Lancashire and South Cumbria Integrated Care Board

Integrated Care Board

Date of meeting	**1 February 2023**
Title of paper	Resilience and surge planning/Urgent and Emergency Care Board Assurance Framework
Presented by	Maggie Oldham, deputy CEO and chief performance, planning and strategy officer
Author	Jayne Mellor, director of urgent, emergency and planned care
Agenda item	12
Confidential	No

Purpose of the paper

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

Executive summary

The UEC Board Assurance Framework is designed to support ICBs to deliver their responsibilities and 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 action plan and demand and capacity schemes are submitted monthly to the regional and national teams.

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

A supplementary Board Assurance Framework – winter plan reset and three-month (i.e. January – March 2023) demand and capacity plan was issued on Monday 9 January with a requirement to submit it to NHS England (NHSE) on 12 January 2023, which the ICB achieved.

On 9 January 2023, an announcement was made by the Department of Health and Social Care about additional national funding of up to £250m to spend on hospital

discharge. This includes up to £200m to buy extra beds in care homes, resulting in a capped budget of £6.525m for Lancashire and South Cumbria ICB, with hospital discharge fund guidance issued by NHSE on Friday 13 January 2023.

Recommendations

The Board is requested to:

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

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

Meeting	**Date**	**Outcomes**
ICB Executive Team	24 January 2023	Supported the paper for the Board

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	
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, deputy CEO and chief performance, planning and strategy officer

Resilience and Surge Planning/Urgent and Emergency Care Board Assurance Framework

1. Action Plan

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

1.2 The status definitions of individual actions or schemes used in this paper are consistent with the guidance set out in the national templates. The table below provides the definitions adopted in Lancashire and South Cumbria (LSC), which, again, align with the national reporting requirements:

Status	Definition
Fully implemented	Provision is in place in all localities across LSC
Partially implemented	Some elements are in place, but not all localities have full provision
Planned implementation	Provision is not currently in place, however there are plans to implement

1.3 The position for LSC in relation to the delivery of the key actions in the Board Assurance Framework Action Plan is outlined below:

Status	December 2022
Fully implemented	16
Partially implemented	27
Planned implementation	4

1.4 The framework is aimed at supporting and ensuring trusts continue to implement best practice. The ICB's BAF is unique to our ICS to reflect the specific capacity gaps identified in agreement with NHS England (NHSE) and a detailed return is submitted to NHSE on a monthly basis.

2. Operational Self-Assessment Good Practice Checklist

2.1 The ICB and its system 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 NHSE 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	December 2022
Fully implemented	29
Partially implemented	19

2.3 Further detail is included in Appendix A.

3. Demand and 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 the regional and national teams required monthly, which the ICB has achieved at each reporting point.

3.2 The LSC position is outlined below:

Status	December 2022
Started	23
Planned	3
Partial	1

3.3 Further detail is included in Appendix B.

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 is working collaboratively with system partners to oversee the delivery of schemes, including via the Resilience and Surge Planning Group and through local A&E Delivery Boards.

5. Going Further on Our Winter Resilience

5.1 A LSC plan has been developed setting out 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 The additional actions from the 'Going further on our winter resilience plans' guidance will be incorporated into the action plan by the national team as required, however the ICB will continue to monitor progress locally.

5.4 Further detail is included in Appendix C.

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 general and acute bed occupancy
- Percentage of beds occupied by patients who no longer meet the criteria to reside.

6.2 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 D.

7. Board Assurance Framework Supplement

7.1 On 9 January 2023, a further request was made by the national team to provide systems with the opportunity to reset and reflect on which winter actions and capacity schemes have had most impact over the past three months and which could be further optimised throughout the remainder of the year in order to meet current demand and capacity pressures.

7.2 The national team advised, this is an opportunity to not just escalate our response to current pressures but also reflect the further step change required to meet our ambitions for next year, including significantly improving ED and ambulance performance.

7.3 The national team developed a template and issued it on 9 January 2023 for completion and submission on 12 January 2023. The ICB submitted this within the required timeframe.

8. Further Hospital Discharge Funding

8.1 On 9 January 2023, the Department of Health and Social Care announced a further up to £250m to buy extra beds in care homes and other settings to help discharge more patients to free up hospital beds.

8.2 The announcement specifically included the following elements:

- Up to £200 million for local areas to buy extra beds in care homes and other settings to help discharge more patients who are fit to leave hospital and free up hospital beds for those who need them
- Discharged patients will be given the support they need from GPs, nurses and other community-based clinicians to continue their recovery
- Additional £50m capital funding to upgrade and expand hospitals including new ambulance hubs and facilities for patients about to be discharged
- Six national "Discharge Frontrunners" will lead the way to explore new long-term initiatives to free up hospital beds.

8.3 On 13 January 2023, NHSE published 'Hospital discharge fund guidance' in relation to the £200m fund, which should be used to purchase bedded step-down capacity plus associated clinical support for patients with no criteria to reside.

8.4 It should be highlighted that the fund is separate and in addition to other sources of funding, such as the Adult Social Care Discharge Fund; the detail of which was set out in the Board paper of 7 December 2002. Also, the fund can only be used to buy care up to and including 31 March 2023 and for up to four weeks for patients who no longer meet the criteria to reside in hospital.

8.5 The capped budget for LSC is £6.525m, which will be reimbursed based on actual spend. The ICB is working closely with system partners to determine the most appropriate use of the fund that will meet the national requirements, have the greatest impact and minimise the risks associated with the short-term nature of the fund.

8.6 Further details and assurance about how the ICB and its partners are using the fund will be provided at the next Board meeting on 1 March 2023.

9. Monitoring and Evaluation

9.1 As outlined in Appendix B, 23 of the 27 demand and capacity schemes have commenced.

9.2 Activity is collated monthly and submitted to the regional and national teams in line with their timetable – the ICB has met the requirements on each occasion.

9.3 In recognition of commencement dates and phased approach for a number of schemes, the Resilience and Surge Planning Group will continue to monitor activity, ensure the schemes are delivering the plans and that there will be an evaluation.

9.4 It is anticipated that evaluation will be completed by the end of April 2023.

10. Exit Strategy

10.1 The national team confirmed funding cannot be used beyond 31 March 2023.

10.2 Discussions will be held via the Resilience and Surge Planning Group to review the schemes, identify the associated risks once the funding ceases and coordinate the development and delivery of associated exit plans where these are required. Evaluations may determine that some schemes will be required to continue into 2023/24. Any schemes identified to continue will require a business case, which will presented for consideration through recently agreed governance arrangements.

11. Risks and Mitigations

11.1 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.

12. Finance

12.1 As previously noted, £12.95m has been allocated to the ICB to enable delivery of 27 demand and capacity schemes. The ICB is closely monitoring planned against actual expenditure for all schemes.

12.2 For December 2022, the year-to-date expenditure was £2,903,772 and the forecast outturn was predicted to be £10,205,032.

12.3 The remaining £2,744,968 is being utilised for Discharge to Assess arrangements which continues to support discharges from the hospitals across LSC.

13. Recommendations

13.1 The Board is requested to:

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

Appendix A – 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: Overview of all patient related incidents and serious incidents with regards to ambulance delays	x		
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 B – 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	Commenced	Monitoring delivery is ongoing	£1.1m
2	Additional Social Care hours	Continuance of additional social care hours	Fylde Coast	Commenced	Monitoring delivery is ongoing	£370,000
3	Support to General Practice	440 additional appts per week plus additional bank holiday support	Morecambe Bay	Commenced	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	Commenced	Phased approach commenced 19th December 2022	£800,000
5	Additional winter beds	12 additional beds to support P2/P3 discharges	Morecambe Bay	Commenced	Monitoring delivery is ongoing	£710,000
6	Ward 22	Additional 27 intermediate care beds	Pennine	Commenced	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	Commenced	Monitoring delivery is ongoing	£80,000
8	Hospices (increased capacity)	Encompasses a range of support and interventions	Pennine	Commenced December	Regular bi-weekly meetings continue to support mobilisation	£323,400
9	Home First	Recruitment of additional therapy resource to support increased home first slots	West Lancs	Commenced	Monitoring delivery is ongoing	£200,000
10	Discharge hub	Additional discharge planning nurses to support team over 7 days.	West Lancs	Commenced	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	Commenced	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	Commenced	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	Commenced	Monitoring delivery is ongoing	£812,000
14	Clinical Assessment Service	To support the continuance of an existing service of GP in hours	Pennine	Commenced	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	Commenced	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	Commenced	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	Commenced	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	Fylde Coast	Commenced	Monitoring delivery is ongoing	£141,000

		discharge from Acute and Clifton hospitals 7/7				
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	Commenced	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 First discharges and to support 2022/23 winter pressures on a non-recurrent basis	Central	Commenced	Monitoring delivery is ongoing	£500,000
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	Commenced	Procurement process completed. Partially mobilised	£150,000
23	Discharge to Assess	Strengthening the availability, process and application of discharge to assess, packages of care across LSC	LSC	Planned	Meetings continue with system partners	£224,000
24	Prometheus	Additional support for patients on a section 136 in A&E. 50 patients per month	LSCFT	Planned	Scheme under development, Task & Finish Group convened and meets weekly to mobilise	£600,000
25	Clinical Assessment Service	Continuation of existing service provision to support deflections from	Morecambe Bay	Commenced	Monitoring of delivery is ongoing	£152,903

		ED and signposting to appropriate services				
26	Communications & Engagement	Advertising campaigns to run that promotes all key messages about winter to the public and to staff.	LSC	Commenced	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	Partial		£226,000

Appendix C – 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	Partial
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	Partial

system, and therefore preventing avoidable conveyances and reducing clinical variation in practice.	
High Frequency Users	
Consider targeted, proactive support for people who have high probability of emergency admission (High Frequency Users) by supporting general practice, PCNs and teams to scale up additional roles (eg social prescribing link workers, health and wellbeing coaches and care coordinators)	Planned
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	Fully
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	Fully
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	Fully
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.	Fully
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.	Fully
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.	Fully

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.	Fully
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.	Fully
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.	Fully
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.	Partial
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	Fully
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.	Fully
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	Partial

Appendix D - Dashboard (Six Key Metrics)

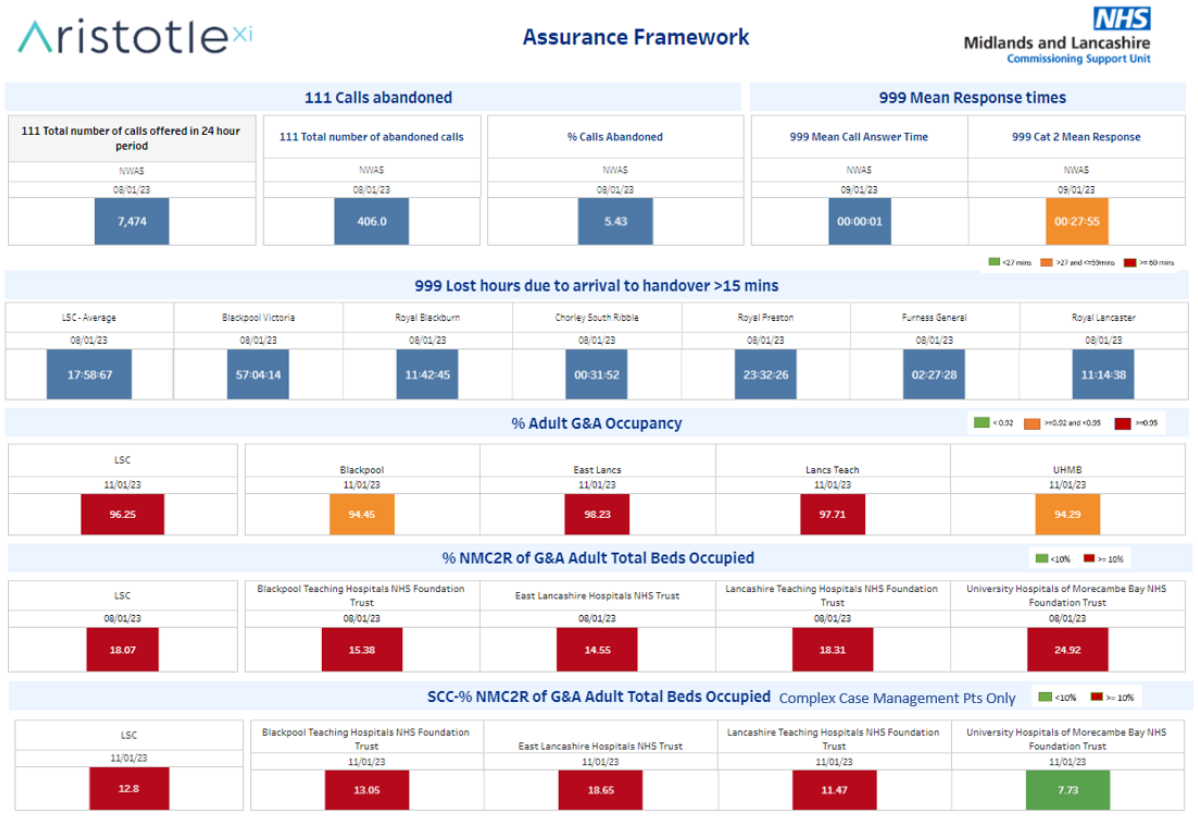
The dashboard below provides an overarching position of the six key metrics.

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.

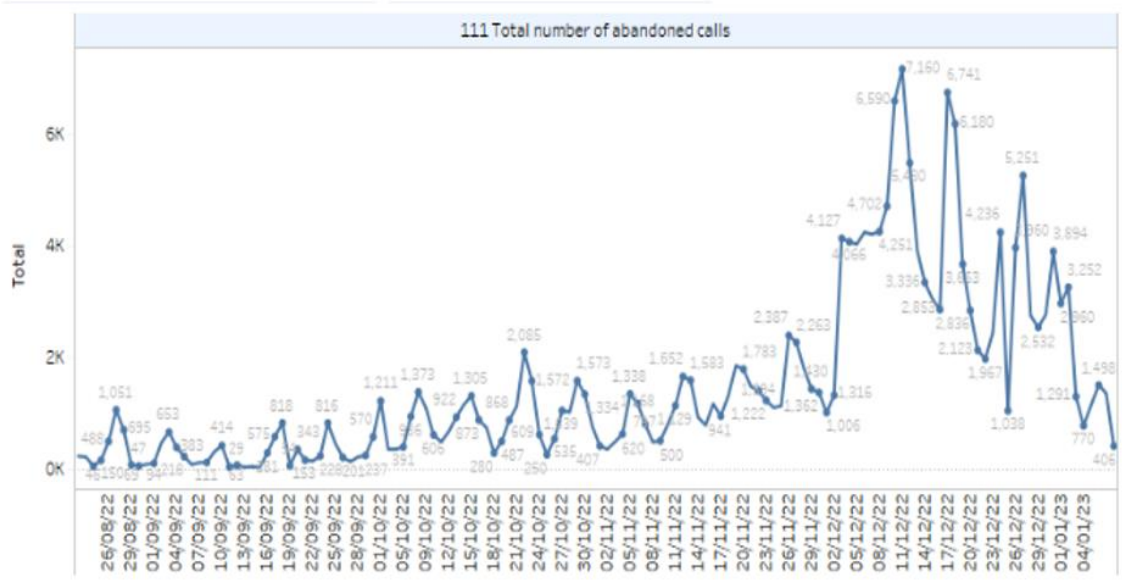
The dashboard is currently under development therefore the graphs are extracted from Aristotle.

Dashboard overview of six key metrics



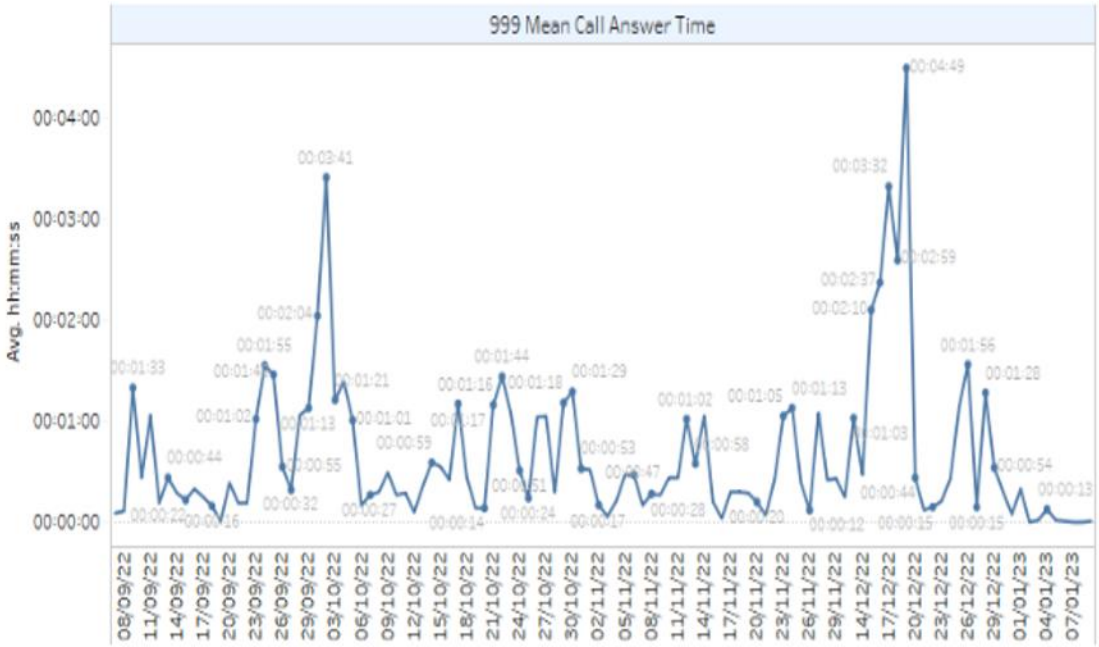
111 Total number of abandoned calls

NWAS Level



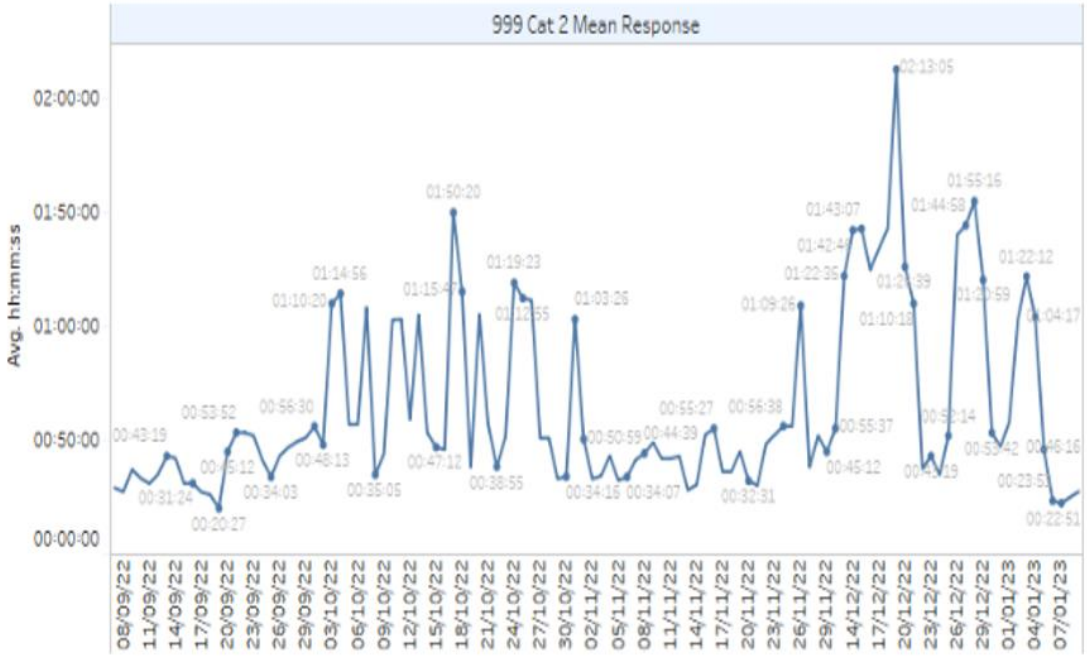
999 Mean Call Answer Time

NWAS Level



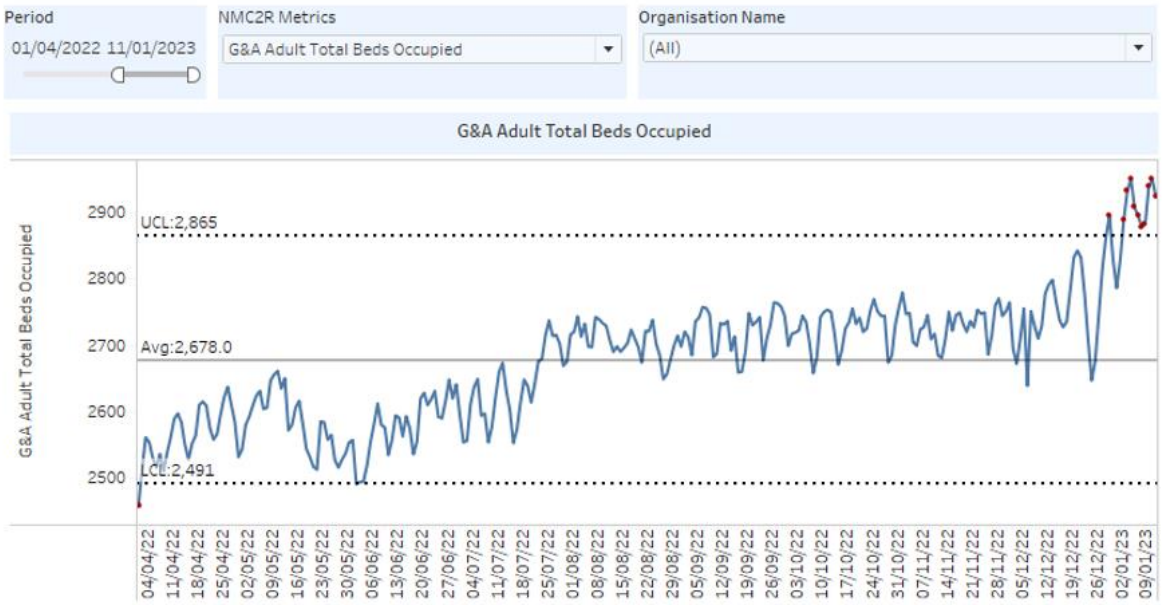
999 Category 2 Mean Response

NWAS Level



999 Lost hours due to arrival to handover >15 minutes

G&A Adult Total Beds Occupied



LSC Not meeting criteria to reside aggregated position

LSC Level – based on National Discharge Sitrep Data