NHS
Lancashire and South Cumbria
Integrated Care Board

Integrated Care Board

Date of meeting	**7 December 2022**
Title of paper	Resilience & Surge Planning/Urgent and Emergency Care Assurance Framework
Presented by	Maggie Oldham, Deputy CEO & Chief of Performance, Planning and Strategy
Author	Jayne Mellor, Director of Urgent, Emergency and Planned Care
Agenda item	11
Confidential	No

Purpose of the paper

The purpose of the paper is to provide an update to the ICB Board on the status and progress of the Urgent and Emergency Care (UEC) Business Assurance Framework, "Going further on our winter resilience plans" and local resilience and surge schemes.

Executive summary

To support the ICB, NHS England have provided a UEC Business Assurance Framework to monitor progress monthly against combined system capacity plans, actions, good practice and improvement priorities.

The UEC Business Assurance Framework is designed to support ICBs to deliver their responsibilities to support and hold the system to account in relation to the information set out in this paper.

The assurance framework comprises five sections:

- Action plan
- Operational self-assessment good practice checklist
- Demand and Capacity
- Dashboard
- Good practice checklist – suite of supporting documents only.

The table below outlines the submission timetable for the action plan and demand and capacity schemes, which the ICB is required to return to the regional and national teams (submissions for September – November completed):

Month 2022/23	Regional submission date 2022/23	National submission date 2022/23
September	26 September	26 September

October	3 November	4 November
November	1 December	2 December
December	5 January	6 January
January	2 February	3 February
February	2 March	3 March
March	6 April	7 April

'Going further on our winter resilience plans' was published on 18 October 2022 setting out the additional requirements of the UEC Business Assurance Framework, which are outlined in this report.

A robust monitoring framework has been developed to combine the UEC Assurance Business Framework, Going further on our winter resilience plans and local resilience and surge schemes.

Recommendations

The ICB Board is requested to:

- Note the content of the report
- Accept the report as assurance that oversight of all associated requirements will be via the Resilience & Surge Planning Group, UEC Network and local A&E Delivery Boards and for the ICB Board to receive updates on a monthly basis.

Governance and reporting (list other forums that have discussed this paper)

Meeting	**Date**	**Outcomes**

Conflicts of interest identified

Not applicable

Implications

If yes, please provide a brief risk description and reference number	**Yes**	**No**	**N/A**	**Comments**
Quality impact assessment completed			x	
Equality impact assessment completed			x	
Data Privacy impact assessment completed			x	
Financial impact assessment completed	x			
Associated risks	x			
Are associated risks detailed on the ICB Risk Register?	x			
Report authorised by:	Maggie Oldham			

Integrated Care Board – 7 December 2022

Resilience & Surge Planning/Urgent and Emergency Care Assurance Framework

1. THE ACTION PLAN

1.1 The Urgent and Emergency Care (UEC) Business Assurance Framework incorporates key actions that focus on admission avoidance, hospital flow, increasing capacity on discharge, elective recovery, primary care, community health care, ambulance handovers, mental health, workforce, monitoring and communications.

1.2 The position for Lancashire and South Cumbria (LSC) in relation to the delivery of the key actions is outlined below:

Status	October 2022
Fully implemented	11
Partially implemented	24
Planned implementation	4
Will not be implemented	N/A
Not applicable	N/A

1.3 As the additional requirements of the "Going further on our winter resilience plans" are due, the action plan will be revised accordingly.

1.4 Further detail is attached at Appendix A.

2. OPERATIONAL SELF-ASSESSMENT GOOD PRACTICE CHECKLIST

2.1 The ICB's Urgent and Emergency Care Team and partners are working collaboratively to develop plans to deliver the actions that have not yet been fully implemented. The baseline position was submitted to the national team on 26 September 2022 to enable them to develop future support offers. The next submission of the checklist to the regional and national team will be during quarter 4.

2.2 The Lancashire and South Cumbria position is outlined below:

Status	October 2022
Fully implemented	29
Partially implemented	19

2.3 Further detail is included in Appendix B.

3. DEMAND & CAPACITY SCHEMES

3.1 The £12.95m allocated to the ICB is supporting the mobilisation of 27 schemes across LSC. The schemes are being monitored through the Resilience and Surge Planning Group with submissions to region and national teams taking place monthly.

3.2 The Lancashire and South Cumbria position is outlined below:

Status	October 2022
Started	19
Planned	8

3.3 Further detail is included in Appendix C.

4. OTHER LOCAL RESILIENCE AND SURGE SCHEMES

4.1 In addition to the 27 demand and capacity schemes, 60 local resilience and surge schemes are progressing across LSC.

4.2 These additional schemes are being delivered at place to meet local need and demand. The key areas of focus are to support delivery of additional domiciliary care and community beds to reduce the number of delayed discharges, patient transport, mental health support and staff recruitment to deliver additional capacity.

4.3 The ICB's UEC team are working collaboratively with partners to oversee the delivery of schemes via the Resilience and Surge Planning Group and local A&E Delivery Boards.

5. GOING FURTHER ON OUR WINTER RESILIENCE PLANS

5.1 The 'Going further on our winter resilience plans' requirements were published on 18 October 2022 setting out the additional actions needed to increase capacity and resilience.

5.2 A LSC plan has been developed outlining the actions required in relation to the following:

- Better support people in the community (falls response, acute respiratory infection hubs and unwarranted variation in ambulance conveyance rates)
- Deliver on our ambitions to maximise bed capacity and support ambulance services
- Winter Improvement Collaborative
- Continue to support elective activity
- Infection prevention and control measures and testing
- Oversight and incident management arrangements

5.3 Further detail is included in Appendix D.

6. DASHBOARD - KEY METRICS

6.1 Six key metrics have been requested for submission to the national team which are outlined below:

- 111 call abandonment
- Mean 999 call answering times
- Category 2 ambulance response times
- Average hours lost to ambulance handovers
- Adult G&A bed occupancy
- % of beds occupied by not meeting criteria to reside

6.2 NHS England (NHSE) will monitor the metrics. It is anticipated that ICBs will monitor internally and link with the national team in terms of progress and actions as necessary.

6.3 Further detail is included in Appendix E.

7. RISKS AND MITIGATIONS

7.1 Risks and mitigations for individual schemes have been identified. A risk log, which includes mitigations and risk owners, has been developed and is reviewed on a regular basis. This forms part of the overall assurance framework process and is reported to the regional team and national team.

8. FINANCE

8.1 As previously noted, £12.95m has been allocated to the ICB to enable delivery of 27 demand and capacity schemes. ICB finance and UEC colleagues are monitoring planned versus actual spend for all schemes however in recognition that several schemes have only recently commenced, a more detailed finance update will be shared in the next board report.

8.2 The Board should be aware that, on 18 November 2022, the Department of Health and Social Care announced the £500m Adult Social Care Discharge Fund. The allocations for LSC are as follows:

Organisation	Amount
ICB	£8.399m
Lancashire County Council	£4.598m
Blackpool Council	£0.753m
Blackburn with Darwen Borough Council	£0.637m
Total	**£14.387m**

8.3 Collaborative work has commenced to determine the best use of these allocations to speed up patient discharge, free up hospital beds to reduce ambulance handover times and improve capacity in social care. It is expected that the allocations will be managed through the existing Better Care Fund and its governance arrangements. Further updates will be provided to the ICB Board in due course.

Appendix A – Action Plan

UEC ACTION PLAN

Action	Deadline	Implementation Status	Comments / Progress	Risks	Gaps	Controls In Place	Deadline
1.1 Ensure sufficient capacity to meet expected demand for this winter							
Open all 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 7000 additional general and acute beds, through a mix of new physical beds, scaling up virtual wards, and improvements in discharge and flow.	Jan-23	Planned implementation (What are the actions, timeframe, risks?)	Of the 24 D&C schemes, 13 have mobilised, the remaining are progressing to mobilisation which will create additional bed capacity. Robust monitoring of D&C Schemes and other winter schemes is underway.	Workforce/recruitment and retention Longer term funding for VW		D&C schemes commencing Virtual Wards beds available with a plan to increase to 65% of the total number of beds required being746 in 23/24. Currently achieving the trajectory. 12.5m has been allocated to Lancashire and South Cumbria to support the delivery of increased beds capacity. 24 schemes have been approved and commence mobilisation from September 2022. Schemes will be robustly monitored and funding will only be released upon demonstrable delivery of schemes. Any potential slippage will be agreed by the ICB.	Ongoing
1.4 Managing demand and aligning capacity							
UTC provision operating at top of specification with capacity matched to local demand.	Oct-22	Fully implemented (What evidence supports this?)		Sudden change in demand, walk in demand is unpredictable Workforce/recruitment and retention T system failure/cyber attacks	Central at present do not accept ambulance conveyance at UTC Blackpool UTC - Standard 17 not currently implemented. Currently D&C modelling suggests there is no current need for telephone/video conferencing facilities.	Blackpool UTC - 33 of 34 Standards are implemented with exception number 17 which is video consultation facilities should be considered as part of an improved patient offer as it help mitigate unnecessary attendances. Therefore the provider has assessed the need and determined due to the transient population/walk in, this option can become available if the need is identified. Daily review on demand and activity and increased staffing for expected peaks Challenges include surges in attendance, increased pressure at the UEC Front Door and	
Ensure all Emergency Departments have appropriate streaming services in place to redirect all appropriate patients to Type 3 services.	Sep-22	Fully implemented (What evidence supports this?)	Agreed aggregated position is green due to the two identified gaps will not change as sufficient processes are in place	IT system failure/cyber attacks Workforce	No plans for streaming at Furness General Hospital due to local community GP provision that is well utilised and very low attendances at ED. Royal Lancaster Infirmary does not have streaming in place although plans are being developed to have a co-located UTC and therefore Type 1 patients will be streamed in this new facility	Data monitored for West Lancashire attends for minors Type 3 patients are low due to UTC and WIC being more accessible within boundary and A&E being out of area. Attends for West Lancashire are older, frail adults. Attendance data shows Frail Elderly patients are highest attenders for Adult ED at Southport. Focus on streaming Older adults via SDEC, Frailty Assessment and Virtual Wards. Home First at Front Door and Community in-reach are in place to divert appropriate patients. Plan to expand provision. Long Term sustainability plan to colocate UTC an ED, will require capital investment	Jan-23
Increase the provision of High Intensity Use services (HIU).	TBC	Fully implemented (What evidence supports this?)	Plans in place at each Trust. Further work underway to review end to end pathways in line with Going Further for Winter	Potential financial investment required	Need to ensure there is an integrated system approach which encompasses end to end pathways	A level of provision is in place for secondary care at Trusts Agreement reached for a small group to review our current baseline position, agree the criteria for HIU patients and align services across LSC.	Oct-22
1.5 Community health care at home services							
Urgent Community Response – increase 2-hour UCR provision by maximising referrals from the ambulance service and other appropriate providers, with the ambition of at least 70% of 2-hour UCR demand to be seen within two hours in each ICB.	Dec-22	Fully implemented (What evidence supports this?)		Lack of aligned Social Care Policy and Resourcing - a community response may initiate additional domiciliary requirements.	Data Quality Issues, particularly for Falls Lifting services - support in place. Direct interconnectivity between NWAS and 2hr Services - Test project in planning phase	Weekly Programme Steering Group with commissioners & providers including NWAS Monthly Maturity Matrix by provider Monthly data submission review with steering group to support Monthly Highlight Report shared	Ongoing
Rapidly scale virtual wards to support patients who would otherwise be in a hospital bed to receive acute care at home –with a focus on ARI and frailty.	Dec-22	Partially implemented (What is the status, actions, timeframe, risks?)		A number of programme risks have been identified, top risks include; - Recruitment of workforce, approx 113wte, potential to destabilise other services - Increased demand for social care response - this is currently being modelled - Implementation of technological remote monitoring aspect - Lack of awareness of service and criteria, potential for inappropriate usage	As of September 2022, 3 of the 5 PBP's are reporting live capacity into the national sitrep, a forth is due live at the end of September and boundary issues are causing delays for West Lancashire. The digital remote monitoring element is only live in 1 PBP, implementation group established to expedite this.	Weekly Programme Steering Group with commissioners & providers Monthly Maturity Matrix established by provider Supportive PBP discussions established with senior leaders in the 2 PBPs which are not live. Monthly dataset established to review early learning Monthly Highlight Report shared with relevant groups - reporting framework in place	Ongoing
1.6 Primary Care							
ICB to actively engage and support General Practices and Community Pharmacies with seasonal preparedness and operational delivery.	Dec-22	Fully implemented (What evidence supports this?)	Primary Care Sub-Cell responsibilities are included in the ICB's Primary Integrated Neighbourhood Care (PINC)Transformation Group which continue to meet monthly. Weekly capture of GP Practice pressures by the Covid SitRep submissions and reporting process, Practices reporting a small increase in pressures caused by increased staffing absences from covid but are coping well. Feedback from wider primary care continuing to be received by PINC groups. Combined reporting of all PINC pressures as required into the ICS's Joint Cells meetings. Work commenced to review and relaunch GP SitRep. The Planning for Future Variants Project, is 95% complete; an additional GP Outbreak Comms Toolkit is being developed for inclusion. Care Navigation continues to be accessible by all GP Practices; this is promoted on the training hub website and by the training hub locality leads who attend practice manager meetings.	Primary Care resilience. Workforce. Wellbeing of workforce. Covid and Influenza vaccine uptake by workforce and population. Responding to any national changes in access requirements. GP SitRep submission compliance. View of Community Pharmacy pressures building.	Inclusion of Community Pharmacy in EMSPlus.	ICB has key primary care colleagues, working at both System and Place, who support general practice, pharmacy and dental providers. Arrangement are in place to actively monitor service delivery based on SitRep reporting, service monitoring data and informal information and intelligence. The ICB has an existing GP Practice Covid SitRep (EMSPlus) and Escalation Approach, work has commenced to be review and adapt these for continued resilience monitoring (wider than just covid) and will be relaunched with practices prior to Winter. Existing Community Pharmacy escalation process are in place in the ICB, linked to their contractual requirements. The LMC and LPN representatives activily participate and feedback issues to Primary Integrated Neighbourhood Care groups. The Planning for Future Variants Project, part of the Primary Integrated Neighbourhood Care work programme, which has pulled together all of the documents and plans utilised during the pandemic, and developed and updated documents where any gaps existed in preparation for future variants. Comms & Engagement plan developed LSC wide which incorporates primary, secondary care. To explore whether any navigation update training would be beneficial for primary care staff (all four pillars). To explore whether all places should have a PLT session in October/November focused on seasonal preparedness and local service provision.	ongoing
ICBs to complete system framework for supporting General Practice to rapidly prioritise practical interventions to improve patient experience of access and staff workload locally and engage in national process to secure potential funding for technology/estates solutions	Dec-22	Partially implemented (What is the status, actions, timeframe, risks?)	GP practice staff absences continue to be captured weekly by the Covid SitRep submissions and reporting process, Practices reporting a small increase in pressures caused by increased staffing absences from covid but are coping well. Work commenced to review and relaunch GP SitRep; discussions have taken place with EMS to move to using OPEL levels, increase practice access to	Recruitment and Retention challenges Availability and cost of Locums Sickness across clinical and non-clinical which may impact due to future Covid variants		Review of current GP Practice Covid SitRep (EMSPlus) and Escalation Approach in preparation for Winter as per 1.6.1. Currently General practice update EMS+ to escalate workforce/staffing challenges weekly or as required dependant on need. Locums are utilised where possible.	ongoing
Consider and support PCNs working with each other and other providers to develop collaborative models to manage specific winter pressures (for example oximetry monitoring for COVID; winter hubs; community and VCS led support for vulnerable)	Dec-22	Partially implemented (What is the status, actions, timeframe, risks?)	The Planning for Future Variants Project is 95% complete; an additional GP Outbreak Comms Toolkit is being developed for inclusion. Work commenced to review and relaunch GP SitRep, discussions have taken place with EMS to move to using OPEL levels, increase practice access to reports showing escalation statuses of neighbouring services. Covid Pulse Oximetry@Home services remain active providing full coverage across the ICB.	Ability of community and at scale providers to provide support to practices and PCNs should they face significant staffing pressures.	No same day primary care service provision in Central Lancashire, East Lancashire or Morecambe Bay.	The Planning for Future Variants work (detailed in 1.6.1) to considers the response to future covid variants. Review of current GP Practice Covid SitRep (EMSPlus) and Escalation Approach in preparation for Winter as per 1.6.1. The escalation approach includes practices utilising buddy agreements, and support between PCNs and communityat scale primary care providers. All of the Covid Pulse Oximetry@Home services have been maintained through the ICB and cover the full geography. The service are predominantly provided by GP OOH services or community providers; all models offer self-monitoring and service led monitoring enabling flexible approaches which can be stepped up to meet demand and reduce asks on primary and	Nov-22
ICBs to offer intensive hands-on quality improvement support to practices working in the most challenging circumstances (such as areas of high deprivation, areas with highest need or workforce challenges) via the national 'Accelerate' support programme available to 400 practices for 22/23 alongside addressing barriers outside the scope of the support	Oct-22	Planned implementation (What are the actions, timeframe, risks?)	Prioritised PINC Enhanced Review Pilot due to launch November 2022. Enhanced Health Checks Scheme has launched across the ICB, with PCNs targeting the most deprived populations and providing an enhanced holistic check on top of the standard Health Check. GP Improvement Week - work continues on the actions and improvements that arised from the first GP Improvement Week,			Prioritised PINC Enhanced Review Pilot to launch 2022/23 targeted at ICB PCNs with the highest deprivation levels will provide patients with COPD or Diabetes vulnerable patient cohorts with a holist enhanced review, on top of their LTC review. The Enhanced Health Checks Scheme as described in 1.6.4. The lessons learned from the initial GP Improvement Week have been shared with all place	ongoing
Technology and Telephony to digitally enable Primary Care - **Cloud Based Telephony in General Practice:** Expand number of practices on cloud-based telephony, supporting transition from analogue to cloud-based through expanded scope and pace of current pilots. **Business Intelligence tools roll out to General Practice:** Expand availability of Business Intelligence tools (to understand demand and capacity). Provide support to build capability to use them for improvement Use of a **unified directory of services** across ICS to direct patients to the right services and communicate clearly on primary care pathways and processes	Oct-22	Partially implemented (What is the status, actions, timeframe, risks?)	Cloud Based Telephony in General Practice: ICB telephony guidance document distributed to all GP Practices, ongoing support continuing to be provided to all practices. Business Intelligence tools roll out to General Practice: All GP Practices have access to Aristotle which provides them with a suite of BI tools and reports. GP Practice access to EMS system is being updated so that all Practices have access to see the current escalation levels of their neighbouring services including community services, care homes and Acutes Trusts. Work to develop the Primary Care Transformational Dashboard, GP Access Data Report and a Primary Care Contracting Group Dashboard remains ongoing. GP Improvement Week pilot Scheme - the second GP Improvement Week planned for Autumn has been postponed until March 2023 due to delays with receiving a revised Data	Second GP Improvement Week will not take place in advance of winter due to delays with EMIS revising Data Capture Tool.	Inclusion of wider primary care in initial data intelligence reporting.	Cloud Based Telephony in General Practice: General practice preferences regarding switching to cloud based technology is down to practice choice as independent contractors. The ICB support practices to move to cloud based options and has developed and distributed a guidance document to all GP Practices which supports practices with the options available and to transition. Business Intelligence tools roll out to General Practice: ICB Primary and Integrated Care Data Intelligence Clinical Reference Group established to develop and integrate System-wide intelligence for General Practice and Community Pharmacy, and in the future development routes for integration with dental, optometry, PCNs and community services. The Group are developing a Primary Care Transformational Dashboard, GP Access Data Report and a Primary Care Contracting Group Dashboard which will include Demographics, Contractual Obligations, Quality markers, Contextual Data (GP survey data, FFT results, GP Appointment Data Dashboard, Workforce) and Outcomes. The above will feed into the PINC contracting and transformational groups and wider IBC reporting.	Ongoing
Promote use of the following community pharmacy services the expansion of CPCS to divert demand away from general practice into community pharmacies aligned to metrics outlined in the Primary Care Investment and Impact Fund the Discharge Medicines Service to community pharmacies to help prevent readmissions to hospital	Oct-22	Partially implemented (What is the status, actions, timeframe, risks?)	Right People Right Care comms campaign includes Community Pharmacy, with leads engaged with re key messaging. The Local Pharmacy Network subgroup continue to meet with a focus on improving access to community pharmacy and CPCS. The previous months CPCS referral data shows increases in the number of referrals received and the number of GP practices making CPCS referrals. Work continues to promote CPCS to GP practices and work with Pharmacies to strengthen services.	Patients will continue to access general practice to be diverted via CPCS Low referral/uptake of CPCS.	Variable referrals into CPCS scheme across LSC practices with Morecambe Bay and Chorley and South Ribble being the lowest referrers per 1000 pop.	The community pharmacists are being covered in the Right People Right Care comms campaign. All Community Pharmacies in LSC are signed up to deliver the CPCS, with 3,732 GP referrals made between March-July 2022. The CPCS programme is being led by NHS England and has been rolled out across LSC; the services receive referrals from GP practices, and 111, in additional LSC is part of a national pilot (Fylde Coast initially) to enable UECs to refer into Community Pharmacy. There is variability between Places and practices in the number of GP referrals made to the CPCS, with Morecambe Bay and Chorley and South Ribble being the lowest referrers per 1000 pop. The Local Pharmacy Network subgroup - improving access to community pharmacy has been established to understand the variability in referrals across LSC. The subgroup brings together all stakeholders who can play a part in improving uptake and reduce the variance across the	Ongoing
1.8 Elective Recovery							

Appendix B – Operational self-assessment good practice checklist

Out of Hospital		Y	N	Partial
1	Directory of services received monthly by ICB executives and with clinical service leads			x
2	Co-located urgent treatment centre operating as the front door to the hospital (or streaming)			x
3	111 clinical contact > 50%			TBC
4	Abandoned 111 call rate	x		
5	Ambulance conveyance to ED <49%	x		
6	Virtual wards in place that support admission avoidance and length of stay reduction			x
7	Ensuring primary care have extended hours for evenings and weekends	x		
8	Urgent community response within 2 hours	x		
Site/Operational Discipline				
9	Focused site/bed management 24/7 with minimum 3 times per day site meeting following a structured FOCUS model (or equivalent) with appropriate accountable actions	x		
10	Site management support & presence within ED to deliver timely flow and support to ED team	x		
11	Daily Executive Director oversight responsible for all escalation and delivery of mitigations	x		
12	Bed/site management function should ideally be clinical or as a minimum has access to clinical colleagues 24x7. Site function should have annualised competency/training.	x		
13	Senior Clinical and Management Directorate staff 24/7 rota to support min twice daily meetings	x		
14	Full capacity protocol in place – infection, prevention and control (IPC) compliant Along with BCPs for every acute service so that no service functions stops or defaults to ED	x		
15	Exec signed off internal professional standards in place appropriately managed with escalation for non-compliance	x		
Emergency Department				
16	Streaming of all patients who could be apprpriately managed by a co-located urgent/primary care service in place at times matching the demand.			x
17	Minimum Consultant management > 16 hours a day (or as required by other specialist centres)	x		
18	Speciality and acute call down within 1 hour of referral. For tertiary units, acute physician presence in ED > 16 hours a day			x
19	ED are granted one way referral rights with no patient being given back to ED at any time			x
20	Mental health 24/7 liaison service	x		
21	SDEC > 12 hours a day/ 7 days a week at least but ideally open at times of demand. Open access criteria to be in place for all system partners. These units should never be bedded.			x
22	Acute frailty service > 70 hours over 7 days At least but ideally open at time of demand			x

23	Dedicated, separate to adults, Paediatric ED / secure area in place			x
24	All Minor illness streamed to GPs			x
25	All Minor injuries streamed to an emergency nurse practitioner (ENP)			x
26	Required capacity (numbers of cubicles and Fit to sit) in place to meet demand			x
27	CDU adjacent or equivalent short stay Emergency patient area	x		
28	GIRFT data should be used to effectively plan against demand and capacity	x		
Emergency Department IT				
29	ED system in place to enable patient flow against national standards	x		
Inpatient Management				
30	Minimum of twice Daily Consultant Led MDT Board Rounds in every ward			x
31	Acute Medical Unit should be in place for maximum 72 hours length of stay. All other specialty patients should be bedded in alternative appropriate areas.			x
32	Daily senior medical review (by a person able to make management and discharge decisions) seven days a week			x
33	Red to Green Process or equivalent in place and audited weekly	x		
34	All patients reviewed by a senior decision maker 7 days a week			x
35	Trust IPS clearly communicated, adhered to, escalated and audited.	x		
36	IPC protocol in place that adheres to the latest national guidance and balances IPC risk with flow and delays related harm risks	x		
Discharge				
37	Expected Date of Discharge set within first 24 hours of admission. Patients should clearly have an acute reason to reside within the acute provider.			x
38	Discharge is profiled against admission demand with a focus on early in the day discharge and weekend discharges.	x		
39	Identify patients in ED or at admission who are likely to need complex discharge support and highlight for early intervention			x
40	Where in place, protect discharge lounge capacity from being bedded	x		
41	7-day Transfer of Care Hub in place			x
System and Trust Oversight				
42	Trust and ICB executive review weekly as a minimum (taking into account variance by provider in an ICB)	x		
43	ED Performance: Over 4 hours in department + 12 hour DTAs + Over 12 hours in department	x		
44	Ambulance Performance: Response times + Hospital Handover delays + Longest handover + Any identified patient harm including SUI	X		
45	Potential patient harm:	x		

	Overview of all patient related incidents and serious incidents with regards to ambulance delays			
46	Overview of all incidents and serious incidents for patients in ED over extended periods	x		
47	Right to reside/delayed discharges	x		
48	In and out of hours clear bronze, silver and gold escalation with recorded actions and outcomes with appropriate training & support programme. Reflective practice should be used to inform future ways of working.	x		
49	Monthly review of agreed data sets and this checklist at trust and ICB boards	x		

Appendix C – Demand and Capacity Schemes

	Scheme Overview	Overview/Deliverables	Place	Status	Progress/Next Steps	Funding
1	Home First expansion	8 patient discharges (pathway1) per day to 20 patient discharges (pathway1) per weekday and 4 to 10 on weekends	Fylde Coast	Planned late Nov/early Dec	Recruitment progressed for additional therapy and support staff commenced Additional domiciliary care sourced Blackpool Council Additional domiciliary care being sourced for LCC	£1.1m
2	Additional Social Care hours	Continuance of additional social care hours	Fylde Coast	Started	Monitoring delivery is ongoing	£370,000
3	Support to General Practice	440 additional appts per week plus additional bank holiday support	Morecambe Bay	Started	Monitoring delivery is ongoing	£420,000
4	Supplementary Hospital Home Care	Creating additional domiciliary care support (650 hours South Lakes and 450 hours Furness General) to support increase discharges	Morecambe Bay	Planned	Discussions ongoing with provider re: delivery and commencement	£800,000
5	Additional winter beds	12 additional beds to support P2/P3 discharges	Morecambe Bay	Started	Monitoring delivery is ongoing	£710,000
6	Ward 22	Additional 27 intermediate care beds	Pennine	Started	Monitoring delivery is ongoing	£1.2m
7	Patient transport	Additional transport capacity 3 vehicles Monday to Friday, 2 at weekends and 1 vehicle provides overnight provision	Pennine	Started	Monitoring delivery is ongoing	£80,000
8	Hospices (increased capacity)	Encompasses a range of support and interventions	Pennine	Planned 1st December	Regular bi-weekly meetings with hospices to enact mobilisation	£323,400
9	Home First	Recruitment of additional therapy resource to support increased home first slots	West Lancs	Started	Monitoring delivery is ongoing	£200,000
10	Discharge hub	Additional discharge planning nurses to support team over 7 days.	West Lancs	Planned late Nov	Recruitment is ongoing and discussions with agencies to provide support	£150,000
11	Transitional beds	Additional transitional beds with four local care homes	West Lancs	Started	Monitoring delivery is ongoing	£100,000

12	Community beds	96 community beds to meet step up/down demand and to enable people to be assessed in the community for their longer-term care needs	Central	Started	Phase 1 commenced, 32 beds available November 22 Phase 2, 64 beds Phase 3, TBC	£3m
13	Hospital at home service	Equity of service provision for Hospital at Home service equates to 30 additional beds	Pennine	Started	Monitoring delivery is ongoing	£812,000
14	Clinical Assessment Service	To support the continuance of an existing service of GP in hours	Pennine	Started	Monitoring delivery is ongoing	£115,000
15	Positive ageing and mental health wellbeing pilot	This Trailblazer programme is focussed on supporting older adults with a mental health need including dementia	LSC	Started	Monitoring delivery is ongoing	£647,893
16	Emergency/Contingency Workforce (social care)	Supports the continuance of the Emergency/Contingency Workforce partnership model between social care providers supporting the overall resilience of provision across care/nursing homes and domiciliary care services	Fylde Coast	Started	Monitoring delivery is ongoing	£205,000
17	Patient Transport	Supports the continuance of the Additional transport (2 vehicles 7 days per week; 12 hours per day. Supports an additional 16-20 discharges per day)	Fylde Coast	Started	Monitoring delivery is ongoing	£200,000
18	Transfer of Care Hub (additional social care hours)	Continuation of ASC staff based within Transfer of Care Hub (ToCH), working as part of full MDT to plan discharge from Acute and Clifton hospitals 7/7	Fylde Coast	Started	Monitoring delivery is ongoing	£141,000
19	Development of 8-8 working ASC	In line with national guidance additional staff posts are required to expand hours of working from 8am to 8pm 7 days a week across ToCH, ED and Rapid Response	Fylde Coast	Started	Monitoring delivery is ongoing	£200,000
20	Additional Pathway 1 support	Additional care and support in Chorley, Greater Preston and South Ribble, in order to maximise the number of Home	Central	Started	Monitoring delivery is ongoing	£500,000

		First discharges and to support 2022/23 winter pressures on a non-recurrent basis				
21	Community Support and admission avoidance	Implement REACT model at FGH Build capacity within the 2hr UCR core team. REACT (Furness General) = approx. 138 contacts per month. Falls (South Cumbria) = approx. 50 per month	Morecambe Bay	Planned	Recruitment advertised commenced.	£175,000
22	Voluntary Sector take home support	Additional take home and settle provision, supporting discharges	Morecambe Bay	Planned late Nov	Procurement process underway. Expressions of interests received and discussions with potential providers commenced.	£150,000
23	Discharge to Assess	Strengthening the availability, process and application of discharge to assess, packages of care across LSC	LSC	Planned	Discussions with key leads to map out next steps. Weekly meetings commenced to progress	£224,000
24	Prometheus	Additional support for patients on a section 136 in A&E. 50 patients per month	LSCFT	Started	Monitoring of delivery is ongoing	£600,000
25	Clinical Assessment Service	Continuation of existing service provision to support deflections from ED and signposting to appropriate services	Morecambe Bay	Started	Monitoring of delivery is ongoing	£152,903
26	Communications & Engagement	Advertising campaigns to run that promotes all key messages about winter to the public and to staff.	LSC	Started	A detailed Communications & Engagement plan has been developed for the winter period.	£75,000
27	Hospital Discharge & Flow Leadership	To support onwards care at the point of acute hospital discharge needs health and care to work across a common ground. This scheme seeks to capitalise on all the creative energy that is transacted in this space to ensure improved flow, collaborative ownership of onward care quality and needs to improve the care we offer to our patients.	LSC	Planned	Ongoing discussions with system wide partners	£226,000

Appendix D – Going Further on our winter resilience plans

Action	Status
Community based falls response (999 and 111)	
Map current provision of community-based falls response services which can respond to level one and two falls between 0800 and 2000, 7 days a week	Partial
Ensure existing provision is being utilised to its full potential by ensuring local directories of service are updated and NHS Service Finder includes accurate provider profiles	Planned
Ensure all UCR services are accepting falls referrals, and that there is full geographic coverage 0800-2000, 7 days a week, of the 9 clinical conditions/needs set out in the national 2-hour guidance. As part of this, optimise use of UCR services to respond to level two falls and provide follow up multifactorial/clinical assessment to level one falls	Fully
Adopt the Association of Ambulance Chief Executives' (AACE) Falls Governance Framework as a minimum national standard as part of pathways	Planned
Virtual Wards	
Deliver Virtual Ward and planning ambition and ensure effective utilisation. Submit timely, high-quality data through national sitrep	Partial
Respiratory	
Actively consider establishing Acute Respiratory Infection (ARI) hubs	Partial
Address unwarranted variation in ambulance conveyance rates in care homes	
Work collaboratively with the care homes in their system to support those with the highest 20% rates of unplanned ambulance conveyances to consider alternatives to 111/999 calls where appropriate. Utilise data from local ambulance trust(s), SUS data and local intelligence including workforce turnover and vacancy rates in identified homes.	Partial
Analyse the data from 111/999 in relation to care homes to determine: • Time and day of call • Reason for call determined by ambulance data • Main reason for conveyance determined by ambulance data	Partial
Map the provision of advanced clinical decision-making services available to care homes after 8pm and before 8am. (Does not include 111/999 or District Nursing services, and assumes a full UCR service 08:00 – 20:00 is in place) Note: An advanced clinical decision maker is likely to be an Advanced Clinical Practitioner (ACP), Geriatrician or similar	Fully
Map provision of the following EHCH contractual requirement to all care homes: Every care home aligned to a named PCN? Does every care home have an assigned clinical lead from the PCN? Is every care home in receipt of a weekly home round supported by an MDT?	Partial
Ensure all 111 and 999 call handlers are aware of and know how to refer to local UCR services	Fully
Going Further – next steps	
It is recommended all systems put in place access to advanced clinical decision-making support for care homes. This could be within a clinical hub that already exists. This would include UCR service provision, as well as access to advanced clinical decision makers such as ACPs, who can lead and deploy appropriate clinical support to ensure the resident receives treatment and care in the right setting e.g. virtual ward/remote monitoring in the care home/community hospital/other, to enable clinical risk sharing across the system, and therefore preventing avoidable conveyances and reducing clinical variation in practice.	Partial
High Frequency Users	
Consider targeted, proactive support for people who have high probability of emergency admission (High Frequency Users) by supporting general practice, PCNs	Planned

and teams to scale up additional roles (eg social prescribing link workers, health and wellbeing coaches and care coordinators)	
Establish 24/7 System Control Centre with operating model agreed via the BAF	
SCCs should operate 7-days a week, 365 days a year, with 0800-2000 staffed provision	Partial
The SCC should have 24/7 access to a senior clinician (senior medical or senior nurse decision maker) who can lead and take responsibility for the proactive management of clinical risk and make system-level decisions to balance risk across the urgent and emergency care (UEC) system. With a specific focus on mitigating clinical risks across the acute, community and mental health urgent and emergency pathway	Planned
Between the hours of 2000-0800 ICBs should have director level on-call arrangements in place to maintain SCC continuity, with the ability to maintain and stand-up full SCC functionality as needed. The director level on-call must have the ability to access senior clinical support as per Ref 2, with agreed minimal triggers to do so	Planned
A named ICB executive should be responsible for the development, implementation, and oversight of the operational delivery of the SCC	Fully
The SCC must utilise national data sets to inform surveillance, decision making and risk management. Specifically, the SCC will have systems and process in place to monitor and respond to the nationally agreed target metrics including but not limited to: • Type 1 ED performance • >12-hour length stays in ED • Category 1, 2 and 3 ambulance response times • OPEL status • Community Rehab Bed Occupancy • Virtual ward bed state To support decision making, ICBs should work with partners to develop systems and processes for the SCC to have sight of the demand and capacity for care home beds and broader social care across the system.	Partial
The SCC must utilise real-time data to ensure proactive management of ambulance handover delays and the proactive and reactive management of actions that will support ambulance response times.	Fully
The role of the SCC must be clearly defined in action cards as they relate to OPEL and REAP level 2, 3, and 4, and critical/major incidents.	Partial
Systems and processes must be in place to ensure that the SCC leads proactive planning as well as reactive management – specifically to include planning daily for 2000-0800, weekends, bank holidays and other events that are potentially destabilising to the system-level health economy e.g., large public gatherings/events.	Fully
SCCs will be appropriately staffed to respond to day-to-day management as well as surge or critical incident scenarios and will be aligned to existing EPPR arrangements.	Partial
SCCs will have systems and processes in place to ensure there is a robust cascade and action of national and regional communications. This should include a single point of contact mailbox that can be accessed in and out-of-hours by relevant SCC staff as needed, and appropriate systems and process to track and monitor returns as needed.	Partial
Systems and processes should be in place to coordinate and manage returns to regional and national teams, ensuring oversight that returns are accurate and provided in line with timelines – including SITREP returns, and completion of the capacity tracker including for community rehabilitation beds.	Fully
SCCs will proactively lead the system response as it relates to the repatriation of patients, and the management of delayed discharges from the acute, community and mental health bed base.	Fully
SCCs will have systems and processes in place to identify, manage and escalate as needed risks and issues as they relate to patient safety and operational performance to system, regional and national teams in and out-of-hours as needed.	Partial

SCCs will have systems and processes in place to proactively ensure the effective management of flow and capacity across both bedded and non-bedded capacity. Ensuring the maximum clinically appropriate use of virtual ward capacity and nonacute bedded capacity.	Partial
SCCs will have agreed access points, 24/7, to partners in local authorities. SCCs will work in conjunction with, and escalate issues and risks to, local authorities as they relate to commissioned services and or matters for which statutory responsibility lies with local authorities.	Planned
SCCs will have the capacity to convene system-wide meetings on a daily or more regular basis, in and out-of-hours, to assess the operational rhythm. Such meetings will have appropriate leadership to ensure immediate actions to mitigate pressures are identified, operationalised, monitored and their impact assessed	Partial
SCCs will operate in conjunction with, and cognisant of, the overall EPPR arrangements of the NHS, and associated statutory obligations of NHSE, ICBs, NHS providers, local authorities, and wider system partners.	Partial
SCCs will maintain appropriate contemporaneous records and decision logs for all actions in line with the standard principles of health command.	Fully
Ensure ambulance services deploy 24/7 mental health professionals in emergency operations centres and on scene	
Ensure ambulance services deploy 24/7 mental health professionals in emergency operations centres and on scene	Partial
Continue to embed 10 best practice interventions	
Identify patients needing complex discharge support early	Partial
Ensure multidisciplinary engagement in early discharge plan	Partial
Set expected date of discharge (EDD), and discharge within 48 hours of admission	Partial
Ensuring consistency of process, personnel and documentation in ward rounds	Partial
Apply seven-day working to enable discharge of patients during weekends	Partial
Treat delayed discharge as a potential harm event	Partial
Streamline operation of transfer of care hubs	Partial
Develop demand/capacity modelling for local and community systems	Partial
Manage workforce capacity in community and social care settings to better match predicted patterns in demand for care and any surges	Partial
Revise intermediate care strategies to optimise recovery and rehabilitation.	Partial
Support Elective Capacity	
Ensure every Trust Board review relevant performance data and delivery plans and share plans with ICB	Partial
Faecal Immunochemical Testing (FIT) in the Lower GI pathway including for patients on Endoscopy waiting lists	Fully
Best Practice Timed Pathway for prostate cancer including the use of mpMRI	Partial
Tele-dermatology in the suspected skin cancer pathway	Partial
Greater prioritisation of diagnostic and surgical capacity for suspected cancer	Fully
Infection prevention and control (IPC) measures and testing	
Providers self-assess compliance with guidance using IPC Board Assurance Framework ahead of Winter	

Appendix E - Dashboard (Six Key Metrics)

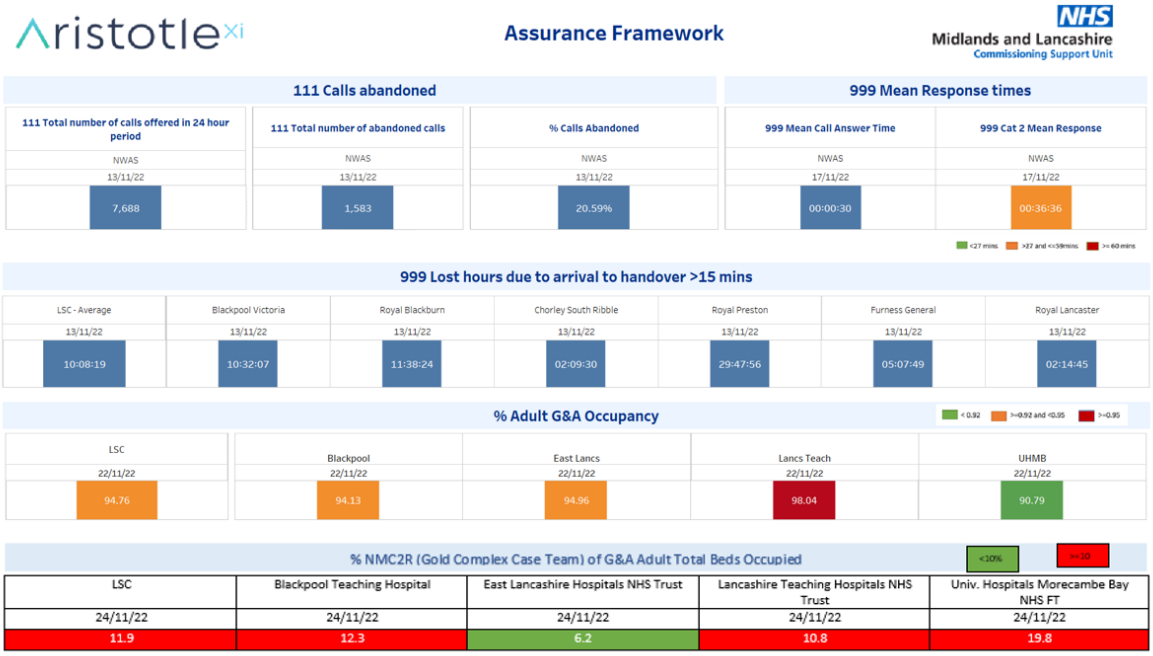
The dashboard below provides an overarching position of the six key metrics.

The not meeting criteria to reside percentage noted within the dashboard has been extracted from local data sources.

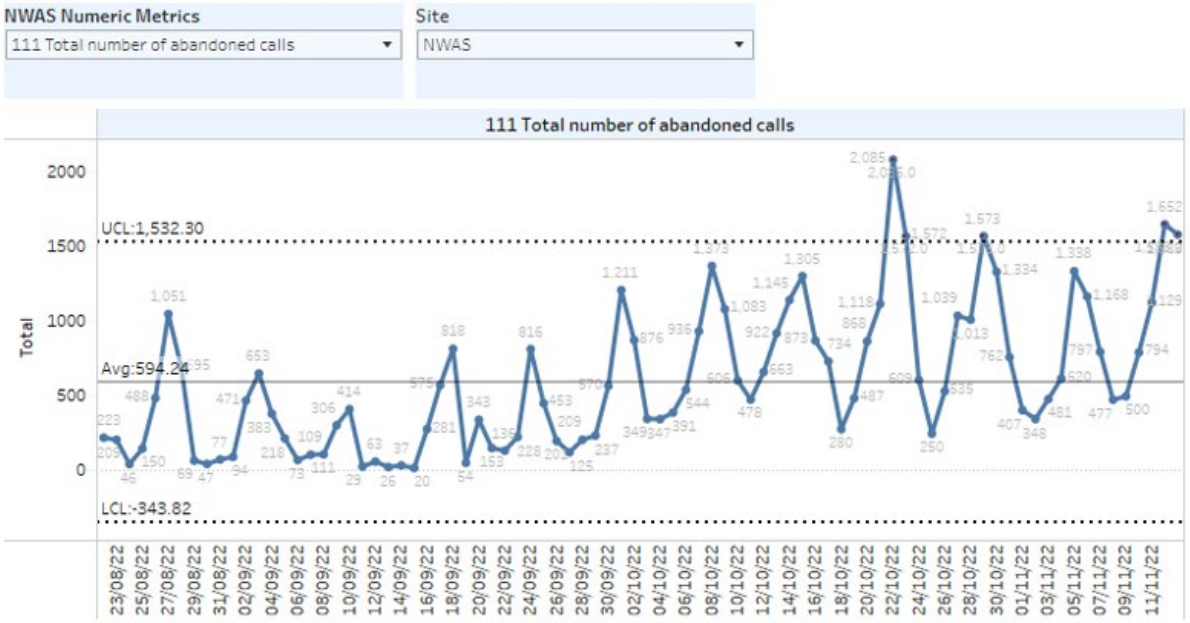
Trusts complete and submit a weekly SITREP to the national team for the previous 7 days not meeting criteria to reside figures. However, discussions are ongoing with the national team and awaiting confirmation of the definitions Trust will be reporting going forward. This will ensure a consistent approach to recording data.

The dashboard is currently under development therefore the graphs are extracted from Aristotle.

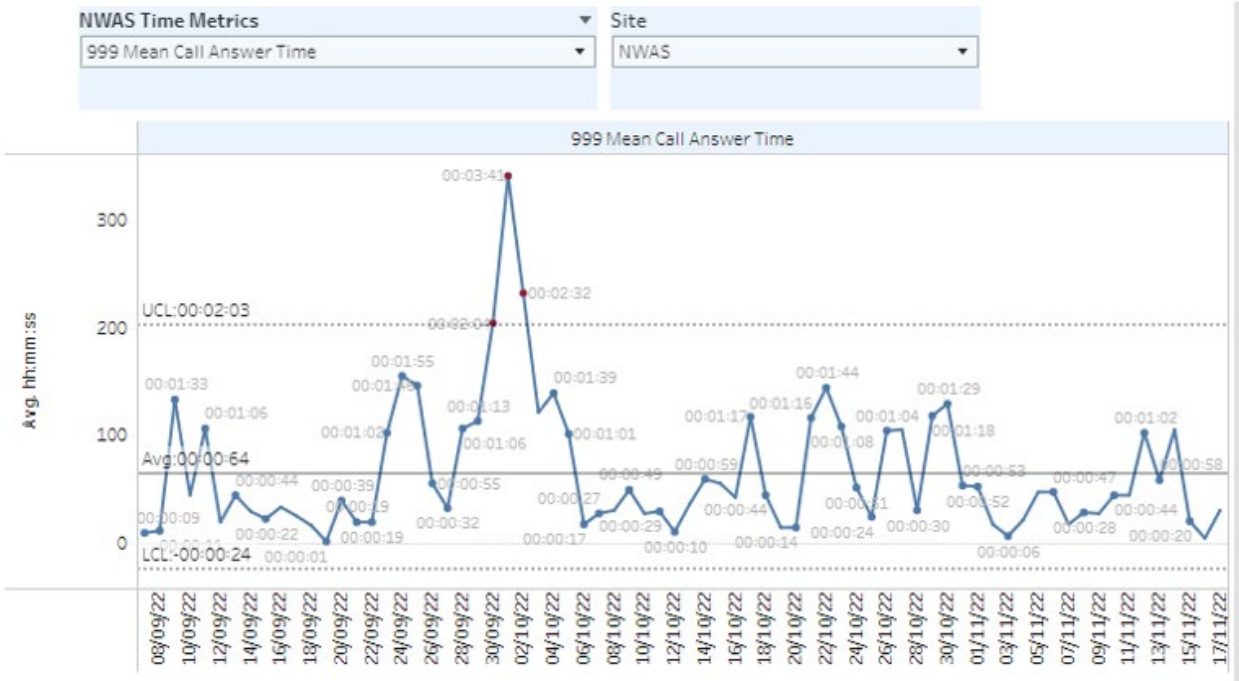
Dashboard overview of six key metrics



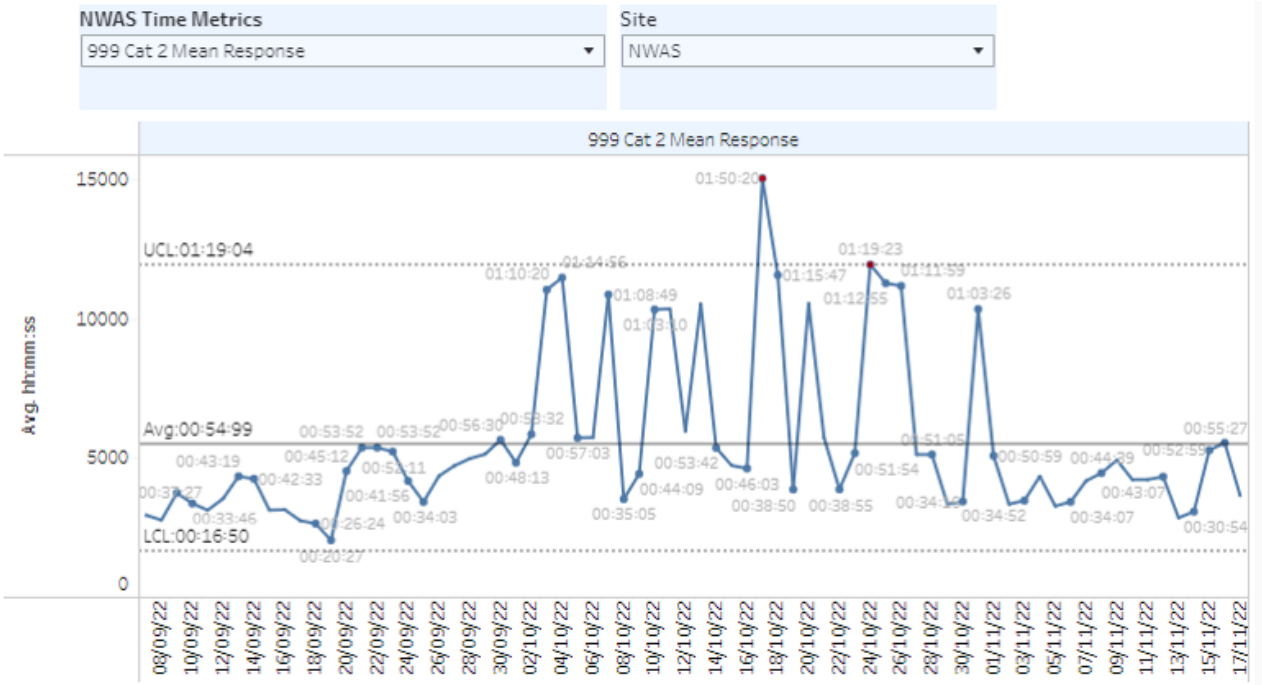
111 Total number of abandoned calls



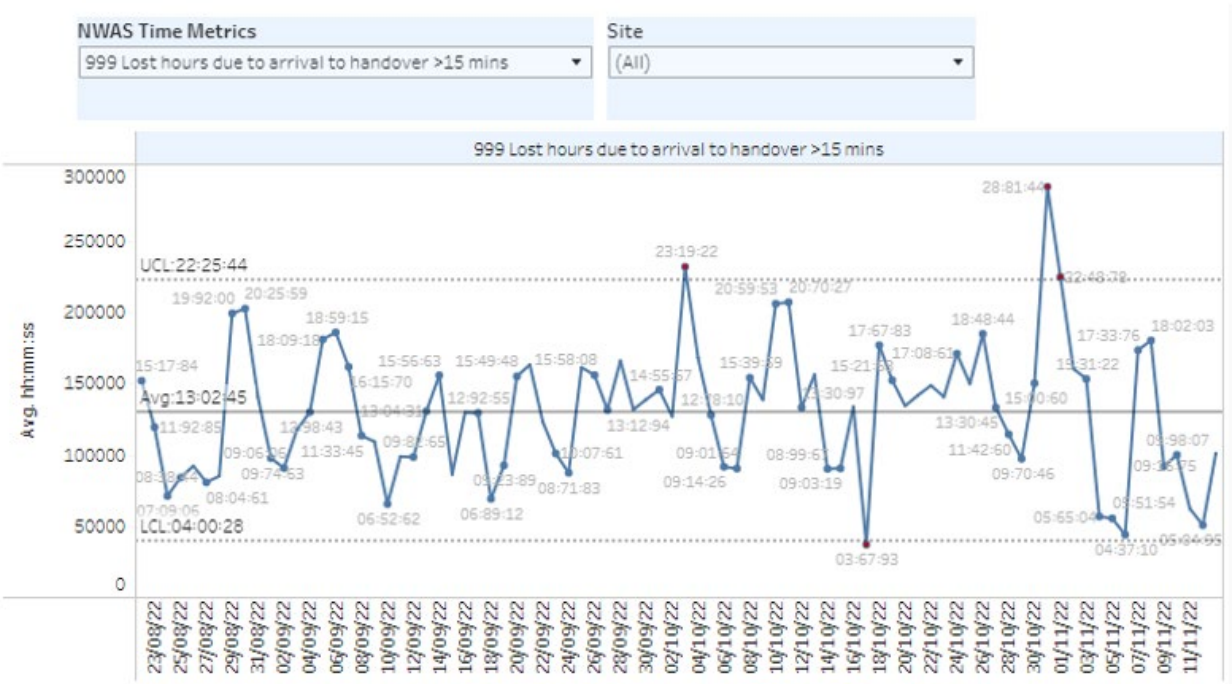
999 Mean Call Answer Time



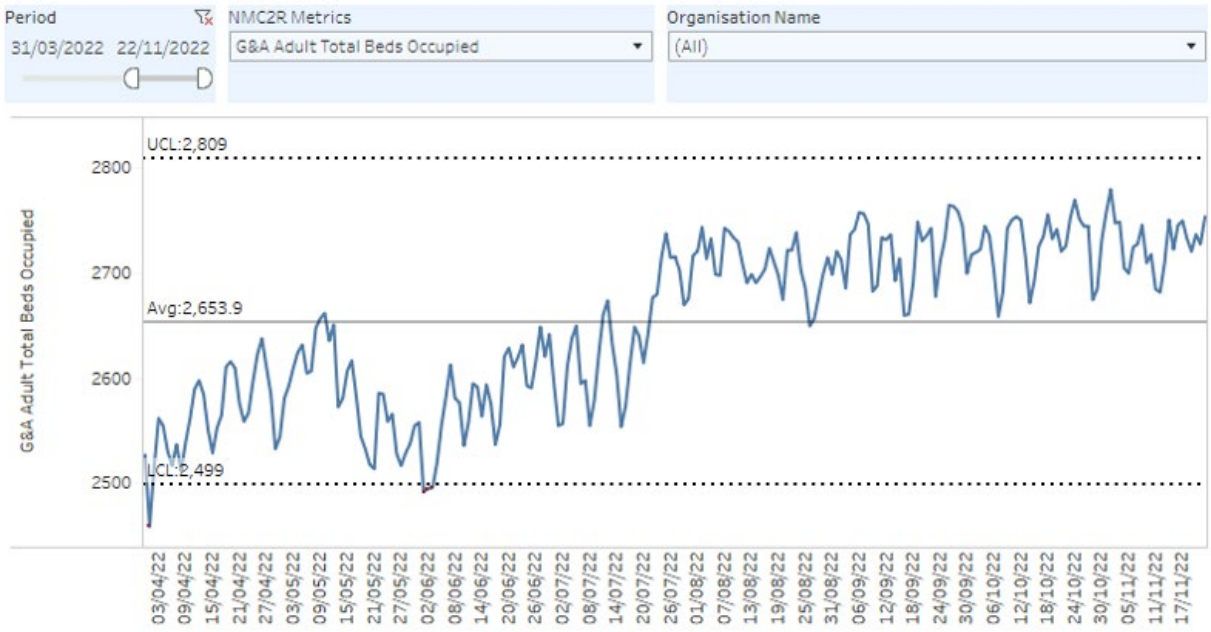
999 Category 2 Mean Response



999 Lost hours due to arrival to handover >15 minutes



G&A Adult Total Beds Occupied



LSC Not meeting criteria to reside aggregated position