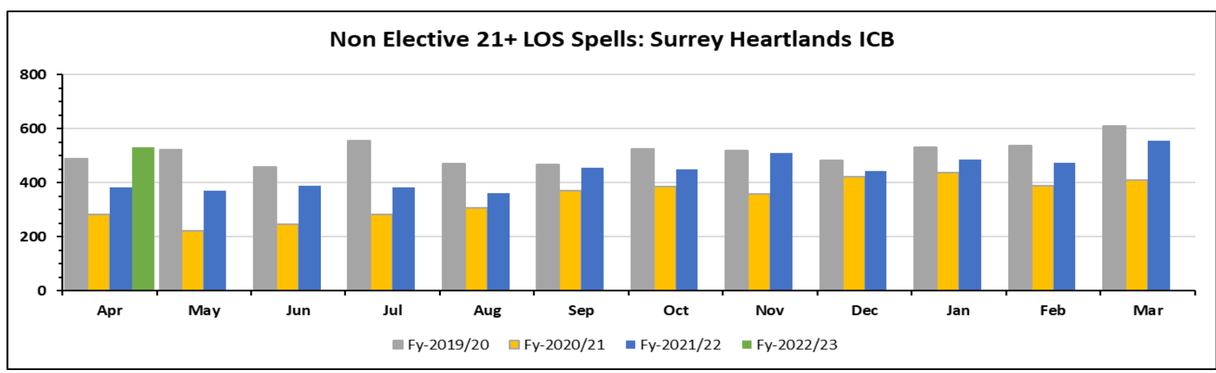
Average G&A Beds Occupied & Average % Occupancy: ESTH

15. Length of Acute Hospital Stays Over 21 Days

15.1 Receiving timely care within hospitals and being able to be discharged as soon as the patient is ready to leave an acute hospital environment is not only better for those individuals, but also helps to free up beds for other patients and eases pressure on ED and other parts of the system such as the 999-ambulance service. To help reduce longer lengths of stay, hospital ward staff are guided by five principles when planning care:

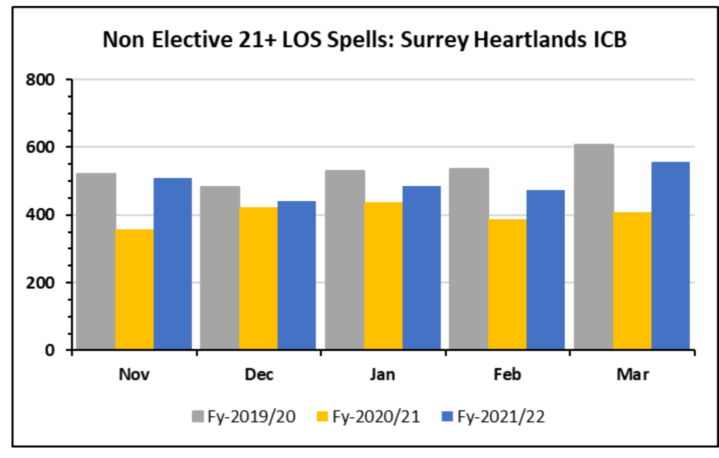
- Planning for discharge from the point someone is admitted and ensuring that plan is shared with the whole team and the patient.
- Involving patients and their families in discharge decisions and explaining to them the benefits of leaving hospital at the right time.
- Identifying frail patients as soon as possible and making a specific plan for their care.
- Having weekly multi-disciplinary team reviews for all longer stay patients, and;
- Encouraging a ‘home first’ approach, which means assessing people at home where possible for longer term care needs.

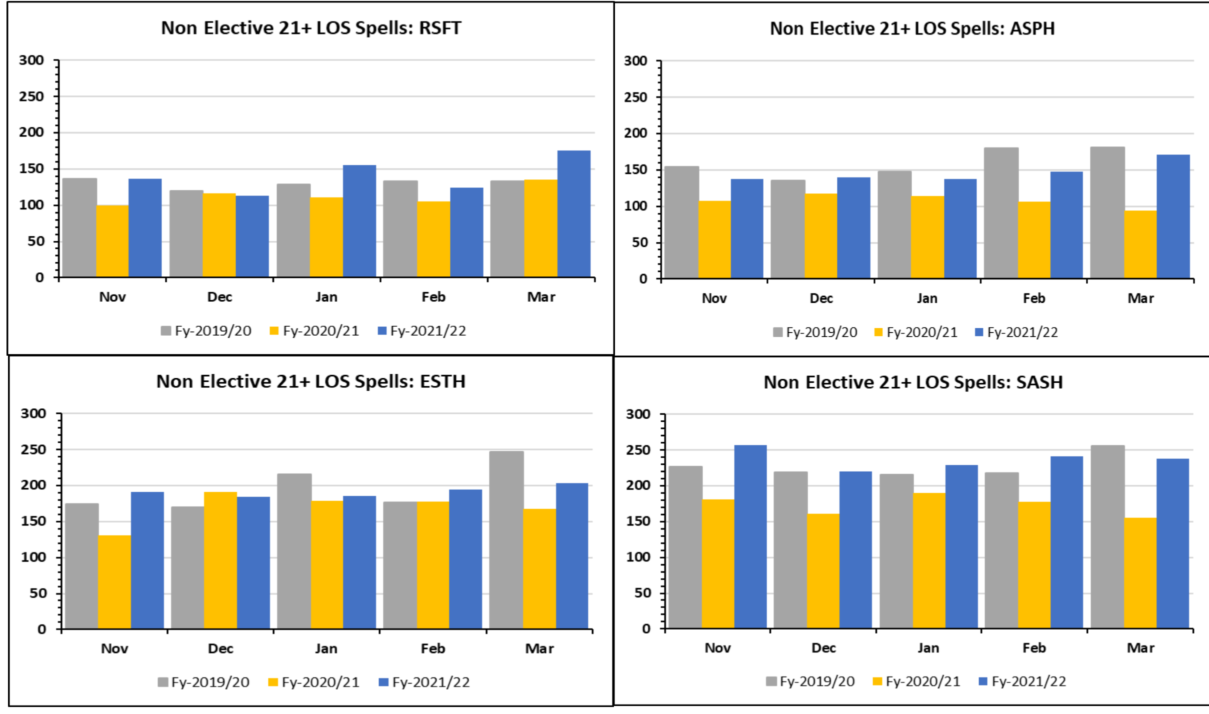
15.2 During the period from April 2019 to April 2022, numbers were at the highest in March 2020; the data below shows that due to the response from all agencies, patients, families and communities to the government’s request in the same month - March 2020 - to create as many available beds as possible in order to respond the pandemic; numbers fell dramatically in April and May 2020. However, since September 2021 numbers of patients staying hospital over 21 days has again increased.



SH ICB	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2017/18	513	556	526	495	482	482	527	510	529	573	461	528
2018/19	475	468	489	449	486	476	506	476	470	517	477	500
2019/20	487	521	458	555	469	468	525	520	483	531	536	608
2020/21	282	223	246	281	306	371	384	359	422	438	388	408
2021/22	382	369	388	382	362	455	450	508	442	484	473	556
2022/23	530											

15.3 The following graphs provide a breakdown of the over 21-day length of stay (LOS) for each of the Acutes from November to March for both the ICB and for each of the Acutes.





15.4 Daily monitoring of long length of stays: this takes place in each of the Acute and Community partners – with each patient being reviewed and actions for partners agreed/followed up. Those patients who have experienced long waits are escalated at Place level and then at the ICS SOC meeting for wider system resolution regarding barriers to discharge – with mitigation agreed, this can be at an operational level; with more strategic actions referred to the ICS Director of Urgent Care and System Resilience. ICS oversight is provided via the ICS UEC Daily report.

16. Hospital Discharges – the 100-day challenge

16.1 Building on the support for discharge from hospitals during the COVID-19 pandemic and discharge to assess processes; a new 100 - Day Discharge Challenge was launched in June 2022 in order to ensure bed availability for patients needing to be admitted into hospital. The challenge was made to all Integrated Care Systems (ICS) as the NHSE Discharge Taskforce found that there is still significant variation between hospitals and systems, resulting in a number of patients staying in hospital when they no longer need to. The challenge builds on the previous aims and objectives of the High Impact

Changes, the work of the taskforce and the learning taken from the 14 NHS pilot sites.

16.2 As a result, there is a need to codify and systematically implement changes across England to ensure consistency and drive improvements for the benefit of patients, carers, and families. The following 10 best practice initiatives have proven to improve patient flow through the system and NHS Surrey Heartlands is currently working through all 10 at a place level, coordinated by the ICB to ensure all initiatives have been implemented to improve discharge processes.

- Identify patients needing complex discharge support early
- Ensure multidisciplinary engagement in early discharge plan
- Set expected date of discharge (EDD), and discharge within 48 hours of admission
- Ensuring consistency of process, personnel and documentation in ward rounds
- Apply seven-day working to enable discharge of patients during weekends
- Treat delayed discharge as a potential harm event
- Streamline operation of transfer of care hubs
- Develop demand/capacity modelling for local and community systems
- Manage workforce capacity in community and social care settings to better match predicted patterns in demand for care and any surges
- Revise intermediate care strategies to optimise recovery and rehabilitation.

16.3 To deliver against the 10 initiatives Surrey Heartlands has engaged with key leaders from the NHS, local government and other relevant local partners who

will collaboratively work together to make a significant difference in facilitating discharge and improving care for patients.

16.4 A number of the initiatives are directly within the control of NHS and NHS-funded provider organisations and generally Surrey Heartlands is in a good position to enhance these. The leadership teams in place; ensure there is focused executive and clinical leadership from medical, nursing and allied health professional colleagues. Our approach to the challenge was to have consistent and regular oversight of discharge performance, which is monitored at the Surrey Heartlands Urgent and Emergency Care Clinical Network and the Surrey Heartlands Urgent and Emergency Care Committee.

16.5 The 30th September marks the end of the official 100 Day Discharge Challenge, however Surrey Heartlands ICB is committed to driving best practices forward via the forementioned groups to ensure patients who no longer meet the 'criteria to reside' (in hospital based care) can benefit from a more timely discharge from hospital and be cared for in more appropriate settings, releasing the much-needed capacity within acute providers and optimising a full and quicker recovery for our patients.

16.6 Multidisciplinary team working is already quite strong in places across Surrey Heartlands whilst other areas would benefit from this being strengthened. Another of the above initiatives suggests 7-day working; and whilst Surrey Heartlands has in place some 7-day working arrangements; namely in occupational therapy and physiotherapy services; it is felt this can be enhanced further to promote 7-day discharges.

16.7 Voluntary / District and Borough Council support has been superb over recent years supporting discharge processes and promoting patients to be able to return directly home by providing a wide range of practical support which includes transport; equipment e.g. key safes; along with safety checks and essential food shopping. This high level of joint working has been much appreciated across both health and social care and has reduced length of stay in the Acutes.

16.8 The main areas of focus throughout the winter 2022/23 and spring 2023 will be:

- To 'discharge to recover and assess' patients for longer term support. This is for any patients leaving hospital who require further support. Temporary arrangements will be put in place to provide the assessment and organisation of ongoing care to be undertaken, preferably, in the persons own home.

- For patients whose needs are too great to return to their own home suitable alternative arrangements will be provided e.g. admission to a Community Hospital or Local Care Home, with the aim of improving the persons independence.

- For those who require long term residential or nursing home care – then support will be offered to the person and their families to make the long-term choice as to where the person wished to reside.

- To discharge plan early - all Surrey Heartlands patients in hospital are receiving a daily clinically led review (some areas this is done twice daily) and patients who no longer need to be in hospital are allocated to a discharge pathway. On decision of discharge, the patient and their family or carer, and any formal supported housing workers are informed and kept informed of next steps (with the patients' permission).

- Community hospital discharges are expected to increase which will help with acute discharge flow. Delays for patients will be reduced by using a similar approach as the acute settings in respect of choice and at least once daily clinical / therapy review of patients. All patients transferred to a community setting will be informed of an expected date of discharge (EDD) and be fully involved with discharge planning.

- Trusted Assessments – this is an area Surrey Heartlands providers will need to focus on. The approach, once in place and working well, will support care homes with timelier assessments. A 'Trusted Assessment' is when one agency 'trusts' another agency to complete an assessment on their behalf - this agreement is generally used when patients are transferring back to Care homes.

- Virtual wards provision has been gathering momentum and Surrey Heartlands ICS Operating Plan identifies the role of the virtual ward in supporting alternative care for those who are able to return to their usual place of residency, but who are on a recovery trajectory. Pathways will be integrated with existing services and admission criteria will be based on existing evidence and NICE Guidance to support safe effective referral into virtual wards. At present Surrey Heartlands has in place Respiratory Wards, Frailty Wards with a 'care home virtual ward' being tested that operates with full oversight from Clinicians and the UEC Committee to monitor provision effectiveness.

17. Non-Emergency Patient Transport Service

17.1 South Central Ambulance Service (SCAS) provide Non-Emergency Patient Transport Services (NEPTS) to patients with a clinical need for NHS funded transportation to and from premises providing NHS Healthcare and between NHS Providers.

17.2 Performance in relation to the Surrey Heartlands NEPTS contract has been strong and sustained with consistent operational delivery. As with most NHS providers, staffing for their contact centre has been a challenge and SCAS have found it difficult to recruit staff which has impacted on the call contact centre performance (please see table below), although it should be noted that these are not emergency calls. The provider has put in place a number of actions to help improve performance such as a rolling call handler advert, implement a 'refer a friend scheme', remote working for call handlers across the virtual platform, and adhoc schemes to incentivise staff.

17.3 Monthly assurance meetings are on-going to support the provider and the wider system, in addition to the daily SOC meetings where there is an update on the current OPEL level of each trust and any 'on the day' issues like staff sickness & broken-down vehicles. A service transformation programme has commenced with the aim of improving and developing the patient transport service within Surrey Heartlands and responds to the recent national Review of Non Emergency Patient Transport services. This involves wider engagement with patients and partners across the system to help scope the changes and

improvements needed in line with national guidance and local recommendations.

Parameter	Threshold	Values	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	YTD
On the day Journey Requests. % of Patients collected within 120 minutes of collection time.	Year 1 ≥80%-85%	Surr02A No. Journeys	1,544	1,383	1,387	1,370	1,331	1,311	1,208	1,195	1,480	1,419	1,380	1,432	16,440
		Surr02A KPI Hit	1,354	1,141	1,166	1,115	1,115	1,033	936	835	1,261	1,253	1,168	1,185	13,562
		Surr02A KPI Performance	87.70%	82.50%	84.10%	81.40%	83.80%	78.80%	77.50%	69.90%	85.20%	88.30%	84.60%	82.80%	82.49%
Advanced bookings collection Journeys % of Patients collected within 60 minutes of booked collection time	≥85%	Surr02B No. Journeys	2,448	2,268	2,591	2,347	2,010	2,367	1,972	2,260	1,886	2,157	2,257	2,170	26,733
		Surr02B KPI Hit	2,249	2,020	2,288	2,055	1,807	2,012	1,681	1,833	1,716	2,039	2,098	1,932	23,730
		Surr02B KPI Performance	91.90%	89.10%	88.30%	87.60%	89.90%	85.00%	85.20%	81.10%	91.00%	94.50%	93.00%	89.00%	88.77%
Advanced Bookings, arrival time at clinic. % of patients to arrive on time at clinic, no earlier than 90 minutes prior to their planned appointment time.	≥85%	Surr02C No. Journeys	2,208	2,033	2,328	2,021	1,703	2,094	1,670	1,933	1,590	1,854	2,049	1,840	23,323
		Surr02C KPI Hit	1,984	1,813	2,074	1,824	1,529	1,765	1,457	1,612	1,437	1,696	1,849	1,605	20,645
		Surr02C KPI Performance	89.90%	89.20%	89.10%	90.30%	89.80%	84.30%	87.20%	83.40%	90.40%	91.50%	90.20%	87.20%	88.52%
% of patients to arrive on time, for appointments where timeliness is essential - e.g. Physiotherapy, Special Imaging, Radiotherapy, MRI etc	95%	Surr02E No. Journeys	525	417	454	354	255	297	216	304	246	371	353	244	4,036
		Surr02E KPI Hit	479	386	423	330	230	258	196	264	223	347	334	220	3,690
		Surr02E KPI Performance	91.20%	92.60%	93.20%	93.20%	90.20%	86.90%	90.70%	86.80%	90.70%	93.50%	94.60%	90.20%	91.43%
Telephone pick up - % of call pick up within 60 seconds	95%	Surr01D1 No. Calls answe	4471	4727	5315	5070	4425	4496	4054	4610	3730	3493	3746	3,812	51,949
		Surr01D1 KPI Hit	4027	4045	4354	4254	3649	3257	2837	3307	3110	1790	2396	1,652	38,678
		Surr01D1 KPI Performance	90.07%	85.57%	81.92%	83.91%	82.46%	72.44%	69.98%	71.74%	83.38%	51.25%	63.96%	43.34%	74.45%

18. Support to Care Homes

18.1 At the start of the pandemic in 2020, government provided funding to the NHS to pay for out of hospital care and to support people being discharged from hospital. SCC set up a temporary spot purchase list of providers with a Care Home Memorandum of Understanding (MOU) in place which secured placements quickly to facilitate discharge from hospital. Since the government funding ended on 31 March 2022, Surrey Heartlands Integrated Care System (ICS) and Frimley ICS have continued funding during the period of 1 April – 30 June 2022.

18.2 Surrey County Council and health partners are now agreeing a discharge model and funding arrangements for September 2022 onwards in line with the Hospital Discharge and Community Support Guidance published in March 2022. https://www.gov.uk/government/publications/hospital-discharge-and-community-support-guidance

18.3 Surrey Heartlands promotes collaborative working between health, social care, the voluntary and community sector, and care home partners to enhance the health and wellbeing of residents living in a care home and to support care home staff and providers.

18.4 There are supportive meetings and networks in situ that has developed a shared work programme across all Surrey Heartlands Places and Surrey County

Council to ensure people living in care homes maintain their independence as far as possible by reducing, delaying or preventing the need for additional health and social care services. Individual places have set their strategic priorities which all include reducing unplanned hospital admissions and enhancing training for staff.

18.5 Practice Plus Group (PPG) run a Star line which is a telephony menu option for providing rapid access to additional clinical support for Care Homes and Paramedics. The advice line is accessible via *6 and this is a 24/7 advice line available to both Health care Practitioners (HCP) and non-HCP who work in care homes offering fast access to a senior CAS clinician. This essentially allows the caller to bypass the operational front end of NHS 111 and get straight through to a clinician in a timelier manner.

18.6 By enabling Primary Care Networks, Surrey Heartlands will have designated teams co - located within neighbourhoods, to extend models of personalised care, embed enhanced health in care homes and develop a consistent set of diagnostic tests. At Place level this will bring together teams that will promote admission avoidance and timely discharges from all Surrey Heartlands bedded facilities including urgent community response, virtual wards and community mental health crisis teams.

18.7 These teams will proactively identify and target individuals who can benefit from interventions by co-ordinating vaccination programmes, screening and health checks in accordance with national standards.

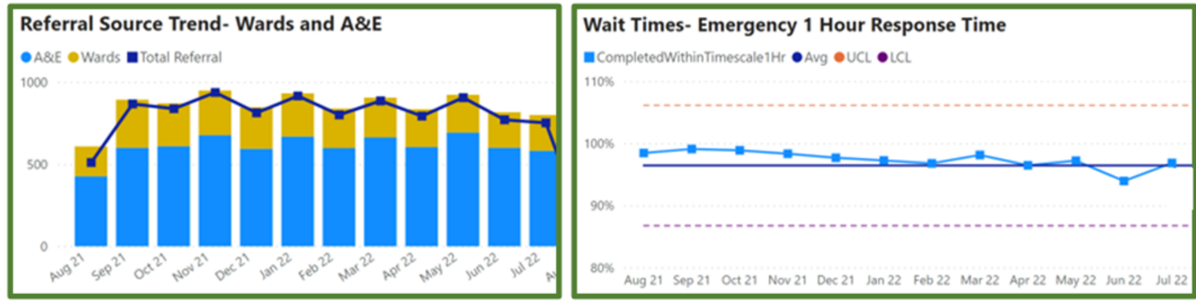
18.8 Surrey Heartlands ICB have agreed with PPG the delivery of an additional 'On Call' GP to support outbreaks of flu within care homes from 26th November 2022 to 31st March 2023. The provision will be in place for the out of hours' arrangements for the administration of anti-viral medication should there be an outbreak of influenza within a Care Home situated in Surrey Heartlands ICB: PPG will supply an On-Call GP/ANP to visit any Surrey Heartlands Care Homes with suspected influenza cases that may require treatment or prophylaxis.

18.9 ‘Older people with complex mental health needs’ specifically refers to people over 65 with mental health conditions including dementia, functional mental health problems and behaviour that challenges. This is a key Surrey Heartlands challenge as there are limited availability to specialist assessment and treatment beds; the Community Mental Health Teams are also stretched with providing ongoing support to an increasing number of care homes. A task and finish group set up in April 2022, sought to identify barriers and challenges preventing care homes from accepting and/or providing ongoing support to older residents with complex mental health needs. The group are seeking to ensure provision of adequate support and training to care homes in identifying mental health related problems in their resident population and managing people with complex mental health needs. The group also aims to mitigate against placement breakdown and to speed up hospital discharge through a step-down model. Through this work, a specialist provider working group was established to support care homes in understanding patients’ needs and have support when needed on an adhoc basis.

18.10 Surrey Heartlands will ensure a coherent communication strategy is in place and work includes bringing 80% of care home providers up to required levels of capability.

19. Mental Health Surge Preparedness

19.1 All Acute Trusts in Surrey Heartlands are supported by 24/7 Psychiatric Liaison Services. These services work efficiently and effectively to have consistently responded to approximately 900 referrals per month. As the graphs below indicate performance is of an excellent standard with response time within 1hr of referral in Emergency Departments close to 100% with no notable variations over the winter months. Therefore, the service is well placed to respond this winter.



19.2 Paediatric Liaison Nurses are in place within every Acute Trust and supplemented by Crisis Support Services from SABP Children and Young People's Services (part of the Surrey Mindworks Alliance). Young People will be seen in a timely fashion and daily SitReps also indicate consistent performance and volumes throughout the year (there is some variation in line with the academic year).

19.3 Mental Health winter preparedness: All Community Services will operate as normal over the winter period and attention is always paid to ensuring that leave is managed to ensure sufficient staff for any working day. The Safe Havens (operated in partnership between voluntary sector partners and SABP) are open every day of the year and Home Treatment Teams operate 24/7 365 days a year, along with the Single Point of Access. Where there are Bank Holidays then consideration is given to the caseloads in our community services and people should be seen appropriately to reduce the risk of a presentation or mental health crisis during Bank Holidays.

19.4 SABP and Community Connections are piloting a 'Recovery & Connect' service within Elmbridge, Guildford and Tandridge CMHRSs over the Autumn and Winter 2022. The service involves non-clinical specialist community care teams employed by Community Connections providers working assertively and intensively in an outreach capacity, with individuals who are identified through meetings with and referrals from CMHRS. The anticipated benefit is that individuals are supported to access crisis support more appropriately and build resilience in managing their own mental health. This model is being field tested to explore the impact on reduction of admissions and readmission to inpatient rehabilitation units.

19.5 Richmond Fellowship employment advisors are already embedded within CMHRSs to support people with mental health needs into employment and/or to help them remain in employment. Given the strong correlation between poverty, unemployment and poor mental health, this service will become even more essential for those facing increased hardship due to the cost-of-living crisis over winter 2022.

19.6 The GP Integrated Mental Health service (GPimhs) provides an integrated mental health team working within Primary Care. It is currently live in 15 PCNs

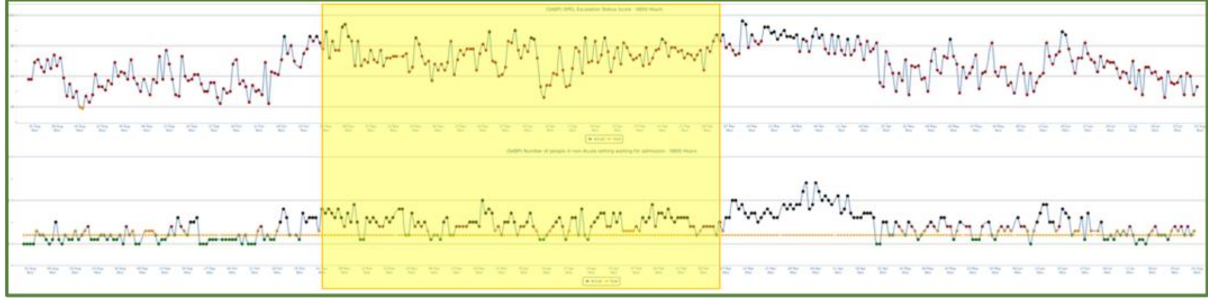
across Surrey Heartlands and due to be rolled out across all sites by December 2022, giving extra resilience for the Winter period. The average number of monthly referrals to the GPimhs service is 427 which we expect to grow as the model matures and embeds during the remainder of 2022/23. 97% of people are seen within 4 weeks. Where a GPimhs service is in place we have seen a 24% reduction in referrals to the adult mental health Single Point of Access.

19.7 As part of the Surrey mental health transformation, work is ongoing to test and spread a 'One Team' approach in Epsom by integrating CMHRS alongside GPimhs, Primary Care, Social Care, and wider VCSE services. The first phase of the testing of the 'One Team' integrated pathway for routine referrals between primary and secondary care has been successful and is now being rolled out across Surrey Heartlands during remainder of this year (2022) into early 2023, helping to build resilience for the winter period. Emerging data has shown that the 'One Team' approach has reduced waiting times for people needing to step up for specialist interventions by 50%, it has reduced waiting times for psychological therapies by 24%, and 20% more social care needs have been identified for vulnerable individuals with mental health needs. As the 'One Team' approach avoids the need to refer via the Mental Health Single Point of Access the likelihood of being bounced between providers and pathways is also reduced. An independent review of the model is currently underway.

19.8 The main challenge and reasons why people remain in Emergency Departments links to bed flow into (and out of) Acute Mental Health beds. If there are high volumes of admissions needed or high levels of s136 (an emergency police power detailed in s136 of the Mental Health Act) this creates a high level of demand. When demand is high because of the ALOS (average length of stay) in mental health beds and the challenges of discharging people (audits show that approximately 20-25% of people will be medically for discharge, but not able to be discharged) bed flow can be difficult to optimise. Due to the fact that bed occupancy rates nationally (and within SABP) tend to be in excess of 95% there are always few available beds at any time. Therefore, discharges have to be created to facilitate admissions and this means that people may wait in all settings (including Acute Hospital Trusts) until beds become available.

19.9 SABP utilise an OPEL methodology and are involved in daily Surrey Heartlands UEC/SOC calls. OPEL scores tend to be Red/Pre-Black and this is indicative of the daily pressure within the Mental Health system. The graphs below indicate the overall adult OPEL score (top line) and number of people waiting in Acute Trusts for Mental Health beds (bottom line). The shaded portion of the image details the months November to February. The following can be noted:

- There is no obvious winter pressure with high OPEL scores through the spring and spikes during summer and autumn.
- There appears to be a broad correlation between an increase in OPEL scores and people waiting in Acute Trusts – indicative of the pressure and challenges to admit people into beds.
- The increase in OPEL scores can be more pronounced and marked than the increase in adults waiting in Acute Trusts. This might indicate that effort is placed upon bed finding and keeping flow through Acute Trusts.



19.10 SABP (and key partners) have a programme of flow work that has reduced the amount of OAPS and have contracted with a number of other local Mental Health hospitals to ensure there is good bed supply this winter (whilst the hospital site in Chertsey is closed due to a rebuild programme). Nonetheless, like all Mental Health Trusts overall bed occupancy will remain high and so OPEL methodology (and support from system partners to enable, facilitate and accelerate discharges) will be critical.

19.11 Plans are in place with a care provider to create a Crisis House (in partnership with Home Treatment Team services) that should offer a meaningful alternative

to a Mental Health bed for a particular cohort of people. The people likely to benefit from this support may also choose to attend ED when in a Mental Health crisis and so this may have a particular system benefit.

19.12 Mental Health services use of digital tools - within Surrey we have a number of examples of this. For example:

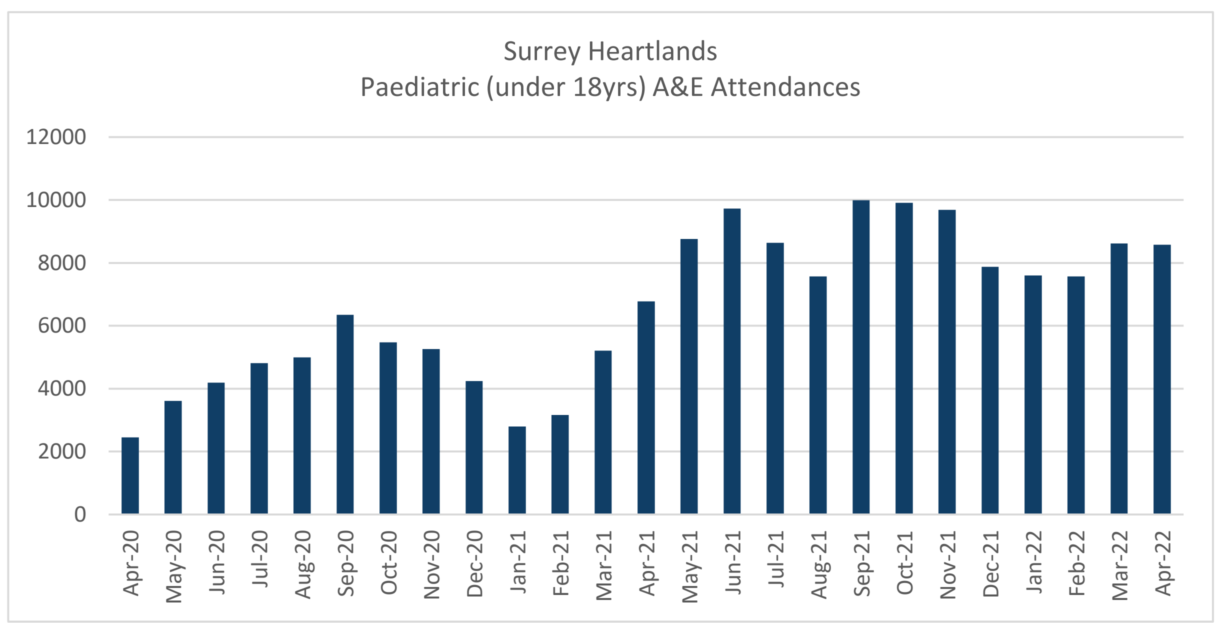
- TIHM (SABP.nhs.uk) – a remote monitoring service (principally for people with dementia) enabling people to stay at home and reduce potential for an ED visit.
- The use of Attend Anywhere for Virtual Safe Havens Safe Havens: Surrey and Borders Partnership NHS Foundation Trust (SABP.nhs.uk);
- The use of Limbic to support people to make IAPT referrals Refer yourself: Mind Matters - NHS Talking Therapies: Surrey and Borders Partnership (mindmattersnhs.co.uk) & Silver Cloud as an online offer.
- The creation of the Surrey Virtual Wellbeing Hub to connect people to available courses to support good mental health (often provided by VCSE organisations) Find a session - Surrey Virtual Wellbeing (healthysurrey.org.uk)
- The integration of Primary care and mental health services through the GPIMS project, integrating data and streamlining processes between sectors.

20. Acute Paediatric

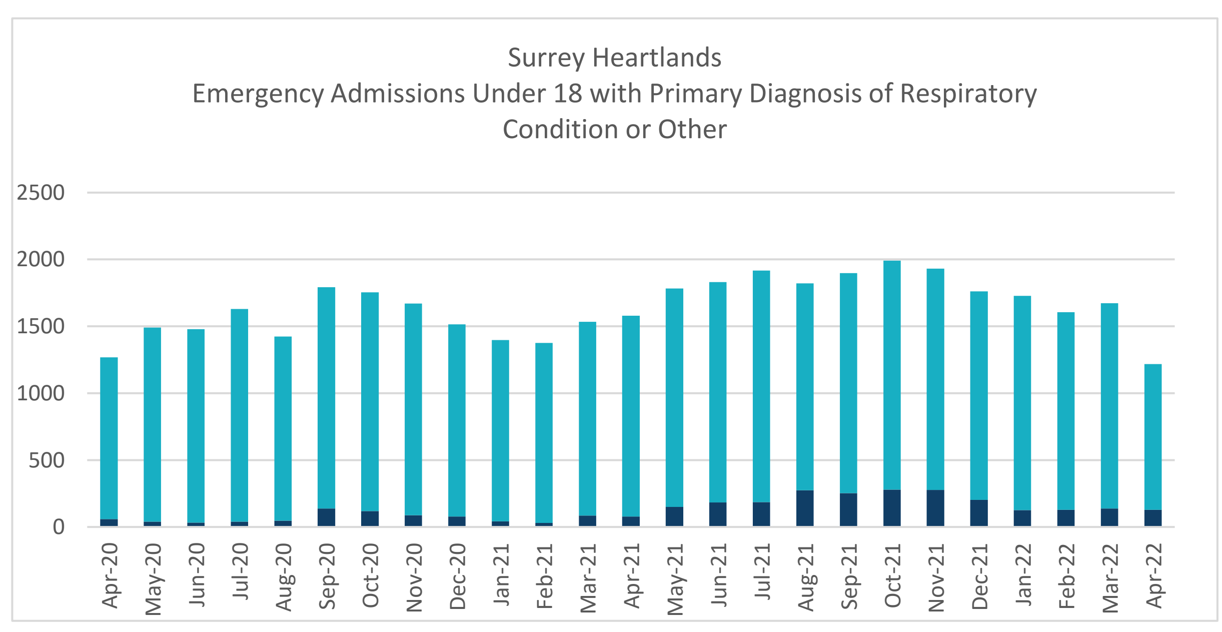
20.1 From April 2017 to May 2020, the general trend was one of growth in relation Paediatric attendances at ED, with significant reduction early 2020 due to lockdown. The sustained attendance rates have continued with some seasonal variances.

20.2 We anticipate that high levels of activity will continue. We will also be working with Place to understand why numbers are increasing and to identify more local

solutions to address this, with the provision of appropriate care and advice for parents for children with minor illnesses in the community.



20.3 Paediatric admissions to Acute Hospitals continue to reflect seasonal variances of respiratory illnesses and remain high. During periods of peak activity, hospitals may request mutual aid from other hospitals, although these actions are only taken in extremis. Our current planning is based on higher levels of activity, and we are currently reviewing last year's plans and working with Acute providers and the South Thames Paediatric Network to understand what actions / mutual aid worked well.



PART B – Surrey Heartlands Covid and Flu Vaccination Programmes

21. Covid 19 (C-19) Vaccination Programme

21.1 Surrey Heartlands has maintained a strong position with C-19 vaccination delivery providing over 2.2 million vaccines since the C-19 pandemic started. Our operating model structure has been revisited to ensure delivery is through a financially viable model, with a sustainable workforce and optimisation of NHS/Local Authority estate. In 2022/23, Surrey Heartlands has implemented a Flu and C-19 Steering Group to ensure we benefit from lessons learnt, understand any interdependences and develop an integrated approach where appropriate. Aligned to the national plan, the Covid -19 Operating Model focus is to:

- Increase uptake in all communities
- Address unwarranted variation
- Provide equality of access as a baseline
- Support and pilot 'Making Every Contact Count' approach through BP and pulse checks
- Take a Value for Money approach

21.2 To further drive engagement for the vaccine and reassure those residents who may be reluctant to take the vaccine, we've developed a geo-targeted comms approach to those populations where uptake has been lower, promoting both the benefits of the Covid-19 vaccination and how someone can book a vaccination appointment. We've also provided on-the-ground comms via the Equity Development Manager and Public Health's community outreach workers. Alongside, relevant and engaging creatives, designed with low uptake cohorts in mind, have also been created to further drive engagement and uptake.

21.3 The Surrey Heartlands Mass Vaccination Programme has been reviewed to ensure that autumn demand and capacity meets population expectation. Work has been undertaken with Local Vaccination Sites, the Vaccination Centre and by linking into the Regional Pharmacy Lead to establish demand profiles, cost

implications and risk. As a consequence, the Covid-19 Operating Plan has been updated, which includes Place/ Neighbourhood based demand profiles as well as recommending piloting a 'Making Every Contact Count' approach so that people receiving a BP and pulse checks will also receive their Covid vaccination; this offer is expected to commence at the end of October 2022.

21.4 Even with the work on demand profiling, there is a risk that a new variant will cause increased activity above the modelled demand profile; to mitigate against this the Surrey Heartlands Mass Vaccination Programme Team will work with NHSE to identify new variant risk and implement surge planning as required.

21.5 Based on JCVI guidance, the Autumn Booster Campaign commences on the 5th September 2022 with cohorts 1-9 being asked to come forward at staggered intervals. Housebound, Care Home Residents and Care Home Staff cohorts will be prioritised as per national guidance.

Data Source: Foundry

Total COVID Vaccine Doses Administered			LATEST DATE
2,285,506 Source: NIMS	+137 Vaccinated on latest day	+138 Recorded on latest day	2022-09-01 Latest date (based on date filters chosen) for which vaccination events are present

Measure	Total	Vaccinated on latest day	Recorded on latest day
TOTAL LVS VACCINATION EVENTS	1,913,677 (Source: NIMS)	+50	+50
TOTAL VC VACCINATION EVENTS	283,400 (Source: NIMS)	+87	+87
TOTAL HH (INCLUDING SAIS) VACCINATION EVENTS	88,429 (Source: NIMS)	+0	+1
TOTAL LVS - PCN VACCINATION EVENTS	1,324,627 (Source: NIMS)	+7	+7
TOTAL LVS - PHARMACY VACCINATION EVENTS	584,641 (Source: NIMS)	+43	+43
TOTAL LVS - MILITARY AND DETAINED ESTATES VACCINATION EVENTS	4,409 (Source: NIMS)	+0	+0

VACCINATION EVENTS BY DOSE					
806,237 Number of people who have received their first vaccination	751,411 Number of people who have received their second vaccination	10,855 Number of people who have received their third vaccination	620,337 Number of people who have received their first booster vaccination	96,666 Number of people who have received their second booster vaccination	56,887 Number of people who received their first booster vaccination coadministered with a flu vaccination

22. Local approach towards seasonal flu programme

22.1 As of 3rd March 2022, Surrey Heartlands had delivered ~590k Flu vaccinations within the 2021/22 Seasonal Flu Vaccinations campaign. Flu cohorts trended close to or above the trajectories, with the exception of 50-64 (53% against a trajectory of 75%) and the Immunocompromised – Close Contact cohort (46% against a trajectory of 75%). The 5-16year cohort tracked just below trajectory

at 53%, however showed significant improvement in uptake compared to the same period in the previous year (~30%). Please see table below.

Data Source: IMMFORM 03-Mar

Cohort	%Target	% Uptake	Uptake	Population
Age 65+	85%	82%	175,300	213,748
Age 50-64	75%	53%	114,300	215,533
Aged 2 to 3 years	70%	59%	13,667	23,564
School (Aged 5 to 16 yrs)	70%	53%	83,500	163,148
Flu at risk (6 months to 64 yrs)	75%	55%	97,800	180,931
Care Home Residents	n/a	85%	5,877	10,310
Frontline Healthcare Workers	85%	62%	16,020	30,226
Social Healthcare Workers	85%	65%	19,119	29,414
Household Contacts of Immunosuppressed	75%	46%	32,507	70,450
Immunosuppressed	75%	84%	26,209	31,353
Pregnant	75%	42%*	500	1,015

22.2 The National Immunisation Strategy: In January 2022 the Secretary for Health stated that a National Vaccination Service is required to support Primary Care recovery. In preparation for this, Surrey Heartlands Mass Vaccination Programme are working with NHSE regional colleagues, Primary Care representatives and the Director for Public Health to support the strategy which is expected to be published later in the year. As a consequence, Surrey Heartlands implemented a Flu and Covid Steering Group which will look to understand interdependencies, co- administration and learn from best practice aligned to the JCVI guidance. The steering group will also oversee both Flu and Covid vaccination programme plans and delivery, offering the community co-administration of both vaccines as able and in line with the persons choice.

22.3 The NHS influenza immunisation programme 2022 to 2023 will include the following additional cohorts:

- those aged 50 to 64 years old, not in clinical risk groups (including those who turn 50 by 31 March 2023). The offer of seasonal influenza

immunisation will be extended to healthy 50 to 64-year-olds later in the season, from 15th October 2022.

- Secondary school-aged children will be offered immunisation through the school age immunisation service. Secondary school children will be offered vaccination as far as it is possible to do so, with primary schools and lower years 7, 8 and 9 prioritised, and older ages offered vaccination once an offer has been made to younger children and subject to vaccine availability. This will be commissioned via the school age service specification.

Part C – Surge and Escalation Planning

23. Modelling Demand and Capacity

23.1 Surrey Heartlands ICS has developed an Urgent Care Model which identifies likely demand, capacity, admissions and discharge rates by week until March 2023. The model uses historical data to predict admissions and applies a range of assumptions depending on the scenario (e.g. increase in Flu or Covid admissions). A number of varables are included in the modelling; these are able to be changed and updated as required. The baseline also considers the return to higher-than-normal 19/20 activity levels, and seasonal activity for Flu and Norovirus. This, along with national modelling, is supporting current planning activity.

23.2 Modelling demand is a key feature of Surrey Heartlands ongoing surge planning, with the day to day operational 'grip' being supported by the system wide senior leads daily System Operations Call (SOC) meetings which promotes utilisation of all system resources during periods of surge. The ambition to reduce wait times from arrival needs to be set in the context of number of people attending ED with Covid and then go onto require admission, currently the modelling shows a continuing and sustained number of 'waves' of re-infection which impacts the level of activity seen.

23.3 However, it should be noted that traditional modelling approaches and projections based on last years performance may not fully correlate to the rising issues in 2022/23. There is a wealth of information (e.g. Faculty of Public

Health) that indicates that the impact of the cost of living crisis / rising inflation and a possible recession will lead to an increase in demand and poorer mental health.

24. Surge and Escalation Planning

24.1 The ICS Surge and Escalation Plan describes the combined ICS response to surges in demand, along with the individual Place based access to locally agreed additional escalation capacity; further actions in relation to adverse weather or an increase in ED attendances due seasonal flu / C -19 / Norovirus. Break planning for the Christmas/New Year period is also undertaken. A single plan which builds resilience and provides the architecture for the ICS Mutual Aid Protocol, along with underpinning the Surrey Outbreak plan.

24.2 The Surge and Escalation Plan is reviewed by UEC partners each year in May and from this the Plan is refreshed in time for the next winter period. The draft plan gains assurance from NHSE; the UEC Committee and the Quality and Performance Committee, with revisions being made until a final version is agreed and the plan ratified.

24.3 In summary, the plan utilises national, regional and local modelling from learnings in previous years demand, previous RSV (Respiratory Syncytial Virus) outbreaks and surges in numbers of patients with C -19 / Flu to create a system approach to planning, capacity, and response at times of escalation. This is a shared approach with all key organisations agreeing the content and methodology, the organisations include:

1. The four Places: Guildford and Waverley, Northwest Surrey, Surrey Downs and East Surrey.
2. Southeast Coast Ambulance Service NHS Foundation Trust
3. Surrey and Borders Partnership- NHS Trust
4. Practice Plus Group
5. NHS England South (Southeast)
6. Surrey County Council - Adult Social Care

24.4 The Surge Plan includes clear escalation process for adult, paediatric and mental health services and considers in-depth:

- Sustainable Corporate Governance
- Integrated Care System Executive Governance
- Sets out the risks and triggers for escalation and mutual aid
- Sets out minimum expectations at each level of escalation
- Clarifies roles and responsibilities
- Sets consistent terminology / definitions
- Defines communication processes e.g. through agreed the ICS System Operations Call (SOC).

24.5 The Plan also describes how the System prepares for events, including Winter Pressures, this includes elements such as:

- Sets out the demand and capacity modelling across:-
  - Acute beds
  - Critical Care beds (Oxygen, Continuous Positive Airway Pressure-CPAP and Ventilated)
  - Provision of Oxygen ($O^{2)}$ across Trusts
  - Independent Hospital capacity availability and utilisation
  - ICP Community /out of hospital capacity – Hospice, community hospital, Care Homes
  - Workforce (Acute) – including disproportionate effect on BAME staff community
- Tracking and surveillance of demand and capacity
- Identification of caps in capacity and supporting decision making

24.6 The Urgent and Emergency Care Early Warning System (EWS) continues to support the system as it contains triggers and actions supported by the modelling. Triggers encompass all elements of the local health and social care system, Primary Care, Secondary Care, Community and Local Authority providers associated actions in times of surge, detailing those services that are required to alter or change configuration and planned levels of activity. The EWS will remain under review and subject to change as the peak seasonal demand unfolds.

25. Funded Place UEC Surge Schemes

25.1 Surrey Heartland ICS are undertaking a number of programmes of work to continue to build resilience within our urgent care services and prepare for extended periods of surge in demand, this includes the winter period. Outlined below are the details of the current programmes and specific projects.

Programme	Deliverable
Paeds Transfer service for ICS currently funded at risk	Capacity funding bid to provide system Paeds transfer service for winter 22/23
SCAS PTS additional resource for all acutes	Provider discharge resource for patient transports
Paediatric and Care Home Virtual Facetime	Limiting requirement for face-to-face interventions to increase capacity.
WSP Modelling	Triangulate system modelling with statistical modelling across the whole Southeast Region.
Reducing incidence of Flu in Care Homes	PPG To deliver anti-virals within care homes should there be an outbreak influenza during weekend and Bank Holidays
Increase in UTC capacity	To aid in redirection and streaming away from ED and reduce admission rate
Case Management Digital solution	To improve discharge processes - part of the Royal Surrey transformation programme.
Transport Flow Manager	To support flow - part of the Royal Surrey transformation programme.

Programme	Deliverable
Enhance Paediatric services at SASH increasing capacity.	To provide additional capacity, redirection and inteventions for Peadiatrics due to current limited capacity
Community Front Door Expansion/Admission Avoidance	Community front door service in reach to ED "pulling" patients out of the acute providing wrap around care in the persons place of residence. Proposal will strengthen and expand MDT - 7 days / extended hours
Consultant support to Paramedics/ Ambulance crew	Oncall Consultant input available by phone/video conferencing to aid crew decision making To agree patient care plan and next steps Proposal will enable smooth redirection of patient to Urgent Community Response / Vitual Wards services
Enhance active complex case management in the community	Reducing risk of going into hospital/ supporting step down from acute linking to Virtual Ward Strengthening proactive care coordination across all neighbourhoods Consultant support and inreach to PCN and Care homes for both crisis support and proactive case management

26. System Oversight

26.1 The Surge and Escalation joint plan is underpinned by comprehensive system oversight, which in turn supports decision-making in times of extreme system pressure by linking the Surge and Escalation Plan to the Urgent Care Data Repository held within Alamac and to the 'live' position data held in My Beautiful Information and SHREWD. By reviewing this information, the system is able to both identify key triggers and early warning triggers with which to evoke a proactive response, rather than reactive. This single plan negates the need for individual Place based winter plans.

26.2 Extending the scope of the daily report to include system wide oversight of the community resources availability and flow, including Primary Care, Adult Social Care, Care Homes and Hospices, ultimately provides the opportunity to seek out possible options for mutual aid and to connect partners.

27. UEC Communications plan

27.1 Partners work closely across the ICS Comms and UEC team to increase communications activity at times of sustained system pressure and have well established protocols in place. This includes the activation of the Opel Communications Plan, which triggers additional communication activity to increase the flow of messages and support the wider system during periods of significant pressure.

27.2 The activation of this plan results in an increase in social media activity (linked to data insight where available e.g., targeted messages to parents following an increase in paediatric ED attendances), specific and targeted information being shared through our networks, website updates and collaborative work with broader system partners to amplify key messages and enhance their reach to achieve greater impact.

27.3 This plan supports targeted messaging out to the wider community particularly in relation to how the person may seek help and support without needing to attend ED; messages are also tailored to each Place system escalation alerting the public to how busy their local hospital is – again advising people to contact NHS 111 or attend a pharmacy or GP for advice; whilst reiterating the

importance of calling 999 and /or attending the hospital ED in cases of emergency. The plan for 2022/23 is currently under review continuing to develop communication out to all sectors of our society.

Part D – Electives

28. Elective Recovery

28.1 Surrey Heartlands continues to maintain a very strong emphasis on wait times for our patients; services have been working on delivering the Recovery Plan; this work is now transitioning to 'business as usual' whilst remaining focused on ensuring those who are most clinically in need receive the health interventions that they require as soon as possible.

29. Elective Activity

29.1 Surrey Heartlands ICS comprises three Acute Trusts; Ashford and St Peter's Hospitals NHS Foundation Trust (ASPH); Royal Surrey Foundation Trust (RSFT) and Surrey and Sussex Healthcare NHS Trust (SASH). In addition, the population of Surrey Downs use Epsom and St Helier University Hospitals (ESTH) which sits within Southwest London. Both ASPH and SASH span two main sites.

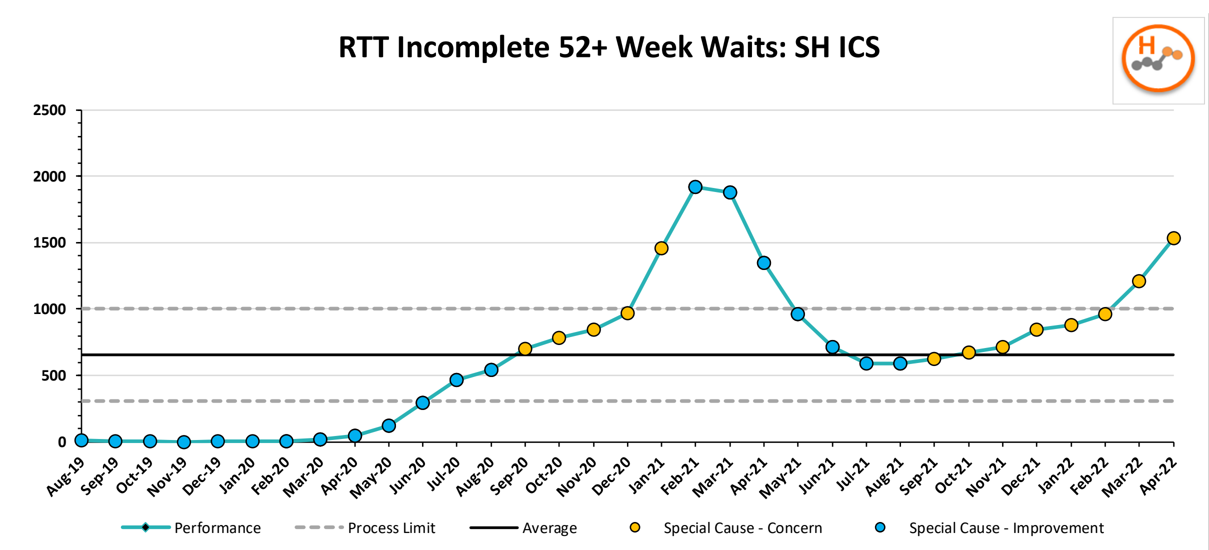
29.2 The high levels of emergency activity can compromise the ability to maintain elective care for patients and Surrey Heartlands ICS will continue to work closely with Regional NHS England colleagues in the delivery of achievable levels of activity that have started to impact on the long waits that developed during the pandemic. Winter planning for electives is a priority and plans are underway to risk stratify patients to prioritise treatment, including P2 patients and cancer patients.

29.3 Referral to Treatment (RTT): Work continues in relation to reducing the number of patients waiting long periods of time for diagnosis and treatment; restoring and improving services remains a major priority for Surrey Heartlands. We have and continue to prioritise where longer waits are associated with higher clinical risk or poorer outcomes. All planned patients are reviewed and allocated a clinical priority based on their past medical history and planned procedure; the patients are also followed up regularly in relation to any changes to the persons

clinical risk as we continue to combine time waited with clinical priority to ensure that we actively manage patient risk and treat the most vulnerable patients.

29.4 Surrey residents continue to have shorter waiting times than the majority of the country. The following figures are for Ashford & St Peters, Royal Surrey and Surrey & Sussex Hospitals combined to form the ICS position.

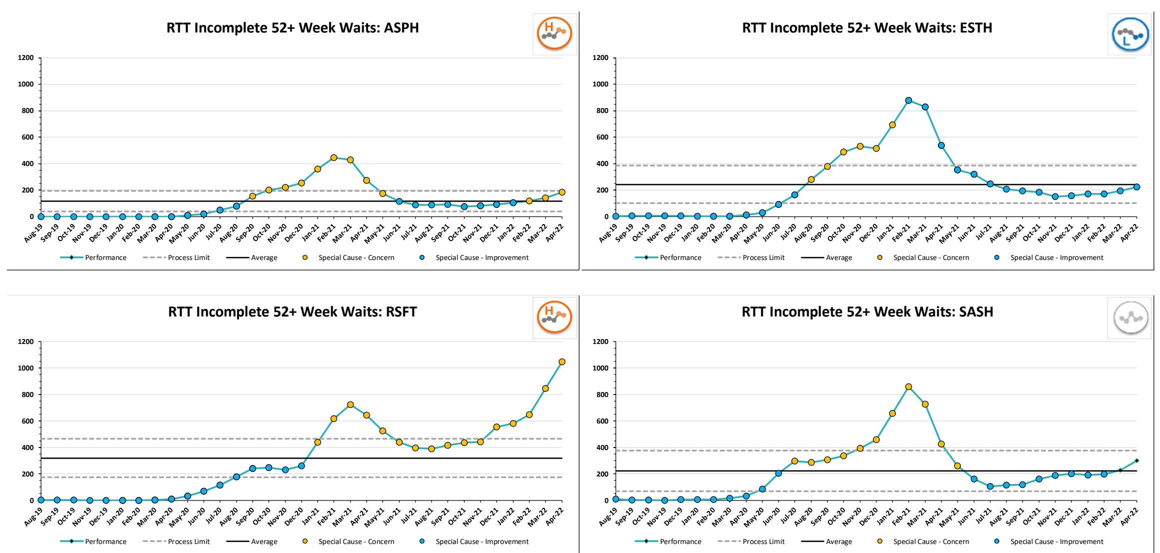
29.5 Whilst excellent progress was made in relation to the 52 weeks wait times from May 2020 to July 2021 with the volume of patients who have been waiting more than 52 weeks for treatment reduced from a peak of 1,900 to 600. The numbers from July 2021 have increased to 1,500 in total; this represents ~1.5% of total wait list, with all three acutes currently being above their planned trajectories. Our ambition continues to be to return to the pre-pandemic level of no more than 10 people waiting, at any one time, for over 52 weeks.



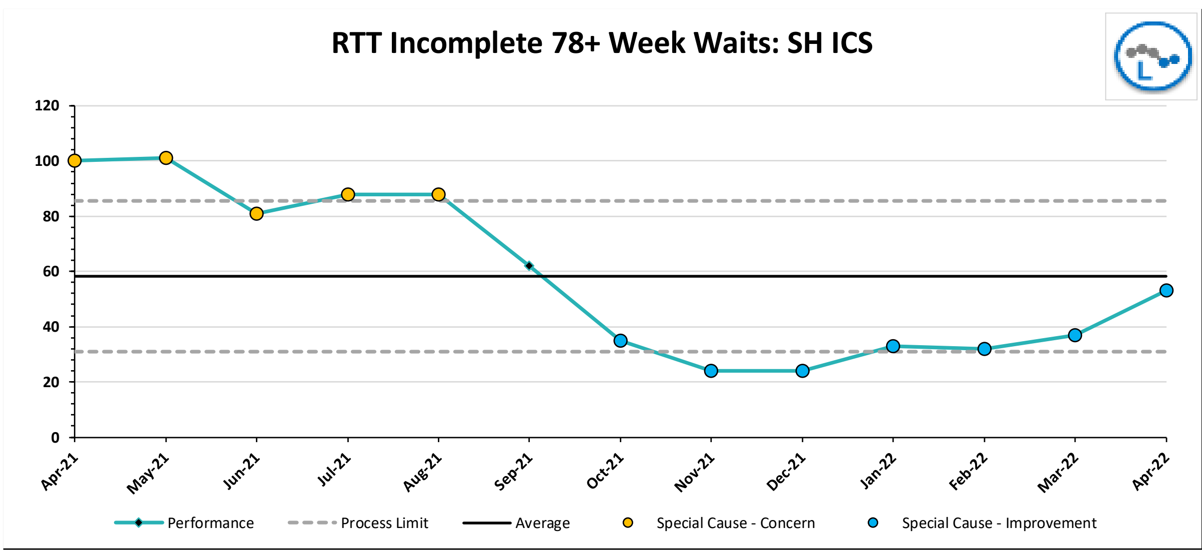
Source: NHSE monthly 'Consultant-led Referral to Treatment Waiting Times' publications.

29.6 The second set of graphs describe performance for the individual Acute Hospitals over the same period.

Acute Trusts:



29.7 Since December 2021 there has been a month on month increase in the volume of patients waiting over 78 week, with Surrey Heartlands ICS currently having 52 patients, who have waited over 78 weeks. These patients are being actively managed operationally by the individual Acute Trusts, with oversight provided by the Surrey Heartlands Elective Care Committee.



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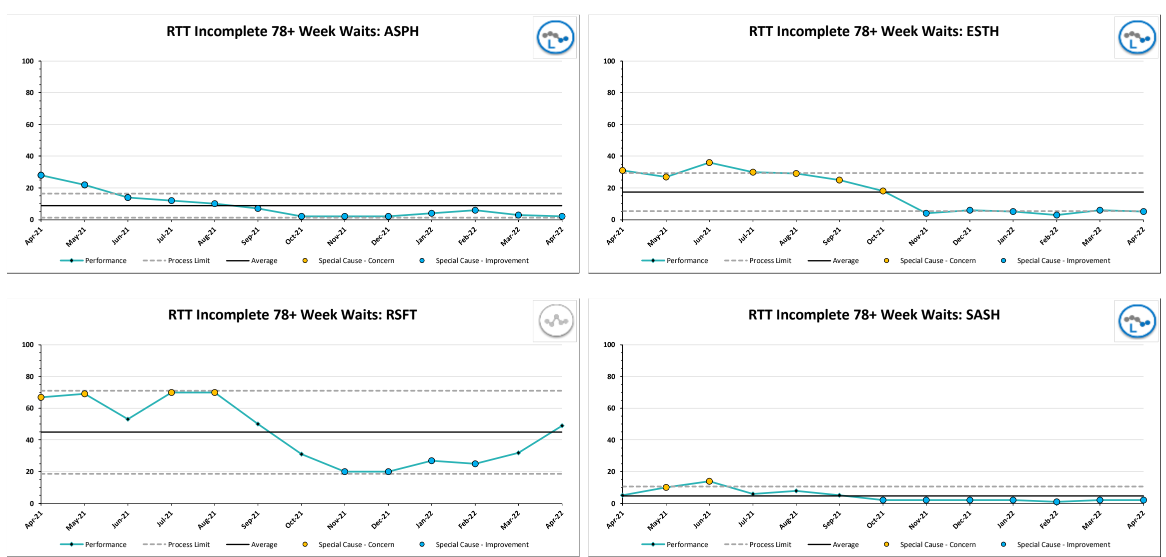
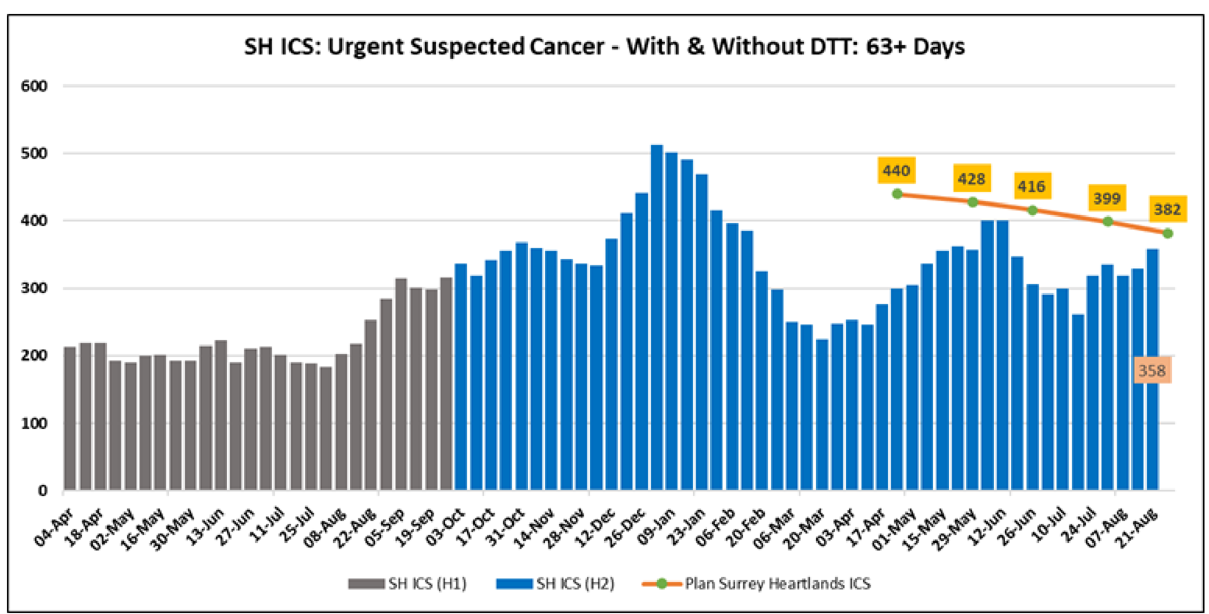


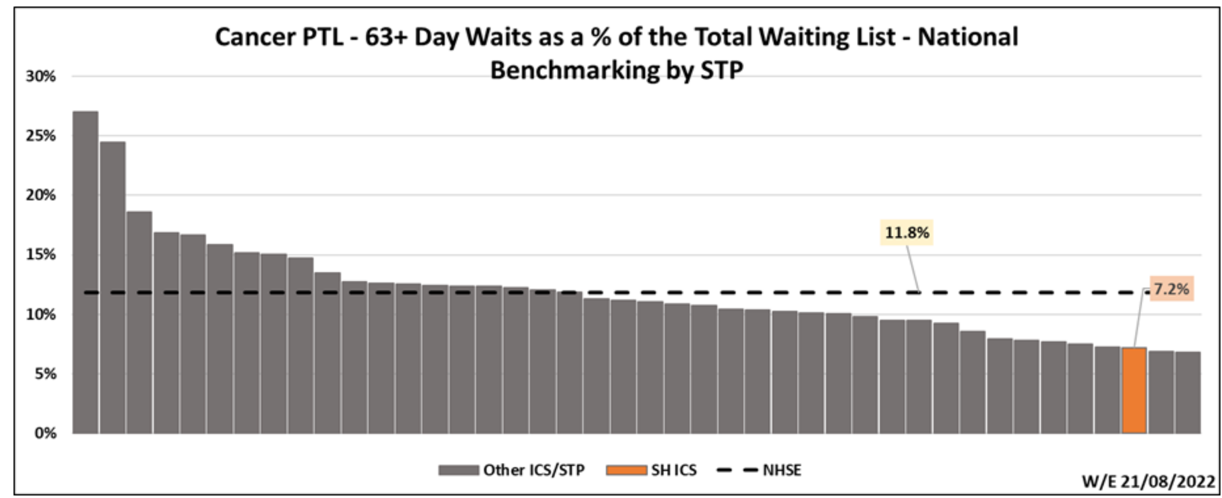
29.9 Many systems have patients waiting over 104 weeks for planned care; Surrey Heartlands has only 1 patient currently waiting this length of time; again, the system is working hard to ensure that nobody should need to wait for 2 years for required treatments. Surrey Heartlands ICS is working with provider organisations to create standardised patient pathways for high volume conditions. By reducing variation, we will enable our workforce to work more flexibly and reduce inequities in waiting times across our system.

29.10 Patients on a cancer pathway are some of the highest clinical priorities. Due to the cessation of diagnostics and treatments during the first wave, along with increased demand has led to a large backlog of patients waiting longer for treatment. Addressing this waiting list remains and will continue to remain a top priority for Surrey Heartlands ICB. Working with Surrey and Sussex Cancer Alliance, all our partners continue to place significant effort into ensuring that patients are treated as soon as possible. The majority of those waiting long periods largely have benign diagnoses, with some patients choosing to delay treatment or are on complex pathways. The total number of people on the Surrey Heartlands cancer wait list is 6,712 at 21st August 2022.

29.11 Surrey Heartlands continues to perform well against the 62 day target, however, the number of people waiting for longer than 63 days has been increasing from April to June 2022. Despite this increase, performance remains good with 358 people waiting (as at 21st August 2022) compared to a projected maximum of 382. Please note that this metric relates to Urgent/ Suspected Cancer with and without discision to treat (DTT). This is a subset of the total number of 63+ day waits on the Cancer Patient Tracking List as it excludes referrals for non-site-specific symptoms.



29.12 Whilst Surrey Heartlands, at 7.2%, is performing better than the England average of 11.8% and ranks 2nd out of the 6 ICS's in the South East region for the lowest number of 63+ day waits; our clinicians and support staff remain dedicated in working to reduce waiting times for all our patients.



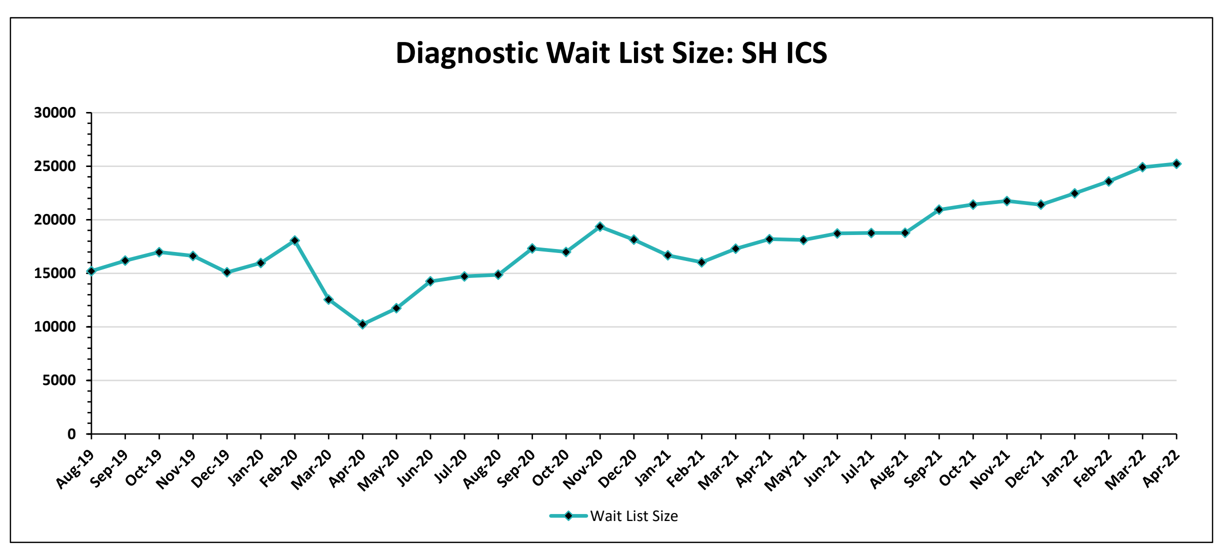
Data Source: Surrey & Sussex Cancer Alliance PTL Summary as at 21-Aug.

29.13 People on the cancer waiting list who have been waiting over 104 days for treatment, reduced from a peak of 445 in June 2020 to 48 in August 2021; this increased again to 99 in August 2022. Work continues to reduce these further with the aim of returning to pre-Covid levels of approximately 30.

29.14 The system has recovered its 28-Day Faster Diagnosis position and has been compliant against the 75% target since February 2022, with performance for May 2022 at 80.5%. This performance is expected to slip slightly in the summer months due to an unprecedented rise in referrals for some types of cancer, following the deaths of high-profile individuals.

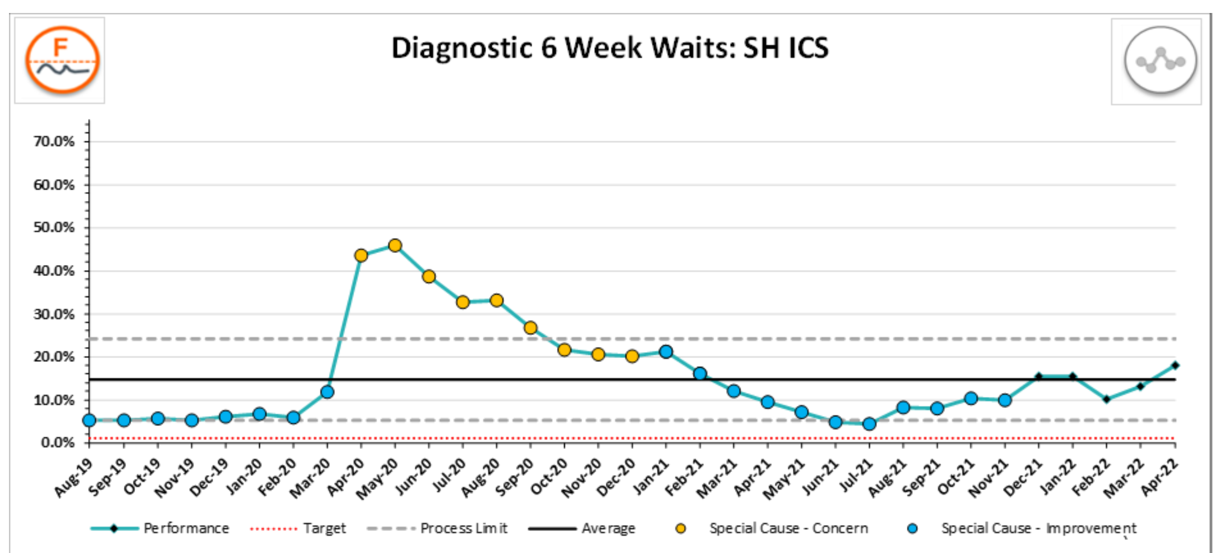
29.15 Work continues in relation to reducing the number of patients waiting long periods of time for diagnosis and treatment. All planned patients are reviewed and allocated a clinical priority based on their past medical history and planned procedure; the patients are also followed up regularly in relation to any changes to the person’s clinical risk.

29.16 The total diagnostic wait list size has been increasing since December; in April 2022 the wait list size was 25,000, an increase of approximately 9,000 since February 2021.



Data Source: NHSE monthly 'Diagnostics Waiting Times and Activity' publications.

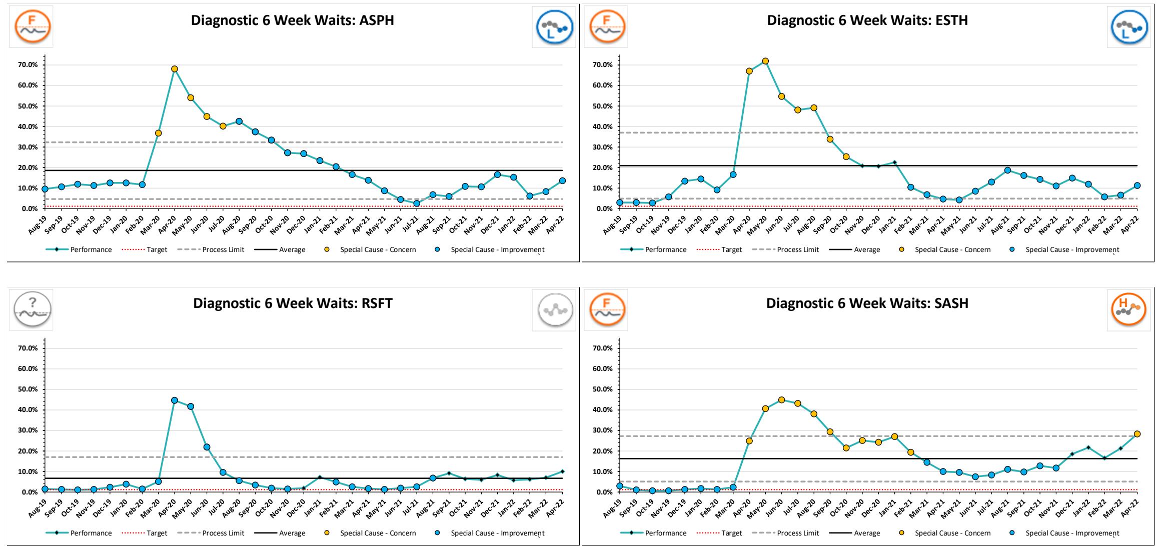
29.17 People waiting longer than 6 weeks significantly decreased from January 2021, however the percentage in relation to the 6-week target increased to 18% in April 2022; this is after reducing at the beginning of February 2022 to 10%.



Data Source: NHSE monthly 'Diagnostics Waiting Times and Activity' publications.

29.18 Below are the individual hospital 6-week diagnosic waiting list numbers.

Acute Trusts:



29.19 The system has refreshed the activity and performance plans for 2022/23 with the trajectories to further recover elective services and plan for winter pressures being agreed by NHSE/I.

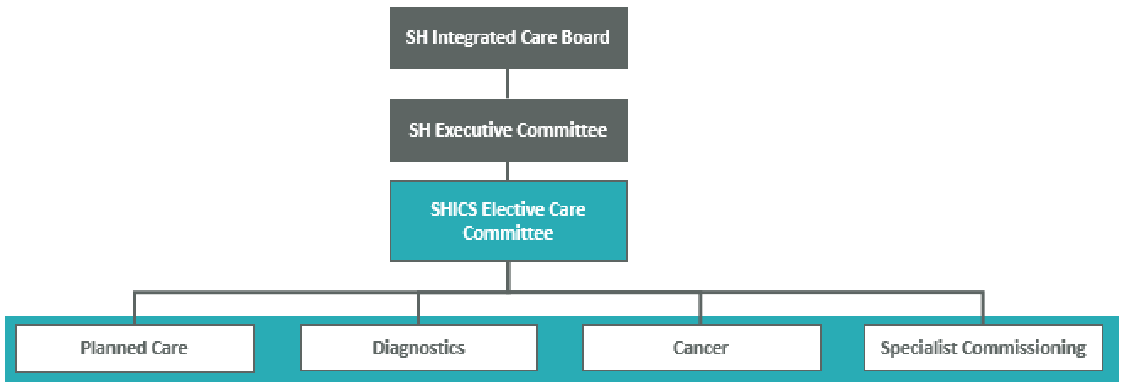
29.20 Surrey Heartlands is actively involved in the National Diagnostic programme. Part of this programme focuses on establishing Community Diagnostic Centres – which deliver additional diagnostic capacity to patients outside of an acute hospital setting. The National Diagnostic Team have supported the Surrey Heartlands ICS business cases for establishing these centres in Woking and Milford, with a further business case underway for the East Surrey area.

29.21 Endoscopy capacity was hit hard through the pandemic as staff were redeployed to ICU. The pressure for endoscopy services has continued to mount following the death of Dame Deborah James earlier this year. Working alongside the acute trusts we have a recovery plan that incorporates long and short-term solutions.

30. Elective Governance

30.1 As well as the acute trusts, independent sector partners supporting elective recovery are assured quality teams. Partners supply quality performance reports monthly, or quarterly, which include RTT, cancer wait times, patient safety, clinical audit, clinical governance and patient experience monitoring data which are reviewed at quarterly meetings. Established processes for notifying Serious Incidents and other concerns are in place. Concerns and risks to quality are escalated through the Elective Care Committee to the ICS Executive and Integrated Care Board, and, where required, through the Surrey Heartlands Quality and Performance Committee.

30.2 Below is the system governance structure in place to monitor and assure against elective recovery and performance, including cancer and diagnostics.



Part E - Assurance

31. System Assurance

31.1 Daily assurance in relation to system pressures is sought via the ICS System Operational Call (SOC); partners share their position statements and from these pressures are identified and actions agreed across the ICS to support a system wide response, with a collaborative approach taken to managing system escalation. A principle aim of the call is to ensure that as partners we have enacted the ICS Surge and Escalation Plan, carrying out agreed actions and ensured a system wide response to share the risk across the system.

31.2 Outputs and issues can then be escalated internally to the ICS Executives and also to Region via the Regional Operational Call.

31.3 Work is ongoing to continue to improve system oversight by further developing the ICS UEC data platform which provides a numerical overview of the system and how it is operating. This oversight helps teams and systems to identify where the pressures are e.g. within ED or perhaps the number of people waiting for specialist assistance in arranging discharge; this information enables staff to create daily, rapid interventions which support individual patients and the wider system flow. This information is able to be shared across, not only the local system, but also on a wider Surrey Heartlands footprint.

31.4 The systems are able to collect and collate information which can be used in presenting and triangulating data – this is vital in helping teams to understand performance trends. The objective and detailed information generated creates the foundation for system calls and reports that can be used on a daily basis. It also informs the systems in their preparation for holiday and winter periods by 'looking back' to previous busy periods and analysing how the system responded.

31.5 A comprehensive surveillance reporting system has been put in place to understand and track bed capacity across the system. These trackers are available at Trust level and are used by the system to monitor daily changes over time and indicate if and when Trusts are approaching the trigger point. They are read in conjunction with more timely operational information obtained through urgent care processes already in place to allow the system to respond on the day. The system relies on daily bed capacity updates from Trusts and is aligned with an agreed Mutual Aid process, ensuring the system is able to track real time situations and seek support from other partners within the system and other ICSs as needed.

31.6 Mutual aid is also a feature of the SOC daily meeting, as strategic partners are able to state whether they are able to offer or are in need of mutual aid. This early ICS system conversation means that wider support to mitigate system risks are sought and agreed earlier in the day which leads to more timely interventions.

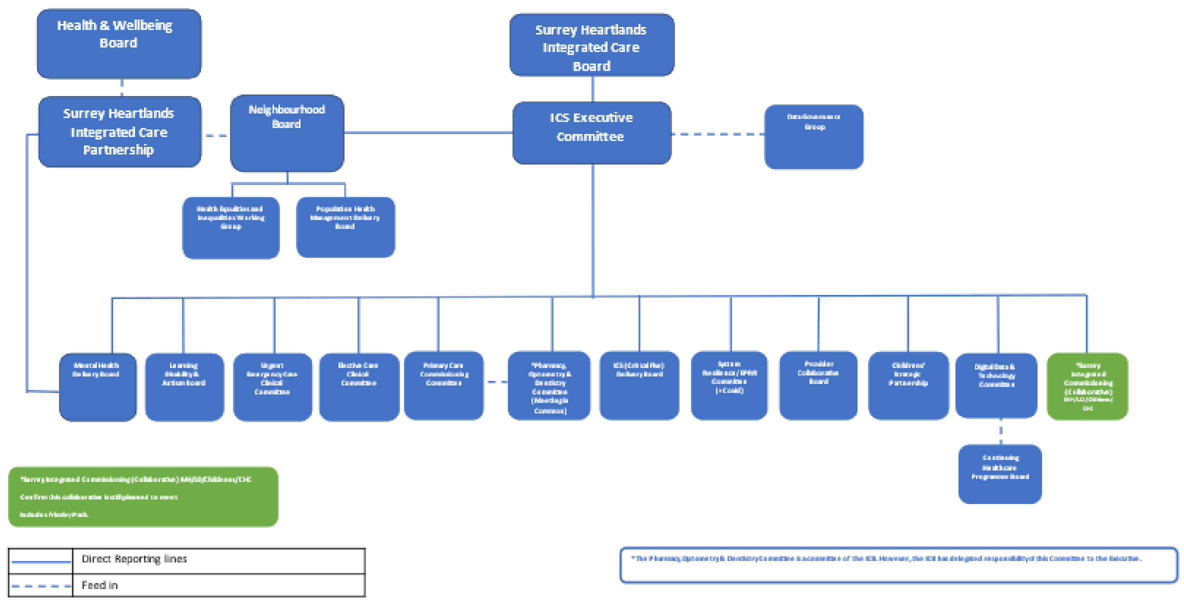
32. UEC Governance

32.1 As a mature Integrated Care System (ICS), Surrey Heartlands has developed strong partnerships across all areas of UEC delivery through introducing a three-year UEC strategy and forming an ICS UEC Committee to oversee its delivery and monitor our performance.

32.2 The UEC Committee has created four delivery groups, which report directly to the Committee, and focus on Same Day Urgent Care within both the Acute Hospitals and the Community, Integrated Urgent Care (as part of NHS 111), Focusing on Discharge; along with working with GPs in identifying those at high risk of needing urgent hospitalisation and putting in plans to prevent or reduce admissions. The actions and deliverables from these groups will together support the delivery of reduced numbers of people waiting longer than 4 hrs in ED.

32.3 The Surrey Heartlands ICS main vehicles responsible for the delivery of urgent care across the area are the Place based Local Accident & Emergency Delivery Boards (LAEDBs) of Northwest Surrey, East Surrey and Guildford & Waverley, along with the Surrey Downs Urgent Care Forum – which links to the Sutton and Kingston Place based LAEDB's. Through these groups each of the systems put in place their plans, with some schemes being established across Surrey Heartlands to ensure that the systems were well prepared to manage sustained surge pressures.

32.4 Overarching assurance in relation to Urgent and Emergency Care is provided by the LAEDB's to the Surrey Heartlands ICS UEC Committee and onward to the ICS Executive and Integrated Care Board.



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ADULTS AND HEALTH SELECT COMMITTEE

Wednesday, 5 October 2022

SOUTH EAST COAST AMBULANCE SERVICE NHS FT: PREPARATION FOR WINTER PRESSURES 2022/23

Purpose of report:

This report updates the committee on South East Coast Ambulance Service NHS Foundation Trust's (the Trust's) planning, timelines and preparation for the anticipated Winter 2022-23 pressures. In addition, this report provides oversight of Urgent Emergency Care (UEC) transformation initiatives, for 999 emergency services and ongoing improvement planning to address the recent 2022 Care Quality Commissioner inspection findings and feedback received through the NHS Staff Survey.

Introduction

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

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 winter pressures foreseen during the financial year.

3. 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.

4. Whilst the Trust delivers the NHS 111/IUC contract across Kent, Medway and Sussex, this service is provided by the Practice Plus Group (PPG) within the Surrey Heartlands ICS. Whilst there are similarities between the Trust's and PPG's service specifications for the NHS 111/IUC services, there are significant

differences in the contracted operating models. The Trust provision is centred around protecting emergency care 999 & acutes via enhanced clinical validation of these 111 triage dispositions, whereas PPG's service centres around a primary care model. It is, therefore, inappropriate to compare the winter planning process directly between these two providers.

5. The UEC winter planning process has changed considerably during the last two years, resulting from the COVID-19 pandemic response and the transformational activities that have been deferred to 2022/23.

6. In addition, the Ageing Well programme has provided focus for Primary Care Networks (groups of GP surgeries and multidisciplinary teams, supporting around 50,000 patients) to better support elderly and vulnerable patients in the community. Urgent Community Response (UCR) is a key programme deliverable from April 2022 and is 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. The Trust is working closely with the Surrey Heartlands ICS workstream lead and all UCR providers to fully embed this pathway during Winter, supported by Winter funding initiatives in progress.

7. The most recent NHSE UEC Winter assurance request was launched on 12th August 2022, with a final return due by all ICS's late September and supplemented by monthly updates thereafter. The ambulance service relevant focus areas include: -

   - Increased resilience in NHS 111 and 999 services, through increasing the number of call handlers.

   - Targeting Category 2 response times and ambulance handover delays through increased utilisation of urgent community response services.

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

8. As a regional provider supporting four ICSs, each with locally determined population-specific priorities, it is key for the Trust to retain a core level of operational consistency regionwide which enables a responsive, effective and high-quality service for all patients. Local tactical planning also supports place-specific priorities where appropriate.

9. 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 2022 CQC Well Led inspection.

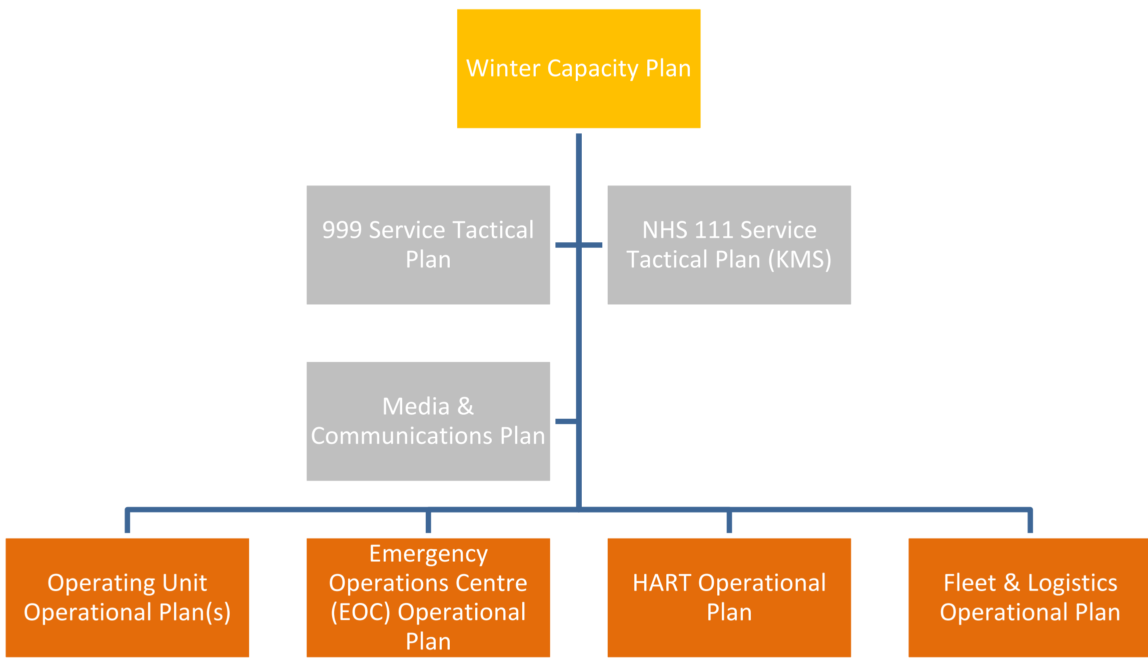
Winter Preparedness

Winter Planning 2022: Process and Timelines

10. The Trust Winter planning process is in its final stages with the Executive Management Board and Trust Board signoff by end September. It will then be circulated to lead commissioners Surrey Heartlands ICB for review and feedback for any final amendments. There is also a Winter preparedness tabletop exercise scheduled for 1st October 2022. Please note that with a final committee report submission date set for the 21st September, the final Trust Winter plan will not be available for sharing in the public domain, however relevant detail will be shared ahead of the 5th October committee meeting where appropriate.

Key Focus Areas

11. The format of the Winter plan for 2022 will be along similar lines to that of the Winter Plan 2021 (attached in **Annex A**) with the following component parts.



12. As per Winter 2021, core focus areas will to be covered include:

- 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, including prior year learning

13. The committee is asked to note that the NHSE guidance on planning assumptions for the demand potential, driven by the combination of COVID-19, influenza and norovirus, has recently been made available. The associated Trust activity forecasting was due for earlier executive management review and Trust Board, however with the recent death of Her Majesty the Queen and associated activities prioritised, this is now rescheduled to the end of September. The Trust will provide the finalised Winter Plan once full governance signoff is completed.

14. Workforce remains challenging across the Trust in the post Covid 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 annual leave carry over and Key Skills training delivery, this all adds to workforce abstraction pressures. The Trust is planning additional frontline operational recruitment from Ireland in year to mitigate this risk. This is not an isolated issue when seen in the context of the increased levels of the Resource Escalation Action Plan (REAP) across all ambulance trusts over the summer period.

15. Workforce information will be incorporated within the Trust's Integrated Quality Report, with links to relevant Trust risks where there is any special cause variation of a concerning nature. This report is currently being finalised for sharing with commissioners.

16. With regards to escalatory processes, the Trust continues to apply its Surge Management Plan (SMP) and 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 a number of factors including activity demand, operational resourcing, levels of abstractions, performance and other system factors including acute systems Operational Performance Escalation Levels status (OPEL).

17. During Winter 2021/22, the Trust had been operating at the highest levels of escalation, as well as in a Business Continuity Incident (BCI) due to being unable

to achieve key response time performance indicators across both its 999 and NHS111 services. It was only in January 2022 that the Trust was able to reduce its Resource Escalatory Action Plan (REAP) from level 4 to level 3 and stand down the BCI after having operated at these levels for many months. There is no anticipated change of escalatory process internally, or with systems externally for Winter 2022/23

18. The Trust was not the only service to have faced these unprecedented challenges. All NHS ambulance services for periods, were operating at REAP level 4, which collectively had not been experienced by the ambulance sector before. Despite these challenges, the Trust has been able to achieve some good levels of performance in its 999 service when compared to national data.

19. 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).

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

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, Leadership & Engagement and Responsive Care) with staff engagement and feedback being incorporated as part of the winter planning process.

22. The Trust works closely with its partners, including the Integrated Care Systems 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 general public, via a number of means including:

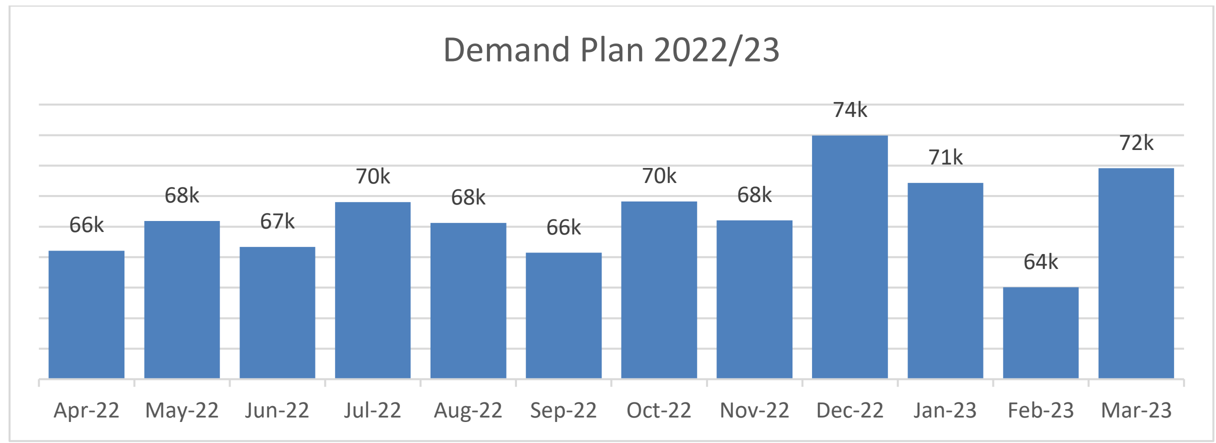
    - Issuing media releases to traditional broadcast and print media
    - Social media across Twitter, Facebook and Instagram
    - Internal communications to staff
    - Engagement with MPs and system partners
    - Specific briefings, if needed, to key stakeholders

23. These communications remind stakeholders of the need to dial 999 only in the event of an emergency and the importance of planning ahead as well as making

use of alternative services to 999 including calling 111 or visiting NHS 111 Online for help and advice.

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:



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 (ICB's) 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 services across England and the wider 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 June, July and August 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 5th, 2nd and 5th respectively across June, July and August. C3 and C4 performance is more challenged and remains the focus of several development initiatives outlined later in the report.

29. Planned productivity improvements are monitored monthly through the Annual Planning Group and in addition to the workforce commentary already provided, the current July 2022 report shows that Hear and Treat 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.

30. 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.

31. As shown in **Annex D** the ambulance handover performance across the four Surrey County hospitals is averaged at 23 minutes 8 seconds for the financial year and hours lost per handover has an increasing trend over the last twelve months whilst the number of transports per day has decreased.

32. The Trust has regular tactical and operational handover reviews with each acute trust to jointly identify and agree key areas for improvement. East Surrey Hospital remains the most challenged in this regard and we have renewed joint efforts to address this further ahead of Winter. The Trust also continues to work on additional UEC transformation initiatives to reduce ED conveyances further where risk appropriate.

CQC Inspection, Rating and Improvement Journey

33. The Trust is committed to making improvements following the publication of a recent CQC report and associated well led rating of inadequate.

34. The inspection, which took place in February 2022 looked at the Trust's management and leadership but also at the emergency operations centres (EOCs) and NHS 111 service.

35. 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.

36. 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.

37. The Trust's Leadership Team has set out key priorities for the year 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.

38. 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.

39. 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.

40. 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 Dignity at Work Advocates and implementing an interactive bystander tool kit which provides all employees with the tools needed to challenge unacceptable behaviour.

41. The Trust is committed to working with colleagues across the organisation to implement changes and ensure the Trust is viewed as the employer, provider and partner of choice.

Other Urgent Emergency Care Transformation Initiatives

42. The Trust is progressing a number of 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.

Category 3 and Category 4 response

43. In order 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 and Medway and Sussex (KMS) 111 consistently validating more than 95% of calls (July 2022 96% – 7961 of 8023 calls), sent through as non-emergency ambulance dispositions in 111. This results in downgrading more than 60% (July 2022 66% - 5056 of 7691) 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.

44. 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.

45. 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 a risk assessed 999 incident direct to more appropriate pathway, without dispatching a physical ambulance resource, or speaking necessarily speaking with the provider.

46. The Trust is working to maximise the potential of PaCCS, to fully enable to all relevant alternate pathways such as Urgent Community Response (UCR), or Same Day Emergency Care (SDEC). These need to be correctly profiled through the Directory of Services (DoS) to allow a direct 999 referral, via the Interoperability Toolkit (ITK), which supports interoperability within local organisations and across local health and social care communities.

47. By working across all four ICSs to enable this functionality in full, in addition to prioritising clinician training and mentoring to increase the usage of PaCCS, this will increase the potential Hear and Treat (H&T) activity outcomes.

48. In parallel, the Trust's Urgent Care Hubs are, with rotas under review to provide 24/7 band 7 clinical support to ambulance crews on scene, to maximise the appropriate usage of the acute same day emergency care and community urgent care pathways 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.

49. The Trust is also undertaking a review 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.

50. 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.

51. The Surrey Heartlands Urgent and Emergency Care Board now provides ICS oversight for the development of these non-ED pathways, with specific focus on the 2 hour Urgent Community Response (UCR), the acute Same Day Emergency Care (SDEC) and Virtual Ward (VW) pathways. Essential work is ongoing with system pathway leads to establish consistent access routes and acceptance criteria for these direct referral pathways for all ambulance crews. In doing so, this should reduce the pressure on ED conveyance activity and the impact of hospital handover delays on patients awaiting handover as well as those awaiting a response in the community.

52. It is also recognised that increased utilisation of the non-ED pathways, especially Urgent Community Response (UCR) services for C3 and C4 incidents should release 999 resources. This will in turn enable more resource to support higher acuity C1 and C2 calls, whilst reducing conveyances to A&E. The Trust is working with lead commissioners to secure winter funding monies to fully mobilise this pathway, particularly for the non-injury fallers that request a 999 response. This is further supported by the 999 UEC contract CQUIN (Commissioning for Quality and Innovation framework) to improve care for elderly fallers, which is further detailed at paragraph 57.

53. All these initiatives will combine over the coming winter to provide enhanced decision making for patients in 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 same day.

Acute Interface

54. 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% (July 2022 5095 of which 3974 were stood down) 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.

55. 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.

56. Non-ED pathways and front door interface - the Trust is working to mobilise effective utilisation of non-ED pathways through work with partners to enable:

    - consistency of approach by ICS,
    - standardisation of acceptance and exclusion criteria, providing support to ICS and place-based forums,
    - effective DOS profiling and consistent pathway formats for ease of access by frontline operational staff,
    - interface with place-based front door admission avoidance teams to enable direct conveyance to the most appropriate receiving unit.

Improved Care for Elderly fallers

57. As part of the Commissioning for Quality and Innovation (CQUIN) framework, the Trust has completed 999-contract negotiations to agree a CQUIN for improved care for elderly fallers.

58. It is recognised that 999 calls received for lower acuity elderly (>65yrs) fallers, are experiencing greater delays in response which can result in interruptions to care and/or potential harm from long lies.

59. Across the Surrey footprint, there are two 999 frequent caller groups associated with elderly fallers, that we are looking to support through clinical education and a faster system response:-

    - careline providers - around 800 calls per month, 40% conveyed to ED

- all care homes – around 850 calls per month, 55% conveyed to ED.

60. 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.

61. Additional winter resilience funding is also being made available to all ICSs to enhance the utilisation of the Urgent Community Response pathway. By combining the system resource and funding streams to provide a first contact falls responder service in Surrey Heartlands, in early trails this has been shown to significantly reduce 999 calls from pendant alarm providers and could equally be applied in care homes.

62. Currently, cross ICS discussions are being held to utilise these bid monies, to mobilise, where resource allows, during Winter 2022/23.

Mental Health Response – Ambulance Conveyance

63. 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.

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

    - providing enhanced mental health training and education to Trust frontline clinicians
    - 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.

65. The Trust is 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 and the initial 3-month review is due during October and will be presented to the following regional Mental Health forum for consideration and expansion by ICS.

66. Initial patient and provider feedback is positive, with early indications showing that the majority of 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.

67. There is a regional mental health governance forum where the 3-month review can be presented and discussed for wider rollout by ICS, although timeframes will depend on the crisis response resource availability to support telephone triage and on scene response where necessary. This discussion is at early stage in Surrey Heartlands.

Conclusions:

68. SECAmb requests the Adults and Health Select Committee to note:

    - The winter planning process, timelines and draft available at time of report, together with the UEC assurance focus areas outlined.
    - The updated performance and planning section with specific focus on the workforce challenges.
    - 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

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

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Sources/background papers

Annex A SECAmb Winter Plan 2021 V1.0 Final

Please note this will be updated by the final 2022 version once internal governance completed and this is anticipated to be available to ahead of the 5 October 2022 committee meeting.

Annex B NHSE documentation

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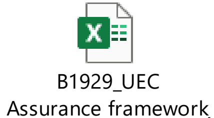
NHSE 2022-23 priorities and operational planning guidance

NHSE UEC Assurance capacity and planning for Winter 2022



NHSE UEC Assurance framework

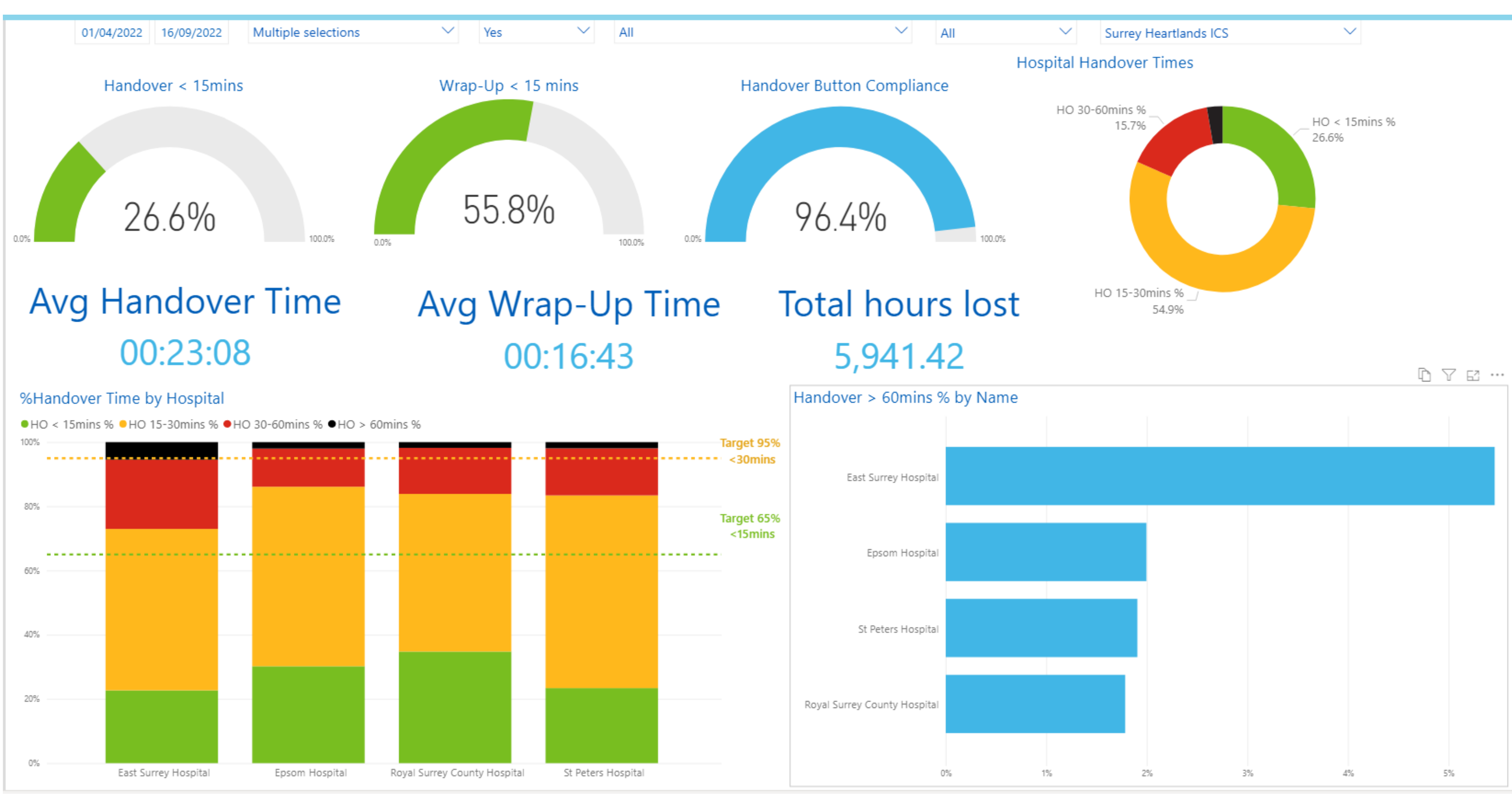
Annex C Ambulance Response Performance Metrics June - August 2022

Date		June			July			August		
Incident Response Level		England	SECAmb	SECAmb National Position	England	SECAmb	SECAmb National Position	England	SECAmb	SECAmb National Position
Category 1	Mean	00:09:06	00:09:04	5th	00:09:35	00:09:34	2nd	00:09:08	00:09:08	5th
	90th Centile	00:16:03	00:16:28	5th	00:16:55	00:16:57	3rd	00:16:20	00:16:28	5th
Category 2	Mean	00:51:38	00:35:31	2nd	00:59:07	00:42:19	2nd	00:42:44	00:35:29	4th
	90th Centile	01:54:17	01:14:10	2nd	02:11:47	01:29:08	3rd	01:33:20	01:13:30	4th
Category 3	Mean	02:53:54	02:46:35	5th	03:17:06	03:36:26	7th	02:16:23	02:44:11	9th
	90th Centile	07:21:14	06:33:14	5th	08:21:47	08:48:23	6th	05:41:13	06:49:13	9th
Category 4	Mean	03:32:07	03:38:13	7th	04:02:57	05:25:09	11th	02:56:39	04:23:48	11th
	90th Centile	08:53:11	08:46:48	8th	09:56:24	12:26:40	10th	07:27:56	11:14:23	10th

* NB - 11 Ambulance Trusts in total

Annex D Ambulance Handover Performance – Surrey Heartlands August 2021 – August 2022

Please note this includes the following hospitals: Royal Surrey, Ashford St. Peters, Epsom and East Surrey



Hospital Handover Report

Glossary of Terms

Surrey Adult & Health Select Committ

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NHS South East Coast Ambulance Service NHS Foundation Trust

SECAmb Winter Plan 2021

Version 1.0 Final

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Version Control

Version Number	Comments
0.1	Initial Draft – Dave Williams, HoEPRR
0.2	Minor additions by S.Fisher / K. Ramnauth
0.3	BI and scoping information added by E. Williams, Exec. DO
0.4	Added elements from J. Griffiths Fleet and Logistics
0.5	Added Ops elements
0.6	Added OU elements
0.7	Minor grammatical changes
1.0	Final With Sign off from Director Ops

SECAmb Winter Plan – Introduction

- The impact of Covid – 19 and the associated impact on the health system has proved to be a significant challenge for SECAmb.
- There is a recognition that, whilst there is a general public view that the Pandemic is ending, the reality for the healthcare system is very different.
- Allied with the delayed health impact caused by Covid, the acuity of patients has been seen to increase during 2021 to date.
- SECAmb as a Trust covers 3 complete Integrated Care Systems (Kent, Surrey & Sussex), and covers the southern part of the Frimley ICS. This plan takes into consideration aspects of the winter plans relating to those systems.
- This is a living and evolving document, which will be developed further in line with lessons identified from exercises and events as outlined later in the plan, and in collaboration with internal and external stakeholders.

Context

- The impact of the changes to Government restrictions post July 19th 2021 have led to an increase in cases of Covid-19, resulting in challenges to the health system as a whole.
- This, associated with an increasing call rate to both the 111 and 999 services have resulted in extended periods at Surge Management Plan level 4 (SMP 4) – see Appendix A.
- The ongoing absence rate has also resulted in SECAmb being at an elevated level of REAP, with the longest period that the trust has ever been at REAP 4.
- The SECAmb workforce, as with every other element of the health service, is increasingly fragile. The availability of staff for overtime has decreased as the impact of the Pandemic continues, although now in a different guise.
- This lack of availability for overtime impacts on SECAmb's ability to cover core shift vacancies caused by short notice absence.
- The provision of Private Ambulance Provider cover for shifts has also been impacted by the same issues.
- This ongoing issue has been reflected nationally, with all 10 of the ambulance trusts moving to REAP 4, as well as Scotland and Wales.

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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.
- Increased time at BCI, due to staff absence and inability to reach patients in a timely fashion.
- 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.
- Despite incentivised overtime being offered, the overtime rate is consistently lower than that seen previously.
- 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

The impact of seasonal variations each year (winter / summer) continues to be an overarching factor when the trust plans for its response. This year there are a number of key factors that will also influence the planning process:

- **Ongoing impact of the pandemic both directly and indirectly** - impact of system wide pressure, Impact of Covid virtual wards on 999/111 service, increasing demand, ongoing impact of IPC guidelines (staff fatigue and staff absence), outbreak management, further surge preparedness.
- **Conflicting and competing demands** - multiple demands on our people in terms of response, planning and delivery. Consideration of the context of the demands from multiple ICS's.
- **Organisational Recovery and Progress** - continued use of our system principles on recovery – bedding in long term transformational change, new ways of working and pathways underpinned by strong clinical leadership.
- **Covid Booster and Seasonal Flu Vaccination programme** – Covid booster programme now from the 11 October to 17 December
- **Learning and building on good practice** - using the learning from the last 18 months in developing our plans for the next period.

Surge and winter demand forecasting - assumptions

- Assuming ongoing surges of Covid –September/October/November, plus another later in the winter.
- Increased flu and viral presentations in Children & Young People and amongst the wider population from late September.
- Negative impact on staff wellbeing with potential for continued high levels of sickness absence if demand levels are sustained into the Autumn / winter combined with circulating infections, and impact of staff fatigue.
- Ongoing impact of infection prevention control on staff productivity and capacity.
- Ongoing and increasing pressures across sectors of acute mental health presentations – adults and children.
- Unknown impact of long Covid in the community.
- Return of seasonal variations in demand such as the Post-Christmas spike in attendances and acuity (as usually seen pre-Covid) as a compounding factor.

Forecast most likely 111 scenario

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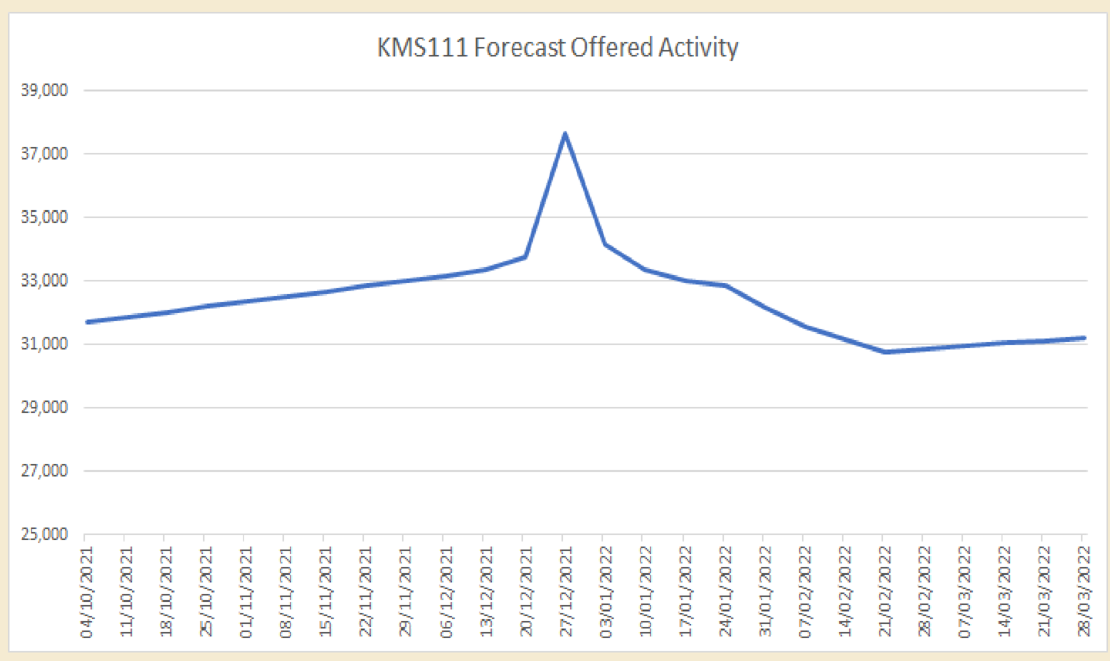
- Call activity is planned with increasing granularity as the service approaches the winter period.
- The forecasts and staffing requirements are calculated at fifteen-minute intervals and utilise a complex workforce planning tool.
- The forecasts consider key metrics such as Average Handling Time (AHT), call profiles, and staff shrinkage.
- Staff planning operates on a rolling 12-week window.
- The winter of 2020-21 was adversely impacted by COVID-19 with calls fluctuating dependent on lockdown status and other NHS E commissioned service capacity. COVID-19 activity into 111 replaced the normal winter illness surge attributed to flu, URTI, LRTI etc.



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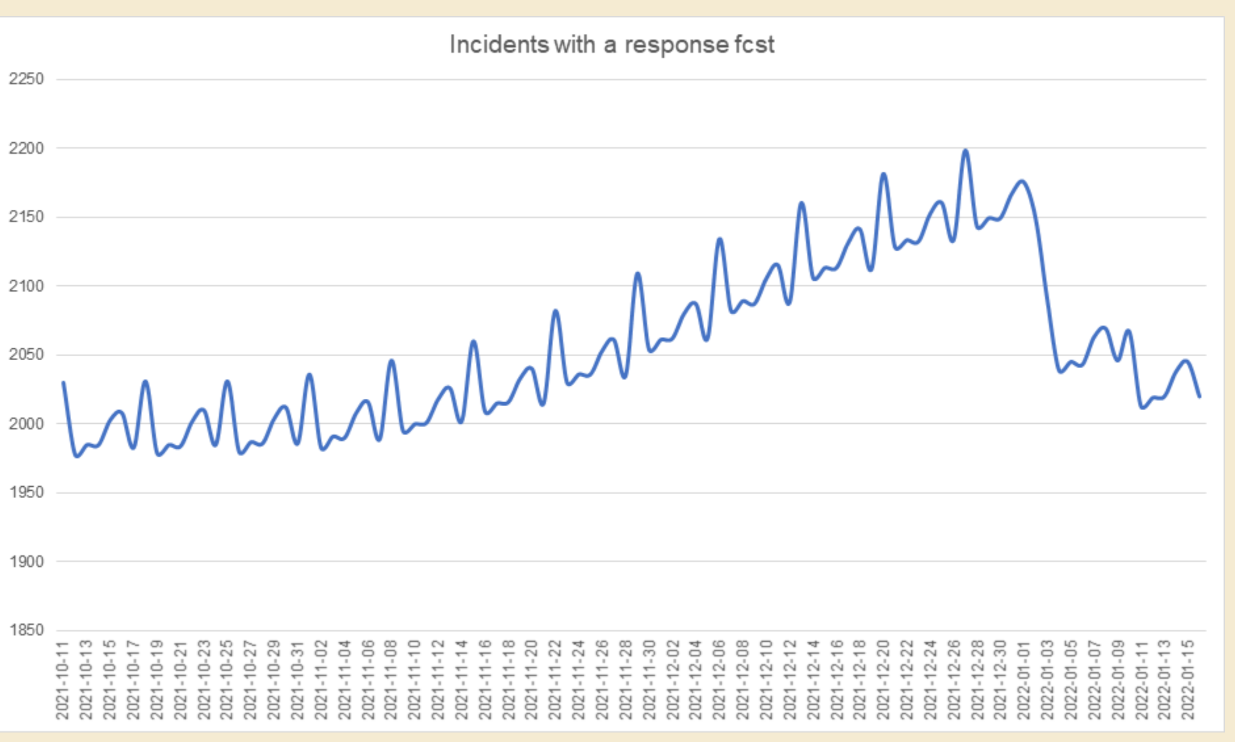
Forecast most likely 999 scenario

- This forecast has been developed based on historic data over the past 3 years, taking into consideration seasonality in demand, key dates (e.g. Christmas & New Year), and fluctuations/trends seen during previous reference periods during the Covid pandemic.
- A group of key assumptions have been included in the calculations such as job cycle time components including hospital handover and wrap-up times.



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 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 SHCCG on the cascade method for appropriate escalation to the wider health system.

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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 4 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 HIOW, London and BOB 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.
  - Enhance command resilience by training extra command members in Operations (Command Support).
  - Ensure robust command structures in place.
  - Tactical Operation Centre (TOC) established from November to oversee operational issues and escalate as required.
  - Exercise Metis – Strategic level exercise in October.
- **External Events**
  - Risk assessment carried out (RAG rating) for each day.
  - Mitigation plans in place for specialist resourcing and potential impact of high levels of absence.
  - SORT Uplift.
  - Operational plans in place with contingencies.
  - TOC to manage escalations.

SECAmb High level actions

- **Resourcing**
  - Targeted Incentivised overtime.
  - Annual Leave management process from December – January.
  - Additional PAP.
  - Use of CFR's in innovative approaches.
  - Collaborative working with other Emergency Services.
  - Voluntary Services agreements.
  - Continued focus on job cycle time management.
  - Consideration of mutual aid as required.
  - Potential for MACA requests.
  - Fleet and logistics to maximise staffing during peak periods.
  - Servicing/MOTs of vehicles will be anticipated to avoid key times.

SECAmb High level actions

- **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.
  - System support via adult and paediatric transfer services.

SECAmb High level actions

- **System Management**
  - Enhanced system calls.
  - Cascade exercise as part of Exercise Metis.
  - Weekly reports on SECAmb status.
  - Continued concentration on hospital handovers.
- **Adverse Weather**
  - Worked with partners to ensure prioritised access to 4x4 vehicles.

Assurance and monitoring

Tactical 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

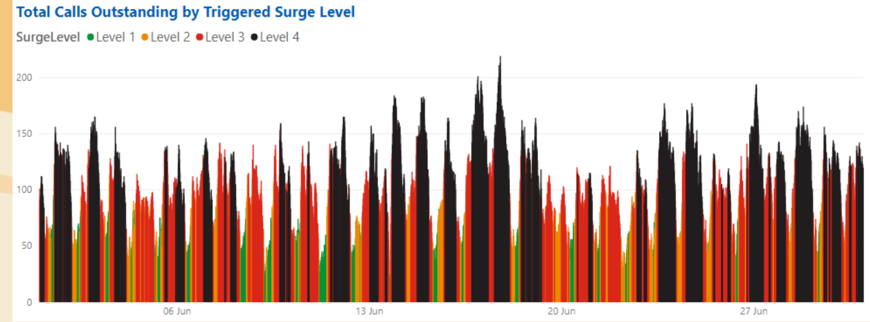
	999 DEMAND	OPERATIONAL RESOURCING	ABSTRACTIONS	EOC	PERFORMANCE	HOSPITAL HANDOVER	FLEET AVAILABILITY	EXTERNAL FACTORS
REAP 1 Steady State	Up to 10% above commissioned activity levels	Within 5% of commissioned resource levels to meet demand	Ops up to 5% above planned level EOC up to 5% above planned level	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

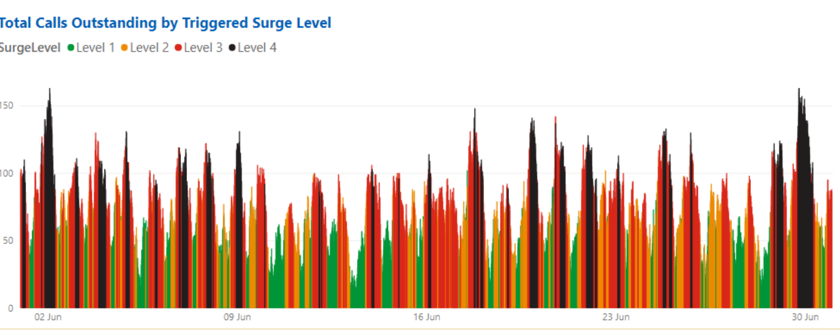
	Triggers	Period in trigger to escalate	Period below trigger to de-escalate	Minimum implementation authority
SMP1	Business as usual - Ability for the Trust to dispatch & respond to meet patient needs as identified within the Ambulance Response Programme (ARP)	n/a	n/a	n/a
SMP2	Any of the triggers below: 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

Appendix A – Historic Surge – 2021 vs 2019

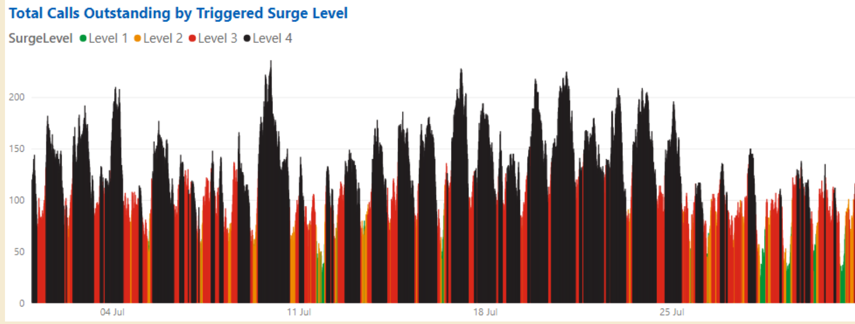
June 2021



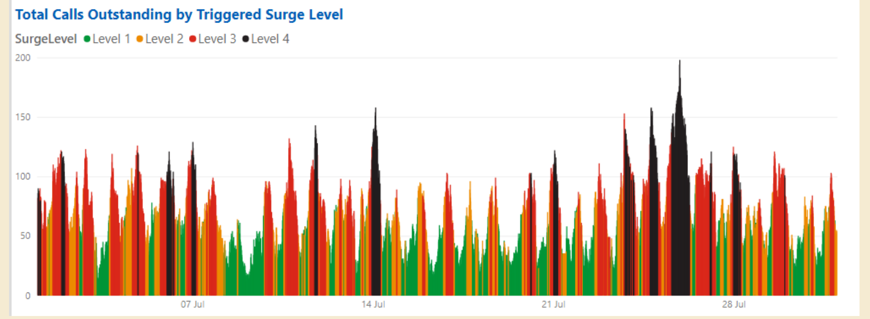
June 2019



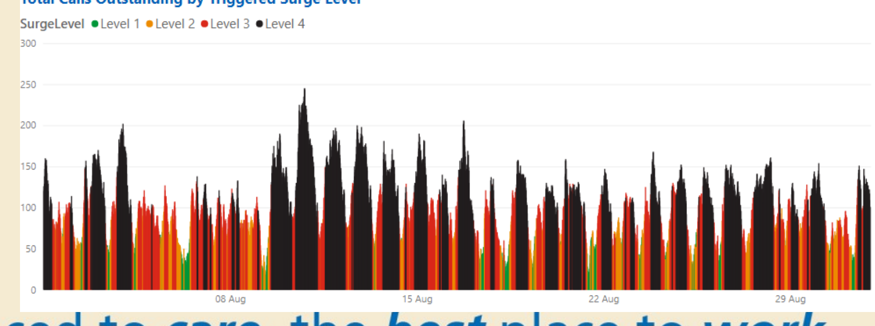
July 2021



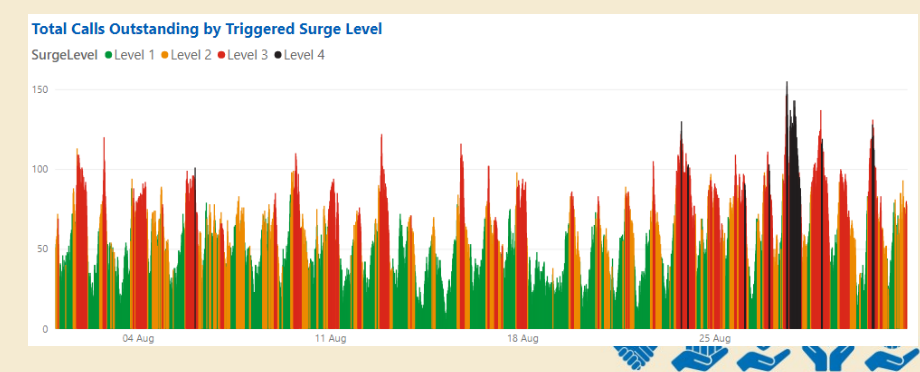
July 2019



August 2021



August 2019



12 month Activity Dashboard 2019

Activity Dashboard

Date Range: 07/01/2019 – 31/12/2019

Operating Unit: All

Dispatch Desk: All

South East Coast Ambulance Service NHS Foundation Trust

Figure	Description
694,168	Count of Incidents with response (ST/SC)
234,848	ST Incidents
738,863	Count of Incidents
459,320	SC Incidents
2,058	Average incidents per day
44,695	HT Incidents
62,772	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	367467	21451	189848	116676	3037
East	370910	23288	205056	104255	2805
	486	21	373	66	
Total	**738863**	**44760**	**395277**	**220997**	**5842**

Count of Incidents by Date

12 month Activity Dashboard 2020

Activity Dashboard

Date Range: 01/01/2020 – 31/12/2020

Operating Unit: All

Dispatch Desk: All

South East Coast Ambulance Service NHS Foundation Trust

701,680 Count of Incidents with response (ST/SC)	264,753 ST Incidents
753,159 Count of Incidents	436,927 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	371807	22404	177959	128595	2355
East	376672	24401	195731	115452	2325
	4680	23	95	35	1
Total	**753159**	**46828**	**373785**	**244082**	**4681**

Count of Incidents by Date

2,400
2,200
2,000
1,800

Jan 2020 Mar 2020 May 2020 Jul 2020 Sep 2020 Nov 2020

9 month Activity Dashboard 2021

Activity Dashboard

Date Range: 01/01/2021 – 30/11/2021

Operating Unit: All

Dispatch Desk: All

502,673 Count of Incidents with response (ST/SC)

179,797 ST Incidents

547,007 Count of Incidents

322,876 SC Incidents

2,088 Average incidents per day

44,334 HT Incidents

63,678 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	272163	18080	142944	77108	1537
East	274726	19426	152008	70215	1378
	118	16	38	5	
Total	**547007**	**37522**	**294990**	**147328**	**2915**

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Directorate Plans

111 KMS Plan

Microsoft Word
Document

999 EOC Plan

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Operating Units

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Chertsey OU

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Context – Each ICP

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- North West Surrey Integrated Care Partnership – 013272 232400.
- Population Covering : Weybridge, Chertsey, Woking, West Byfleet, Shepperton, Staines.
- A&Es : Ashford and St Peters NHS Trust.
- Minor Injury Unit : Woking MIU.
- Urgent Treatment Centre : Ashford & St Peters.

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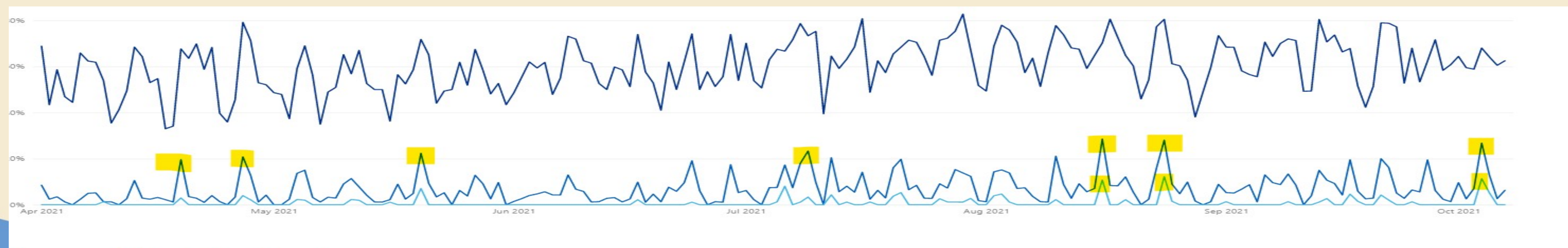
Taking Pride · Continuous Improvement · Acting with Integrity · Demonstrating Compassion · Assuming Responsibility

What are we seeing locally - OU

Isolated Hospital Handover delays

Past 6 months indicates ASPH has isolated periods of significant handover delays. Surrey Heartlands ICS is under persistent pressure, Which ASPH copes with very week. However will have on average a monthly or bi-weekly day of significant hours lost.

Hours Lost at ASPH Past 6 months.



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Actions to mitigate

- 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.
- Agreed escalation plans for on the day Handover delays by Duty OTL and Site Manager. Agreed way of working with Senior Site Manager and SECAmb Tactical.
- Local push for admission avoidance pathways within the OU. Service finder reports to support usage of pathways and frontline crews accessing them.

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Lessons identified (Optional)

- Maintain welfare and contact with colleagues with meaningful face to face meetings following concerns.
- Ensure sickness is managed consistently and fairly across the OU.
- Support welfare vehicles.
- Awareness of an increase of long on scene times and job cycle times due to new starters and inexperienced colleagues.

Ashford OU

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Context – Each 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.

What are we seeing locally - OU

- 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, strike action and weather.
- Regular 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.

Actions to mitigate

- 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.

Guildford OU

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Context – Each ICP

- Guildford Operating Unit serves two ICP's

  - Guildford & Waverley ICP – Incorporating Royal Surrey Hospital – A 520 bed facility with Trauma Unit Status.
    - Absorbs 38% of the OU's See and Convey patients.
    - Accountable for 326 Lost Hours fYTD.

  - North East Hampshire and Farnham ICP – 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 799 Lost Hours fYTD.

What are we seeing locally - OU

- 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 below Trust average.
- C3 performance is in keeping with Trust average.
- Staffing is currently at budgeted levels.
- Delays at Frimley park account for high use of OTL time and lost hours.

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Actions to mitigate

- Demand & Capacity
  - We use innovative methods 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.

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Tangmere and Worthing OU

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Context – West Sussex ICP

- The ICP has strong engagement across stakeholders, Primary care, Commissioning, community trusts, social care, Acute hospital and Ambulance providers.
- 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.

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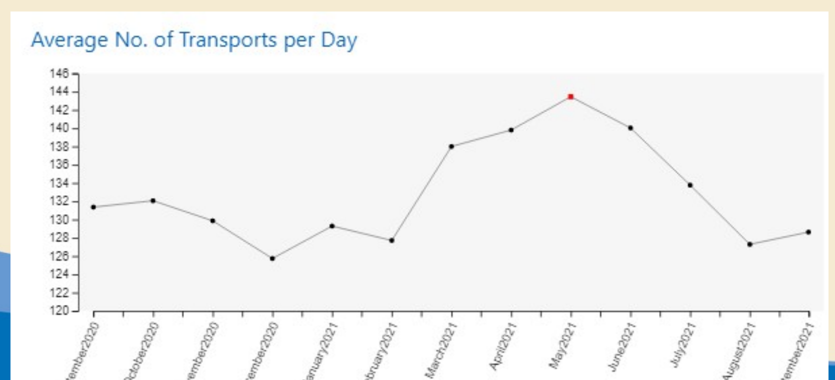
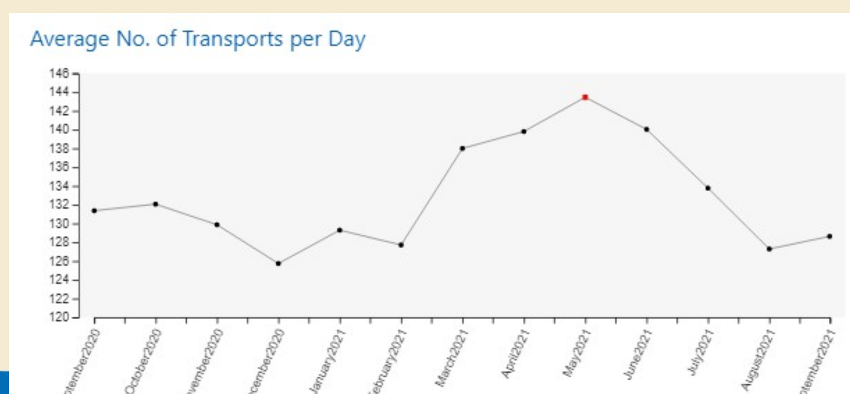
What are we seeing locally – Tangmere and Worthing

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.





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	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

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Lessons identified (Optional)

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

Redhill OU

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Context – Each 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 in the local area.
- AEDB attendance when meetings planned.

What are we seeing locally - OU

- Challenged hours due to high abstractions (Sickness / Secondments / Alternative duties).
- Lack of suitable facilitated ACRP's putting pressure on Gatwick and Redhill stations at peak times for meal breaks.
- Crews travelling long distances to support adjoining OU's.
- Good engagement between operational staff and local leadership team regarding Banstead MRC project.
- Development OTLs supporting team across OU.
- Changes in Churchill contract are causing issues with lack of MRO / VPP staff and KPI compliance.

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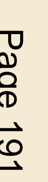
Actions to mitigate

- 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.
- OTL's 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.

Polegate and Hastings OU



Context

This plan refers to the geographical area served by the East Sussex Operating Unit. This includes the towns of Eastbourne, Hastings, Uckfield, Hailsham, Heathfield, Bexhill, Rye and Seaford. Along with a number of villages and hamlets within the East Sussex County footprint. There are a number of key stakeholders within the OU which include East Sussex Healthcare NHS Trust, Sussex Partnership NHS Trust, Sussex Community NHS Trust, local CCG's, Social Care Providers, East Sussex Fire and Rescue, Sussex Police and HM Coastguard.

SECAmb & ICP in East Sussex

Acute Hospitals & Healthcare System

The two acute Hospitals in East Sussex are operated by one NHS Trust. East Sussex Health Care NHS Trust (ESHT). We have a positive working relationship with the Trust at both an operational level, between OTLs and senior nursing staff, and also at a Tactical level. We liaise with the Trust daily at 10 AM during an East Sussex System call. This allows for us to acknowledge the challenges each organisation faces day to day and react accordingly.

We have worked together throughout the pandemic to optimise performance and keep ambulance handovers within the national standard parameters.

Community Healthcare

Some GP practices within East Sussex have bypass numbers which are available on NHS Service Finder. This allows quicker access to a duty doctor for ambulance crews over the phone. This practice is not consistent and access to a patients GP can be challenging. This accessibility is an issues experienced across the trust and is often worse out of hours.

We have access to community nursing teams via social care connect and direct access to crisis beds in Eastbourne and Hastings for mental health patients experiencing acute episodes. Overall access to community pathways is reasonable however due to no national standards existing it is challenging to hold them to account.

Covid – 19 Pandemic

Staff shortages due to illness and isolation felt across the partnership.

High infection rates led to significant system pressure at various points during the last 12 months.

Workforce tiredness and exhaustion following pandemic response status for 18 months.

Other Agencies

We work closely with our local authority partners in a number of different forums. From suicide prevention at Beachy Head to highways teams when planning roadworks access.

We have a positive working relationship with ESFRS who now support us on a number of different incidents. They regularly provide support with complex extrications and provided staff when we required additional drivers.

We work with HM Coastguard on a regular basis due to our coastal border. We have a good working relationships with the volunteer coastal teams however our recent experience of joint working with the HM SAR Helicopter has been very poor.

What are we seeing locally in East Sussex?

Hospital Handover delays

We have been working closely with ESHT (East Sussex Healthcare Trust) to develop a new handover process which has now been active for about 8 months. The process is the same at both of the acute sites operated by ESHT. This has seen a general improvement in handover performance and a better patient experience. Recent system pressure has led to an increase in delay frequency and with hospitals operating at 98% capacity due to discharge difficulties we have seen increased queuing at emergency departments.

Hospital Wrap Up Delays

Earlier this year we recognised that our post handover wrap up performance was well above the national target. We then developed an action plan to address the poor performance. This has led to some improvement in this area however we still continue to be a trust outlier in this area. We have since set up prescribed times for the OTL to visit the Hospital and these timings are based on when wrap up performance is at its worst.

High HCP / IFT numbers

Due to the variance in services available at each acute site in East Sussex we on occasion see a high number of inter facility transfers.

Response Times

Populated but remote villages and towns in East Sussex mean that response times can be extended especially at times of high demand. ARP targets are challenging to meet when the incidence of calls is higher in remote areas of East Sussex.

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What are we seeing locally? 2 (Identified 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.

Risk 1: Staff Welfare and Absence
A reduction in available staff due to sickness, isolation and leave presents a risk during their period.

Staff are likely to receive meal and rest breaks outside of agreed windows during periods of high demand. This has an impact on staff wellbeing and workforce morale. Staff across the Operating Unit have been working under significant pressure for over 12 months and this is likely to have an impact on health and wellbeing possibly leading to absences. Our Team Leaders and Operational Managers will work with staff to support them wherever possible by sign posting them to the various wellbeing provisions available. We will also utilise the OU Mental Health Practitioner to again support staff across the OU. We will utilise existing absence management mechanisms and policies to find collaborative ways to keep colleagues within the workplace.

Risk 2: Demand / Call Surge
Historically we have operated in high levels of SMP during the winter period and will frequently hold calls for long periods within our “stack”. Our EOC and Clinical colleagues will handle calls being held and where possible when demand and training allows our local PP team will also provide support. Certain calls that sit unassigned within the dispatch stack can worsen and the likelihood of conveyance to an acute hospital increase with every hour. We will be proactive and dynamic by using RCMs, CFRs and when safe ESFRS to support with response to mitigate the risk.

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What are we seeing locally? 2 (risks continued)

Risk 3: Operational Response

Due to the geography within East Sussex and the road network response delays can be worsened by inclement weather or traffic congestion. This often mixes with high numbers of outstanding calls leading to lengthy response delays. C1 performance can be poor if ACRPs within outlying or remote Towns are uncovered. We will work with our local CFR teams to increase cover during this period and consider the use of SRVs within a select zone.

Risk 4: Hospitals

East Sussex Healthcare NHS Trust operates two acute Hospital sites within the Operating Unit. With an expected increase in demand across the NHS we will likely see poor patient flow throughout the acute system. This will lead to ambulance handover delays which have a direct impact on total job cycle time, response times and have a negative clinical impact on patients waiting for ambulances in the community. Major Trauma patients and patients requiring specialist services at the weekend such as MRI will likely be conveyed to hospitals outside of the OU. This can lead to cross border working which can result in a reduced level of DCA cover for a period.

We will undertake a daily East Sussex Systems call weekdays at 10AM via Microsoft Teams. This will allow for information sharing and increased situational awareness regarding system pressures. These calls can be scheduled at the weekend at times of severe pressure along with standard Sussex wide system calls. Emergency handover procedures can be utilised in order to protect patients waiting in the community. We will continue with our zero-tolerance approach to patients being held outside hospitals in the back of ambulances. Our Duty Operational Commanders will visit the acute hospitals at prescribed periods during the day.

What are we seeing locally? 2 (risks continued)

Risk 5: Alternative Care Pathways
We will work with all system partners to make sure that alternative care pathways work effectively during the winter period. This will be done via our local PP team, OTLs and with some OM support when required. Issues will be escalated via system calls and updates will be disseminated via the NHS Service Finder.

Inability to access community services can lead to unnecessary conveyances to acute sites.

Risk 6: Events
Seasonal events during this festive period can have an impact on service delivery. New Year celebrations will be planned for, and risk assessed by Tactical managers and any planned events will be reviewed locally. Tactical and Operational managers will attend relevant SAG meetings and communicate event details amongst colleagues and operational staff when required.

Risk 7: Weather
Adverse weather or extreme temperatures may limit response capabilities within the OU. 4x4 provision will be reviewed and any required measures will be implemented. Our estates will be safety maintained supplied with grit to reduce slip, trip or fall risks.

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Actions to mitigate

Demand

We are utilising resource planning tools within the Power BI app to plan operational duties to match expected spikes in demand. This activity planning based off reliable data and local knowledge should allow us to supplement existing core shifts accordingly. Our scheduling team regularly advertise overtime via a number of platforms in an attempt to cover required shifts. Our local operational commanders work in conjunction with the on duty tactical commander to react accordingly to demand. Our daily safety huddle allows us to identify shortfalls and then plan accordingly to address them.

Capacity

Working closely with system partners on a daily basis to flex resourcing accordingly. Our daily safety huddle held within the OU each day allows us to maximise our daily capacity and set action plans to maximise the following day if a shortfall is identified. We will continue to meet with our system partners daily at 10:00 am via teams to maintain situational awareness and understand the challenges faced by stakeholders.

Workforce

We are using a scorecard system to track and manage staff performance. Within this approach we have imbedded a focus on welfare and wellbeing by ensuring that staff have regular 1-2-1 meetings will line managers and a meaningful appraisal. We already have a dedicated OU Mental Health Practitioner who works within the unit and is available for all operational staff. OTL teams are well practiced at appropriate sign posting to wellbeing services and share information effectively about critical incidents so that follow up conversations or welfare checks can be completed.

Actions to mitigate continued

Exit Flow

We already have an established ambulance handover process in place at both acute sites. This plan is the identical at each site in order to optimise effectiveness. We also have a wrap up improvement plan aimed at reducing ambulance turn around delays. We have a prescribed approach to OTL presence at acute sites and they will attend daily during these times. The PP Hub oversight on crews assessing patients on scene allows us to intervene early when it comes to transferring care to community providers to avoid ED attendances.

External Events

We anticipate that fluctuating staff absences for varying reasons will spike at unpredictable times. We have become well practiced at dealing with this when it occurs. The local team have a good grip on any known events and plan accordingly for them. We have robust plans in place for likely adverse events and expect to see weather challenges during the winter. The road network provides a significant challenge in East Sussex this

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Lessons identified (Optional)

- Importance of 1-2-1 meaningful meetings with staff.
- Importance of operationalising strategies so that those at the front end can understand what it means for them.
- Engaging with staff regularly.
- Utilising the right resource for the right patient.

Medway and Swale OU

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Context – Medway & Swale 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.
- 111 being viewed as a key component in system resilience through the managing of unheralded activity.
- Swale UTC comes online 1st November 2021.
- Medway & Swale Falls Car is on the line and looking to increasing operating hours during winter.

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What are we seeing locally - OU

- 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.
- Increased Road works for A2 Works.

Actions to mitigate

- 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.
- 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 Dartford & Medway OU.

South East Coast Ambulance Service
NHS Foundation Trust

SECAmb Tactical Winter Plan 2021

Paddock Wood Operating Unit

Version 0.1

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Context – West Kent ICP

- Continued pressure across the Kent system.
- System partners working to capacity.
- 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.
- Continued system pressure causing capacity issues at acute sites – however this rarely causes notable ambulance handover delays. There is the potential for delays to become more frequent over winter months of we see a peak in ED attendances and hospital admissions. Crews and local managers are well-versed in delayed handover procedures should these be necessary and there is plenty of corridor space to offload onto hospital furniture.
- Reviewing available pathways and access, including maximising utilisation of community based UTCs.

What are we seeing locally - OU

- Daily under-supply in unit hours due to vacancies (189 WTE vs 229 target), compounded by high levels of sickness Trust wide.
- Relatively small proportion of ambulance handover delays in comparison to other parts of Kent.
- Continued high ambulance demand - high proportion of patients conveyed to hospital.
- Minimal conveyance to non-ED destinations (e.g. UTCs) – potential for wider use.
- 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.
- What is the local story – bullet points – what have you seen locally, what have been the challenges, what have been the wins?

Actions to mitigate

- **Demand**
  - 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).

- **Capacity**
  - 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 including financial enhancements within the financial envelope available.
  - Continued utilisation of Private Ambulance Providers.
  - Engagement with Fire and Rescue and Community First Responder teams to align resource availability to demand profile.

Actions to mitigate

- **Workforce**
  - 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.
  - Staff on alternative duties directed to activities that support staff welfare and patient care (e.g. HALO).
  - 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.

Lessons identified

South East Coast Ambulance Service
NHS Foundation Trust

Challenges last winter include:

- High levels of COVID sickness and isolation following a local outbreak.
- Exhaustion amongst the Band 6 paramedic workforce due to the need to provide support to a large number of preceptees who had received minimal induction or equipment familiarisation.
- Lack of resilience in operational command cover.
- Poor skill mix caused a high amount of downtime due to single-staffed vehicles.

Lessons learned include:

- Strong enforcement of PPE requirements (all managers are challenging staff on non-compliance).
- Maintaining social distancing in non-clinical areas and avoiding complacency during downtime (this is supported by limits on room capacity, spacing of furniture and enforcement by local managers).
- Introduction of local familiarisation programme for Newly Qualified Paramedics to include equipment familiarisation and contact shift with an OTL/OM.
- Work underway to develop a small pool of Band 6 staff to provide support to the operational command function.
- New skill mix introduced to provider greater flexibility with crewing.

Brighton OU

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Context – 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 ie local UTC / alternative acute trust site.*
- *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.*

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What are we seeing locally - OU

- *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 affecting 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.*
- *Estates / building work at ED reducing vehicle flow and capacity.*
- *Improvement of local, UTC, provision to reduce ED attendance.*
- *Reduction in command resilience due to local management team attendance at ED as HALO / capacity team.*

Actions to mitigate

- *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 PP's 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.*

Lessons identified (Optional)

- Inconsistent or changeable messaging across the organisation resulting in confusion and a lack in confidence of messaging and content.
- Lack of a 'single voice' for messaging resulting in miscommunication.
- Locally - information collated to create single standardised and simplified briefing document disseminated daily / weekly to address above.
- OTL availability maximised to ensure accessible at all times.

CFR Provision

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Context

- *Local Leadership Team engagement with CFRs*
- *Active communications WITH CFRs and monitoring of C1 Performance*
- *Active list of 4 x4 trained CFRs (with own vehicles) to support trust during inclement weather (List sits with Operational Support Desk)*

What are we seeing

- *Reduced number of CFRs post Covid-19*
- *However - those 287 responding are attending more incidents and making a clear and tangible impact on C1 performance*
- *Still underutilisation within EOC of CFRs booked on across the Trust (Could be tasked to more incidents)*
- *Effective engagement between Community Resilience Team and CFRs*
- *Good engagement between OU's and CFRs*

Actions to mitigate

- *Effective communications to CFRs through Everbridge to ensure maximum booking on*
- *CFRs booking on must book on for C1 and C2 calls (unless CFR is in their workplace then only C1s)*
- *Posters into EOC to remind dispatchers of "THINK CFR"*
- *SMP calls being joined by leadership team*
- *Leadership team focussing on CFR welfare issues*

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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To:
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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.

Frimley Health and Care ICS

Winter Planning 2022/23

Winter Planning 2022/23

- Urgent & Emergency Care Strategy
- Urgent & Emergency Care Priorities
- National Winter Planning Process

Urgent & Emergency Care Strategy

- In common with all parts of the country right now, there is significant pressure on the delivery of Urgent & Emergency Care (”UEC”) services. This is not just about acute hospital services or Emergency Departments; it is an impact being felt in all parts of the Health and Social Care sector.
- Many of these issues have arisen as a result of the COVID-19 pandemic and are novel challenges for our partnership to overcome. Other issues are exacerbations of existing challenges within our system.
- To improve this position we have been working as a system partnership over the Summer of 2022 to develop a new Urgent & Emergency Care Strategy for the Frimley Health and Care System.
- Working with our Clinical & Professional leaders (over 120 stakeholder interviews, in addition to cross-system & cross-sector working groups) we have now completed a proposed Urgent & Emergency Care Strategy for the Frimley system.
- This strategy contains the objectives and guiding principles for the future decisions we will have to take around service design and delivery, working with our population and local professionals to evolve a delivery system which meets their needs.
- Today’s presentation to the Board provides an overview of:
    - The proposed Core Objectives
    - The proposed Enabling Objectives
    - How this translates into immediate action for Winter 2022
    - Future focus areas for 2023 and beyond

Our UEC vision

Frimley Health and Care

Why?

Patients and communities are central, they are the reason we exist. We recognise and address the differences that exist across our system.

How?

We are part of a high performing ICS with mature 'best in practice' services that patients trust.

Our local residents receive safe, connected and reliable care to support them when they need it most

How?

Patients move through our services without realising different providers are involved as they receive full continuity of care. They know that they will receive the care they need, when they need it.

What?

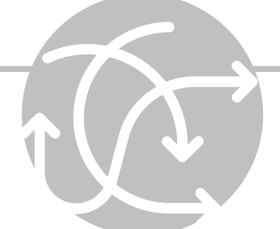
Our patients need rapid care at the most critical times in their lives - speed is of the essence.

The Frimley ICS UEC system will be known as…

Delivering patient-centred care, with ongoing close collaboration with the community

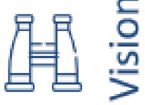
Fast adopters and implementers of the latest technology to reduce demand, increase flow and improve discharge

Flexible and agile when needed, to effectively manage demand and capacity pressures across the system



Thought leaders with a reputation for continuous innovation to improve UEC delivery

Fully integrated, with shared workforces, resources and goals



Vision

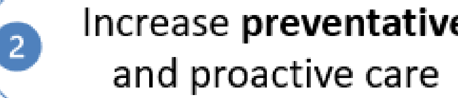
Our **local residents** receive **safe, connected and reliable** care to support them **when they need it most**

Outcomes

1. Maintained health
2. Improved health
3. Accessing the right UEC service
4. Receiving timely care
5. Safe and timely quick discharge
6. Continuity of care
7. Same outcomes

Core objectives

1 Meet **population** needs



2 Increase **preventative** and proactive care

3 Improve **access** and service delivery

4 Ensure efficient **exit**

Enabling objectives

5 Support **workforce**

6 Simplify operating model and **governance**

7 Increase innovation and **transformation**

8 Improve **comms** and engagement

Interventions detailed on further slides

Core Objectives

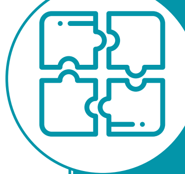
These core objectives help to drive one or more outcomes and are underpinned by multiple interventions

1. Understand the needs of our population to deliver equitable clinical outcomes system-wide and reduce health inequalities

Use population health management and risk stratification to understand and design initiatives tailored to our populations and reduce UEC service variation across the ICS so that patients receive the same care and same clinical outcomes regardless of where they live.

2. Support preventative care and develop proactive management services to reduce avoidable contact with urgent and emergency care

Support our population to proactively manage conditions by developing interface services and technology to reduce risk of deterioration and management outside of acute hospital settings aligned to Ageing Well and Living Well strategic ambitions.



3. Adapt the urgent and emergency care offering to improve access and service delivery efficiency

Identify and optimise services within the ICS to provide alternate pathways to ED in order to address operational capacity and demand challenges and support our population to access appropriate care closer to home.

4. Ensure timely exit and support the provision for continuity of care through transformation of the discharge process

Work with community/social care and secondary care to support a more effective exit from ED through a positive governance and risk approach and increased data visibility in order to allow the ICS to design services that better meet need and demand.

Enabling Objectives

Frimley Health and Care

These enabling objectives support the core objectives to deliver on the outcomes

5. Adopt alternate workforce solutions that develop and support the UEC workforce to provide the right care for patients

Support our UEC workforce by using alternate workforce models and providing attractive and flexible career opportunities to increase attraction and retention.

6. Implement a system wide UEC operating model to share risk, reduce complexity and support a more resilient, sustainable system

Reduce complexity and increase visibility by integrating UEC across the system, strengthening collaboration and governance, and supporting a positive risk sharing culture.

7. Continue to transform how care is delivered by embracing opportunities to innovate and lead on best practice care

Embed transformation in the health and care system by piloting, testing and rolling-out new opportunities to improve patient outcomes and apply learnings from best practice, partners and initiatives.

8. Improve patient awareness and understanding of how to access the right care

Empower our population through targeted and meaningful communications, address perceptions of care and increase availability of information to support them to make the choice that is clinically right for them.

Core Objectives

1) Population Health

Use population health management and risk stratification to understand and design initiatives tailored to our populations.

2) Prevention

Support preventative care and develop proactive management services to reduce avoidable contact with urgent and emergency care

Self care

Preventative care

Elective care

Non emergency ambulatory care

Remote monitoring

Routine primary care

Mental health services

Cancer services

3) Access

Adapt the urgent and emergency care offering to improve access and service delivery efficiency

NHS 111

Pharmacy

OOHs Primary care

Same-day Primary care

Ambulance

Emergency Department

Urgent Community Response

999

MH Crisis services

Walk-in centres (UTCs / MIUs)

4) Exit

Ensure timely exit and support the provision for continuity of care through transformation of the discharge process

Social care

Acute care at home

Hospital

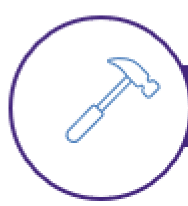
Community health

VCSE Sector

'At home' services

Interface services

UEC services



UEC Priorities – Phase 1 - Organising ourselves for improvement: September 2022

		STRATEGY	LEAD	SUPPORT	CLINICAL LEAD	STATUS
1	**UEC Escalation Arrangements** (BCI)	6	DG	GK	n/a	Complete
2	**ICB On-Call Arrangements**	6	DG	GK	n/a	Complete (starts 1/10)
3	**UEC Governance**	6	SD	SB	n/a	Due 30/09
4	**UEC Resources** (Staffing)	6	SD	PK	n/a	Due 30/09
5	**Winter Planning** (NHSE returns)	6	NA	NW	n/a	Due 30/09
6	**Demand & Capacity Bids** (additional capacity)	4				
	- FHFT		DB	RW	n/a	£2.7m bid complete
	- Out of Hospital		DG	RW	n/a	1,000 Beds ongoing
7	**SCAS** (Working arrangements and delivery of Winter Plan)	3	RW	ShB	n/a	Ongoing
8	**Performance Reporting** - EPIC reporting issues - Weekly report - Board reports - “SHREWD”	6	SD	OW	n/a	Due 30/09
9	**UEC Contracts**	3				
	- WPH GP Streaming		PK		JMc	Due 30/09
	- Out of Hospital Services		RW		JMc	Due 30/09
10	**Minor Injuries Pilot** (Pathway Proposal)	3	CF		JMc	Due 30/09

Bracknell Forest North East Hampshire and Farnham Royal Borough of Windsor and Maidenhead Slough Surrey Heath

UEC Priorities – Phase 2 – Service transformation focus: Winter 2022

		STRATEGY	LEAD	SUPPORT	CLINICAL LEAD	STATUS
1	**Community Transformation Initiatives** - Virtual ward roll-out - UCR (including Frailty) optimisation - Call Before Convey - Enhanced Care Homes Support	❷	NA	YM	tba	
2	**Proactive Management of High Risk Patients** - Population segmentation approach - Remote monitoring & other pro-active interventions	❷	SBu	NA MS SB	LI	
3	**111 Pathways** - DOS management - CAS - High Intensity Users	❸	RW	ShB	JMc	
4	**Same Day Demand** - Primary Care - Minor Injuries Pathway	❸	CF	PK	JMc	
5	**Respiratory Hubs** (Hampshire model)	❷	tbc		GR/LI	
6	**D&C Bid Additional capacity** - Heathlands - Ward 18 @ WPH	❹	DG	RW	JMc	
7	**FHFT Length of Stay Improvements**	❹	DB		JS	
8	**Local Authority Discharge Capacity**	❹	DG	DM	JMc	
9	**Pan-ICS** (Discharge Community, Rehab Beds)	❹	DG	DM	JMc	
10	**Mental Health Pathways**	❶	NB		KS	
11	**Seven Day Services**	❷	SD	CC	JMc	

National Winter Planning Process

National Policy Position

- On 12th August, NHS England released guidance to all ICB and NHS Provider Chief Executives; ***Next steps in increasing capacity and operational resilience in urgent and emergency care ahead of winter***

The main areas of focus and objectives of the guidance included:

- Building operational resilience & increasing capacity
- The need to deliver on planned care and cancer recovery as a part of overall system improvement
- Supporting improved flow and better managed operational pressures
- Having a realistic and deliverable approach to workforce resilience
- The need to work with systems on reasonable worse case covid scenarios

To support all delivery organisations to achieve these objectives, it is proposed that:

- Partners bring a new and renewed focus on system working, including working with Local Authority organisations, and that ICBs should lead on assurance of winter performance

- *"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."*

- NHSE has proposed performing a more supportive role – stress testing plans to "check and challenge"

- There is an expectation that systems will have mapped winter capacity and demand & identified known areas for improvement

NHS England defined Key Performance Indicators

Performance metrics:

- A national “Board Assurance Framework” has been developed for ICB Boards to track service delivery through winter.

- The standard Key Performance Indicators are as follows:
    - 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
    - To include local performance trajectories to sit alongside these measures

    - Unless and until the adoption of the Clinically-led Review of Standards is agreed with the Government, current standards remain for emergency department performance and flow.

    - Objectives set out in Planning Guidance, which includes reducing 12 hour waits for patients in acute hospital emergency departments remain in effect.

Delivery expectations for inclusion in the Winter Plan

Upcoming actions / deadlines in response to the ask:

- Demand and capacity assurance: Plan against demand and capacity funding (£2.735m) with regular assurance process (not yet confirmed) to enable progress to be aggregated nationally (draft plan completed & submitted). Update and refresh of plans required 22/9. with national submission 26/9

- UEC Action Plan: Template to be completed by ICBs (regional deadline 14/9, peer review process, final regional draft 22/9 & national deadline 26/9) with monthly tracker

- Good practice checklist: Return required from ICBs so regional teams can collate to ID themes/gaps to national team to ID development support (regional deadline 14/9 & 22/9 and national deadline 26/9). No recurrent reporting requirement so for ICBs just an internal assurance tool to see if using good practice/where making progress.

- Library of good practice/improvement framework: for Operational Management and Improvement and ICBs. Optional sharing with regional team

A Frimley ICS planning team comprised of colleagues from the ICB and NHS Provider organisations are currently working on the formal response to meet the deadlines stated above, liaising with relevant partners including local authorities.

Frimley Health and Care

ADULTS AND HEALTH SELECT COMMITTEE

Wednesday, 5 October 2022

ENABLING YOU WITH TECHNOLOGY – TRANSFORMATION PROGRAMME

Purpose of report: To update the Adults and Health Select Committee on the Enabling You with Technology (Technology Enabled Care) Transformation Programme

Introduction:

1. The “Enabling You with Technology” transformation programme was initiated to deliver a technology enabled care offer for people with eligible social care needs and potentially for self-funders to purchase, with the aim of supporting people to live independently in their own homes for as long as possible. Technology Enabled Care [TEC] is a broad term that can include telecare, telehealth telemedicine etc and is the use of technology to assist people with activities of daily living, such as, personal alarms, monitors, sensors, smart plugs, pulse oximeters, self-care apps, falls devices etc. Technology can enhance the care and support provided by carers and others, it can help to right-size the care package required by providing valuable insights and, in some cases replaces or reduces the need for personal care, increasing the person’s independence.

2. This report provides an update on the transformation programme further to the report presented to the Select Committee on 21st October 2021.

Telecare in Surrey

3. District and Borough Councils either provide or commission telecare services in Surrey; these are the traditional community alarms and pendant devices to enable people living at home to raise an alert when a person falls or needs urgent assistance. The alarms are linked to a monitoring centre which operates 24/7 all year round. Though the provision of such services is at the discretion of local councils, they are well established and around 16,000 people benefit from these services in Surrey. Telecare services provide an income stream for Councils, this is often used to invest in other discretionary services, such as meals at home and day centres and other community-based activities. Private providers also offer alarm and monitoring systems for purchase, though there is

no data available on the extent to which private providers have a presence in Surrey, it is unlikely to be significant.

4. There are different monitoring arrangements in place in Surrey; Mole Valley District Council provide installation and monitoring services covering Mole Valley, Reigate and Banstead, Tandridge and Spelthorne and monitoring for Epsom and Ewell. Runnymede provide an installation and monitoring service covering Runnymede and Surrey Heath. Woking, Elmbridge, Waverley and Guildford Councils arrange installations locally but outsource their monitoring to external agencies. Well established telecare services provide a good foundation for the development of any enhanced Technology Enabled Care offer as the basic telecare technology not only enables connection to a monitoring centre to raise alerts but also supports two-way communication between the individuals and the monitoring centre in the event of an alert being raised. The “Enabling You with Technology” Transformation programme sought to build on the existing arrangements as well as explore new opportunities to use technology to support individuals with their eligible needs in Learning Disability & Autism [LD&A] and Mental Health [MH] Services.

Enabling You with Technology Transformation programme

5. Members of the Adults and Health Select Committee may recall from the previous report that in August 2020, we commissioned Public Digital Ltd, a digital transformation company to undertake a discovery phase focussed on research with a range of users to identify the best approach to developing a wider technology enabled are offer. Their overarching recommendation was to incrementally enhance the Surrey-wide offer through partnership with organisations across the county, primarily working with the District and Borough Councils.

6. In January 2021, we began working with Mole Valley District Council for the first pilot phase of our transformation programme and focussed on using technology at the point of an individual’s discharge from hospital into the Adults Social Care reablement service. We worked with the reablement service operating locally in Mole Valley and it quickly became apparent that the technology we were trialling could be beneficial to people supported by the Locality Team in Mole Valley too. The “new” technology was the use of Cascade 3d an IoT (Internet of Things) data and analytics platform connected to sensors, smart plugs and other devices. The core sensors monitor air temperature and movement. The smart plugs monitor the use of electrical equipment and, for example, can evidence whether someone is using their kettle or microwave. Other devices, such as bed and chair sensors can also be used to help monitor falls.

7. The monitoring is discreet; there are no cameras or audio and generally people need to be able consent to monitoring. However, in some circumstances, a best interest’s decision will have been made, where we believe an individual would be kept safe by using sensors rather than other approaches to support independence. For example, long periods of one-to-one supervision can feel intrusive for an individual, causing anxiety but discreet monitoring can keep people safe, without the person being restricted.

8. In September 2021, phase 2 saw the expansion of the pilot to Reigate and Banstead and Tandridge, thereafter, we have continued to roll out the use of the technology to Adult Social Care teams in Guildford, Epsom and Ewell, and Spelthorne. We have had very positive discussions with the remaining District and Borough Council's about how we can use this technology alongside the existing telecare services without compromising responses to alerts from their monitoring centres. These conversations will continue in September with the intention of confirming the further roll out plan.

9. One of the benefits of working with Mole Valley District Council in the way that we approached the project, was to establish a joint programme team; adopting a trusted assessor model, with the installation of equipment being at the discretion of their installer; undertaking joint-visits where necessary. This led to very close working arrangements and the sharing of knowledge for the benefit of people supported by Adult Social Care. The approach of "designing by doing" also meant that we were learning what works well as a team, removing some of the barriers to joint-working. This approach was so successful that the team was nominated for and won the Innovation and Improvement Award at the Surrey Downs Health and Care Partnership inaugural "Better Together" awards in July this year.

10. In general, we have used the technology for short term monitoring to provide information to support the assessment process and right-size the individual's care and support. This can mean that the care and support is reduced or increased according to the evidence. For example, we were recently able to show that care at night was not needed for an individual. This resulted in a significant cost saving, as well as, meaning the person was no longer under unnecessary 24-hour supervision in their own home. From April to July 2022 case studies, we estimate that the full year effect of savings/cost avoidance achieved is in the region of £257k.

11. Some of the real-life anonymised cases are attached at Appendix A to illustrate the difference the technology can make to an individual. In the story of Danica, we were alerted to the fact that the care agency was not visiting Danica in accordance with the planned care. This led to a follow up investigation with the care agency. It was not the intention to use the technology in this way but it does show the broad scope of application of this type of technology. [Following this incident, Commissioning colleagues have been alerted to the issue to consider how electronic monitoring data from providers can be accessed more routinely.]

12. In Rita's story, there was conflict between Rita's wishes to remain in her own home and those of her family. This is not unusual and the person's wishes may be over-ridden where there is concern that the person cannot managed at home even with support. The data from sensors and other devices provides independent information to facilitate decision making in a way that is particularly supportive of the person receiving care at home.

13. There have been more than 150 installations since we started the pilot. We can reuse the equipment as no data is stored on individual devices but in the next phase, we will be evaluating the benefits of long-term monitoring. We currently have 16 people who have had the sensors for more than 6 months and evidence of the long-term benefits, will help to inform the self-funder option which has not yet been established. We had anticipated long-term monitoring being the norm but from an Adult Social Care perspective, we have gained more insight from short term monitoring to inform decision making, influencing ongoing care and support arrangements. While the sensors and the data platform has been hugely beneficial, there are other technologies that could provide the same or similar data without the need for the same installation costs. We plan to trial other technology in the coming months so that we are using the right technology, at the right time, to good effect.

14. We are on target to roll out the use of sensors and monitoring via the data platform to all areas by the end of this year. The roll out of a self-funder model has been delayed but we are exploring with our District and Borough colleagues, how we might achieve such a model on the back of the existing telecare services. It is likely that a self-funder model will include a variety of packages of support; from the basic telecare system that currently exists, to additional sensors and monitoring, plus an option of the wellbeing and responder service, subject to successful expansion of that service. We do need to ensure the self-funder model is sustainable. There is no evidence at this stage that the equipment is unreliable, however, we have instances of people moving sensors, or switching off sockets and these instances require investigation. The batteries in devices need periodic replacement too, so the maintenance and support arrangements need to be clearly understood before we roll out a self-funder model.

15. It is a challenge to consider the place that technology could have in supporting an individual with their care and support needs (there is often a crisis or some other change in the persons circumstances that has precipitated the involvement of Adult Social Care) and we continue to strive to place the technology conversation at the front of discussions with the person and their carer or family. Close working with District and Borough colleagues could help us embed this approach, particularly if we can achieve a consistent offer and one that is widely understood. There is no single model of excellence working elsewhere, though through Mole Valley District Council and their links with the TSA (Telecare Services Association), we are exploring good practice and how we can learn from other initiatives.

Wellbeing and response service

16. In March 2022, we began phase 3 of the project with the trial of a wellbeing and response service. The response service is run by our partner Mole Valley District Council. The service operates from 6am to 10pm daily and is funded by

Transformation funding from Surrey County Council as well as resources from Mole Valley District Council.

17. The responder service is currently available to telecare users in Mole Valley, Reigate and Banstead, Epsom and Ewell and Tandridge. Around 4,500 people are covered by the responder service. From March to August 2022, there were 336 incidents, of which 170 were non-injured falls and the responder was able to assist the person and 28 incidents were accidental use. On other occasions a response was provide by a family member, carer, or care agency etc. Of the total, only 77 cases required an ambulance and, in 29 cases though an ambulance was called, the ambulance was subsequently stood down.

18. The impact of the responder service appears hugely positive for not only the person receiving support but also the ambulance service in terms of reduced call outs and is also likely to have had a positive impact on reducing the number of conveyances to hospital. Long-lies are a contributory factor to hospital admissions (i.e. where a person has fallen and spends a long period of time on the floor). The average response time for the responder service from time of call to attendance was 23 minutes, this is very likely to have avoided many long-lies that would routinely result in a conveyance to hospital.

19. In partnership with Mole Valley, we have worked closely with SEC Amb to ensure that the operating model is effective. However, the current service is limited in its reach, and is only funded until March 2023. An evaluation of the service to date will be undertaking in October 2022 and discussions are underway with Health to explore the funding options for a county wide service and the approach that might be taken, as well as the potential linkages between a responder service and the Urgent Community Response model that aims to keep people out of hospital. The future of the responder service will also inform the self-funder opportunity referenced in paragraph 9 above.

Technology to support Learning Disability and Autism and Mental Health

20. We have continued to explore the use of technology with our Learning Disability and Autism service and our Mental Health practitioners, for those individuals with eligible care and support needs under the Care Act. There have been a few cases of using Cascade3d and sensors to support people with adult social care needs in both LD&A and MH services but the issue of consent to monitoring can be more challenging. The case for monitoring the individual, must be in the best interests of the individual and not a carer or family member and needs to be focussed on keeping the person safe rather than providing reassurance to the carer. This type of monitoring is distinct from clinical monitoring such as the TIHM system (Technology Integrated Health Management) provided by SABP. There is a place for both systems as they are addressing different concerns. However, we will be exploring the opportunities

for more joined up working in this space going forward, acknowledging that the needs we are supporting under the Care Act, will be different to the treatment approach that might be needed in the first instance.

21. We have had some limited success with an initial pilot of HandiCalendar app with a small group of people supported by our LD&A service and are intending to trial this with people supported by our Adult Social Care Mental Health service. We are also eager to trail “Just Roaming” an application for use in supported living environments, (similar to the sensors and monitoring system we are using with individuals) where there are multiple occupants. This is dependent on identifying a suitable location, provider and individuals who might benefit from monitoring to increase their independence and reduce unnecessary supervision, particularly at night.

Conclusions:

22. The ‘Enabling You with Technology’ Transformation Programme has evidenced the benefits of using emerging technologies to support people in their own homes to be independent. The strong partnership approach with Mole Valley District Council has been key to the success of the pilots to date. This was recognised by the recent Innovation and Improvement Award at the Surrey Downs Health and Care Partnership inaugural Better Together awards. From joint visits between Adult Social Care and Mole Valley colleagues to the Trusted Assessor model, (whereby Mole Valley installers prescribe the TEC solution based on the outcomes the person is trying to achieve), we have a solid basis for embedding technology as a means of supporting people to remain in independent. This approach will be taken forward with other District and Borough Councils.

23. The wellbeing and responder service indicates the need for a different approach that enables people to have an appropriate and timely response to an incident, particularly a non-injured fall that is not ambulance led but given the financial climate, the service needs to be not only efficient but also cost effective. Further work is needed to explore the options for extending this model.

Recommendations:

24. The report to be noted by all members of the Select Committee.

Next steps:

25. To roll out the use of sensors and monitoring to other areas to ensure consistency for people supported by Adult Social Care.

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26. To evaluate the wellbeing and responder service and explore funding options to extend the service beyond March 2023 and look at expansion across the county.

27. To undertake further work with the LD&A and MH teams and SABP to explore the use of technology.

Report contact

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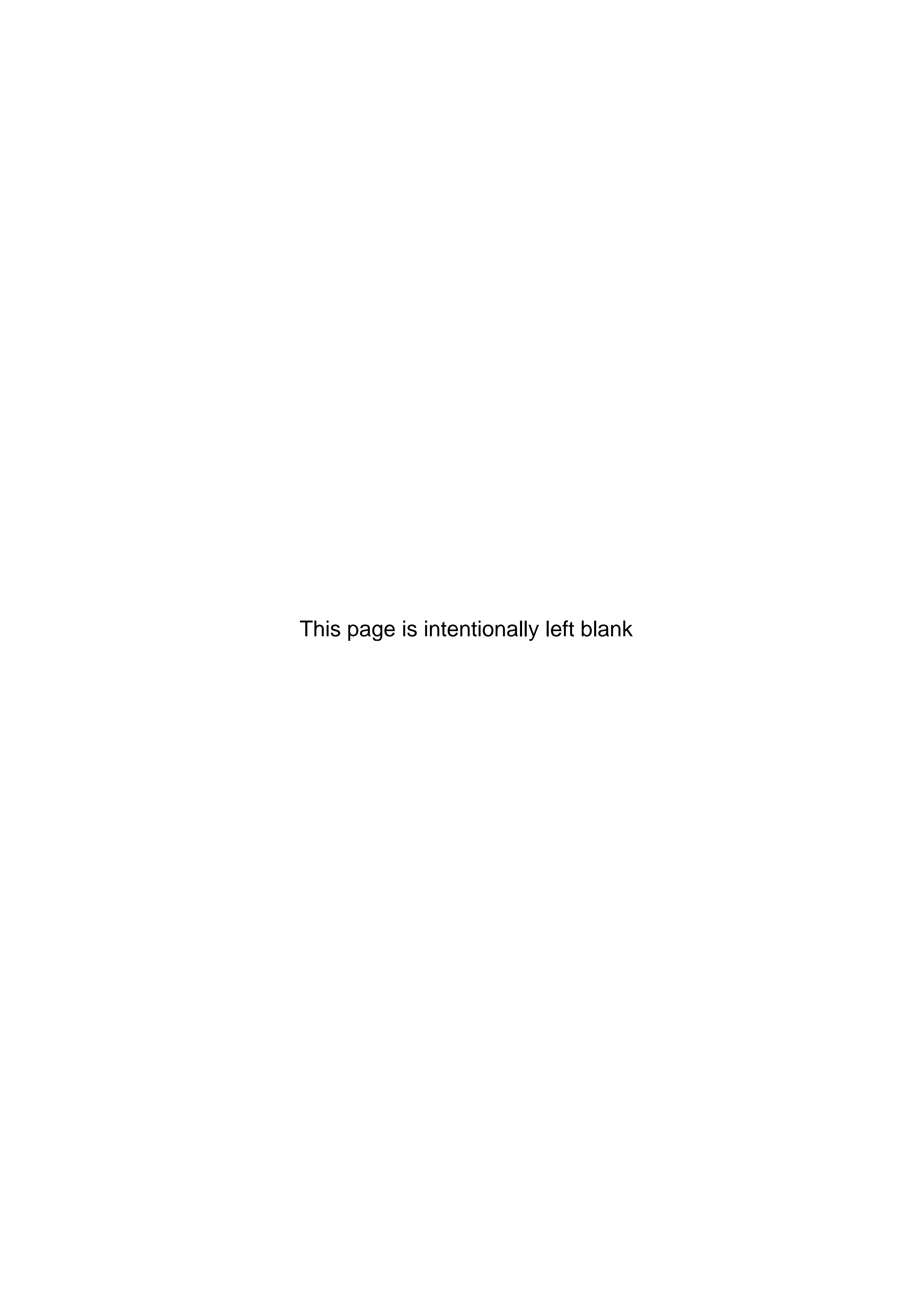
Sources/background papers

Pioneering “Enabling You With Technology” pilot project wins award for innovation | Surrey News (surreycc.gov.uk)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Enabling You with Technology -Transformation Programme – Case Studies

Sarah's Story: Right-sizing care

Sarah's family members and her care agency raised concerns that she wasn't engaging with the care and her family felt that she required additional support at night. Sarah required a re-assessment, and sensors and smart plugs were installed in her home to support this process.

The data showed day and night-time activity which gave an indication of what was needed going forward.

The data presented a clear picture of Sarah's activity and was used to adjust her care and support to meet her increased needs to achieve the best outcome for Sarah, providing support at the appropriate time.

Danica's Story: Baselining needs

Danica is in her 80s and has been diagnosed with early dementia, she lives alone. 4 care calls a day alongside social calls were recommended to support her to establish a normal routine leading up to bedtime. Neighbours had been reporting that she was leaving her home at unusual times during the night.

Sensors and smart plugs were installed in her home with her agreement because of the concerns raised about Danica's ability to manage independently, which conflicted with her own view. The technology was an opportunity for Adult Social Care to gain an objective view of Danica's life at home.

The data initially showed that Danica was unsettled during the night but not leaving the property. The technology also flagged that the door was only being opened twice during the day, even though she was expected to receive 4 care calls daily. As there were no other doors leading into the property, concerns about the care agency's visits were raised and an investigation was initiated. With the planned support, (4 calls per day) in place, it has been possible to support Danica with her night-time routine. The plan is to keep the technology in place to enable Danica to remain in her own home in long as possible.

Sam's Story: Supporting independence at home

Sam has a history of falls and UTIs. After his most recent fall he was discharged from hospital into a care home on D2A.

At the D2A assessment Sam said he wanted to go back home and be with his dog. Sam has full capacity and agreed to explore technology options that could support him to maintain his independence safely at home. There were concerns that the stairs in Sam's property would increase his risk of falls. To reduce this risk, Sam agreed to set up a micro-living environment in his home and was supported to go home with 4 care calls per day and motion sensors. Within two weeks, Sam was at home and celebrated his birthday with family and dog.

The motion sensors reassured everybody that Sam was not using the stairs and was managing safely at home. The sensors also showed a reduction in falls and trips to the toilet (indicative of UTIs) and this was this thought to be due to the care calls providing Sam with regular food and fluids.

The technology enabled Sam to maintain his independence in an environment he wanted, Sam has not had any falls since being at home and continues to manage safely with 4 care calls per day.

Rita's story: evidenced based decisions

Rita was receiving 3 calls a day before going into hospital. Upon discharge, the hospital initially advised that Rita should return home with 24-hour care but with support from the Technology Enabled Care Team, it was agreed that it was safe for Rita to go home with 12-hours of care alongside smart plug and motion sensors. Rita has full capacity and was on board with this decision.

Rita's family do not live close by and they had concerns about her being home alone with a high risk of falls. There were also pre-existing concerns that she would not be able to make herself drinks or take herself to the bathroom outside of care calls. The data showed this wasn't the case, relieving the family's anxiety as well as increasing Rita's confidence.

The data helped to support the conversation with the family and enabled Rita to make her own decision about how and where she received her care - it was felt that the family may have encouraged Rita to consider a placement in residential care.

ADULTS AND HEALTH SELECT COMMITTEE

Wednesday, 5 October 2022

MENTAL HEALTH IMPROVEMENT PROGRAMME: UPDATE ON PHASING OF SYSTEM PRIORITIES

Purpose of report: To provide an update to the Adults and Health Select Committee on progress since the June 2022 meeting.

Introduction:

1. An update on the Surrey's Mental Health Improvement Programme (MHIP) was provided to the Committee in June 2022. Recommendations following that meeting included:

   "For Surrey Heartlands, SABP, and Mental Health leads in Surrey CC to provide a future update and report to the AHSC on how existing and additional funding will be effectively used to deliver on the MHIP, and to provide a timeline as to when the plan is expected to be delivered on."

2. We look forward to bringing the Committee a report in due course which fulfils this recommendation and provides a full update on our collective work to deliver the MHIP. At the 23 June meeting of the Committee, we discussed the need for system priorities to be clearly phased. We are currently undertaking an exercise to do this, commissioned by our new Mental Health System Delivery Board at its first meeting in August. This phasing exercise will set out clearly how and when we will deliver improvements to mental health support and services for Surrey residents.

3. We are not yet in a position to report to the Committee on the outcome of the phasing exercise. This report is therefore a brief update on progress since June 2022 and the work currently underway. Because of the nature of this report, it focuses on how we will get our partnership structure and system accountability right, in order to enable delivery and effective oversight of progress.

4. The next meeting of the Mental Health System Delivery Board is on 29 September, therefore, we will be able to provide a further verbal update to the Committee during the meeting on 5 October.

5. It is anticipated that a fuller update, meeting the recommendation in paragraph 1 above, will be provided in the near future.

Context

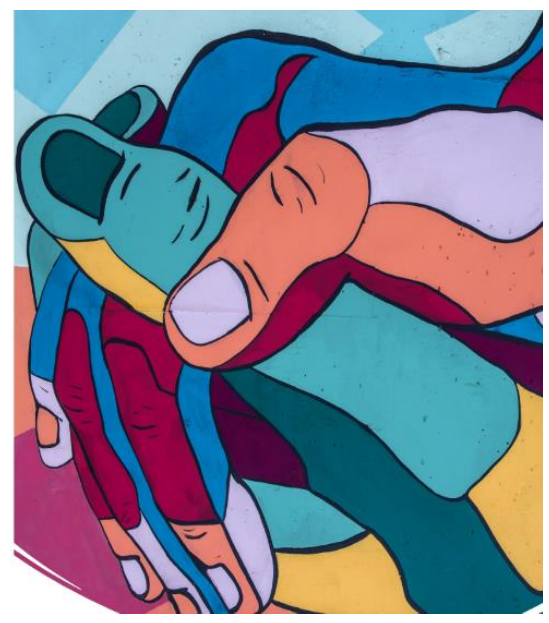
6. Approximately 63,000 people were in contact with mental health services during 2020/21. These contacts ranged from nearly 600,000 primary care appointments and 30,000 Improving Access to Psychological Therapies (IAPT) referrals to 900 inpatient admissions at Surrey and Borders Partnership NHS Trust (SaBP) and 500 open care packages for mental health with the County Council. Analysis by NHS Providers suggests that 180,000 people in Surrey would benefit from contact with mental health services. Comparing this figure to the activity, it suggests that only a third of people are being directly supported.

7. The Mental Health Improvement Plan (MHIP) is in place to deliver the 19 recommendations from the report *Emotional wellbeing and mental health in Surrey: A review of outcomes, experiences and services*, dated May 2021 and ratified by the Health and Wellbeing Board in June 2021. This report itself followed a previous Task Group established by the Adults and Health Select Committee and a system Mental Health Summit held in November 2020. Each of these highlighted that there were significant improvements which could and should be made to better promote the mental health and emotional wellbeing of Surrey residents.

8. The MHIP is a system plan, being designed and delivered collectively by NHS, local authority and third sector partners. The voice of users, carers and those with lived experience is vital and is embedded into our work. The MHIP works to deliver our vision, co-produced with service users:

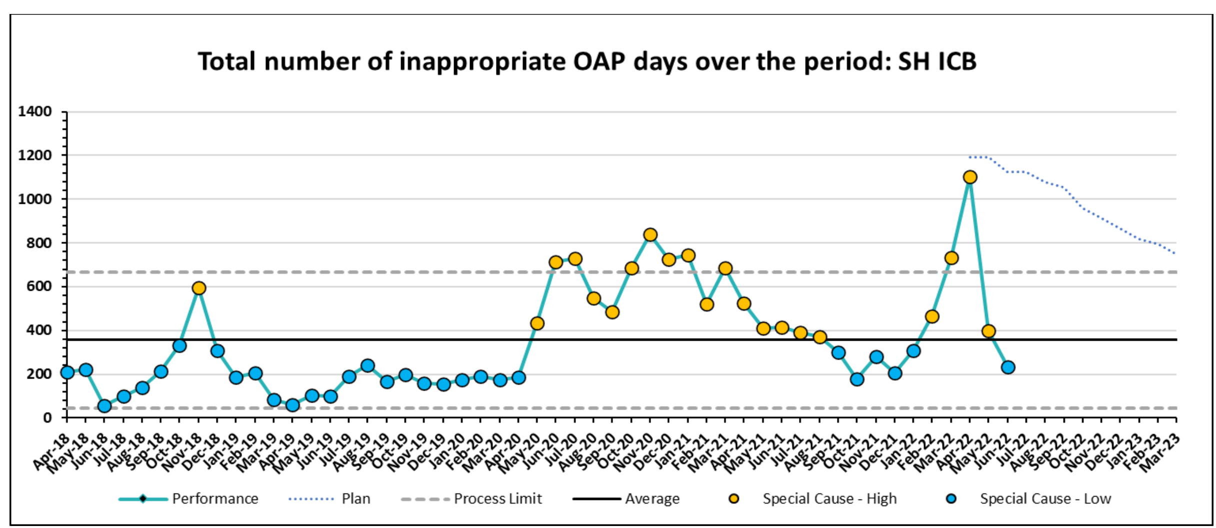
The re-worked draft vision

"Together, we build and nurture good mental health and emotional wellbeing for all. If anyone needs help, they will find services on offer for themselves, their family and carers, which are welcoming, simple to access and timely. No-one is turned away from a service without being given support to get the help they need"



9. Alongside the work of the MHIP, we are also seeing signs of improvement in 'business as usual' in historically challenging areas. Examples include:

- A reduction in Out of Area Placements, as illustrated by the below (data currently subject to validation)



- Improved responsiveness in responding to complaints and investigating and learning from serious incidents (SaBP had 89 serious incidents open at August 2022, down from 139 in June 2021)

- SaBP, our specialist secondary care provider, is rated as 'Good' by the Care Quality Commission both overall and in each domain they assess.

Update on MHIP progress since June 2022

Scope of mental health improvement and transformation

10. Mental health improvement and transformation in Surrey is a broad agenda with many activities and plans in need of prioritisation and phasing. The scope of mental health improvement and transformation covers:

    i. The 19 recommendations underpinning the Mental Health Improvement Programme ('MHIP');
    ii. 'Priority 2' of Surrey's Health and Wellbeing Strategy (refreshed in summer 2022);
    iii. 10 year plan for Mental Health (currently being prepared by NHS England);
    iv. Sustainability and financial recovery requirements of the health systems in Surrey;
    v. Delivery of the NHS Long Term Plan; and

vi. System ambitions around place, in line with local priorities and the Fuller Stocktake (see below).

11. This broad range of activities, plans and priorities cannot all be delivered at once, and a lack of system focus on the most critical issues will hold us back.

12. At the 23 June meeting of the Adults and Health Select Committee, we discussed the need for system priorities to be clearly phased. This phasing exercise will form the foundation of a plan which will set out:
    i. When interventions are able to be delivered
    ii. What resources are required to deliver and where they will be drawn from
    iii. The impact and reach of our choices

13. Annex 1 is our workplan setting out how we intend to do this. The workplan was circulated to system partners and stakeholders at the start of the phasing exercise to support discussions about our approach and expected outputs.

14. Key milestones already concluded include two workshops:

    - Initial workshop with a number of senior leaders from across the system, representing NHS, local authority and voluntary sectors for both adults' and children's. This workshop tested and developed our approach to the overall phasing exercise.

    - A workshop with the (shadow) Co-Production and Insight Group, which includes representation from a wide range of stakeholders including service users and people with lived experience, Healthwatch, police, ambulance services, elected representatives, public health and others. This workshop provided an opportunity for this diverse group to contribute their views and insight on the areas which are most important to them and those they represent.

15. Our approach includes gathering together the plans, data and information which already exist among system partners and bringing them together into a way which can inform and drive our collective system priorities. The process of gathering and drawing together this information is ongoing.

System leadership

16. At the 23 June meeting, we discussed the need for refreshed governance and leadership and our plans for putting this in place. Since the meeting, we have had the first meeting of the new Mental Health System Delivery Board, which has a remit to oversee mental health improvement and transformation in Surrey.

17. This Board has been established by both the Health and Wellbeing Board and the Integrated Care Board, with accountability for the full scope described in paragraph 3, above. The Board is independently chaired by Jonathan Perkins, formerly acting chair of NHS Surrey Heartlands CCG, with Clare Burgess, CEO of Surrey Coalition of Disabled People, as vice-chair.

18. At its first meeting in August, the Mental Health System Delivery Board discussed our approach to the phasing, or prioritisation, of our work. The workplan set out in Annex 1 is the result of that discussion. The Board will receive an update and initial recommendations on the phasing exercise at its September meeting. The Co-Production and Insight Group provides a key route for engagement and co-production with our stakeholders.

Timetable for completing this work

19. In preparing for this work, we considered accelerating the pace of our work by commissioning support from external health consultants. We have, however, decided to proceed using existing and internal resource. Two factors have been key to this decision: use of public money and the desire to align our work with wider system prioritisation.

20. In May 2022, Dr Claire Fuller, Chief Executive of Surrey Heartlands Integrated Care System published a report commissioned by NHS England, *"Next steps for integrating primary care: Fuller stocktake report."* The 'Fuller stocktake' looked at integrated primary care, what is working well, why it's working well and how we can accelerate the implementation of integrated primary care (incorporating the current 4 pillars of general practice, community pharmacy, dentistry and optometry) across systems. Surrey Heartlands, as well as all local systems nationally, is preparing a response to the recommendations of the Fuller stocktake, due to be completed in the autumn. This response will review our priorities as an Integrated Care System and consider what support and services are delivered at home, at neighbourhood, at place and at a system level. The Fuller stocktake is, therefore, key to our approach to improving mental health and emotional wellbeing in Surrey.

21. In October, we are anticipating publication of reviewed and refreshed outcome metrics for the Health and Wellbeing Strategy, following the strategy refresh over the summer. These metrics have been developed to better link with the updated priorities, outcomes and priority populations and will provide clarity on the areas in which our Early Intervention and Prevention work will need to focus.

22. We are holding two workshops in October which will combine system expertise to consider the current demand and capacity challenges we are facing in mental health, both for adults and children. The aim of the workshops is to review the

sustainability of our current models of care and identify opportunities for improvement. It is anticipated that these workshops will generate plans and actions which will need to be integrated into our phasing.

23. As we phase our system priorities for mental health improvement and transformation, we must do so in a way which aligns with wider changes to primary care and system working. Considering this, alongside the additional financial cost of commissioning support from an external consultancy, we have decided to continue with existing resource. We acknowledge that this does have an impact on the pace of work, in particular during the summer.

24. Our new Mental Health System Delivery Board will receive an update with initial recommendations on the phasing of our system priorities when it meets on 29 September.

Conclusions:

25. The exercise to phase, or prioritise, our work across this broad agenda continues to be high priority for the system. The Mental Health System Delivery Board will receive an update with initial recommendations when it meets on 29 September and we will be able to provide a verbal update on this by the time of the Committee's meeting on 5 October.

Recommendations:

26. A final report, responding to the recommendation of the AHSC in paragraph 1, will be provided in the near future, at a time to be agreed with the Committee.

Next steps:

27. Conclusion of the phasing exercise as described in this report.

Report contact

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Sources/background papers

Annex 1 – Phasing workplan (as circulated to stakeholders)

ADULTS AND HEALTH SELECT COMMITTEE

Wednesday, 5 October 2022

MENTAL HEALTH IMPROVEMENT PLAN TECHNOLOGY UPDATE

Purpose of report: To provide the Committee with an update on use of technology and digital tools in the Mental Health Improvement Plan.

Introduction:

1. Technology can be a key tool in improving mental health and emotional wellbeing, both through directly delivering support and services through digital or technologically enabled means and by augmenting and improving existing services. The Covid-19 pandemic accelerated the roll out of digital tools as we adapted to meet the needs of residents. As in-person services and support have returned, we have looked to harness the value of digital tools where they can add most value, while recognising the vital importance of face-to-face interactions.

2. Mental health support and services are delivered as a system, with NHS, local authority and voluntary sector organisations working together in partnership. Our work on digital and technology is done in the same way. Working in partnership creates opportunities to deliver better support to our residents and also presents challenges in terms of data sharing, pathways, relationships, funding and digital approaches. These can be relational as well as technical. Working in partnership can be as simple as a shared sign-posting or as complex is navigating the challenges of data infrastructure across multiple organisations and sectors. The examples of technology cited later in this report are drawn from across the system.

3. The purpose of this report is to provide an update on how technology is helping us deliver the Mental Health Improvement Plan (MHIP) and addresses the following recommendation following the Adults and Health Select Committee meeting on 23 June 2022:

   "For Surrey Heartlands, SABP and Mental Health leads in Surrey CC to provide a future update and report to the AHSC on the technology being sought, and the progress being made in rolling out technological systems to improve Mental Health Services in Surrey."

4. Across England, each local NHS system is currently developing a 3 year Costed Investment Digital and Data Roadmap, in line with guidance set by NHS England. In Surrey, our digital and data strategy for mental health is embedded within this work. A brief summary of this strategic work and associated national policy is

included in Annex 1 but is not the focus of this report. The timing of this is currently uncertain, having been recently delayed.

Digital and Data workstream of the Mental Health Improvement Plan

5. The Digital and Data workstream was set up to deliver three of the 19 recommendations which underpin the MHIP (see Annex 2). Digital is a key enabler of other work. For example, our Prevention, Signposting and Self-Help work supports delivery of the key outcomes of Priority 2 of the Surrey Health and Wellbeing Strategy (see Annex 3).

6. We have identified six delivery and outcome areas which align to the Mental Health Improvement Plan alongside national policy and the Costed Investment Digital and Data Roadmap.

   a) Prevention, Signposting and Self-Help
   b) Integrated Analytics (including population health management, demand and capacity)
   c) Flow and Proactive Prevention
   d) Virtual Care
   e) Improving Access to Psychological Therapies (IAPT) – new models of care
   f) Programme Resource to co-ordinate, shape and lead this ambitious area across the system including embedding people with lived experience and carers as funded resource

7. These areas align with the wider objectives within Surrey. Annex 4 shows how the 6 delivery and outcome areas map to the original 19 MHIP recommendations, highlighting how Digital and Data is an enabler across the whole MHIP. These areas also inform the MH element of the system digital and data plan.

8. Success will be subject to appropriate investment to get it right, alongside having a cohesive system plan which Surrey wants to action and implement collectively. Decisions on local and national investment applications are subject to the conclusion of the Costed Investment Digital and Data Roadmap.

9. Technology moves so fast; we need to be prepared to be flexible and iterative. We will also be horizon scanning what works well elsewhere from other health and care systems, inclusive of our Voluntary, Community and Social Enterprise (VCSE) partners, across the country. We also need to be mindful technology is not the answer to everything (see 'Challenges' section, below).

Where we are already making a positive impact as a system

10. Across Surrey, technology is being applied in a wide range of ways to support the mental health and wellbeing of residents. Some of this is at individual organisational level and some of this is at a multi-agency or system level. A selection of examples is provided here – drawn from across the health and care system, including VCSE partners – to illustrate the various types of tools being deployed and the impact we have seen or expect to see through using them.

11. Examples have been aligned to the 6 delivery and outcome areas outlined in paragraph 6 above, though it should be noted that individual examples can often sit across more than one area. Future examples in Integrated Analytics will depend on future investment.

12. Annex 5 provides further detail and examples, although an exhaustive list is beyond the scope of this update.

Prevention, sign-posting and Self-help

13. For children and young people, Kooth provides an online mental health and wellbeing support service which aims to reduce the stigma associated with receiving MH support whilst allowing young people to find the support that's right for them. The platform functions include a magazine, journal and goal setting, live text chat (with immediate access to qualified counsellors) and drop-in/booked text chats, pre-moderated safe peer-to-peer forums and an activity hub (to support self-expression and healthy coping strategies). In the first quarter of 2022/23, there were 6,822 log ins by 952 users accessing a range of services.

14. Our perinatal mental health service offers a 12-week maternal coping skills course available online. This means that support is more accessible for mothers who may find travelling difficult, for example following a caesarean section.

15. Surrey Virtual Trips has supported 200 individuals facing the most barriers to getting out, by facilitating virtual tours or visits. For some participants, these trips have acted as a stepping-stone towards visiting in real life.

16. As use of technology increases, we are aware of the potential for health inequalities to be increased. Tech to Community Connect is a digital inclusion service which provides devices, digital literacy training and confidence-boosting support to people from all over Surrey. The service has supported approximately 5,000 residents to date. Residents are offered a device, data (a 6-months free Vodaphone sim), matching with a volunteer Tech Angel and a menu of training modules to work through.

17. We are working with ORCHA (the Organisation for the Review of Care and Health Apps) to deliver an online Health Apps library focussed on supporting young people in Surrey. The aim is to make it quicker and easier to access safe and accredited health & wellbeing apps.

18. There are a variety of online platforms including Healthy Surrey (where three of the top ten most popular pages related to mental health), the Surrey Information Point and the Surrey Virtual Wellbeing Hub. Further details are included in Annex 3.

Flow and Proactive Prevention

19. Following a QI project at SABP's Juniper ward exploring a number of digital solutions to support bed flow, in the data up to January 2022 there has been a 22% decrease in the average total weekly bed days and an 18% decrease in the average length of stay of those admitted to Juniper Ward. Flow is an important

area in delivering and managing services effectively when people need them, with knock on effects impacting the whole system.

20. Social workers are utilising the 'S12' (section 12) app to support with assessments under the Mental Health Act 1983. S12 has helped connect Approved Mental Health Practitioners (AMHPs) with a local and available doctor, with 262 assessments created on the platform in July, 246 of which had a doctor booked against the assessment. This avoids the increased delays and distress which can be caused by inefficient and slow processes.

21. Our Proactive Prevention of Crisis project aims to proactively identify and support people who are at high risk of experiencing a mental health crisis, to improve patient outcomes and experience for this population group. People with mental health challenges are significantly (3.6x) more likely to experience a potentially preventable emergency admission than those without such challenges. Areas such as Learning Disabilities services have demonstrated the potential to implementing operational and digital solutions to prioritise intervention and prevent admission and we hope to apply this learning to improve outcomes and experience for those with mental health challenges.

Virtual Care

22. Oxehealth (a contact-free, vision-based patient monitoring platform for use in hospitals) has so far prevented 8 ligature, 6 self-harm and 8 serious incidents. Alongside saving 8 lives, 3776 hours were saved on serious investigation work. In addition, time to take observations have reduced from a minimum of 4 minutes to 1 minute. All of this gives time back to clinicians, and has allowed them more time to engage with people using their services.

23. In residents own homes, the technology integrated health management service (TIHM) has supported 550 residents through smart technology. Impact includes a 42% reduction in care home admissions, 60% of users feeling less anxious and a 32% reduction in emergency admissions. We are currently seeking sustainable funding for TIHM.

24. A variety of services run virtual appointments or sessions as all or part of their support offer. Examples include virtual carer support groups within Early Intervention In Psychosis, which led to an increased 20% in attendance.

Improving Access to Psychological Therapies

25. Improving Access to Psychological Therapies (IAPT) is a well-established programme for treatment of adult anxiety disorders and depression. Our virtual IAPT offer includes a fully text-based service. As well as broadening the service offer, the transcripts from the text-based service also help us maintain and improve the quality of care we provide.

26. 'Limbic' is a web-based tool to aid self-referrals using a 'chat bot', which aims to improve our service by increasing the speed and number of referrals. It can also benefit staff by reducing the clinical and administrative time required to make preliminary assessments on referrals.

Other examples: using technology and data to support clinical and/or operational work

27. Mi-Fi devices have been rolled out to support specialist mental health colleagues working in the GP Integrated Mental Health Services (GPiMHS). This workaround addresses existing connectivity issues could have previously led to cancelled appointments or staff working from home, defeating the purpose of providing mental health support from within a GP surgery.

28. We have tested the use of the SystmOne system to record patient information across the Mindworks alliance, as part of the National Autistic Society (NAS) and Barnardo's new out-of-hours call lines service. This is to address the challenges of partners in the Mindworks alliance using different systems and processes. The co-designed interface has a high level of satisfaction and is delivering an excellent user experience and optimised clinical pathway, reducing clinical risk while facilitating accurate and efficient data capture.

Challenges

29. Although the strategic element of our digital development is not the focus of this report, delivering an ambitious digital and data strategy is inherently challenging. Fragmentation, digital literacy (for both users and our workforce), lack of system interoperability, digital exclusion and the risk of increased health inequalities are all significant challenges for us to overcome.

Where we need to focus, build capability and capacity

30. While there is a lot of positive work already underway, things can be fragmented, duplicative and not joined up. As a system, we still need to put in more effort to best align and locate the relevant scale-up opportunities. As part of this, we have identified three key enabling foundations:

    a) **Development of Data Infrastructure** to allow us to flow data more easily, getting the right data to the right person for the right need, with easier system information governance and ethics processes in place. This needs to include people with lived experience of mental ill-health and carers, alongside VCSE partners who currently face barriers accessing data. We are on the start of this journey and key developments include the Surrey Care Record programme, the Adapt+ Programme (Electronic Patient Record evolution for both SABP and partners) and the Surrey Data Strategy.

    b) **Mental Health Data Analytics**, once we get the data infrastructure and flows right, we need to optimise that data to develop a system view, understand the gaps and develop insight to make informed decisions (recognising there may also be shorter term work involving more manual processes as the appropriate infrastructure is developed). This may be at an individual level (e.g. we need to expand on the work underway in the Mindworks programme where we are making a real difference to the safety of children and young people) or population health management. This must also include how people

with lived experience of mental ill-health and carers can make better use of their own data to influence and inform their care.

c) **Service Redesign Capacity** to allow us to really understand the problem we are fixing, ensuring the best technological solutions are being implemented, can be iterated, and have the best opportunity to succeed in improving outcomes for both people who need our support, carers and clinicians. We will need to enhance existing service redesign capacity and capability to deliver this effectively. This needs a true system lens approach and must include a person centric design approach and both digital and clinical experts working together:
   - A person centric design approach is needed to ensure the co-creation of solutions which address the real issues faced by people with lived experience of mental ill-health and carers
   - A Surrey Heartlands-wide, cross organisational forum of Chief Clinical Information Officers and Chief Digital Information Officers starts later this month. Its aims are to: better understand system level cross-organisational care pathways; identify the associated requirements of technical architecture; integration; and exploit available digital and data systems. This will support health and care professionals in accessing timely & right information, as well getting the appropriate access and tools/apps for patients.

31. Surrey Heartlands is also currently completing a 'digital maturity' self-assessment, which will help inform the areas we need to focus on.

Resources

32. Our ability to fund dedicated resource continues to be a limiting factor. The current programme of work to deliver system level digital and data capacity (as a whole, not just for mental health) is in early stages with funding not secured beyond Outline Business Case development. While funding arrangements are yet to be confirmed, we know that national digital funding has been reduced and we are not yet clear on the impact on Surrey. It is likely that many initiatives will need to be funded via clinical transformation programmes' monies.

33. As the funding picture develops, both locally and nationally, we will be able to determine how we can ensure that we secure the required resources and maximise them to the best effect for those who need our support.

34. As in other areas of health and social care, workforce pressures can impact the utilisation of technology. There are challenges both nationally and locally recruiting in digital roles, and both the capacity and digital expertise of the wider workforce are critical to the effective design and implementation of new products.

35. As we continue to emphasise the role of the Voluntary, Community and Social Enterprise sector, we need to recognise the specific resourcing challenges they face. Digital infrastructure and data sharing arrangements can be particularly significant barriers for this sector and dedicated digital resource, including workforce, is typically more limited than is available to public sector partners.

Learning from other areas

36. Digital mental health is a growing community with both formal (e.g. via NHS England) and informal (e.g. via social media) mechanisms to share from others as well as work in the open. Examples include understanding patient portal work done by other local authorities or how different systems are using dashboards to support physical health checks for individuals with serious mental illness. Working with Academic Health Science Networks also provides an additional route to engage with the market, including our own Health Tech Accelerator site in Surrey.

37. Several of the examples in this paper, both cited above and in Annex 5, reflect learnings taken from other areas. For example, our work on proactive prevention of crisis takes learning from Learning Disabilities services and applies it to mental health. Third party tools such as OxeHealth have been brought in to support Surrey residents after being used effectively elsewhere. These tools will be purchased after assessing the options available on the market and how well they meet the need we are trying to address.

Conclusions:

38. Technology is, and will continue to be, a core part of delivering the best support and care to our users and residents. This report sets out a number of examples of the impact these tools as well as the foundations we are hoping to lay to continue improving services and user experience.

Recommendations:

1. That the focus of the Digital and Data workstream is refreshed following conclusion of the phasing of the wider MHIP and the Costed Investment Digital and Data roadmap.

Next steps:

1. Conclusion of the phasing exercise within the wider Mental Health Improvement Plan will enable alignment of Digital and Data with agreed system priorities

2. Assessment of the resource required to deliver Digital and Data elements of system priorities and the scale of potential funding sources as they emerge, and the size of any potential shortfall.

3. Ongoing alignment of mental health digital and data with system-wide (i.e. all healthcare) system plans and governance, including the Costed Investment Digital and Data Roadmap and aligned to upcoming NHS mental health ten year plan

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Sources/background papers

A Plan for Digital Health and Social Care

Digital Mental Health Priorities

Mental Health Improvement Plan

Physical health competency framework for mental health and learning disability settings

About the National Clinical Audit of Psychosis (NCAP) (rcpsych.ac.uk)

NHS England » Adult Improving Access to Psychological Therapies programme

Innovative new primary care-based mental health services nominated for HSJ Award : Surrey and Borders Partnership NHS Foundation Trust (sabp.nhs.uk)

NHS England » Perinatal mental health

Early Intervention in Psychosis : Surrey and Borders Partnership NHS Foundation Trust (sabp.nhs.uk)

Annex 1: Broader Digital & Data Policy and Work – National and System

Surrey Heartlands 3 year Costed Investment Digital & Data Investment Roadmap

There is a national ask for every Integrated Care System (ICS) to develop a three year digital and data investment roadmap. The Surrey Heartlands work is underway and to date has identified 192 potential initiatives across the ICS.

Eight strategic areas, mapped to What Good Looks Like, have been identified. These are (1) electronic and shared care records (2) ICT enterprise infrastructure (3) cybersecurity (4) digital workforce and passport (5) Personal health records and portals (6) ICS Clinical redesign (7) integrated digital and data platform (8) Other including pharamacy. This work has built new and positive system relationships key to future delivery, which will help to accelerate this agenda.

Prioritisation to take place in Q3. A parallel piece of work has recently commenced across the Frimley Health & Care Partnership. We are also expecting the recruitment of digital mental health leads at a regional level.

National Policy

Recent policy and national guidance includes A Plan for Digital Health and Social Care and the Digital Mental Health Priorities which are included below. The refreshed Long-Term Plan and Mental Health 10-year plan is expected in coming months. We have considered the national mandate and recommendations in developing the P7 digital and data workstream of the MHIP.

Priorities for digital mental health

1. Ensuring the digital basics are in place
2. Enhancing data sharing
3. Improving how people get the support they need
4. Supporting the workforce to deliver the highest-quality of care
5. Embedding digital products and services in mental health pathways

Guiding principles for digital mental health

To deliver on these priorities and achieve effective digital transformation in mental health, these principles must underpin everything we do.

1. Personalise where possible - Provide people greater choice of how they access and share information and use services
2. **Identify and design for the excluded** - Identify who is being missed and design services and support to meet their needs
3. **Make the journey intuitive** - Make the care journey easy to understand and navigate, so people know where they are and what comes next
4. **Inform decision making** - Make sure people have access to high-quality evidence and information to make the right choice for them or their patients
5. **Ensure its safe and secure -** Build services and products that support safe and secure care, building trust with service users and clinicians

6. **Collect good data once -** Collect high quality data, in a timely way that can be appropriately shared to avoid duplication
7. **Meet people where they are -** Acknowledge varied digital literacy and poverty for service users and staff and tailor support accordingly
8. **Breakdown and bridge silos** - Support data flow, connected systems, collaboration and the sharing of learnings across the system

Annex 2: MHIP Recommendations in scope of the Digital and Data workstream

Recommendation 10 (Technology): Develop and exploit the full capability of digital technologies (e.g., online consultations, emotional wellbeing apps, Health Tech Lab) in supporting emotional wellbeing and mental health outcomes and preventing ill-health, especially capitalising on the positive applications that have been introduced during the Covid19 pandemic.

Recommendation 6 (Consistent Data and Outcomes Focus on): good data and using it to good effect creating a system-wide team and resource to agree what information is needed to understand need, monitor demand, identify priorities, assess and improve performance and outcomes, and make better informed decisions for the mental health system as a whole. This team should execute a mapping exercise to establish and redress the capacities and approaches necessary to ensure all partners can collect, house, share, and analyse the data necessary in such a way as to deliver the information and insight identified by this team as essential.

Recommendation 15 (Information and Data Sharing Arrangements): Improve awareness and understanding at all levels of data sharing issues, arrangements, protocols, and agreements (e.g. the Surrey 'Multi Agency Information Sharing Protocol') to ensure the appropriate and necessary free flow of data across the system to benefit outcomes.

Annex 3: Priority 2 of the Health and Wellbeing Strategy

WHAT WILL BE DIFFERENT FOR PEOPLE IN SURREY?

Priority Two of the Health and Wellbeing Strategy focuses on enabling our citizens to lead emotionally healthier lives. This priority area is focused on prevention, removing barriers, and supporting people to become proactive in improving their emotional health and wellbeing.

OUTCOMES By 2030:

- Adults, children, and young people at risk of and with depression, anxiety and other mental health issues access the right early help and resources
- The emotional well-being of parents and caregivers, babies and children are supported
- Isolation is prevented and those that feel isolated are supported
- Environments and communities in which people live, work, and learn build good mental health

Priority Two aims to impact in the following ways:

- Ensuring the right early help and resources are available to support mental health across life stages
- Support during pregnancy and for young families
- Recognising and addressing the impact of isolation
- Building good mental health in the range of spaces and places including schools and workplaces

Our refreshed HWB strategy 2022, highlights a focus on reducing health inequalities to ensure no-one is left behind. In addition to the needs of those experiencing mental illness of some sort, which is itself a priority population in our recently refreshed health and wellbeing strategy, across the priority populations (of identity and geography), it is recognised that many of these groups will have increased needs with regards to mental health.

Annex 4: Delivery and outcome areas mapped to MHIP 19 recommendations

Appendix – mapping to 19 recommendations

	Prevention, Signposting & Self-Help	Integrated Analytics	Flow & Proactive Prevention	Virtual Care	IAPT – New Models of Care	Programme Resource
1. Commitment by all agencies						
2. Shared Vision						
3. Access to, mapping and navigation of services						
4. Relational Diagnostics						
5. System Model						
6. Consistent Data & Outcomes						
7. Funding						
8. Engagement						
9. System Governance						
10. Technology						
11. Covid 19 Focus						
12. Training & Awareness						
13. Communication, Resilience & Preventative Strategy						
14. Preventing Gaps in Service & Improving Transition for people						
15. Information & Data Sharing Arrangements						
16. Engage with and improve access, reduce barriers to groups that do not engage with traditional services.						
17. Review Capacity of Mental Health Crisis and Inpatient Services						
18. s136 health based place of safety & follow						
19. Improving Access to Psychological Therapies						

Annex 5: How the system is making an impact

Initiative	Background	How the system is making an impact
Early Intervention In Psychosis – virtual carer support groups	The Early Intervention In Psychosis (EIIP) teams provide specialist treatment and care for people aged between 14 and 65 who have signs of psychosis. These multidisciplinary teams provide a range of treatment and support to individuals and their family/carers. The service has utilised digital platforms as a means for engagement for carers support groups, running monthly friends and family groups.	An increase of 20% in attendance demonstrates that virtual has made it easier for carers to attend. Recognising the need to explore a blended model going forwards.
Epilepsy Sensors	Epilepsy sensors in Learning Disabilities homes can prevent serious injury or even death by alerting staff to a seizure. An epilepsy sensors trial (using AlertIT epilepsy sensors) took place in Rosewood. A subsequent evaluation concluded that the sensors enabled staff to provide safer and more effective care than the previous solution. By using a system which does not disturb or require checking of the service user, it also promotes dignity and respect. As a result, the SABP Learning Disabilities directorate chose to rollout the sensors across all SABP learning disabilities care homes. This is currently in implementation, with rollout to further care homes (Kingscroft and Larkfield) complete in June 2022, and trial care homes are transitioning to BAU.	Care home staff involved in the trial reported an increased confidence in the new alert system. 4 in 5 found the alerts faster and the system easier to use.
Flow Project – SABP Juniper Ward	People must often become so unwell before they are able to access a bed, once people become unwell	In the data up to January 2022, there has been a 22% decrease in the average total weekly bed days (this is the

	and require hospital admission, they are often left waiting, as there are no beds available. People who are in beds are often left waiting to leave, even though they are medically fit for discharge. Using the IHI Model for Improvement and Agile Project Management, a variety of digital solutions were tried and tested to improve flow, paying particular attention to setting SMART actions every day to progress with discharges. These included smartboard, training on smartboard, alerts for discharge pathway, digital walk around, smartboard as single source of truth for meetings and virtual management for community teams.	total number of days that each person has spent on the board divided by the number of bed occupied) and an 18% decrease in the average length of stay of people who use our services and have been admitted to Juniper ward. On average there is a reduction in the total bed days of 296. A recent flow workshop with system partners was held in May 2022 with a Flow Programme now underway.
GP Integrated Mental Health Services (GPihms) with Mi-Fi Devices and a PCN dashboard.	GP Integrated Mental Health Service (GPimhs) is an innovative primary care based mental health service which provides people with specialist care at their GP surgery. They are providing people who have significant mental health needs with quick and easy access to help in primary care. The nature of multidisciplinary teams has driven a range solutions to support a one team approach. This includes: 1) The rollout of Mi-Fi devices to support SABP staff working in GP practices. This was due to a variety of problems all leading back to internet connectivity issues.. 2) Replacing the unstable platform with an interim PCN dashboard	Since rollout of Mi-Fi devices (portable, wireless devices that use mobile phone networks to create a mini broadband hotspot), zero connectively issues have been raised. This could have previously led to cancelled appointments or staff working from home, which defeated the purpose of providing mental health support within a GP surgery. The development of the PCN dashboard from an Interim Tactical Solution which was unstable to an in-house interim solution built on SystmOne. This provided a more user-friendly and intuitive product meeting the neds of the service, as well as reducing clinical safety risk reduction.

Healthy Surrey	The Healthy Surrey website “can help you lead a healthier life, whether you want to be more active, drink less alcohol, stop smoking, and more”. It is supported by the **Health and Wellbeing Board**, helping both people with lived experience and professionals find self-care information, as well as signposting to local services available as Surrey residents. The Healthy Surrey website recently underwent a re-design and an evaluation took place following this.	Following re-design, within the top ten most popular pages, those relating to mental health had over 5,700 more visits. Three of the top ten most popular pages related to mental health and collectively had 36,800 visits: “Local Mental Health Services” (21402) “Adult Health and Wellbeing” (9162) “Virtual Wellbeing” (6236) 320 referrals via Healthy Surrey (accounted for 50% of all Healthy Surrey referrals) =ACTUALS: 325 49.5% There is also work underway to track usage of referral forms embedded within the re-designed website, these can be used by both Surrey residents and professionals. In the year post re-design, over 650 events were recorded and referrals for mental health services accounted for nearly 50% of all events with 325 events logged. Drug and alcohol services accounted for a third of all events logged. These are not currently integrated however signpost to the relevant referral page.
IAPT virtual delivery	Nationally, the Improving Access to Psychological Therapies (IAPT) programme began in 2008 and has transformed the treatment of adult anxiety disorders and depression in England (see more on the NHS website). There are six IAPT providers working across Surrey, many if not all providing a virtual offer. This includes ieso which is a fully online IAPT. ieso therapists provide 1:1 text-based cognitive	Surrey Heartlands ICB has seen that where patients self-refer to ieso, choosing text based therapy from the outset, they respond very well. Recovery has shown a 55% reliable improvement 68% (since April 2022) “This was an excellent service, especially my therapist, who was very understanding, clear and didn’t rush me at any point. I have already recommended this service and would HIGHLY recommend my therapist, she was

	behavioural therapy (CBT) informed by insights from 300,000+ hours of transcripts which have been analysed to show give us a reliable understanding of recovery rates for different conditions. Our therapy insights model has also allowed us to rely more on therapists who are seen to adhere to CBT principles and identify training needs for those therapists who are deviating from the typical CBT principles and protocol. This helps us deliver a consistently quality service. Therapy transcripts remain available for patients to access even after therapy is completed.	outstanding. Not to be too dramatic, but this service literally saved my life**.**" Surrey patient's PEQ comment in June 2022
Kooth	Kooth provides online mental health and wellbeing support for young people and young adults aged 10-25. Kooth's overarching principles are anonymity and therapeutic choice. They strive to reduce the stigma associated with receiving MH support whilst allowing young people to find the support that's right for them. The service in Surrey is commissioned for 10-19th birthday. Key features of Kooth include being available 24/7 including out of hours, free at the point of sign up, and a humanistic integrative, 'whole-person' approach to online therapeutic support. Users are the central decision-makers in their journey towards well-being The platform functions include a magazine, journal and goal setting, live text chat (with immediate access to qualified counsellors) and drop-in/booked text chats, pre-moderated safe peer-to-peer forums,	Usage of Kooth during the first quarter of 22/23 includes: 227 Chat sessions (111 service users) 3242 messages (433 service users) 1209 articles (285 service users) 7510 forums (392 service users) 634 new registrations 6822 log ins (952 users) 70.21% logged in "out of hours" (i.e. not 9am – 5pm) 67.22% returning log ins (i.e. more than once in the period) Awareness of Kooth, where feedback was given, was most likely via the GP, School/Teacher or CAMHS (Child and Adolescent Mental Health Service).

	activity hub (to support self-expression and healthy coping strategies).	
Limbic 'chat bot' in IAPT	Limbic is an automated web-based system using artificial intelligence 'bots' to complete preliminary assessments and aid self-referrals. This tool makes referrals easier and quicker for users and improves the number of IAPT referrals which can be processed. It is available 24/7 and reduces the processing and assessment times for clinicians and administrators.	Limbic was launched as a secondary referral option for Mind Matters IAPT service in July 2021 and became the primary option in September 2021. A validation study in summer 2022 found that Limbic was one of several changes which led to improvements in the service in the period, both for users and for staff. Further work, including research with current and former users, is required to demonstrate the benefits specific to Limbic and suggest areas for further improvement.
Mindworks Dashboard	Mindworks Surrey is an emotional wellbeing and mental health service that supports children and young people across Surrey. Together as partners, they deliver targeted and specialist services, connecting with universal services to ensure support is available at entry level, from primary mental health in schools through to urgent needs. A Mindworks PowerBI Dashboard has been developed, which replaces a manually monthly produced Excel spreadsheet. This dashboard provides information refreshed daily from SABP and alliance partners.	The dashboard was used to analyse the number of referrals waiting over 1.5 yrs for a first attended appointments. 435 were identified in December and, by using the 'drill through' and working with operational and Digital colleagues, the number has been reduced to circa 200, with the balance all clinically reviewed for discharge. This work has now been extended to all waiting times over 6 months. The dashboard provides an up-to-date view of performance without any manual data production.
Orcha Apps Library for Young People in Surrey	Surrey & Borders Partnership Foundation NHS Trust (SABP) are working with ORCHA (the Organisation for the Review of Care and Health Apps) to deliver an online Health Apps library focussed on supporting young people in Surrey. The aim is to make it quicker and easier to access safe and accredited	An evaluation of this solution within children's services is in development (postponed due to the recent extreme heat) and there is ongoing work as part of the Surrey Digital and Data investment roadmap to explore expanding this including to support people with learning disabilities who have obesity.

	health & wellbeing apps. Health Apps is an opportunity to provide people with important health information and help them live healthier and happier lives. ORCHA carry out independent reviews of health and care related apps, assessing apps for clinical validity, data security and user experience – providing assurance that the apps people with lived experience choose are of high quality. Use of ORCHA for people with lived experience is completely free without the need to create an account. An optional account can be created to save details of favourite apps, or to track app recommendations, favourites and downloads as a health professional.	
National Autistic Society & Barnados out-of-hours platform	As part of the vision for Mindworks Surrey, being able to share data easily and safely, between partners, is important. But at the time the alliance was formed, many partners were using different systems or using simple tools like MS Excel to record patient information. This project tested the use of SystmOne to record patient information across the alliance, as part of the National Autistic Society (NAS) and Barnado's new Out-Of-Hours call lines services. This was an opportunity to test on a relatively small scale the implementation of SystmOne Units. This was not just about developing a technical solution, but exploring ways to collaborate as system partners.	The new co-designed interface has a high level of satisfaction and is delivering an excellent user experience and optimised clinical pathway, thereby significantly reducing clinical risk while facilitating accurate and efficient data capture. Feedback quotes include: "It's been really easy to navigate and access...it's been really easy to use." "…it was good again to be able to see the other services that are recording on the patient file and where the child's been in terms of assessment and diagnosis and the time frame for that" "It is fit for purpose. What has been delivered by Design Team is really positive"

		"The Design Team did it at the pace and they did it with the understanding that us as a team needed, and they were just really lovely... They were really supportive. It was a good team to work with." Quantitative feedback is not available because the call volumes and usage of the tool was very low, this mirrors the out of hours call volumes received and both organisations are now increasing promotions and comms around the service. The piece of work has however enabled learning in a number of areas including but not limited to testing, training, functionality, information sharing.
OxeHealth	Oxehealth's Oxevision is a contact-free vision-based patient monitoring platform for use in hospitals. It gives ward teams the early warning signs and risk factors they require to plan patient care and proactively intervene to help their patients. Oxevision uses a secure contact-free optical sensor to monitor pulse rate, breathing rate and activity of an individual in a room – serving up warnings, alerts, reports and observations to clinicians at the right time. It empowers the clinical teams to deliver proactive care, which results in fewer incidents and injuries, improved quality and operational savings.	Impact data based on March 2022 evaluation Lives saved and serious incidents • 8 ligature, 6 self-harm and 8 serious incidents prevented • Average Legal costings over the last 3 serious incidents have been at £360,652. This does not include any of the insurance costs. • Oxehealth has been involved in stopping 8 potential serious incidents = 3,776hrs saved (based on a mapping of 472 hours (conservative estaimate) / 4 months per serious incident Observations • Before Oxehealth: observations take a minimum of 4 minutes per person (from floorwalking exercise), post Oxehealth observations take 1 minute per person. • 83% of survey responders felt that Oxehealth made observation rounds faster, allowing for more time to engage with persons who use our services. "Saves time

		and resources – reduction in physical checks which gives a bit of time back. Can give time back for planning for the assessment." Non-Medical Prescriber, 136 Suite, ACU " Qualitative feedback – experience and safety: • "One patient asked a member of staff why they weren't using Oxehealth and informed them that other staff used it and they should use it as they were disturbing them" • "I was monitoring a patient with high blood pressure, taking pulse, and breathing vitals. As their signs were fluctuating, we were able to check regularly and often"
Perinatal Mental Health – virtual consultations and support	Perinatal mental health (PMH) problems are those which occur during pregnancy or in the first year following the birth of a child. Perinatal mental illness affects up to 20% of new and expectant mums and covers a wide range of conditions. (NHS England Website). Throughout the pandemic, Attend Anywhere was used to facilitate assessments (face to face continued where necessary). The service has recently used to the Airmid solution within SystmOne. The service also offers a 12 week maternal coping skills group, for women with emotion dysregulation difficulties who are pregnant and/or just had a baby who would like to learn skills to deal with emotions and relationships more effectively. The sessions are virtual and tend to run out of school pick up hours.	Enabling video consults enables face to face contact to continue in comparison to a telephone call. The service is performing better with women being seen quicker. There is also increased data quality on SystmOne including outcomes due to streamlined processes. Benefits of running the maternal coping skills group virtually: • Running sessions out of school pick up hours enables more people to attend • Babies are welcome during the group, recognising their attention will be needed during the session • Can support those who may find travelling difficult or inconvenient (for a range of issues including for example recent caesarean section)

Point of Care Testing – Physical Health Checks in Serious Mental Illness	Improving access to physical health checks for people with severe mental illness (SMI) is part of the NHS Long Term Plan, with the aim of 390,000 people with SMI receiving physical health checks by 2023/24. Compared with the general patient population, patients with severe mental illnesses are at substantially higher risk of obesity, asthma, diabetes, chronic obstructive pulmonary disease (COPD) and cardiovascular disease. Point of Care testing is a technological solution which can support with equipment and devices for diagnosis, monitoring and screening, with a number of products on the market. It can support the uptake of physical health tests. One pilot to date has been the Cardiovascular Monitoring in Mental Health (*CARMEN*) project) which included funding to roll out Point of Care technology to Early Intervention in Psychosis (EIP) services across the South East of England and Surrey & Borders Partnership (SABP). This projected aimed to establish if introducing point of care testing for blood glucose and cholesterol can increase the number of physical health checks in patients with severe mental illness.	Following the Point of Care Testing rollout as part of the CARMEN project, National Clinical Audit of Psychosis (NCAP) results (Nov 21) showed an increase with those with completed health checks from 72% to 81%. There are opportunities to use point of care testing to support Physical Health Checks more widely and work is underway across the system to understand options for wider community teams broader than Early Intervention In Psychosis.
Proactive prevention of crisis	This project aims to proactively identify and support people who are at high risk of experiencing a mental health crisis, to improve patient outcomes and experience for this population group. People with mental health challenges are significantly (3.6x) more likely to experience a potentially preventable emergency admission than	Following implementation we hope to be able to demonstrate reduced admissions and improved outcomes in this population group.

	those without such challenges (Nuffield Trust). Areas such as Learning Disabilities services have demonstrated the possibility of implementing operational and digital solutions to prioritise intervention and prevent admission (although risk stratification is not recommended in predicting specific outcomes such as suicide or self-harm). Supporting and encouraging professional curiosity must be central. A secondary purpose of this work is to provide an additional potential user case for the Mental Health Digital Roadmap, feeding into the ICS Costed Investment Digital & Data Investment Roadmap.	
S12 App (for Section 12)	Mental Health Act assessment teams can often rely on inefficient paper processes. Inefficient processes can cause delayed assessments, and increased distressed for the person waiting. S12 Solutions is a platform which connects AMHPs with local, available, section 12 doctors.	July 2022 report – July – 262 were assessments created. 246/262 of these had doctors booked against the assessment.
SABP Application Development	The Application Development Team are part of the Design and Solution Department within SABP Digital, creating new applications and platforms based around the Microsoft Power platform to provide better processes and compliance for the Trust.	Some case studies include: **Ligature Audit App** Previously a ligature audit was completed on paper and then entered in an Excel Spreadsheet. Our App enables automation of the ligature audit process, replacing a series of complex spreadsheets and adding robust data validation. The app also includes integrated reporting giving an overview of audit compliance and enabling staff to identify key risk areas.

		The LD Day Planner provides a digital view of the week ahead, promoting well-being and providing a routine, vital to some of our residents' wellbeing. Staff use the admin side of the app to build custom plans of activities and day events. Residents then access the Day Planner via a large format display in communal areas, by selecting their name and avatar. Designed for our LD care homes, the app replaces a manual solution using laminated paper and Velcro stickers and provides and improved experience for residents and care staff alike. **Flu Hub** It's of vital importance our staff receive the option to have a Flu Jab, assisting in the safety and protection of our local population. Previously this vital service was recorded on paper forms and updated to a spreadsheet. The Flu Hub enables users to book their flu vaccination and record the uptake of the Flu vaccinee. Plans for a re-design for winter 2022-3 are already underway and promise to make a great app even better with enhanced reporting and reminders for staff with booked vaccinations. **COVID Risk Assessment** This was a paper form and email service previously, the COVID Risk Assessment generated a lot of data, which need to be recorded in a safe and secure manner. During the height of COVID, all staff were asked to complete a COVID Assessment on their personal risk, family risk and needs around COVID. This App enabled staff to securely record information and enable the Trust to assist staff as required. This App provides clear reporting and secures the data

Surrey Care Record	The Surrey Care Record is an Electronic Health Record (EHR) linking system that brings together patient information across health and care systems in a secure manner, giving a summary of your information which is held within a number of local records	The following data is from the SCR 2022 annual survey (this comprised of 1413 replies). Of the respondents: 90% would recommend the Surrey Care Record to others 60% used the Surrey Care Record every day or a few times a week 20% used the record less than once a month 74% described the record as 'essential', 'very useful' or 'useful' 73% said that the record had improved the way they deliver care 66% felt that the record had improved decision making at the point of care Top benefits from those with a clinical role: 1. Increases patient safety/reduces clinical risk 2. Influences care/treatment provided 3. Facilitates a timelier patient journey 4. Informs a more joined up pathway when moving across health and social care 5. Influences prescribed or administered medication The use of the Surrey Care Record across the system including at SABP continues to grow. Note there is not impact data available beyond provider level. There is further work to do in raising the awareness of specific data sets available relevant to different teams. "Having the Surrey Care Record where details of past psychiatric history is given, whether somebody had admissions in the past, was detained, previously prescribed

		antidepressants, or whether there was any past history of deliberate self-harm, really helps me do assessments. I found that having this facility has improved my ability to care for my patients, manage my time and have a good management system for patients which is safe, robust, and also evidence based. The Surrey Care record is a very good example of the interface between mental health and physical health. Historically, they are considered two separate things and getting access to medical notes can be a difficult thing from a psychiatrist's point of view, and for consultants in hospitals it can be difficult to access mental health notes. The Surrey Care Record helps you look at a patient holistically. I believe it is a very good way of working together and should be the way things move forward." - **Kapil Kashyup, consultant psychiatrist, older adults**
Surrey Information Point	For anyone living in *Surrey* for local care and support, health and wellbeing *information* for adults. With lots of information on mental health	• On Surrey Information Point, there were **178 page views to the Mental Health landing page in June 2022**. • On the Surrey CC website, there were **256 page views on the Mental Health landing page in June 2022**. An exercise is currently underway to evaluate both current and potential new Surrey Information Point to inform the future service.
Surrey Virtual Wellbeing Hub (Surrey wide via VCSE (residents – adults focus)	With lockdown looking likely, this platform was set up to provide digital connections across VCSE organisations in one place. It continues to provide details for online offers.	The visibility of offers helps providers to collectively consider where there is a need to fill gaps (e.g. at the weekend or in the evenings). There are opportunities to evolve and develop this product.

Surrey Virtual Trips	Via the voluntary sector, a selection of virtual trips have been provided. These have been to an array of different locations, in Surrey and beyond, including Monkey World in Dorset, Hever Castle in Kent and Brooklands Museum in Surrey.	Approx. 200 Surrey residents facing the most barriers to getting out and about again have joined group live virtual trips. These have, in some instances, acted as a stepping stone for people to build confidence to attend in real-life and 'practice' before they do so.
Technology integrated health management service (TIHM) remote monitoring	TIHM is a remote monitoring service that utilises smart technology to aim to improve quality of life for vulnerable people, as well as allowing them to live more independently in their own homes. It also offers support to families and informal caregivers and has supported 550 people living in the community. Due to the impact of COVID-19 on vulnerable people, including those with dementia, TIHM was adapted to help support those who were isolating and may have felt uncomfortable with attending hospitals. It is based on the award-winning TIHM for dementia system developed by Surrey and Borders Partnership, University of Surrey and Howz. The service combines digital devices installed in homes with data analytics and a dedicated NHS Monitoring Team monitoring care.	Evaluation data – based on collection Dec 2020 – Jan 2021 Social outcomes: 42% reduction in care home admission and also quality of life benefit 60% of users feeling less anxious. 0kg of C02e emissions saved per TIHM user per year Patient outcomes: 32% reduction in emergency admissions 13% reduction in ambulance callouts 23% Reduction in inpatient stays in hospital 27% Reduction in attendees that required no treatment Financial outcomes: £6.7 million Potential gross saving to local authorities over 5 years by reducing care home placements £1.10 5 year ROI for every £1 spent
Tech to Community Connect	Tech to Community Connect is a digital inclusion service Surrey wide via the VCSE. "We provide devices, digital literacy training and confidence-boosting support to people from all over Surrey"	Impact of intervention measured against 1) digital exclusion and 2) loneliness (measure designed by Surrey University). For both outcomes, the service has delivered over 90% of respondents showing a decrease after 3-months.

	The service has supported approx. 5, 000 residents to date. Residents are offered a device, data (a 6-months free Vodaphone sim), matching with a volunteer Tech Angel and a menu of training modules to work through.	
Workforce development – smart technology and independent living	System workforce groups have received training, both to become 'Tech Angels' and also in smart technologies that are commercially available and their applications for independent living.	

ADULTS AND HEALTH SELECT COMMITTEE

5 OCTOBER 2022

ACTIONS AND RECOMMENDATIONS TRACKER AND FORWARD WORK PROGRAMME

Purpose of report: The Select Committee is asked to review its actions and recommendations tracker and forward work programme

Recommendation

That the Select Committee reviews the attached actions and recommendations tracker and forward work programme, making suggestions for additions or amendments as appropriate.

Next steps

The Select Committee will review its actions and recommendations tracker and forward work programme at each of its meetings.

Report contact

Omid Nouri, Scrutiny Officer

Contact details

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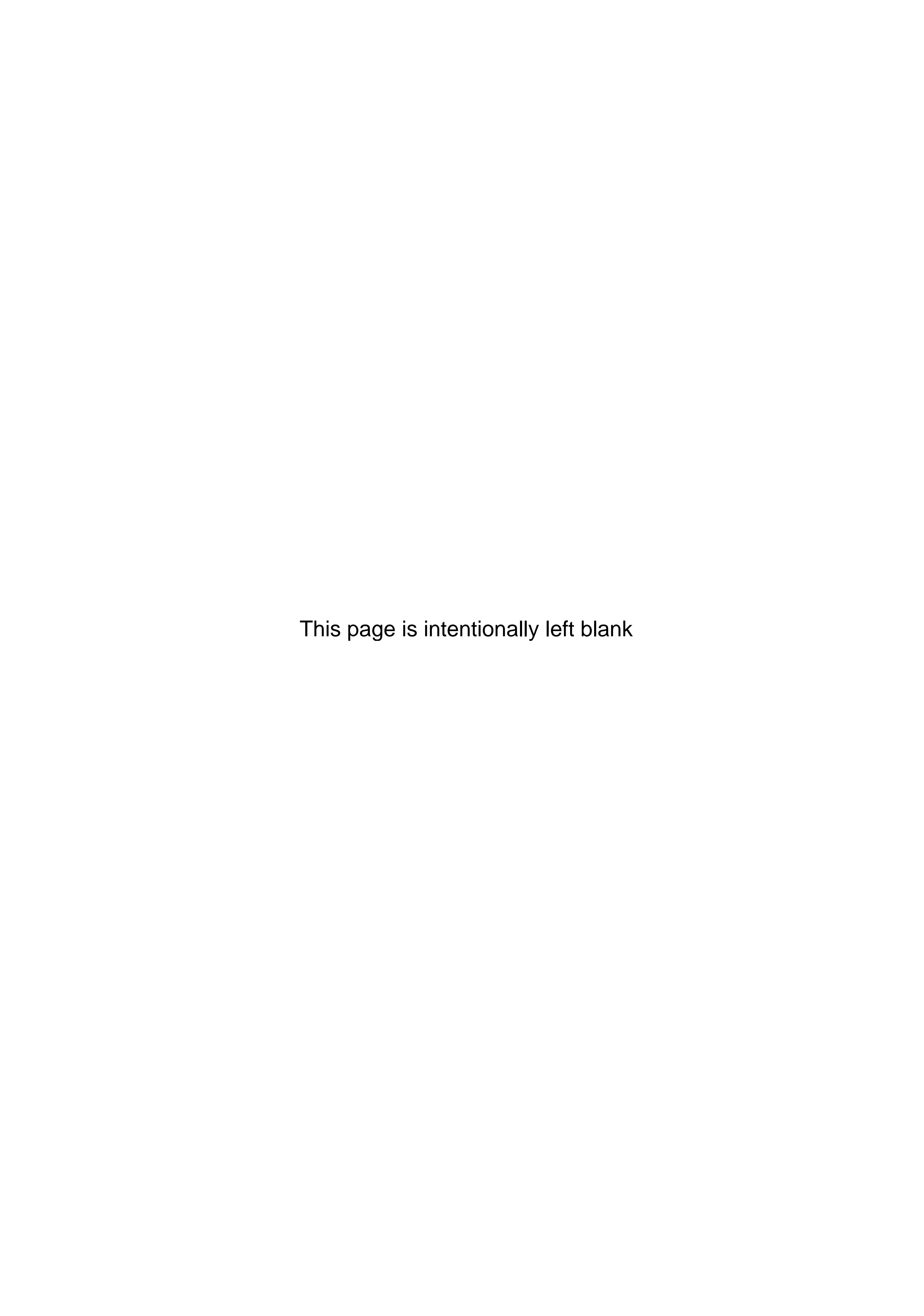
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ADULTS AND HEALTH SELECT COMMITTEE
ACTIONS AND RECOMMENDATIONS TRACKER
OCTOBER 2022

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Recommendations

Meeting	Item	Recommendation	Responsible Officer/Member	Deadline	Progress Check On	Update/Response
3 March 2022	Update on the Implementation of the Community Mental Health Transformation [Item 5]	**AH 3/22:** The Select Committee: Requests the following reports at future meetings: i. Individual Placement Support (IPS) – Employment support and collaboration with local businesses to support their own staff, ii. Update on progress and impact of community mental health transformation in 12 months' time.	Helen Rostill, Deputy Chief Executive (SABP) Georgina Foulds, Associate Director for Primary and Community Transformation (SABP) Ane Sosan, Community Mental Health Transformation Programme Manager (SABP)			The report is due to come to the meeting in April 2023.

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	Primary Care Access [Item 7]	**AH 7/22:** The Select Committee urges Surrey Heartlands to: i. Ensure that the total triage model and investment in cloud telephony is delivered. ii. Work closely with the Surrey Coalition of Disabled People, Sight for Surrey and the Surrey Minority Ethnic Forum to ensure the new cloud telephony system is accessible for all. iii. Regularly deliver training to all members of staff to ensure they are able to fully support people with accessibility needs. iv. Provide the Select Committee with an update report on the	Surrey Heartlands Primary Care team			The report is due to come to the meeting in April 2023.

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		above recommendations later in the year.				
		AH 8/22: The Select Committee agrees to explore how it can best share information about this work with citizens as and when relevant, helping to promote the associated engagement and co-design activity. The Surrey Heartlands team will link in with the Surrey County Council Communications team to help facilitate this.	Surrey Heartlands Primary Care team and Surrey County Council Communications team	5 April 2022	October 2022	The Surrey Heartlands Primary Care team have confirmed that this work will take place over the next few weeks as part of the wider work around access, and they will be including Surrey County Council in developing communication and engagement plans. The co-design communication and engagement will be focused on the period following the current procurement processes, though there has been lots of patient engagement happening via their practices over the last few months

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						as they have been developing their new enhanced access services.
23 June 2022	All-Age Autism Strategy Review [Item 5]	**AH 12/22:** For Learning Disabilities and Autism Leads at Surrey County Council and other partners involved in the strategy to raise further awareness of Autism amongst elements of the BAME/GRT community. To have an informal meeting on progress toward this in a future informal Adults and Health Select Committee meeting.	Hayley Connor, Director – Commissioning, CFLL (SCC) Steve Hook, Assistant Director, LD&A (SCC)	2 August 2022	October 2022	A date for this briefing is being arranged.

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		AH 13/22: For Learning Disabilities and Autism Leads at Surrey County Council to closely work with Surrey Heartlands and Frimley ICSs to ensure that knowledge and consideration of autism is emphasised in EDI training and as well as in EDI principles surrounding staff recruitment and work practices.		2 August 2022	October 2022	The Leads have been contacted for a response.

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		AH 14/22: For Learning Disabilities and Autism Leads at Surrey County Council and other partners involved in the strategy to adopt a meaningful co-production approach, a shared vision, resourcing and prompt timelines to implement the strategy, given that the success of the strategy will largely rest on being able to collaborate effectively with other partners.		2 August 2022	October 2022	The Leads have been contacted for a response.
		AH 15/22: Bring this item back to the Adults and Health Select Committee in an informal session, with specific updates on the ***work with Employability*** as well as the ***preparations for the Adulthood Board Activities.***		2 August 2022	October 2022	A date for this briefing is being arranged.

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	Adult Social Care Complaints – October 2021 to March 2022 [Item 6]	**AH 16/22:** That a thorough review is undertaken by Adult Social Care Leads at Surrey County Council, with the assistance of relevant corporate system providers, of the current CRM system in place to make it as user-friendly as possible, and to harness all the functions within the CRM system.	Liz Uliasz, Deputy Director, ASC (SCC) Kathryn Pyper, Senior Programme Manager, ASC (SCC)	N/A	N/A	Response: We fully recognise the importance of having the right customer relationship management (CRM) capabilities to deliver the best experience for our customers when they contact us, as well as being able to better gather and use insights from our interactions with customers to improve our services. The Council's Digital Design Team is currently working on a user centred design to support a new Relationship Management and Insights (RM&I) Programme. This Programme will identify how we can gain better insights (data) to inform how we engage with residents in Surrey. It will identify the technology needed to improve the customer experience (including
		AH 17/22: For Adult Social Care Leads at Surrey County Council to review what is being considered, and the parameters being used, in the process of acquiring a new CRM system.		N/A	N/A	

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						customer relationship management (CRM) and digital channels), as well as improvements to processes and ways of working, and opportunities to work better with other council services and SCC Partners. The Programme is currently in the early discovery and design phase. Research has been conducted to understand what our customers want and need, and these insights will be used to scope the technology and systems required to make it easier for people to get support in the way they want it across a range of contact channels, including phone, online, SMS, social media and more. We will take a phased and agile approach to the programme, building on the design work

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						completed. We will be putting in place improved technical capabilities and business process and will be working towards replacing Achiever and Zendesk (our current CRM systems) over the next 12-18 months. Sarah Bogunovic, Head of Customer Strategy is the Senior Responsible Officer (SRO) and Marie Snelling is the Accountable Sponsor for this programme of work.
		AH 18/22: That a follow-up informal session is held to address/investigate how Issues of Concern are recorded and dealt with, as opposed to formal complaints.		2 August 2022	October 2022	Response: The Adult Social Care complaints process is statutory and so our priority must be to meet these responsibilities. In Adult Social Care the focus continues to be upon being responsive, open to

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						feedback and resolving any issues of concerns as close to the point of service as possible, because that delivers the best outcomes for residents and staff. As good practice, any issue of concern will always be addressed by members of staff at the time it is raised by a resident and recorded in a case note as appropriate. We also complete the ASCOF annual customer survey and if issues are identified they will be followed up. We will be making significant changes to how we interact with the public in preparation for the forthcoming Adult Social Care charging and fair cost of care reforms and will investigate how we might be able to capture issues of concern as part of that process, without introducing a resource intensive process. Sarah

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						Bogunovic, Head of Customer Strategy has offered to attend a future Select Committee to talk about the upgrade to the Council's customer relationship management (CRM). A date for this briefing is being arranged.
		AH 19/22: For Adult Social Care Leads at Surrey County Council to look into investigating training available from the Ombudsman to learn from cases upheld.		N/A	N/A	Response: The Adult Social Care Customer Relations Manager and Officer will be attending a forthcoming LGSCO course which focusses upon accepting, investigating and deciding complaints for councils and social care providers. This online skills course is delivered by experienced Ombudsman staff. Participants can draw on knowledge gained from LGSCO

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						experience of over four decades of complaints investigation, decision-making and remedy recommendations. The Customer Relations Team will then seek approval from the Adults Leadership Team to fund and roll out the training across Adult Social Care (£450 full course fee for 18 delegates).
	Mental Health Improvement Programme Stocktake after 12 months [Item 7]	**AH 20/22:** For Surrey Heartlands CCG, Surrey and Borders Partnership NHS Foundation Trust, and Surrey County Council to continue to campaign for a change in the National Allocation Formula that would accurately reflect some of the mental health issues faced by Surrey Residents.	Surrey Heartlands, Surrey and Borders Partnership, and Surrey County Council	2 August 2022	October 2022	Response: We agree with this recommendation, which has the potential to affect funding flows in the longer term. System partners (including SaBP and SCC) have raised issues with the National Allocation Formula in regional and national forums and will continue to do so. We believe that our case will be stronger if we seek the

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						support of other systems who are similarly disadvantaged by the formula, and we will discuss the case for change with them. We appreciate the support of elected representatives in campaigning and believe that members would have a key role to play in any successful attempt to change the National Allocation Formula. A meeting will be arranged with the Scrutiny Officer to discuss this work further in due course.

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		AH 21/22: For Surrey Heartlands CCG, Surrey and Borders Partnership NHS Foundation Trust, and Mental Health leads in Surrey County Council to provide a future update and report to the Adults and Health Select Committee on the technology being sought, and the progress being made in rolling out technological systems to improve Mental Health Services in Surrey.		N/A	N/A	This will be included in the report at the meeting in October 2022.

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		AH 22/22: For Surrey Heartlands CCG, Surrey and Borders Partnership NHS Foundation Trust, and Mental Health leads in Surrey County Council to provide a future update and report to the Adults and Health Select Committee on how existing and additional funding will be effectively used to deliver on the Mental Health Improvement Programme, and to provide a timeline as to when the plan is expected to be delivered on.		2 August 2022	September 2022	This item is scheduled for October 2022.

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Actions

Meeting	Item	Action	Responsible Officer/Member	Deadline	Progress Check On	Update/Response
17 December 2020	Scrutiny of 2021/22 Draft Budget and Medium-Term Financial Strategy to 2025/26 [Item 5]	**AH 2/20:** Democratic Services officers to look into the possibility of organising for Members to visit Learning Disabilities and Autism services (whether remotely or in person).	Scrutiny Officer, Democratic Services Assistant	January 2021	October 2022	These visits are being looked into.
16 December 2021	Scrutiny of 2022/23 Draft Budget and MTFS to 2026/27 [Item 5]	**AH 5/21:** The Cabinet Member for Adults and Health to feed back to the Select Committee her views and findings of the care home shadowing work she will be undertaking.	Sinead Mooney, Cabinet Member for Adults and Health	January 2022	October 2022	The Cabinet Member is preparing a response.

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3 March 2022	Primary Care Access [Item 7]	**AH 9/22:** Surrey Heartlands Primary Care team to provide an updated infographic on the delivery of services.	Surrey Heartlands Primary Care team	N/A	N/A	The infographic has been shared with the Committee Members.
23 June 2022	All-Age Autism Strategy Review [Item 5]	**AH 23/22:** The Director of Commissioning (CFLL) to provide additional information on annual reviews of EHC Plans.	Hayley Connor, Director – Commissioning, CFLL (SCC)	2 August 2022	October 2022	A response is being prepared.
		AH 24/22: The Director of Commissioning (CFLL) to provide an answer regarding private diagnoses not being recognised by the NHS from a Children's Services perspective.		N/A	N/A	Response: The most important consideration in regards to an Autism diagnosis is the standard of the assessment rather than whether or not the diagnosis has been obtained privately or through the NHS. If it follows NICE guidance and has been completed by relevant specialist professionals the diagnosis should be accepted.

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						It is of note that Mindworks CYPS Community team practitioners cannot recommend any specific provision, so for example need for a specialist school versus a mainstream school. The health report will describe the potential needs of a child or young person.

Adults and Health Select Committee Forward Work Programme 2022

Adults and Health Select Committee Chairman: Bernie Muir I Scrutiny Officer: Omid Nouri I Democratic Services Assistant: Emily Beard						
Date of Meeting	**Type of Scrutiny**	**Issue for Scrutiny**	**Purpose**	**Outcome**	**Relevant Organisational Priority**	**Cabinet Member/Lead Officer**
2 November 2022	Overview, policy development and review	**Accommodation with Care and Support Strategy**	For the Select Committee to scrutinise progress made in delivering Extra Care Housing and Supported Independent Living Accommodation to the elderly and those with learning disabilities and mental illness.	The Select Committee received a report on progress made in delivering the strategy, and will provide recommendations accordingly.	Empowering communities, tackling health inequality	Mark Nuti – Cabinet Member for Adults and Health Jonathan Lillistone – Assistant Director (commissioning)
	Overview, policy development and review	**Mental Health Investment Fund**	For the Select Committee to scrutinise the establishment of the new Mental Health Investment Fund (MHIF) and its efforts in supporting the Mental Health of Surrey residents subsequent to the emergence of the Covid Pandemic.	The Select Committee received a report on the nature and scope of the MHIF, and will provide recommendations accordingly.	Empowering communities, tackling health inequality	Mark Nuti – Cabinet Member for Adults and Health Kate Barker - Joint Strategic Commissioning Convenor

6 December 2022	Performance and finance	**2023/24 Draft Budget and Medium-Term Financial Strategy**	For the Select Committee to scrutinise the draft 2023/24 budget, Medium-Term Financial Strategy and other relevant information, before it is finalised in January 2023.	To ensure the 2023/24 budget and Medium-Term Financial Strategy deliver good value for residents and are compatible with the Council's organisational polices.	Growing a sustainable economy so everyone can benefit	Mark Nuti – Cabinet Member for Adults and Health
	Overview, policy development and review	**Adult Social Care Complaints Bi-Annual Review**	The Select Committee has identified complaints received by Adult Social Care as a key area for examination. Reports highlighting complaints activity will be provided to the Select Committee on a bi-annual basis.	The Select Committee is to review complaint activity in Adult Social Care.	Empowering communities, tackling health inequality	Mark Nuti – Cabinet Member for Adults and Health Kathryn Pyper – Senior Programme Manage, Adult Social Care
	Overview, policy development and review	**Surrey Safeguarding Adults Board Annual Report**	The Surrey Safeguarding Adults Board is a multiagency partnership that has representation from organisations that support adults who have care or support needs. Safeguarding Adults Boards have a statutory duty to publish an annual report.	The Select Committee will review the Safeguarding Adults Board Annual Report to better understand key themes, provide comment and recommendations, and highlight opportunities for future scrutiny.	Empowering communities, tackling health inequality	Mark Nuti – Cabinet Member for Adults and Health Simon Turpitt – Independent Chair, Surrey Safeguarding Adults Board

Items to be scheduled						
	Overview, policy development and review	**Access to GPs**	At its public meeting on 3 March 2022, the Select Committee received a report from Surrey Heartlands ICS on the current status of accessibility to GPs in Surrey and what was being done to improve patient access. It was agreed that a report would be presented to the Select Committee at a future public meeting to update Members on the progress made in implementing its recommendations.	The Select Committee will review the current status of accessibility to GPs in Surrey and any potential barriers being faced by residents, making recommendations accordingly.	Empowering communities, tackling health inequality	Nikki Mallinder – Director of Primary Care, Surrey Heartlands ICS
	Overview, policy development and review	**Community Mental Health Transformation Implementation Review**	The Select Committee is to receive an update on the implementation of the Community Mental Health Transformation Programme, as well as information on Individual Placement Support.	The Select Committee will review the progress of the Community Mental Health Transformation Programme, making recommendations accordingly.	Empowering communities, tackling health inequality	Professor Helen Rostill – Deputy Director, Surrey and Borders Partnership
	Overview, policy development and review	**Joint Health and Social Care Dementia Strategy for Surrey (2022-2027)**	The Select Committee is to receive a report outlining the progress made on the implementation of the new Joint Health and Social	The Select Committee will review and scrutinise the implementation of the Joint Health and Social Care Dementia Strategy for Surrey (2022-2027),	Empowering communities, tackling health inequality	Mark Nuti – Cabinet Member for Adults and Health

			Care Dementia Strategy for Surrey (2022-2027), as agreed at its public meeting on 14 January 2022.	making recommendations accordingly.		Jane Bremner – Head of Commissioning (Mental Health), Surrey County Council
	Scrutiny	**Reconfiguration of Urgent Care in Surrey Heartlands**	NHS England has developed clear guidance for commissioners responsible for the development of Urgent Care. This report will provide an update on the impact and risks associated with the reconfiguration of Urgent Care services in Surrey Heartlands and the preferred options for the proposed changes.	The Select Committee will scrutinise the programme's preferred options prior to their approval.	Empowering communities, tackling health inequality	Simon Angelides – Programme Director

	Overview, policy development and review	**Mental Health Improvement Plan**	The select committee is to receive a report and update on the delivery of the Mental Health Improvement Programme, as agreed at its public meeting on June 23rd 2022.	The select committee will scrutinise and review the implementation of the MHIP, making recommendations accordingly.	Empowering communities, tackling health inequalities	Mark Nuti – Cabinet Member for Adults and Health Liz Williams – Joint Strategic Commissioning Convenor (LD&A) Professor Helen Rostill – Deputy Chief Executive of Surrey and Borders Partnership and Director of Therapies
	Scrutiny	**Access to Dental Care**	The select committee is to receive a report and update on the initiatives undertaken by Surrey Heartlands and Frimley CCG to increase access to dental care and treatments.	The select committee will scrutinise and review steps being taken to increase dental care access for Surrey residents who cannot afford private dental care, particularly in the context of the cost of living crisis. The select committee will also make recommendations accordingly.	Empowering Communities, tackling health inequality	

	Scrutiny	**Mindworks**	The select committee is to receive a report and update on the recent work undertaken by the mental health and emotional wellbeing service provided by Mindworks Surrey.	The select committee will scrutinise and review the work undertaken through mindworks to improve the mental health and emotional wellbeing of Children within Surrey.	Empowering Communities, tackling health inequality	

Task and Finish Groups

Time scale of task group	Issue for scrutiny	Purpose	Outcome	Relevant organisational priority	Task group members
October 2021 – April 2023	**Health Inequalities**	For Members of the Task Group to develop an understanding of health inequalities in Surrey, scrutinise the progress being made on tackling these, and contribute to the development of future policies.	The Task Group will seek to contribute to the reduction of health inequalities being faced by Surrey residents, contribute to the Council's strategic priority to "drive work across the system to reduce widening health inequalities", support both the Council and the wider health and social care system in Surrey to understand how they can address and tackle health inequalities faced by residents, create a	Tackling health inequality	Angela Goodwin (Chairman), Trefor Hogg, Riasat Khan, Carla Morson, Bernie Muir (ex-officio)

			shared understanding of barriers being faced by residents with lived experiences of health inequalities, and take an elevated view of services and support available in Surrey by considering individual experiences of those with lived experience of health inequalities and their interactions with different agencies.		

To be received in writing and informal briefing sessions

Date of briefing session (if applicable)	Issue for scrutiny	Purpose	Outcome	Relevant organisational priority	Cabinet member/Lead officer
28 September 2022	**Dunsfold Branch Site (Chiddingfold Surgery) -Informal Briefing Session**	For the select committee to receive an update on the implications of the Dunsfold Branch Site of Chiddingfold Surgery.	The select committee will scrutinise the extent to which the closure of the Dunsfold site may cause transportation and access issues for patients.	Empowering Communities, Tackling Health Inequality	Mark Nuti – Cabinet Member for Adults and Health

10 October 2022	**Weybetter Weybridge Programme - Informal Briefing Session**	For the Select Committee to receive an update on the Weybetter Weybridge Programme	The select committee will scrutinise the extent to which the programme is up to schedule, and how the new site can help to improve the health and overall wellbeing of residents.	Empowering Communities, tackling health inequality	Mark Nuti – Cabinet Member for Adults and Health
TBC	**Adult Social Care CRM System AND Issues of Concern- Informal Briefing Session**	For the select committee to receive an update on work being undertaken to improve the existing Adult Social Care CRM system, as well as an update on how Issues of Concern are recorded and dealt with.	The select committee will scrutinise how the CRM system can be improved, as well as how Issues of Concern are addressed by Adult Social Care. Both of which are in line with recommendations produced from the 23 June 2022 select committee meeting.	Empowering Communities, Tackling Health Inequality.	Mark Nuti- Cabinet Member for Adults and Health Kathryn Pyper – Senior Programme Manager, Adult Social Care
TBC	**Raising Awareness of Autism amongst the BAME/GRT Community- Informal Briefing Session**	For the select committee to receive an update on work undertaken by Autism/learning disability leads to increase awareness of	The select committee will scrutinise the extent to which such awareness raising is taking place amongst	Empowering communities, Tackling Health Inequality	Mark Nuti – Cabinet Member for Adults and Health

		Autism amongst the BAME/GRT community.	ethnic minorities. This is in line with a recommendation that came out of the 23 June 2022 select committee meeting.		Hayley Connor – Director for Commissioning (CFLL)
TBC	**Update on the *work with Employability* AND *preparations for the Adulthood Board* Activities- Informal Briefing Session**	For the select committee to receive an update on work undertaken by Autism/learning disability leads to work with Employability, as well as the preparations for the Adulthood Board Activities.	The select committee will scrutinise the degree to which work with Employability has taken place as well as any preparations for the Adulthood Board Activities. This is in line with a recommendation that came out of the 23 June 2022 select committee meeting.	Empowering Communities, Tackling Health Inequality	Mark Nuti – Cabinet Member for Adults and Health Hayley Connor – Director for Commissioning (CFLL)
Joint Committees					
Time scale of joint Committee	**Joint Committee name/structure:**	**Purpose**	**Outcome**	**Relevant organisational priority**	**Relevant Committee Members**

Ongoing	**South West London and Surrey Joint Health Overview and Scrutiny Committee**	The South West London and Surrey Joint Health Overview and Scrutiny Committee is a joint standing committee formed with representation from the London Borough of Croydon, the Royal Borough of Kingston, the London Borough of Merton, the London Borough of Richmond, Surrey County Council, the London Borough of Sutton and the London Borough of Wandsworth.	The Joint Committee's purpose is to respond to changes in the provision of health and consultations which affect more than one London Borough in the South West London area and/or Surrey.	Empowering communities, tackling health inequality	Bernie Muir, Angela Goodwin, Riasat Khan (substitute)
Ongoing	**South West London and Surrey Joint Health Overview and Scrutiny Committee – Improving Healthcare Together 2020-2030 Sub-Committee**	In June 2017, Improving Healthcare Together 2020-2030 was launched to review the delivery of acute services at Epsom and St Helier University Hospitals NHS Trust (ESTH). ESTH serves patients from across South West London and Surrey, so the Health Integration and Commissioning Select Committee (the	A sub-committee of the South West London and Surrey Joint Health Overview and Scrutiny Committee has been established to scrutinise the Improving Healthcare Together 2020-2030 Programme as it develops.	Empowering communities, tackling health inequality	Bernie Muir, Angela Goodwin (substitute)

		predecessor to the Adults and Health Select Committee) joined colleagues from the London Borough of Merton and the London Borough of Sutton to review the Improving Healthcare Together Programme as it progresses.			
Ongoing	**Hampshire Together Joint Health Overview and Scrutiny Committee**	On 3 December 2020, the Hampshire Together Joint Health Overview and Scrutiny Committee, comprising representatives from Hampshire County Council and Southampton City Council, was established to review the Hampshire Together programme of work, and Surrey County Council was invited to attend meetings as a standing observer.	The Joint Committee is to scrutinise the Hampshire Together programme of work and associated changes in the provision of health services.	Empowering communities, tackling health inequality	Trefor Hogg, Carla Morson (substitute)

Standing Items

- **Recommendations Tracker and Forward Work Programme:** Monitor Select Committee recommendations and requests, as well as its forward work programme.