Surrey Heartlands Urgent and Emergency Care 10-point action plan

Appendix 3

Introduction

- This year has seen significant pressure put on Urgent and Emergency Care (UEC) services. As demand has returned to pre-pandemic levels, managing this activity whilst impacted by, for instance, staff isolation and Infection prevention and control measures has constrained the capacity within the system to manage this demand.
- There are further, complex, reasons for the current challenges within UEC which mean that it will take all parts of the system working together to ensure a strong recovery across urgent and emergency care services.
- The NHS has a plan on how the whole system will work together to ensure UEC services have resilience, by:

1. Supporting 999 and 111 services
2. Supporting primary care and community health services to help manage the demand for UEC services.
3. Supporting greater use of Urgent Treatment Centres (UTCs)
4. Increasing support for Children and Young People
5. Using communications to support the public to choose services wisely
6. Improving in-hospital flow and discharge (system wide)
7. Supporting adult and children's mental health needs
8. Reviewing Infection Prevention and Control (IPC) measures to ensure a proportionate response
9. Reviewing staff COVID isolation rules
10. Ensuring a sustainable workforce

1a. Supporting NHS 111

System commitments: what's expected of us

Actions at regional level

111:

Participate in bi-lateral discussions with National colleagues to discuss:

- Service funding;
- Service demand and required resource;
- Performance; and
- Implementation of strategic developments.

Ensure continued implementation of NHS 111 First.

Implement Further, Faster (where applicable).

Consider regional networked call handling.

Actions at system/ICS level

111:

Demonstrate system leadership across UEC.

Ensure appropriate commissioning of UEC services and oversight of CAS services.

Facilitate discussions with local primary care, urgent care and secondary care services.

Continue to embed the principles set out through the NHS 111 First Programme.

Actions at provider level

111:

Ensure performance and quality of service.

Spend funding appropriately to maximise resource.

Plan for forthcoming winter.

Actions being taken to improve 111 service delivery

- We are working with Practice Plus Group (PPG) our Integrated Urgent Care (IUC) Provider to strengthen existing capacity across Health Advisor / Clinical advisors / Clinical Assessment Service Staffing through incentives for existing staff.
- Additional recruiters have been brought in to focus targeted recruitment campaigns on part-time/ short term / flexible workers
- Social media campaign and media video to promote working for PPG and 111 as well as retention initiative
- Investment into additional support tools and equipment to support for example home working.
- PPG are currently running a proof-of-concept operational change in the validation of Emergency Department (ED) dispositions to optimise clinical resource within 111 service provision and other services such as Patient Transport Services (PTS) and Same Day Emergency Care (SDEC) that sit across the system to support ED avoidance. ED referrals have reduced and of those that continue to be referred to ED, a higher percentage has had a clinical input and are deemed appropriate.
- We are achieving the national Think 111 first target of 70% of ED dispositions booked into an emergency department appointment slot, with acutes now offering 24hrs slot availability. In excess off 21,154 appointment slots booked since March 2021.
- Consider additional paediatric clinical support in the Clinical Assessment Service (CAS).

1b. Supporting 999 services

System commitments: what's expected of us

Actions at regional level

999

Ensure the £55m allocations are spent through ICSs.

Ensure that tackling ambulance handover delays is a system priority in order to reduce risk of harm to patients both in the community and delayed at hospital.

Actions at system/ICS level

999

Make sure there are robust steps in place to avoid handover delays and swift escalation and resolution of delays

Ensure alternative pathways (such as urgent community response, falls service, mental health crisis) are available to ambulance services to limit avoidable ED conveyance.

Ensure PTS is being most effectively deployed to support UEC and elective recovery.

Actions at provider level

999

Use the £55m allocations to drive improvement against trajectories.

Ensure C3/4 validation amends are implemented as needed.

Make sure capacity issues are escalated rapidly.

Acute providers to accept ambulance transfers rapidly (including to SDEC and specialities).

Actions being taken to improve 999 service delivery

- South East Coast Ambulance Service (SECAmb) have been under sustained pressure which the system is supporting through the actions outlined in the Urgent and Emergency Care 10 point plan. Demand remains exceptionally high, with SECAmb operating under REAP and SMP 4 actions. This is reflective nationally across the ambulance sector.
- SECAmb have stood up strategic commanders to ensure senior presence, support oversight 7 days per week in Emergency Operation Control (EOC)
- Provision of clinical and operational decision support for ambulance crews is in place with Paramedic Practitioner Hubs and Tactical Commanders on-duty 24/7.
- All available clinicians have been placed in patient facing roles. “Business as Usual” meetings have been suspended with all training cancelled (except university programmes for development to Paramedic qualification). SECAmb Leadership teams are working to support staff welfare and positive team working across the entire organisation.
- Cross border 999 impact is under review with predictive conversations being scheduled through with SCAS 999 during times of significant demand to ensure cross county awareness particularly in light of current operational challenges and knock-on impact within Hampshire footprint.
- All Emergency Departments across Surrey are proactively reducing handover delays to support SECAmb.
- Regional escalation calls remain in place on Friday morning with follow up calls continuing across weekends to provide oversight and support.

Actions being taken to improve 999 service delivery

- Central funding has now been allocated to support ambulance performance going into winter 2021/22. The total funding allocated to SECAmb is £4.3m (of £55m)

- SECAmb initiatives include:

  - Recruitment of a cohort of Emergency Medical Assistants (EMA) to reinforce call answer performance.

  - Expansion of capacity through additional crews on the road – considered via the use of Private Ambulance Providers (PAP) and the backfill of Operational Team Leaders and Operational Managers by admin staff (agency)

  - Strengthened additional clinical support in control rooms through recruitment of nurses and other generalists trained in PACCS to welfare call and close down call before physical response is required. This will increase the proportion of Hear and Treat and See and Treat which support less conveyance to ED's. Working with ICS teams, SECAmb will continue to utilise and develop Service Finder and the DOS to identify more appropriate pathways also gives a system wide benefit.

  - Increased Operational Team/Operational Manager hours to support extension of Hospital Ambulance Liaison Officer (HALO) cover at the most challenged acute trusts

  - Development of an approach to enhance the use of taxis to transport patients once initial virtual triage is undertaken that require transport support but do not require clinical attendance at scene. This Non-Emergency transport response will free the Ambulance Fleet up to deliver to C1 and C2 calls.

2a. Supporting Primary care to help manage the demand for UEC services

System commitments: what's expected of us

Actions at regional level

Workforce

Work *with systems and Primary Care Networks (PCNs) to* achieve full use of the Additional Roles Reimbursement Scheme funding in 2021/22 to recruit 15,500 FTE by end of 2021/22. 14 roles are included in the scheme, with paramedics and mental health practitioners added to the scheme in April 2021. Continue to work with the ambulance trusts to introduce rotational models for trainee First Contact Practitioner paramedics in PCNs.

Access

Work with ICSs to effectively plan and deliver support to PCNs and practices to develop effective PCN extended/enhanced access approaches which enable use of digital tools in general practice and PCNs.
Continue to support local implementation and uptake of community pharmacist consultation services, from all referral points, working with 111 and GPs.

Dental

Maintaining urgent dental care systems and current contracted activity. Utilising flexible commissioning and local schemes to target highest need with their populations.

Actions at system/ICS level

Workforce

Work with Primary Care Networks (PCNs) to achieve full use of the Additional Roles Reimbursement Scheme. Utilise the PCN Development funding and funding for training hubs to provide PCNs with the support required to recruit, train and retain the additional staff. Continue to work with PCNs to develop system-wide workforce plans.

Access

Use national DFPC funding to provide support to PCNs and practices to enable effective use of digital tools in general practice.
Ensure PCN plans FOR extended/enhanced access form part of a cohesive ICS approach.
Make plans to roll out PCN wide implementation and uptake of community pharmacist consultation services, from all referral points, working with 111 and GPs.

Actions at provider level

At Trust Level

Workforce

Continue to work with PCNs to developed rotational working models where it is appropriate to do so.

At PCN level:

Access

Use new network DES to develop additional capacity to support practices and PCNs across core and extended hours and make better links with IUC system.

At Practice level:

Access

Access support to enable effective use of digital tools in general practice to support improved access and improved practice workflows.
Implement referrals to community pharmacist consultation service for low acuity patients.

Workforce:

Primary Care Networks to use their full entitlement of Additional Roles Reimbursement Scheme (ARRS) funding to recruit additional staff into PCNs.
Continue to support GPs and additional staff through accessing support offers like #LookingAfterYouToo.

Actions being taken by Primary Care

- **Demand and capacity/ Operational Pressures Escalation Level (OPEL) framework for general practice**
  - Daily data upload from GP providers
  - Activity management framework supporting surge/pressures
  - OPEL framework based on demand and staff absences
  - Constant monitoring of modes of contact (ie. face to face versus virtual)
- **Additional capacity/access**
  - Accelerate delivery and referral to community pharmacy General Practice Community Pharmacist Consultation Service (GPCPCS)
  - Additional winter investment to support OPEL framework and capacity
  - Virtual consultations via external supplier
- **Workforce**
  - Additional Roles Reimbursement Scheme (ARRS) trajectory monitored, with support from CCG in recruitment/employment
  - Refocus on GP recruitment and retention
  - Scoping Surrey Heartlands receptionist accreditation scheme
- **Digital tools**
  - Remote monitoring tools for Long Term Conditions
  - Systems (AccuRx/Flories) – Quality and Outcomes Framework supported by additional digital data gathering
- **Wider system support**
  - All practices accessing 111 Slots
  - Hot hubs (with particular focus on paediatrics)

2b. Supporting community health services to help manage the demand for UEC services

System commitments: what's expected of us

Actions at regional level

Continue to support systems with the rollout of two-hour crisis response services.

Support systems and providers in working collaboratively with providers of NHS111 integrated urgent care services.

Where needed, support coordination and linking of 999 ambulance services with community health services.

Ensure systems and providers are working with directory of service (DoS) leads to add services to the DoS to ensure visibility and coverage of two-hour crisis response (UCR) services across the system.

Ensure any local communications campaigns align with national messaging and requirements around two-hour crisis response (UCR) and support the dissemination of national communications.

Actions at system/ICS level

Continue to support the rollout of two-hour crisis response services across the ICS in line with the NHSE/I Operational Planning and Contracting Guidance 2020/21.

Work with providers and DoS leads to profile (add) two-hour crisis response (UCR) services onto the DoS.

Work to understand potential demand for two-hour crisis response (UCR) services from key referral sources including NHS111 and 999 and link with wider UEC work around admission avoidance and care in the right place.

Along with 999 ambulance Trusts and community health service providers develop streamlined referral pathways to support ambulance hear and treat and see and treat.

Actions at provider level

Ensure delivery of two-hour crisis response (UCR) services in line with the NHSE/I Operational Planning and Contracting Guidance 2020/21.

Work with local DoS leads to profile (add) two-hour crisis response (UCR) services onto the DoS.

Work collaboratively with local NHS111, clinical assessment services (CAS) and 999 ambulance Trusts to agree streamlined and well governed referral pathways for clinicians (non-clinician referrals can be agreed locally). This may include validated cat3/4 999 calls.

Work collaboratively with local NHS111, CAS and 999 Ambulance Trusts to engage and support referring clinicians' knowledge and understanding of two-hour services to maximise referrals from these sources, through sharing of comms, CPD events and local feedback mechanisms to share learning.

Continue to monitor numbers of referrals from key sources and identify and address any gaps.

Actions being taken by community services

- All of our community providers have funding in place in the process of rolling out the urgent 2 hour community response service. Where we can this is being accelerated to be in place before the end of 21-22.
- Rapid community response to care homes is being stepped up to support keeping patients in their homes.
- The directory of service through 111 has been reviewed at place as part of the think 111 first programme. This ensures all community services are made available.
- Our urgent care services like our walk in centres and minor injury units along with Urgent Treatment Centres (UTCs) are all mapped on the Directory of Service (DOS) and have the ability for patients to be booked an appointment.
- We have mobilised the NHS Digital (NHSD) streaming and redirection tool to provide a digital triage offer at the front door of our EDs and UTC. To date 4515 unheralded patient's have used the tool and our ICP's are utilising this baseline data to consider opportunities to develop or improve alternative pathways where we can either internally stream or redirect to alternative services, with the aim of getting patient's to the right place first time and reducing pressure at the front door.

3. Supporting Greater Use Of Urgent Treatment Centres (UTC)

System commitments: what's expected of us

Actions at regional level

Ensure that systems are reviewing demand and capacity for lower acuity urgent and emergency care, and that the status of temporarily closed Type 3 and 4 services is reviewed to ensure capacity is aligned to local demand.

Work with their systems to explore UTCs or other enhanced triage services for lower acuity patients at the front door of ED, where this would address demand and capacity issues.

Actions at system/ICS level

Review capacity and demand across their portfolio of type 3 & 4 services, including those temporarily closed during Covid.

Ensure available capacity and capability of Urgent Treatment Centres is matched to demand, and that UTCs are commissioned and delivering against the agreed UTC standards.

Agree and develop new pathways for lower acuity patients as an alternative to ED, including booking from NHS 111.

Where outstanding, agree long term reconfigurations to adopt the UTC model.

Actions at provider level

Deliver the UTC model and support implementation of new pathways.

Where necessary, enhance current UTC capability and/or capacity to meet demands (e.g. extended hours, enhanced case mix.)

Where this would manage ED demand more effectively, review the need for enhanced triage and/or redirection at ED front door, with an emphasis on primary and community led-provision.

Action being taken to optimise use of urgent care provision

- Surrey Heartlands maintained all urgent care provision during wave one and two of COVID and in some parts of the system services have been increased to support reducing demand on the EDs
- Our UTCs are commissioned against the UTC standards.
- We have reviewed the DOS and ensured we have maximised the opportunity for directing patients from 111 in to UTC , Walk in Centres (WiC) and Minor Injury Units (MIU).
- UTC service has been extended to meet demand at Ashford & St Peters Hospital (ASPH) , other urgent care provision is exploring the potential to enhance the service but skilled workforce is a challenge.

4. Increasing support for children and young people

System commitments: what's expected of us

Actions at regional level

To oversee Regional surge planning/mitigations for RSV/seasonal demand in CYP services.

Actions at system/ICS level

To implement agreed surge planning and mitigations for RSV/seasonal demand in CYP services as appropriate.

Actions at provider level

To implement agreed surge planning and mitigations for RSV/seasonal demand in CYP services as appropriate.

Actions being taken to support young people and children.

- Proactive monitoring of surges in activity for all Children and Young Persons (CYP) regarding seasonal uplifts such as Respiratory Syncytial Virus (RSV)
- ICS Paediatric respiratory surge plan that identifies surge capacity, procurement of additional cots/equipment, improve process of early supported discharge, and agree mutual aid process.
- Paediatric transfer vehicle to support mutual aid to move lower acuity children to other sites across Kent, Medway, Surrey and Sussex (KMSS) to support paediatric units that are under surge and require capacity to treat our sickest children.
- Targeted comms to parents to support self care use of social media.
- Additional workforce in acutes to support surge beds.
- Paediatric specific Improved access appointments in primary care.
- Scoping use of clinical paediatric call back service for parents in the community.

5. Using communications to support the public to choose services wisely

System commitments: what's expected of us

Actions at regional level

Ensure signposting messaging is accurate and consistent across ICSs and providers in your region.

Amplify national campaigns and cascade regionally.

Ensure take-up of campaigns at provider level i.e. length of stay or flu campaigns.

Ensure local campaigns are consistent with national messaging.

Actions at system/ICS level

Work in partnership to co-ordinate consistent messaging across your ICS area.

Ensure messages/campaigns are shared, where appropriate, to your strategic partners such as local councils and voluntary sector.

Actions at provider level

Ensure promotion of length of stay campaign within your trust.

Work with ICS and regional colleagues to ensure understanding of other system pressures (i.e. NHS 111) before signposting patients to alternative services at busy times.

Actions being taken to support communications and citizen engagement

Leading system-wide communications

- As part of our system-led communications and engagement approach, we proactively reinforce national campaign messages across the ICS. Proactively sharing messages across our full suite of channels and platforms about where to seek help, and how to use services appropriately, forms a key part of this strategy.
- On a day-to-day basis, we reinforce national messaging through a range of different channels and tactics including social media (including paid advertising to target specific areas or demographics where needed), our CCG and ICS websites, the media (including putting a trained clinical spokesperson on radio to reiterate key messages), promotion of national campaign assets (including Help us Help you and Think 111 First messaging) and other forms of advertising, where needed.
- We also work closely with local partners including Surrey County Council, public health, district and boroughs and our providers to co-ordinate activity and campaigns, sharing assets to further amplify messages and maximise the use of all channels to reach and engage Surrey residents. This includes actively contributing to bi-weekly winter/ system planning meetings, meetings of the Surrey Health and Wellbeing Board communications Group and bi-weekly meetings with provider comms leads across Surrey Heartlands to ensure a coordinated approach.

Actions being taken to support communications and citizen engagement (continued)

Activating our Opel communications plan in response to sustained system pressure

- We work closely with the urgent care team to increase communications activity at times of sustained system pressure and we have well established protocols in place.
- This includes the activation of our Opel Communications Plan which triggers additional communication activity to increase the flow of messages and support the wider system during periods of significant pressure.
- 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.

Actions being taken to support communications and citizen engagement (continued)

Targeted campaigns

- In addition to the activity mentioned, the following campaigns are also in train to further amplify messages and help people understand how to access services appropriately.
- ***Help us, help you*** **campaign** – having secured match-funding from the regional team, we are developing a multi-channel campaign that is due to launch in November 2021.
- Working with a full service creative agency, the campaign will take a more creative approach to help educate people on which service to access when (based on their clinical needs). Campaign activity will include the development of an animation and other assets, targeted paid for social media advertising, outdoor advertising, radio and the creation of a micro-site that will sit under the ICS website. As part of the campaign, we will be working closely with Surrey County Council and other partners to amplify reach and we are also exploring plans to work with schools to incorporate a focus on behavioural change, educating young people on how to choose the right services in a fun and engaging way.
- As part of the broader '*Help us help you*' message, we are also supporting providers with the introduction of the streamer tool in A&E and messages linked to this. We are also working with national colleagues to further develop our communications plans as part of a national *'Further, faster'* pilot.
- Our campaign will complement the national *Help us, help you* message and we will also reinforce the **national NHS111 campaign** across the ICS, when this campaign launches in November.

Actions being taken to support communications and citizen engagement (continued)

Targeted campaigns

- The **'Face of support' mental health campaign**
- Following an increase in demand for mental health services, linked to the pandemic, we are also working as a system (with provider, Surrey County Council, district and boroughs, public health and the voluntary sector) to deliver a 'Face of support' campaign.
- Campaign activity includes the refresh of the Healthy Surrey website mental health pages, the development of a series of local assets for use on social media (including videos where staff talk about how to look after your own health and wellbeing and how to access support), paid for social media, outdoor advertising and a leaflet door drop to all households in Surrey (planned for November 2021 and also to include some wider system/ 111 messages).
- The campaign is already live on social media and further activity will launch to coincide with World Mental Health Day on 10 October 2021.
- Given the increase in the number of young people accessing support, there will also be a separate element of the campaign that will focus on young people – how they can stay resilient and look after their own emotional wellbeing, also with signposting to the new Surrey Mindworks service. Assets and materials will be an extension of the 'face of support' creative but will be developed to appeal to young people.

Actions being taken to support communications and citizen engagement (continued)

Targeted campaigns

- **Boost your immunity campaign**
- We are also actively promoting the national 'boost your immunity' campaign across the ICS, working with partners through a range of multi-agency groups.
- This includes working closely with Surrey County Council colleagues to target communications at specific cohorts (e.g. 12-15 year olds and other cohorts for Covid vaccinations/ boosters and cohorts that form part of the flu vaccination programme), using a range of different channels and tactics, supported by broader outreach work with communities, particularly in areas of lower uptake (e.g. pregnant women).
- Campaign activity is far reaching and includes social media (including paid for advertising), articles in publications, websites and the inclusion of messages in a door drop to all households in Surrey.

6a. Improving in hospital flow and discharge (SDEC)

System commitments: what's expected of us

Actions at regional level

Assure plans to implement direct referral from GP/111/999 to SDEC / secondary care.
Dedicated regional leadership to support SDEC/ Acute Frailty.
Assure provider plans to restore SDEC provision.
Escalate provider constraints to restoring SDEC minimum requirements to national team.
Assure capital spend for additional SDEC capacity, identifying gaps in estate provision against capital funding.
Identify providers requiring additional support with SDEC modelling.
Communicate new guidance and best practice to providers.

Actions at system/ICS level

Drive system culture and leadership plans to support Direct Referrals into secondary care/ SDEC.
Drive best practice sharing, peer reviews.
Own and monitor improvement programmes.
Drive conversations on capital spend for SDEC activity.
Drive provider plans to deliver SDEC/ AF to minimum standards.
Undertake system wide demand and capacity reviews for SDEC services ensuring these are aligned to ED demand.
Develop/strengthen governance arrangements to support collaboration.

Actions at provider level

Have plans in place to restore SDEC provision 12hrs, 7 days as a minimum. Promote direct referral provision from GP/111/999 and virtual ward.

Ensure Rapid Demand and Capacity Reviews match ED Demand, supporting patient flow.

Ensure sufficient estate to meet the increase in demand and constraints around IPC.

Avoid usage of SDEC as a bedded ward overnight.

Ensure acute Frailty SDEC Provision 70hrs + per week.

6b. Improving in hospital flow and discharge Commissioner Requested Services (CRS)

System commitments: what's expected of us

Actions at regional level

Assure system plans to measure:

- time to initial assessment for all patients presenting to A&E.
- the proportion of patients spending more than 12 hours in A&E from time of arrival.
- the proportion of patients spending more than one hour in A&E after they have been declared Clinically Ready to Proceed.

Assure system plans to incorporate daily reviews against the metrics, that meaningful conversations are taking place with referring specialties and that long waits are improving.

Actions at system/ICS level

Drive system culture and leadership plans to support CRS.

Drive best practice sharing, peer reviews and case studies.

Own improvement programmes with ongoing monitoring.

Drive provider plans to operationalise CRS metrics with specific focus on mobilisation and implementation plans.

Develop/strengthen governance arrangements to support collaboration.

Actions at provider level

Develop processes to implement time to initial assessment within 15 minutes of arrival.
Early senior review to support early discharge/ admission.
Review proportion of patients residing in ED for more than 12-hours.
All patients presenting to ED will have CRtP recorded.
Timely onward care once a decision has been made that the patient no longer requires treatment in ED and is ready to proceed to their next point of care, or discharged home – within 60-minutes.
Processes in place to review patients in ED longer than 60-minutes when declared CRtP with referring specialities.
Review 12+ hours waits - patients should not spend longer than 12 hours in ED from time of arrival.
Processes in place to treat the sickest patients quickly and departments do not become crowded by those patients who do not require admission into hospital.

6c. Improving in hospital flow and discharge (reducing Length of Stay - LoS)

System commitments: what's expected of us

Actions at regional level

Undertake data driven conversations, paying particular attention to key metrics to monitor progress.
Drive implementation of the National Operational Hospital Discharge policy
Maximise flow over seven days including increasing weekend discharges.
Drive clinical leadership and engagement to support discharges and reduce LoS .
Promote implementation of the RCP Ward Round/Board Round best practice.
Promote use of Criteria to admit improvement tools.
Continue to identify and work with Trusts of Focus.
Work with ECIST/Improvement colleagues where needed and promote Trust participation in the forthcoming Winter Alliance.

Actions at system/ICS level

Provide robust system leadership and undertake data driven conversations, paying particular attention to key metrics to monitor progress.
Drive implementation of the National Operational Discharge policy
Maximise flow over seven days including increasing weekend discharges
Promote clinical leadership and engagement to increase discharges and reduce LoS
Undertake system wide capacity/service provision gap analysis and apply integrated commissioning approach

Develop/strengthen governance arrangements to support collaboration.

Actions at provider level

Undertake data driven conversations, paying particular attention to key metrics to monitor progress
Drive implementation of the National Operational Hospital Discharge policy
Maximise flow over seven days including increasing weekend discharges
Utilise clinical leadership and engagement to increase discharges and reduce LoS
Promote implementation of the RCP Ward Round/Board Round best practice
Promote use of Criteria to admit improvement tools.
Work with ECIST/Improvement colleagues where needed and actively participate in the forthcoming Winter Alliance.
Building on Transfers of Care around Medicines (TCAM) work with AHSNs, providers should increase referrals into the community pharmacy discharge medicines service, to support safe and timely discharge of patients with complex medicines usage and to reduce emergency readmissions due to medication issues.

Actions being taken to improve hospital flow

- ICS have established a Urgent and Emergency care Board. This board oversee the delivery of the urgent care strategy and maintain oversight of our system response to surge. Its works in parallel to the System resilience and Emergency Preparedness. Resilience and Response (EPRR) board that oversees our preparedness and response to incidents.
- Improving flow through schemes like Think 111 first (further faster pilot) CRS, SDEC and reducing length of stay are overseen at an ICS level by the UEC board which the Local Accident and Emergency Delivery Board (LAEDB) at place report into.
- Acute providers all provide SDEC services across the 7 days. 200-260 patients per day utilise the Surrey Heartlands SDEC services.
- Through the Think 111 first programme and the ED streamer tool we are working with providers to identify patients that can bypass ED into SDEC services.
- Surrey Heartlands have been selected as on e of 7 sites to participant in the national "Further Faster" programme, this offers additional support (consultancy and funding) for areas that have an advanced position with regard to front end urgent care access, like developed Think 111 first programmes. Part of the Further Faster programme requires the meeting of the national SDEC commitments.

Actions being taken to improve hospital flow

- ICS UEC team are establishing a system resilience and surge hub to maintain operational and system oversight across the 7 days.
- The UEC team oversee performance against key metrics we collate through an information system called Alamac.
- Using the Alamac platform we identify triggers and are working towards ICS early warning system.
- We use this platform to also produce reports and it provides a live operational dashboard for all on call manager across the ICS to use.
- We hold daily ICS GOLD calls with providers to assessment the risks, agree the level of escalation as an ICS and agree actions.
- We have developed OPEL scoring matrix across providers to understand OPEL escalation level using same set of metric to compare providers level of surge,.
- We have a ICS surge plan we use to ensure we facilitate the right response and outline the roles and responsibilities.
- As an ICS we are developing our modelling and forecasting data with Alamac (Data provider) and providers to proactively manage surge. This include modelling for COVID, winter surge and paediatric demand.

Actions being taken to improve hospital flow

- All providers at place are finalising local winter surge plans
- ICS support this through bidding for additional funding from NHSE.
- Providers monitor length of stay and patients that are medically fit for discharge and all system partners meet daily to work through these patients to expedite discharges. This is extremely challenging with current workforce challenges across Health and Adult Social Care (ASC).
- Urgent Care (UC) and Mental Health (MH) regional leads are integral to development of winter planning.

7. Supporting adult and children's mental health needs

System commitments: what's expected of us

Actions at regional level

UEC and MH regional leads to ensure MH integral to winter planning.

Use ECDS dashboards to identify ICS with high/worsening mental health ED pressures, as well as where improvements have occurred.

Bring systems together to share learning.

Ensure all local areas have s.140 compliant MH service escalation in place as well as clear regional process.

Ensure MH funding allocated in line with MHIS; provide system support/challenge where spend not in line with expectations or LTP delivery off track (based on regular assurance returns).

Support use of discharge/LTP MH funding to enable multi-agency discharge planning / admission avoidance across providers CCGs and LAs and VCS, including through MADE events.

Promote and encourage access to staff wellbeing hubs and other initiatives.

Actions at system/ICS level

Promote 24/7 urgent MH helplines locally. Ensure all are profiled onto NHS 111 DoS as a minimum in short term (ahead of formal access to urgent MH care via 111 as per LTP).

Expand capacity and range of alternative spaces to A&E to meet urgent MH needs in the community.

Explore liaison at ED front door to support diversion where possible.

Allocate share of local capital funding for MH capacity pressures.

Ensure MH integration with ambulance response for see and treat to minimise conveyance toE.

Ensure NHS working alongside LA mental health services, including through place-based funding, s.75 arrangements, regular MADE events and use of discharge funding.

In particular, work with LAs on adult bed pressures – by commissioning and developing market of short/long term supported housing and AMHP provision as priorities.

Work with CYP LA services to avoid lengthy delays in ED or paeds wards for CYP with MH needs while awaiting LA input.

Put in place s.140 compliant bed escalation protocols.

Afford funding/operational freedom to provider collabs, embed light touch approach to contracting avoiding lengthy processes.

Actions at provider level

Invest in staff wellbeing initiatives.

Recover face to face care in CMHTs, particularly to prevent relapse for people with SMI to prevent relapse and high acuity presentations to crisis services.

Focus on reducing excessively long LoS in inpatient MH services using approaches such as setting estimated discharge dates, recording purpose of admission, red to green, D2A, 'perfect week'.

Ensure exec clinical/operational oversight of bed escalation and MH inpatient flow, with daily flow meetings, senior alerts for ED waits above 4/6hrs, long stayers in wards.

MH providers should work with the police to reduce avoidable use of s.136.

Acute providers should work with MH services to ensure dedicated MH assessment space available in or near acute hospital sites.

Provider Collaboratives to develop capability to directly sub-commission at place flexibly, including VCS and LA providers, with reduction in l contracting and procurement processes.

Actions being taken to support mental health

- Rolling out a mental health escalation protocol across all acute sites to manage mental health demand.
- Face to Face Care provided by Community Mental Health Teams (CMHT) for those patients with Severe Mental Health Illness (SMI)
- Enhance home treatment teams to increase resource to provide assessments and support in patients home.
- To continue remote monitoring of mental health patients in the community implemented through COVID. Providing in-reach through senior mental health nurses into patients homes.
- Enhance psychiatric liaison service to support holding patients in the community and following up patients at home after discharge.
- Enhance younger persons crisis support across all acutes.
- Young persons MH pathway workers to help with discharge and ongoing support.
- Extend the paediatric triage line for mental health support and advise.
- Extend financial support for packages of care outside of core services for young people. Includes children with ASD , LD and challenging behaviours.

8. Reviewing Infection Prevention and Control (IPC) Measures to ensure an proportionate response.

System commitments: what's expected of us

Actions at regional level

Actions will be formulated following the review of the IPC guidance.

Actions at system/ICS level

Actions will be formulated following the review of the IPC guidance.

Actions at provider level

Actions will be formulated following the review of the IPC guidance.

9. Reviewing Staff COVID Self Isolation Rules

System commitments: what's expected of us

Actions at regional level

Monitor the impact of staff absence due to isolation across Regional footprint supporting challenged organisations to take mitigating actions where appropriate.

Actions at system/ICS level

Monitor the impact of staff absence due to isolation across ICS footprint supporting challenged organisations to take mitigating actions where appropriate.

Actions at provider level

Ensure Compliance with updated Staff Isolation guidance.

Actions around managing COVID

- Each provider adheres to the IPC rules and have established COVID (Red) pathways (Amber) non COVID pathways and Green (Clean) elective pathways
- Each day providers have to review and adjust bed provision to meet demand of patients coming through these three pathways.
- As a system we are working to protect all three to maintain both urgent care demand but also elective and cancer demand.
- All provider monitor staff for COVID through Lateral flow testing. Attrition rated due to COVID infection or isolation are collated through specific COVID sit rep reporting

10. Ensuring a sustainable Urgent Emergency Care (UEC) workforce

System commitments: what's expected of us

Actions at regional level

Ensure sufficient Pillar 1 testing is available to support self-isolation.

Actions at system/ICS level

Work with the local Domiciliary and Care Home market to develop ICS led response to workforce shortages

Actions at provider level

Fully support and engage with staff on local and national HWB offers.

Plan recruitment across 111 services.

Repatriate workforce back to SDEC – looking at new way staffing models/ skill mix.

Planned Actions: Workforce

Workforce factors continue to pose limitations on the ability of services to meet current and future surge demands. Issues centre on the backlog of annual leave, simultaneous rollout of C19 and flu vaccination programmes, general staff health and wellbeing and the age profile of community care and primary care staff. These issues result in reduced capacity to respond to latent demand which are further compounded by circulating CoVid 19 (C19) infections, unknown demand from long COVID and increase patient acuity.

RISKS/ ISSUES	MITIGATIONS
Annual Leave – There is a risk that operational capacity may be impacted if a backlog of annual leave, and the potential sharp uptake of annual leave post lockdown, coupled with staff absence due to ongoing health and wellbeing concerns.	• Trusts have updated policies in relation to buying back / AL carry over • Annual leave monitoring and use of HR Director (HRD) Network and Surrey Heartlands People Board as escalation points • MOU in place to facilitate staff sharing across organisations.
Health & Wellbeing - Negative impact of Covid-19 pressures on staff wellbeing with potential for increasing levels of sickness absence if demand levels are sustained into the Autumn.	• All NHS providers have a Wellbeing Guardian function in place, along with the establishment of health and wellbeing groups. Health and wellbeing conversations are taking place both informally on a regular basis and formally on an annual basis, depending upon provider. • Moving forward with enhanced HWB and inclusive HWB programmes (includes HWB conversations and staff safety). • The Surrey Heartlands Resilience Hub provides access to health and wellbeing services. • Health and Wellbeing initiatives across the system include Mental Health First Aid (MHFA) training, Trauma Risk Management (TRiM) training, (Freedom to Speak Up (FTSU) guardians, Staff Igloos at RSFT, Pods at SASH, and a new Wellbeing Centre at ASPH.
Recruitment and retention - Reduction in international recruitment rates due to several challenges (quarantine rules, agency delays, border controls, available mentors).	• Partners continue to manage recruitment of international staff internally, with escalation to the Resourcing Network and then Surrey Heartlands People Board where appropriate. • International Retention programme to commence in order to address issues related to turnover of internationally recruited staff • Vaccine Workforce Programme to commence in order to fill vacancies with individuals that have signed up to work for the vaccine programme. • Surrey Heartlands Recruitment campaign
Vaccination - Both the C19 and flu vaccination programmes are primarily delivered by out community and primary care providers, creating staffing and service delivery pressures during the recovery phase. There are also WF pressures at some of the Vaccination Sites as people return to their lives.	• Ongoing work with SJAB to support vaccination sites • Recruitment via Landmark into roles that can support CSH Surrey services • Ongoing communication between ICS and vaccination providers to ensure stability of services, with escalation where required
Community health – The increase in acuity and dependency of complex patients, both on inpatient wards and domiciliary caseloads, demand for long COVID services, and the age profile of our People in this area, create increasing pressures on our services.	• Workforce Development Funds to be used to develop the Out of Hospital workforce • Enhanced Health and Wellbeing programme to develop support for long COVID • Provision of support as per the Health & Wellbeing mitigations • Surrey Heartlands Recruitment campaign
Primary Care – Increased demand & workforce capacity gaps in particular in practice nursing, and difficulties in filling some professional ARRS roles to support.	• Surrey Heartlands Recruitment campaign • Commencing Primary Care digital staff bank. • Launching Return to practice Programmes for Occupational Therapists. • ARRS recruitment model will link with GP Integrated Mental Health Service (GPIMHS) model. • Surrey Training Hub delivering action learning sets, coaching and mentoring to support development.

Surge Planning & Modelling

ICS Surge Planning

- The Surge plan for Surrey Heartlands is a live document which incorporates emerging guidance, modelling and learning from previous years of winter operations, Flu outbreaks and the first two waves of the CoVid19 pandemic such that it will continue to be a developmental plan and therefore this plan be updated to reflect the current situation in which we are operating.

- A UEC Early Warning System (EWS) has been developed which, in conjunction with the CoVid Early Warning System, contains triggers and actions supported by the modelling.

- Triggers encompass all elements of the local healthcare system, Primary Care, Secondary Care and Community providers associated actions in times of surge detail those services that are required to alter or change configuration and planned levels of activity.

- The EWS will remain under constant review and subject to change as the peak seasonal demand unfolds.

ICS Surge Planning

- In summary, the Plan:
  - Sets out the risks and triggers for escalation and mutual aid within prescribed and dictated responses,
  - Sets out minimum expectations at each level of escalation,
  - Clarifies roles and responsibilities,
  - Sets consistent terminology / definitions,
  - Defines communication processes e.g. through agreed ICP and ICS System Call Terms of Reference.

- The plan will continue to be updated and reflect the UEC Recovery 10 point action plan which identifies the way in which the whole system will work together to ensure UEC services and maintain resilience through 999 and 11 services, Primary Care and community, UTCs, Children and Young People, Communications, Patient flow in hospitals, Adult and Children's Mental Health, IPC, CoVid and Workforce

- The current winter plan has been submitted to NHSE/I for comment and assurance checks, future adaptations will be validated in this manner throughout the winter period as appropriate.

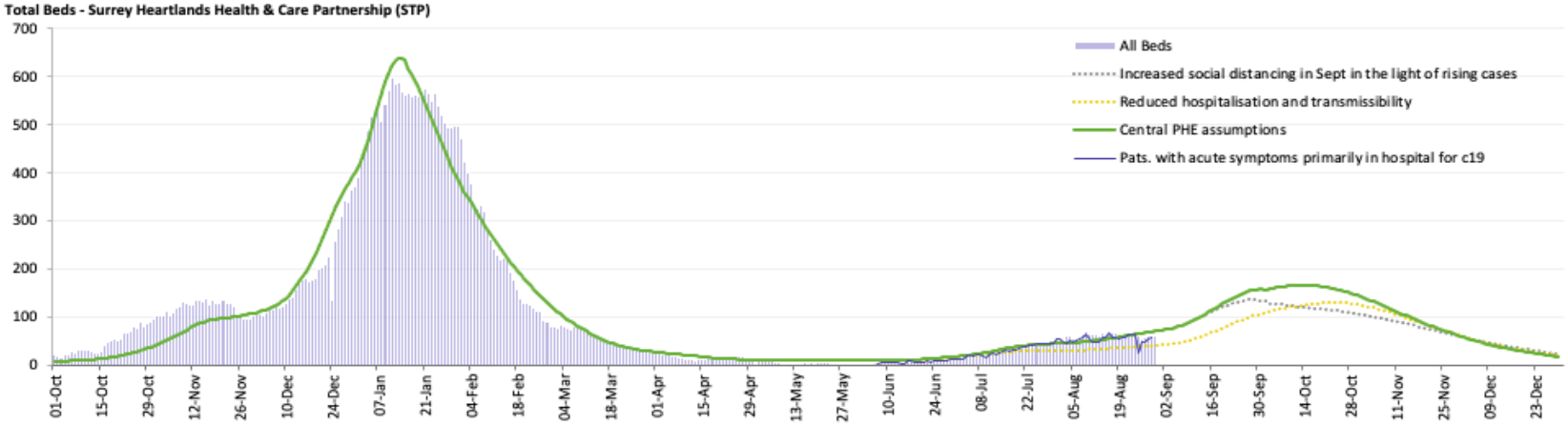
ICS CoVid Models

The modelling outputs are based on current understanding which is evolving rapidly around a number of pivotal modelling assumptions. They are therefore transitory in nature and there are inherent uncertainties in the modelling. They may be helpful for understanding the potential relativities in alternative scenarios but should not be relied upon as a source of projected absolute values for any output variables.

The scale and timing of further waves of CV19 demand on NHS services are driven on ***very uncertain modelling assumptions***, including:

- real world vaccine effectiveness against infection and severe disease leading to hospitalisation
- vaccine uptake in addition to rollout speed
- extent to which our local populations will continue to effectively practice the social distancing practices asked of them by the government to reduce transmission

ICS CoVid Model



- The modelling **does not take** account of a widespread new variant significantly decreasing the effectiveness of the vaccines.

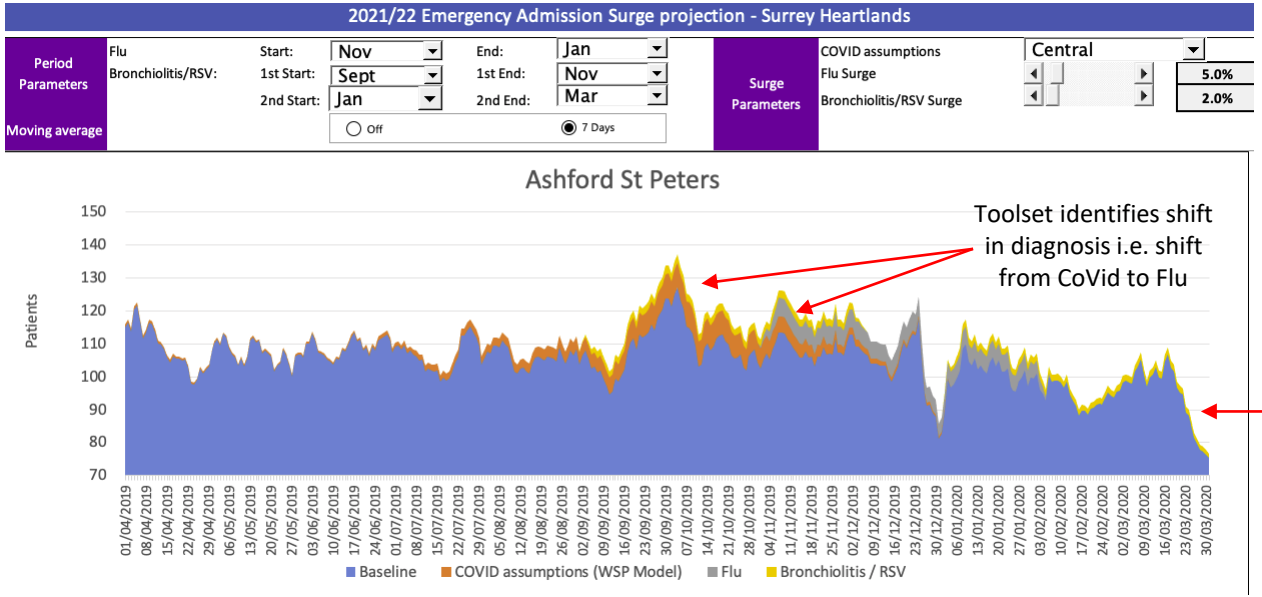
- Three reasonable scenarios have been produced based on the current understanding. It is highly probable the outputs of these scenarios will change in the coming weeks as we learn more.

- Long term scenarios are currently highly uncertain and should be used to inform colleagues of possibilities rather than used as the basis for planning numbers.

Trust Toolset - Summary

- The toolset has been developed to aid in operational decision making at each Trust, focussing on likely requirements for bed numbers,
- The toolset is built on a baseline from 2019/20 (as the last stable year statistically) the impact of CoVid plus a percentage uplift for Flu and RSV is then applied and can be altered reflecting actual % uplift for each group of patients admitted,
- Each Trust has their own, tailored model which has been constructed to reflect bed numbers, service offering and bed capacity and capabilities,
- In Covid waves 2 and 3, the observed lag between the peaks in new cases and beds occupied was approximately two weeks.
- Planning for additional uplift requires a significant lead time in order to work operationally, the addition or reduction of beds affects workforce, estates, processes and demand on external partners in all health settings

Trust Toolset - ASPH

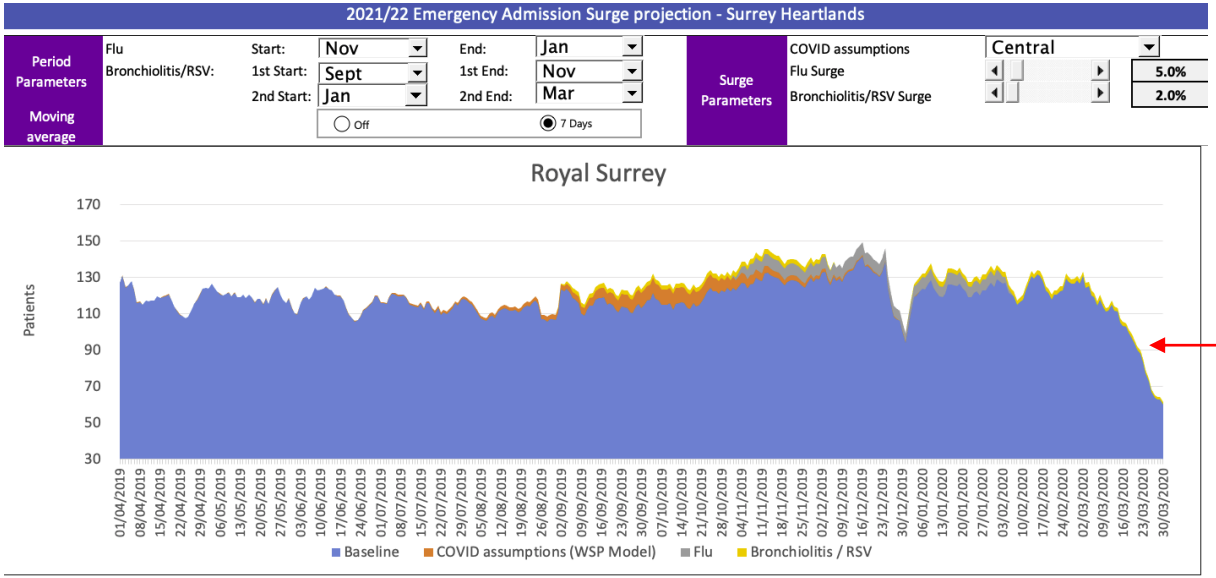


N.B Baseline is based on 2019/20 activity with surge uplift applied

1st CoVid wave affected bed occupancy mid / end March as elective activity ceased

ASPH baseline reflects a volatile baseline assumption which was heavily influenced by availability of beds and capability of the Emergency department – with regards to this years peak, a new build has been completed which increases flow and operational efficiency and smooth out the general requirement of admissions

Trust Toolset – Royal Surrey

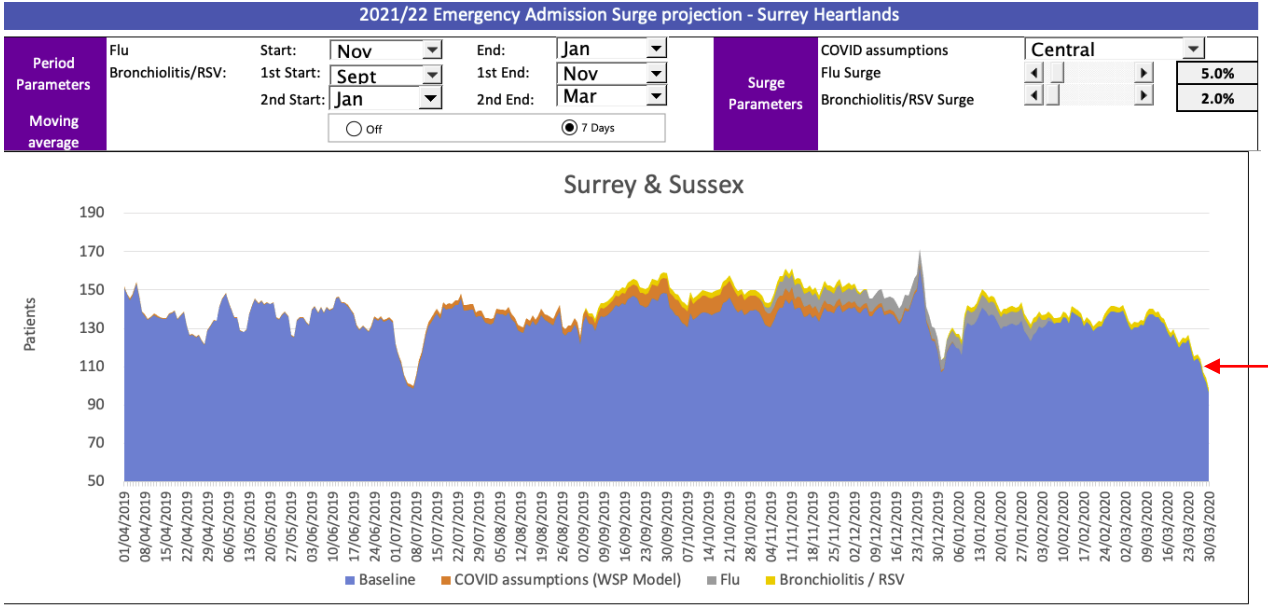


N.B Baseline is based on 2019/20 activity with surge uplift applied

1st CoVid wave affected bed occupancy mid / end March as elective activity ceased

- Less volatile profile than ASPH, but follows same trend
- Drop in occupancy more severe as high proportion of elective activity affected through cancellation. (Royal Surrey is also Cancer Tertiary centre)

Trust Toolset - SaSH



N.B Baseline is based on 2019/20 activity with surge uplift applied

1st CoVid wave affected bed occupancy mid / end March as elective activity ceased

- SASH elective activity less than other Trusts in the ICS, although same trend exists
- Independent providers utilised to enable maximum efficiency in bed utilisation

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