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PUBLIC

To: Members of Improvement and Scrutiny Committee - Health

Friday 11 November 2022

Dear Councillor

Please attend a meeting of the **Improvement and Scrutiny Committee - Health** to be held at **2.00 pm** on **Monday, 21 November 2022** in Committee Room 1, County Hall, Matlock, Derbyshire DE4 3AG; the agenda for which is set out below.

Yours faithfully

Helen E. Barrington

Helen Barrington
Director of Legal Services

A G E N D A

PART I - NON-EXEMPT ITEMS

1. Apologies for absence

   To receive apologies for absence (if any)

2. Declarations of Interest

   To receive Declarations of Interest (if any)

3. Minutes of Previous Meeting (Pages 1 - 6)

To confirm the non-exempt minutes of the meeting of the Improvement and Scrutiny Committee - Health held on 11 July 2022.

4. Public Questions (Pages 7 - 8)

   30 minutes maximum for this item. Questions may be submitted to be answered by the Scrutiny Committee or Council officers who are attending the meeting as witnesses, on any item that is within the scope of the Committee. Please see the procedure (below) for the submission of questions.

5. The Transition of Services from Glossop to Derbyshire ICB (Pages 9 - 16)

6. Derby and Derbyshire ICS Mid-year Financial Update (Pages 17 - 20)

7. Healthwatch Derbyshire IIA - Update (Pages 21 - 32)

8. Scrutiny Review of Section 75 Agreements - Final Report (Pages 33 - 42)

9. Preparing for Winter (Pages 43 - 76)

10. Work Programme

PUBLIC

MINUTES of a meeting of **IMPROVEMENT AND SCRUTINY COMMITTEE - HEALTH** held on Monday, 11 July 2022 at County Hall, Matlock, DE4 3AG.

PRESENT

Councillor J Wharmby (in the Chair)

Councillors D Allen, E Fordham, P Moss, G Musson, L Ramsey, P Smith and A Sutton.

Apologies for absence were submitted for Councillor M Foster.

Officers present: Juliette Normington (Democratic Services Officer) and Jackie Wardle (Improvement and Scrutiny Officer).

14/22 DECLARATIONS OF INTEREST

There were no declarations of interest.

15/22 MINUTES

RESOLVED – to confirm the non-exempt minutes of the meeting of the Improvement & Scrutiny – Health held on 7 March 2022.

16/22 PUBLIC QUESTIONS

Question posed by Keith Venables:

"What is the difference between the current CCG and, from 1st July, the new Derbyshire ICS? Do they have different powers?"

Response from the Derbyshire Integrated Care Board:

Integrated Care Boards, Integrated Care Partnerships and Integrated Care Systems

Integrated Care Boards (ICBs) will replace Clinical Commissioning Groups from 1 July 2022 under the Health and Social Care Act. Integrated Care Partnerships (ICPs) will be established at the same time. The ICB and ICP are what will make up the legally-constituted Integrated Care System (ICS).

The ICB will take on the NHS commissioning functions of CCGs as well as some of NHS England's commissioning functions. It will also be

accountable for NHS spend and performance within the system. Commissioning responsibilities for additional primary care services will transition to ICBs. Currently, this sits with NHSE, but primary medical care services have been successfully delegated to CCGs for some time. ICBs will become responsible for the commissioning and arranging of primary medical services, dentistry (primary, community and secondary services), community pharmacy and general ophthalmology from April 2023 with NHS England retaining a more limited oversight role.

Each area will also have an ICP, a joint committee which brings together the ICB and their partner local authorities, and other locally determined representatives (for example from health, social care, public health; and potentially others, such as social care or housing providers). The ICP will be tasked with developing a strategy to address the health, social care and public health needs of their system, and being a forum to support partnership working. The ICB and local authorities will have a legal duty to have regard to ICP strategies when making decisions. The ICB and ICP will also have to work closely with local Health and Wellbeing Boards (HWBs) as they have the experience as 'place-based' planners, and the ICB will be required to have regard to the Joint Strategic Needs Assessments and Joint Local Health and Wellbeing Strategies (JHWSs) produced by HWBs.

A supplementary question was asked:

"To what degree does the Health and Care Bill allow private companies onto committees and sub-committees?"

Response:

The Bill does not cover that in detail however, all work on committees must be open and transparent. Any future privatisation would have no affect on NHS services.

17/22 <u>ENHANCED ACCESS TO PRIMARY CARE SERVICES</u>

Emma Prokopiuk introduced the report, which had been circulated in advance of the meeting and was supplemented by a presentation, providing assurance that engagement was taking place on the Enhanced Access Services (EAS), which was due to commence on 1 October 2022 and that the engagement process would be included in the PCN Plan for delivery.

It was noted that this was not to introduce a new system but to provide services already available in a different way and which had run since 2016.

Committee members asked a number of questions and requested further data on the survey and a breakdown of the results, together with the PCN national document.

RESOLVED to note the engagement process was going ahead.

18/22 THE TOBACCO DEPENDENCY PROJECT

Angela Deakin and Samantha Robinson introduced the report, which had been circulated in advance of the meeting, informing the Committee of the NHS 3-year Tobacco Dependency Treatment (TDT) Programme and which was aimed at offering all people admitted to hospital plus maternity and Mental Health patients who smoked, NHS funded tobacco treatment services, by 2023/24.

Disease prevention had been recognised as vital to managing costs and sustaining the viability of the NHS in the future. Delivery of smoking interventions had been consistently and widely recommended throughout all areas of clinical practice by NICE. The NHS Long Term Plan (LTP) Prevention Programme aimed to deliver commitments to address behavioural risk factors and tackle health inequalities, which had been exposed and exacerbated by the Covid-19 pandemic.

Committee members asked a number of questions around the new programme and requested data on the impact the programme had on patients how many returned to smoking.

RESOLVED to:

1. Keep the Committee informed of the direction of travel for the effective delivery of the Tobacco Dependency Treatment Programme; and

2. Ensure that the programme was delivering a consistence approach across its Integrated Care System.

19/22 ICS PEOPLE AND COMMUNITIES STRATEGY

Sean Thornton, Deputy Director Communications and Engagement with NHS Derby and Derbyshire Integrated Care Board (ICB) introduced the report, which had been circulated in advance of the meeting seeking support for the approach to community engagement as set out in the Communities and Engagement Strategy.

The presentation highlighted elements of the report and the evolving document, which was agreed in May 2021. This was a statutory

requirement following the enactment of the Health and Care Bill and NHS England's set requirements for all prospective ICB's to submit its strategic approach to implementing these principles as proof of its 'readiness to operate'.

The strategy had been developed collaboratively across health, care and voluntary sector partners who sought to ensure principles and initiatives were at the heart of the development of the Strategy. It had also been reviewed and approved by the Derbyshire Engagement Committee. The presentation went on to list its strengths and areas for development.

The Committee welcomed the Strategy. It also requested benchmarks for comparison and for Mr Thornton to attend the meeting in November to provide an update.

RESOLVED to:

1. Receive the strategic approach in its current form;

2. Note the iterative status of the document; and

3. Comment on the Strategy to help inform future developments.

20/22 COMMITTEE WORK PROGRAMME

Jackie Wardle, Scrutiny Officer introduced the item and provided an update on the Work Programme.

The Derby and Derbyshire Clinical Commissioning Group (CCG) had transformed to the Derby and Derbyshire Integrated Care Board (ICB) on 1 July, on the enactment of the Health and Social Care Act 2022. As well as the ICB, an Integrated Care Partnership (ICP) had been established and these would work together to facilitate a robust and efficient Integrated Care System (ICS) across the county. The Committee would continue to receive reports from the Integrated Care Board on changes to NHS services.

The Committee's review of Section 75 Agreements was on-going, with further working group meetings scheduled over the next few weeks. Working group members had also received examples of current or draft Section 75 Agreements between the Council and local health providers and were now looking at the monitoring and reporting processes for arrangements where Section 75 Agreements were utilised. It was anticipated that a final report would be brought to Committee in November.

RESOLVED to:

1. Note the update on the Work Programme; and

2. Invite the Integrated Care Board Lead officers to the November meeting to report on the progress of implementing the new system of ICB and ICP and how these bodies continue to support the local ICS.

The meeting finished at 3.20 pm

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Procedure for Public Questions at Improvement and Scrutiny Committee meetings

Members of the public who are on the Derbyshire County Council register of electors, or are Derbyshire County Council tax payers or non-domestic tax payers, may ask questions of the Improvement and Scrutiny Committees, or witnesses who are attending the meeting of the Committee. The maximum period of time for questions by the public at a Committee meeting shall be 30 minutes in total.

Order of Questions

Questions will be asked in the order they were received in accordance with the Notice of Questions requirements, except that the Chairman may group together similar questions.

Notice of Questions

A question may only be asked if notice has been given by delivering it in writing or by email to the Director of Legal Services no later than 12 noon three working days before the Committee meeting (ie 12 noon on a Wednesday when the Committee meets on the following Monday). The notice must give the name and address of the questioner and the name of the person to whom the question is to be put.

Questions may be emailed to democratic.services@derbyshire.gov.uk

Number of Questions

At any one meeting no person may submit more than one question, and no more than one such question may be asked on behalf of one organisation about a single topic.

Scope of Questions

The Director of Legal Services may reject a question if it:
• Exceeds 200 words in length;

• is not about a matter for which the Committee has a responsibility, or does not affect Derbyshire;

• is defamatory, frivolous or offensive;

• is substantially the same as a question which has been put at a meeting of the Committee in the past six months; or

• requires the disclosure of confidential or exempt information.

Submitting Questions at the Meeting

Questions received by the deadline (see **Notice of Question** section above) will be shared with the respondent with the request for a written response to be provided by 5pm on the last working day before the meeting (ie.5 pm on Friday before the meeting on Monday). A schedule of questions and responses will be produced and made available 30 minutes prior to the meeting (from Democratic Services Officers in the meeting room).

It will not be necessary for the questions and responses to be read out at the meeting, however, the Chairman will refer to the questions and responses and invite each questioner to put forward a supplementary question.

Supplementary Question

Anyone who has put a question to the meeting may also put one supplementary question without notice to the person who has replied to his/her original question. A supplementary question must arise directly out of the original question or the reply. The Chairman may reject a supplementary question on any of the grounds detailed in the **Scope of Questions** section above.

Written Answers

The time allocated for questions by the public at each meeting will be 30 minutes. This period may be extended at the discretion of the Chairman. Any questions not answered at the end of the time allocated for questions by the public will be answered in writing. Any question that cannot be dealt with during public question time because of the non-attendance of the person to whom it was to be put, will be dealt with by a written answer.

FOR PUBLICATION

DERBYSHIRE COUNTY COUNCIL

IMPROVEMENT AND SCRUTINY COMMITTEE – HEALTH

21 November 2022

Report of the Integrated Care Board

Commissioning of Healthcare Services in Glossop

1. Purpose

1.1 To provide information to the Improvement and Scrutiny Committee – Health on the process of transitioning the commissioning of healthcare for the Glossop population from the former Tameside and Glossop Clinical Commissioning Group (TGCCG) to the newly formed NHS Derby and Derbyshire Integrated Care Board (DDICB) on 1 July 2022.

2. Information and Analysis

2.1 Integrated Care Systems are partnerships of health and social care providers. Each part of England has an Integrated Care System (ICS), and the ICS for Derbyshire is called Joined Up Care Derbyshire (JUCD). In 2021 the draft Health and Care Bill, which would go on to establish ICSs in legislation, outlined that Health and Social Care provision should be coterminous. In July 2021, the then Secretary of State for Health and Social Care Rt Hon Sajid Javid confirmed his decision that the boundary of the Derbyshire ICS would be amended to incorporate the area of Glossop, with effect from 1 April 2022.

2.2 The decision was underpinned by the principle that aligned boundaries deliver clear benefits in integration between local authorities and NHS organisations. With Glossop already being geographically part of Derbyshire, social care and other services were being managed across two ICS footprints by Derbyshire County Council and High Peak Borough Council.

2.3 In late 2021, it was agreed that the implementation of legislation would be deferred until 1 July 2022; this boundary change would therefore take effect on that date.

2.4 Following notification of the boundary change in July 2021, the transition programme commenced with the formation of the Glossop Steering Group and four associated workstreams, with equal membership from TGCCG and the Derby and Derbyshire CCG. This transition process concluded on 30 June 2022 with the successful and safe transition of responsibility for Glossop health provision into DDICB on 1 July 2022.

The four established workstreams were:

- Finance, Contracting, IT and Primary Care/Estates
- Statutory Duties and People
- Communications and Engagement
- Neighbourhood Development

2.5 Each workstream met monthly to 6-weekly and was led by a Senior Responsible Officer from either TGCCG or DDCCG (or jointly) with responsibility for achieving a set of key deliverables. Workstream members were specialists in their field and able to commit time and expertise to achieving the goals. The workstreams were accountable to the Steering Group (meeting monthly) which in turn reported to the Transition Assurance groups within the respective CCGs to provide assurance on progress and risk management.

Decisions requiring DDCCG approval were also taken through formal governance groups, including the Clinical and Lay Commissioning Committee, Engagement Committee and Audit Committee as well as through local NHSE/I Midlands Transition Assurance. Additional project management resource was funded by NHS England to support the transition.

3. Alternative Options Considered

3.1 Alternative options were not considered due the mandated amendment to the boundary announced by the Secretary of State for Health and Social Care.

4. Implications

4.1 As part of the transition, DDICB inherited 39 contracts for the provision of various aspects of healthcare - with contracts split in the following way:

- 14 service contracts for the provision of general acute services
- 9 service contracts for the provision of community health services
- 8 service contracts for the provision of mental health services
- 8 service contracts covering a range of other services, including, NHS111, 999 and primary care out of hours.

4.2 Work continues to understand how commissioning arrangements, enshrined in these contracts compares with those arrangements that DDICB works to. A particular focus in this regard is to understand how policies on clinical treatments differ. In the meantime, all services will be maintained without change and the flow of patients through all services remains unaltered.

5. Consultation & Engagement

5.1 Consultation on this transition was not undertaken due to the boundary change being mandated by the Secretary of State for Health and Social Care. Views were collected from local stakeholders prior to the Secretary of State for Health and Social Care's decision making. In making the decision, the Secretary of State outlined that there was no local consensus in this area and while the historic partnership and strong relationships developed in Tameside and Glossop were noted, the decision was taken based on a consideration that the benefits of coterminous boundaries outweighed the challenges. The benefits of the decision are that alignment enables more opportunities for joined-up working with the local authority and the creation of joined-up plans for prevention and population health to improve provision for local people as well as greater alignment between community, mental health and ambulance service provision which provide a county-wide service.

5.2 The local NHS has worked closely with community leaders from the Glossop area to understand local sentiment and taken steps to help alleviate concerns. This has included days spent in Glossop speaking with local people and answering their questions, and such opportunities continue. A designated area was created on the JUCD Engagement Platform to provide updates and collect feedback from residents: https://derbyshireinvolvement.co.uk/glossop-ics-transition

5.3 A recurring concern from local people has been the likelihood of a change in access to services, or a loss of services due to the boundary change, along with the potential impact on staff. It was confirmed from an early point that the decision itself would not impact any individual patient's right to choose or use services outside of their ICS, nor would the amended boundary mean that any local services would change because of the transfer. As with any health and care system, services may naturally evolve over time to ensure to continued improvement of

integrated care for local people. Local people and service staff will be involved in those discussions as usual.

5.4 Staff working for Tameside and Glossop CCG at the point of transfer were covered by NHS England's employment commitment for colleagues impacted by the legislative changes. All TGCCG staff had their employment transferred to the new Integrated Care Board for Greater Manchester on 1 July 2022. Staff working in NHS provider organisations that serve patients from Glossop also saw no change because of the transfer. Patients continue to access services in the same way, have the same choices of care available to them and existing patient pathways, for example into the Manchester health system, continue. General Practice became part of the Derbyshire Primary Care Network and Place Alliance arrangements, with some change in relationships and geographical integration, but services to patients remain the same.

5.5 Services may naturally evolve over time to ensure to continued improvement of integrated care for local people, and staff will be involved in those discussions as usual. A commitment was given to the residents of Glossop that no services would be changed for a minimum period of 12 months following the change to boundary, therefore before 1 July 2023. Any future proposals will be discussed with the Improvement and Scrutiny Committee – Health at the appropriate time.

6. Background Papers

6.1 The full report outlining the boundary decisions by the Secretary of State for Health and Social Care is available on the Department of Health and Social Care website.

7. Appendices

7.1 Appendix 1 Implications.

8. Recommendation(s)

That the Committee:

1) note the process for the transition of healthcare arrangements into the Derby and Derbyshire Integrated Care System from 1 July 2022;

2) note the engagement undertaken to build and sustain relationships with local community leaders; and

3) note the process currently being undertaken to understand variation on health service provision across Derbyshire.

9. Reasons for Recommendation(s)

9.1 To provide assurance and transparency on the background to change and the ongoing processes for arranging healthcare for the whole population of Derbyshire.

Report Author:

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Zara Jones, Executive Director of Strategy and Planning
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Appendix 1

Implications

Financial

1.1 The budget for the provision of NHS services

Legal

2.1 Alongside the ICS due diligence process for the closedown of DDCCG and initiation of DDICB, there was a process of due diligence for the transition of Glossop into DDICB to provide assurance to DDCCG's Audit Committee, Chief Officer and NHSE/I Midlands that the Glossop transition programme followed due process. This process identified any assets and liabilities that DDICB would be responsible for following transition and included staff and property (in its widest sense). This information was included in the Schedule of Staff and Property Level 3 template shared with NHSE/I Midlands together with the letter of assurance from TGCCG's accountable officer to DDCCG's accountable officer.

2.2 During the transition period, colleagues from both DDCCG and TGCCG made connections to share knowledge and information about services and service delivery. They discussed service challenges and variations in provision.

Arrangements were made, via an approved data sharing agreement, to share 'Live' caseload information through a secure share point to facilitate safe transfer of clinical cases from TGCCG to DDCCG case managers. Clinical cases were transferred appropriately in time for the transition on 1 July 2022.

Human Resources

3.1 Implications described in Section 5.4.

Information Technology

4.1 Implications described in section 2.1 above.

Equalities Impact

5.1 Equality Impact assessments were completed for a range of issues in relation to this boundary change. These included Commissioning for Individuals, Continuing Healthcare and Individual Funding Requests.

Corporate objectives and priorities for change

6.1 The overarching aim of the Glossop Transition Steering Group was to ensure the safe transfer of healthcare commissioning responsibilities from TGCCG to DDICB on 1 July 2022, including full due diligence, assets transfer and reassurance and transparency for local patients that their health services would remain unchanged due to the boundary change for a minimum of 12 months. These objectives were felt to be successfully delivered.

Other (for example, Health and Safety, Environmental Sustainability, Property and Asset Management, Risk Management and Safeguarding)
Not applicable.

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FOR PUBLICATION

DERBYSHIRE COUNTY COUNCIL

IMPROVEMENT AND SCRUTINY COMMITTEE – HEALTH

21 November 2022

Report of the Integrated Care Board

Derby and Derbyshire ICS Mid-year Financial Update

Context

This report covers the aggregate financial position for the five NHS providers across Derby and Derbyshire as well as the ICB with its primary care, commissioning, Prescribing and CHC responsibilities. The total annual allocation for the system stands at £2.9bn, and when the 22/23 annual plans were compiled, there was a commitment to breakeven. However, after assuming a 3% efficiency would be achieved across the board, there was still a residual gap of £65m for breakeven to be achieved. System partners accepted this challenge and work continues to close this gap despite services being under unprecedented operational pressure.

The Current Position

For the period ending 30 September 2022 the system has an aggregate overspend of £29.3m and is now forecasting a gap to breakeven by the year end of £39.8m: a reduction of £25.2m from the £65m referenced earlier. This needs to be viewed in the context that the national allocation formula assumed COVID costs would cease by 30 June 22, whereas it's widely acknowledged that COVID remains with us: plus, the rapid increase in the cost of living affects the NHS like it affects all parts of society. The additional cost burden these two items have created for the NHS total £8.1m and £6.3m respectively. These pressures are included within the residual gap of £39.8m referred to above.

Clearly there are also cash implications with running a deficit which itself puts added challenge into capital investment plans but currently we are continuing

to commit to break even by the year end and are making strides in this direction. Accordingly capital plans are currently not affected.

All the above needs to be viewed alongside the determined effort that is being made to meet the urgent care pressures, clear the backlog in elective waiting times and work alongside Local Authority partners in maximising the out of hospital capacity for safe discharge. Not surprisingly all this requires people on the ground, so our biggest challenge is finding scope for efficiencies whilst also needing to recruit. In the current climate we are therefore focussing hard on productivity, both in core hours and at weekends/out of hours. For the medium term we are also examining all options for transforming clinical pathways using digital and flexible working/pooling arrangements.

Financial Outlook

As is to be expected, any non-recurrent solutions to achieving breakeven in 22/23 may have implications for 23/24 and beyond so in parallel with achieving break even for this year we are modelling for 23/24 in advance of formal notification of allocations from NHSE- expected in the new year. There are many uncertain variables in predicting this allocation, so the immediate focus is on reducing our cost base and obtaining maximum value from the £2.9bn that we do have rather than focussing on the £39.8m that we don't. For these reasons It is too early to be talking specific Income and Expenditure positions for future years but we expect clarity from the national team in the new year.

System Working

Positively, the first few months since the creation of the ICB has seen genuine collaboration on our collective financial challenge by all our providers, which bodes well for the future. It must be acknowledged that two providers are now formally posting an Income and Expenditure surplus at the 22/23-year end to partly offset the deficits that are appearing in the others. This is critical for maximising value out of the £2.9bn and reputationally is important for the system. The ambitious aim is to ensure every organisation achieves break even this year as this is the most secure way of maintaining liquidity. It also helps deliver confidence to the public that we are well led and using public resources appropriately. Thus, there is real evidence of continued openness and joint planning alongside managing the operational challenges our front-line colleagues are facing relentlessly. Equally as we plan for future years, our aspiration is to protect additional resources to help address the health inequalities and wider population health issues across our communities. A specific commitment in this regard is being modelled for 23/23, which by association, and with a cash limited allocation, will put added financial pressures on our provider/primary care organisations. Similarly, conversations

are already underway across health and local authority finance teams to ensure we can support each other's challenges in a mature and strategic manner; and seamlessly align our priorities.

Summary

In short, the operational challenges facing the Derby Health System are unprecedented as we emerge from the pandemic. These have been exasperated by the work force challenges both health and care are experiencing, which ultimately means that financially we have a significant challenge. Despite this environment the evidence demonstrates the financial gap is closing for 22/23 and we remain positive that Income and expenditure break even by the year end is eminently doable. Harnessing now, the genuine collaboration and collegiate working that is already across health and care providers is the most secure way of delivering affordable, safe, care and improving population health for 23/24 and beyond.

Recommendation

That the Committee notes the report.

Keith D Griffiths
Chief Finance Officer
Derby and Derbyshire ICB November 2022

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DERBYSHIRE COUNTY COUNCIL

IMPROVEMENT AND SCRUTINY COMMITTEE – HEALTH

21 November 2022

Report of Healthwatch Derbyshire

Insight, Intelligence and Action (IIA) Report

1. Purpose

1.1 To present to the Committee the Healthwatch Summary report demonstrating current key and emerging themes and priorities for Healthwatch Derbyshire.

2. Information and Analysis

2.1 Healthwatch Derbyshire gather public and patient feedback on health and social care services. Feedback is shared with providers and commissioners as examples of patient experience. Gathered insight and intelligence directs and contributes towards Healthwatch Derbyshire key themes and priorities.

3. Alternative Options Considered

3.1 N/A

3.2 N/A

4. Implications

4.1 N/A

5. Consultation

5.1 N/A

6. Background Papers

6.1 N/A

7. Appendices

7.1 Full copy IIA Report November 2022

8. Recommendation(s)

That the Committee accepts and notes the report.

9. Reasons for Recommendation(s)

To inform the Committee of the roles and responsibilities of Healthwatch Derbyshire and current themes and priorities of its work in the county.

Report Author:

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Engagement & Involvement Manager
Healthwatch Derbyshire

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Appendix 1

Implications

Financial

1.1 N/A

Legal

2.1 N/A

Human Resources

3.1 N/A

Information Technology

4.1 N/A

Equalities Impact

5.1 N/A

Corporate objectives and priorities for change

6.1 N/A

Other (for example, Health and Safety, Environmental Sustainability, Property and Asset Management, Risk Management and Safeguarding)

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healthwatch Derbyshire

Insight, Intelligence & Action (IIA) Report

November 2022

About Us

Healthwatch Derbyshire is an independent voice for the people of Derbyshire. We are here to listen to the experiences of Derbyshire residents and give them a stronger say in influencing how local health and social care services are provided.

We listen to what people have to say about their experiences of using health and social care services and feed this information through to those responsible for providing the services. We also ensure services are held to account for how they use this feedback to influence the way services are designed and run.

Healthwatch Derbyshire was set up in April 2013 as a result of the Health and Social Care Act 2012 and is part of a network of local Healthwatch organisations covering every local authority across England. The Healthwatch network is supported in its work by Healthwatch England who builds a national picture of the issues that matter most to health and social care users and will ensure that this evidence is used to influence those who plan and run services at a national level.

Continuing Key Themes and Priorities

Access to GP Appointments

The ways in which patients access their GP services is changing, the Covid-19 pandemic has accelerated many of these changes but even prior to the pandemic many GP's were increasingly offering a wider range of ways to access their services.

Face to face appointments are traditionally how many patients would access their GP, however this is not the only option available, and for some patients and their individual health concerns, alternative appointments may be more suitable and even preferable for their lifestyle.

In response to the Covid-19 pandemic, GP surgeries offered alternatives to face to face appointments that included access to care moving to a triage system, online bookings, and video and phone consultations.

Part of the role of Healthwatch Derbyshire (HWD) is to understand the experience of people using these services and to give people the opportunity to speak up and have their voices heard. Collecting feedback and providing opportunities for people to share their experiences with HWD means that we often hear about the issues and difficulties people face. As services started pandemic recovery and a level of normality returned, patients were contacting us with their frustrations at not being able to access face to face appointments. The perception from some patients appeared that they expected GP services to be delivered in the same way as before the pandemic.

The comments that HWD was hearing from patients prompted us to carry out some further work in gathering feedback to give an impression of people's experiences of accessing GP appointments.

Throughout Summer 2022 Healthwatch Derbyshire ran a survey to hear from patients, carers, and the wider public, offering an opportunity to share their views and recent experiences of accessing their GP. Feedback from the survey will help local health providers to understand how the ways in which appointments are accessed effects patients.

Over 1300 responses were received to the survey. The final report, findings and recommendations are currently being collated.

Access to Dentistry

Following on from previous worked carried out by HWD is 2021, access to dentistry remains a key theme for HWD. Unfortunately, HWD continues to hear from patients who cannot access routine dental treatment, or those who have been informed that their dentists are moving to private practice. Members of the public tell us that they simply cannot find a dental practice accepting new NHS patients.

HWD are working with the local dental network and commissioners to be informed about guidance for the public, and have also created a widely shared and well received infographic around what steps to take if you cannot find a dentist, as well as if you require urgent treatment.

HWD volunteers are continuing to review the Find a Dentist website, and feedback to us their findings. HWD engagement officers are contacting those dental practices with out of date or no information, and this will also be shared with commissioners to encourage practices to update information.

HWD are involved with the Dental Transformation Board and have had sight of the NHS England Midlands Region Dental Strategy 2022-2024. We continue to have good relationships with commissioners, local dental network chairs and are part of a Healthwatch dental network.

Discharge from Hospital

In response to patient feedback regarding the hospital discharge process, HWD have begun discussions with the relevant hospital teams, and other organisations including those in the voluntary sector involved in the Home from Hospital service.

We understand that there are other work streams looking at the process involved with the flow of patients through hospitals, using patient experience to inform training resources for professionals, as well as the role that discharge from hospital can play in easing winter pressures.

HWD continues conversations with local CVS to understand how feedback is collected on patient experience of hospital discharge and the Home from Hospital service. We will work with hospital

trusts to understand more about the discharge process, in order to compare this to patient experience. Any information collected will be shared to contribute to the projects undertaken by other work streams.

Closure of DCC Day Care Centres

HWD have closely followed Derbyshire County Councils consultation into the proposed closure of 8 day centres and a redesign of the service. We promoted opportunities for local residents to take part in the consultation, and have been kept informed as to the outcome of the consultation and the decisions taken.

It has now been confirmed following a decision made by Cabinet that the proposed closures will take place, and that a new model will be put in place which includes the expansion of a Support Service Team and Community Connectors. The eight centres will be closed in phases over the next 12 months, with 4 existing day centres to remain open.

We are keen to understand how these changes have been communicated to those who use the services, and how they will be supported during the transition. Through our links with Derbyshire Carers Association we are gathering comments and feedback.

It is important that once the new model is in place and being used, and those accessing the service have experience of the new model, that feedback is sought from those impacted by the changes and using the new model to gauge whether the redesigned service continues to meet their needs.

Potential Key Themes and Priorities

The following items are potential key themes and priorities that have been identified through various methods including; patient/public feedback and comments, signposting and enquiries, and Healthwatch England key themes.

Maternal Mental Health

HWD are supporting the Healthwatch England campaign around Maternal Mental Health. With one in four women experiencing mental health problems during pregnancy and in the first year following the birth of a child, support from maternity services can significantly impact their mental health and wellbeing. A recent Healthwatch England review of the evidence of 2,500 people's experiences of maternity services showed that, overall, people's experiences are worsening.

Healthwatch England are launching a national survey to better understand what is working and what needs improving for people who develop mental health difficulties relating to their maternity experience. We also want to know whether the six-week checks meet the needs of new mothers and birthing parents.

The goal of the campaign is to improve mental health support in maternity care and ensure birthing parents are supported before, during and after birth.

HWD will gather local data and responses to contribute towards the national survey, as well as understand the experiences of maternal mental health support for new mothers and birthing parents in Derbyshire.

Increasing numbers of referrals to Health/Mental Health Advocacy

A core function of HWD is the gathering and receiving of comments, feedback and people's experiences of using health and social care services. Part of this often includes signposting to other organisations for help and support.

As part of a regular review of comments, signposting and enquiries there indicates that there are increasing numbers of referrals to health/mental health advocacy services. The majority of referrals are to Derbyshire Minds for their advocacy service. We are working with Derbyshire Mind to establish the number of referrals they receive via ourselves and whether HWD could offer any support into the process, and how we make referrals. This would also assist in gaining an understanding of waiting times in order to inform public, as well as the demands upon this service.

Engaging with Children and Young People

Healthwatch Derbyshire were invited to join the JUCD Children's Board following on from a previous piece of work on engaging with young people. The Board were impressed with the previous work carried out and saw it as impactful and influential.

In September 2022 HWD was given the opportunity to engage with young people on a face to face basis at two further education colleges in Derbyshire as part of their Fresher's Fayres. Due to the length of time that had elapsed since quality discussions had taken place with young people, it was vital to use the opportunity to find out what young people do to help them thrive and keep physically and emotionally. Over 200 young people shared their views on their physical & emotional wellbeing.

The key issues raised included, a desire from young people for information about help and support to stay well. There is a lack of knowledge with young people that can be provided by the health and care system, using trusted sources that are easy to access and understand. The need for greater availability and access to exercise opportunities, and concerns around the cost of accessing activities and gyms. Overall young people have a good knowledge and awareness of the need to stay physically and emotionally well.

HWD see the value of engaging with young people as future adults, and users of services which directly effects them. HWD continues to share information with JUCD Children's Board as they establish their emerging priorities for children and young people.

Referrals to care

This is a Healthwatch England theme looking into people's experiences of delays or problems when being referred for care. Healthwatch England were gathering experiences between August to September 2022. HWD have supported and shared opportunities to gather feedback and will request any local data when available. A report is due in January 2023 and HWD will review this report for local data and insight to inform future work around referrals to care.

Contact

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FOR PUBLICATION

DERBYSHIRE COUNTY COUNCIL

IMPROVEMENT AND SCRUTINY COMMITTEE – HEALTH

21 November 2022

Report of the Director of Legal Services

Review of Section 75 Agreements – Final Report

1. Purpose

To inform the Committee of the outcomes of the review of the use of Section 75 Agreements between the County Council and partner organisations and to seek approval to the report recommendations.

2. Information and Analysis

The Committee, at its meeting on 17 January 2022 agreed to undertake a review of the use of Section 75 Agreements between the Council and partner organisations in the joint provision of Adult Care and Health Services. The health and wellbeing of Derbyshire people is a crucial part of the Council Plan and the development of effective and efficient partnership working arrangements is important for both the County Council and local NHS Commissioners and Providers.

Partnership working has developed over recent years between the County Council and external organisations. This includes the establishment of the local Integrated Care System (ICS) which was formally adopted on 1 July 2022, and which saw the transfer of the Derby and Derbyshire Clinical Commissioning Group (CCG) to the new Integrated Care Board (ICB). The national initiative of introducing and developing Integrated Care Boards to deliver Integrated Care Systems is intended to ensure greater effective and efficient collaboration between Local Authorities and NHS partners when delivering health and social care services across the county.

This review by the Health Scrutiny Committee was proposed by Cllr. Jean Wharmby, the Committee Chairman. The aim of the review was to consider the current use of Section 75 agreements between the Council and other service commissioners and providers. The review would investigate the

benefits – or otherwise – of the use of Section 75 Agreements and identify any areas for improvement or potential extension of their use.

Section 75 of the NHS Act 2006 allows partners (NHS bodies and councils) to contribute to a joint fund which can be used to commission health or social care related services. This power allows a local authority to commission health services and NHS commissioners to commission social care. It enables joint commissioning and the commissioning of integrated services.

To facilitate the review, a working group of Committee Members was established with representatives from the Majority and Minority Groups. Cllrs. Wharmby, Foster, Musson, Sutton and Allen were appointed to the working group and a series of meetings was held to obtain information from appropriate officers.

Research and Information Gathering

Throughout the review, meetings were held with officers from the County Council's Public Health and Adult Care teams, Commissioning and Finance Officers and staff of one of the Council's major NHS partners, Derbyshire Community Health Services (DCHS).

These meetings enabled the working group Members to receive the following information:

- Section 75 of the NHS Act 2006 is a vehicle to make contracts for services. Officers believed that this is preferable to the traditional method of contracting in some circumstances, as it allows for changes to be made to service specifications quickly and easily.

- Services provided via Section 75 Agreements take up a substantial spend of the Public Health Grant. Details of what the local Public Health Grant will be over future years are not available well in advance and this can sometimes make it difficult to plan long-term spending on all services, including Section 75 Agreement services.

- Prior to the use of Section 75 Agreements, NHS provided services were commissioned and provided under tendering processes. The tender process can be challenging for both commissioners and service providers for a number of reasons;
    - It can be difficult for the provider organisation to be involved in shaping the requirements of new services due to the competition perception issue.
    - Providers may worry about losing the service contract and the impact this has on staff wellbeing due to uncertainty created by the tendering process
    - Staff may also worry about losing their jobs if a tender bid is unsuccessful and sometimes this results in staff seeking

employment elsewhere, resulting in the provider losing good, experienced employees.

- The commissioner risks losing a good provider, should they choose to not bid in for a newly tendered service.

- There was a good relationship between the Council's Public Health and Adult & Social Care commissioners and NHS service providers which enabled them to work together to improve services without the concern of potentially losing the contract. Section 75 Agreements formalise these arrangements and allow Council and NHS officers to collaborate and create a partnership agreement which has mutual risk and benefit for both parties.

- Under the tender method, if the provider was at risk of being unable to offer a particular element of the service – however small – they were at risk of defaulting on their full contractual requirement. This would have a negative impact on any future contracts the provider bid for as it is legally required that this be declared in procurement processes. Section 75 Agreements allow an "improvement aspect" to agreements where both parties can work towards continual improvement without impacting on the service during the process.

- Under Section 75 Agreements, officers from both the Council and NHS organisations are in constant dialogue to provide services most effectively, especially in reacting to changes to population and community needs. The tender process is more restrictive whereas Section 75 Agreements allow a quick response to changing needs. Staff particularly appreciate this as they can raise concerns about any aspect of a service which they feel needs altering, without the risk of endangering contract commitments under a tender. This helps ensure that the patient/service user is always at the forefront of any decisions about their care.

- The tender process allows bidders from organisations from anywhere in the UK who often use a set model of service provision and may include an element of profit margin within their financial modelling. Whilst this may be in keeping with achieving best value for money, the experience and knowledge of local services providers can be more important when developing specific services for individual clients. As an example, the Section 75 Agreement for Children's Services has ensured services are delivered by a local provider with significant knowledge of the needs of Derbyshire children, along with the benefit of a vast number of long-established connections with professionals and voluntary organisations. Section 75 Agreements facilitate the sharing of knowledge and expertise between parties. This helps structure the best method of providing a service using systems established with partners that have extensive experience and knowledge of the needs of local service

users. This ultimately results in all parties contributing to a seamless service for individual clients.

- The tender process can also be intense for the commissioner, requiring resources to go through the process at the end of which, nationally, approximately 85% of contracts are awarded to the incumbent provider. In addition, Section 75 Agreements offer the benefit to the commissioning body in that they are not at risk of losing a very experienced provider. This was highlighted during a meeting with officers from Derbyshire Community Health Services (DCHS) who believed that this has been recognised by the Council's Director of Public Health who supported the use of Section 75 Agreements.

Potential Improvement to Section 75 Agreement arrangements

- The use of Section 75 Agreements has already improved the historic relationship between contracting parties which had previously been perceived as a relationship where "power" was a key factor. For example, the provider was vulnerable to financial penalties being imposed if an area of service provision was underperforming. This could result in the service provider focussing on those KPIs that potentially risked the financial stability of the contract and therefore detract from considering the performance of the service as a whole.
- A Strategic Governance Group has been established to oversee joint service provision but, due to delays imposed by the covid pandemic, there was still work ongoing to embed how the group operates. When planning joint care services, it is important to maximise the benefit of having the right people around the table who can offer an understanding of needs for a service, what should be provided, and how.

- It was suggested that the Strategic Governance Group should link closely to the Joined Up Care Derbyshire (JUCD) Children's Board. The JUCD Children's Board has real potential to do further early intervention and prevention work. Providing key services at an early stage in a child's life would reduce the need for additional services further down the line. Officers who raised this suggested that there should be a higher profile/presence of early intervention and prevention services within JUCD.

Financing Care Packages

- In order to establish if the use of Section 75 Agreements could be used more widely across jointly funded care provision, the working group met with an Accountant in the Corporate Services and Transformation department who had previously worked on Adult Care funding and the Service Manager for the commissioning team responsible for providing care packages and supported living for young people with disabilities (including learning disabilities). Although they were not directly involved

in funding services via Section 75 Agreements, they had experience of alternative funding arrangements. The review working group asked for details of their experiences of joint funding arrangements.

- The officers explained that individuals' needs may be complex and/or consistent and that these can only be met in conjunction with the provision of housing. In such cases the Council relies heavily on the private sector.

- Care packages can give rise to significant costs with support staff charges amounting to up to £3500 per week for one staff member and total care packages costing up to £10000 in some cases.

- On occasion, Sec. 117 of the Mental Health Act and Continuing Healthcare funding results in many care packages being jointly funded by the Council and NHS partners. Periodically, disputes can arise as to the funding arrangements, particularly as eligibility criteria differs between the two Authorities/agencies. Whilst there is an expectation for the parties to work collaboratively to resolve funding disputes, there would be significant benefit in developing a joint local protocol to provide a clear procedure to determine the responsibility for funding and for dispute resolution to avoid protracted delays occurring when agreement is not possible. Disputes can give rise to large cost and resource implications with the need for ongoing meetings involving staff from the Council and Mental Health Services.

- Section 75 of the NHS Act 2006 does not govern funding responsibility for joint care packages nor provides any framework for dispute resolution. However, as Sec 75 Agreements are used where both sides contribute money to a pooled budget, there could be scope to set out in detail the expectation of the parties as to the relative areas of responsibility in joint packages of care. This, in turn, should reduce the volume of disputes arising.

- It was noted that the Adult Social Care Department was looking at overarching systems as part of its work with the ICB. This could be a good time to raise the matter of parity of funding with senior managers of both the Council and NHS organisations.

- Although the concerns raised during the meeting were not directly relevant to the review of the use of Section 75 Agreements, the working group had a subsequent meeting with Adult Social Care and Health senior managers to explore this issue further. Details of these discussions are set out in the following section.

Information from Adult Care Senior Management Team

The review working group met with Linda Elba-Porter, Adult Care Service Director, Partnerships and Transformation and Dominic Sullivan – Adult Care Assistant Director, Prevention.

Cllr Wharmby outlined the remit of the Health Scrutiny Committee's review of the use of Section 75 Agreements and the discussion the working group members had had previously with officers (the Accountant from the Council's Finance team and the Adult Care Commissioning Service Manager) who had raised the issues they had with joint funding arrangements. These concerns had been shared with Linda and Dominic previously and the meeting was an opportunity for Members to learn more about the process of joint funding with NHS partners and how the system would change with the formalisation of the ICS and the introduction of the ICB.

Linda Elba-Porter gave an overview of the strategic perspective for joint funding services between the Council's Adult Social Care Service and NHS partners. During the Covid pandemic, follow-on care for anyone leaving hospital was funded by the NHS via Government funding. This included other streams of funding such as "Continuing Health Care", which is fully funded by the NHS, "Joint Funding" with joint agreement between partners, and funding under Section 117 (of the Mental Health Act) Agreements which is for people with complex mental health needs and is usually provided jointly by Adult Care and NHS partners. These funding streams were used prior to the covid pandemic and are continuing post-covid.

Service provider partners are now in a new era with the formalisation of the ICS and funding arrangements between Health and Social Care will be more integrated. To facilitate this, there are a number of initiatives such as "Living Well", which is a joint initiative with the NHS to help people with early-stage dementia and "Team Up" which addresses how teams work together to provide the right help at the right time.

In addition, there has been a "deep dive" investigation into joint care packages. The care packages referred to by the finance officer and the commissioning service manager were for people with very complex needs and these were much more difficult to agree. The Council and the NHS are currently looking at better ways of working together to provide different and complex care packages.

From a national perspective, more funding is coming into Adult Social Care via the NHS and it is recognised that ill-health prevention is as important as health care. The new ICS mechanism is a good opportunity to channel this funding to Adult Care Services and the use of Section 75 Agreements will be changing as a result. However, it was noted that, at present, no legislation had been tabled around future funding therefore, Section 75 Agreements will continue to be used positively until any changes are made to legislation. The Director and

Assistant Director undertook to notify the Committee of any developments in this respect.

The working group members stressed that they believed there should be a robust monitoring and auditing process, both for Section 75 Agreements and any new arrangements introduced via the ICS/ICB. It was important that Members were reassured that the Council was making the best use of available funds.

Summary of key findings

The review working group wishes to highlight the following points:

- The way both parties in a Section 75 Agreement work together seems a good approach to adopt for the effective and efficient provision of services. It offers an improvement on the contract tendering method in some circumstances, and it especially helps retain services provided by organisations that have local knowledge and expertise and not by remote, profit based organisations.

- The review outcomes should include the recommendation that Children's Services Early Intervention and Prevention receive a high priority with the JUCD Children's Board.

Report to Cabinet

If agreed by the Committee, the review outcomes will be reported to Cabinet with recommendations that any actions to facilitate improvements be agreed by Cabinet.

The review findings and recommendations will also be shared with the Council's partners who have participated in the review.

The implementation of recommendations accepted by Cabinet and the Council's Section 75 Agreement partners will be monitored by an action plan which will identify those who will be responsible for any changes and will set out a timeline for implementation.

After an appropriate time, the Committee may wish to revisit any areas where changes have been recommended, to ascertain the success – or otherwise - of any new arrangements.

3. Alternative Options Considered

3.1 None

4. Implications

4.1 Appendix 1 sets out the relevant implications considered in the preparation of the report.

5. Consultation

5.1 Throughout the review process, the working group has engaged with service commissioners, providers to enable them to contribute.

6. Background Papers

6.1 Documents held on behalf of the Committee by the report author.

7. Appendices

7.1 Appendix 1 – Implications.

8. Recommendations

That the Committee:

a) Notes the findings of the Review of Section 75 Agreements;
b) Recognises the benefits of the use of Section 75 Agreements, in appropriate circumstances, between the Council and NHS partners and supports their continued use.
c) Promotes that the Children's Services Early Intervention and Prevention receive a high priority with the JUCD Children's Board.
d) Submits the findings of this review to the Integrated Care Board and the Integrated Care Partnership to recommend that future joint funding structures between the Council and the NHS are a key element of the new partnership working arrangements to ensure parity and transparency for all funding contributors.
e) Submits a report to Cabinet seeking agreement to the recommendations of this report.

9. Reasons for Recommendation(s)

The Review, undertaken by this Committee, found that the use of Section 75 Agreements is beneficial to officers of the County Council and those of our NHS partners, in providing a more streamlined mechanism for joint funding health and care services. The Committee wishes to highlight the advantages of the use of Section 75 Agreements and suggest that their use could be extended further across other health and care options.

With the development of the local Integrated Care System (ICS), the formal adoption of ICS's nationally on 1 July this year, and the transformation of the Derby and Derbyshire Clinical Commissioning Group to the new Integrated

Care Board (ICB), it is very timely that this review has investigated methods of joint funding between parties to the ICS.

The outcomes and recommendations of this review should be shared with ICS partners with a view to enhancing relationships involved in the joint provision of health and care services across the county.

Acknowledgements

The review working group would like to thank the following contributors to this review:

Derbyshire County Council
Dean Wallace (Former Director of Public Health)
Helene Denness (Assistant Director of Public Health)
Abid Mumtaz (Adult Social Care & Health)
Carol Ford (Adult Social Care & Health)
James Gough (Adult Social Care & Health)
Dominic Sullivan (Assistant Director ASCH - Prevention)
Linda Elba-Porter (Service Director ASCH – Transformation and Partnership)
Claire Hendry (Business Partner, ASCH – Finance and IT Services)

Derbyshire Community Health Trust
Jayne Needham – Associate Director; Strategy, Health and Wellbeing
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Implications

Financial

1.1 The review will promote that the best use of available budgets are maximised in commissioning and providing health and care services across the county.

Legal

2.1 The review acknowledges that joint funding arrangements between the Council and partner organisations will adhere to legal regulations as appropriate.

Human Resources

3.1 n/a

Information Technology

4.1 n/a

Equalities Impact

5.1 n/a

Corporate objectives and priorities for change

6.1 The corporate objectives and priorities for change are embedded in the formalisation of the local Integrated Care System and the partnership arrangements with the Integrated Care Board.

Other (for example, Health and Safety, Environmental Sustainability, Property and Asset Management, Risk Management and Safeguarding)

7.1 n/a

FOR PUBLICATION

DERBYSHIRE COUNTY COUNCIL

IMPROVEMENT AND SCRUTINY COMMITTEE – HEALTH

21 November 2022

Report of the Integrated Care Board

Preparing for Winter

1. Purpose

1.1 To brief the Committee on the substantive aspects of NHS Derby and Derbyshire Integrated Care Board's plan for winter (November 2022-March 2023).

2. Information and Analysis

2.1 In August 2022, NHS England published its expectations on how Integrated Care Boards (ICBs) should be increasing capacity and operational resilience in urgent and emergency care ahead of this winter. This was supplemented with extra guidance in October 2022, focussing on further action that ICBs should be taking.

2.2 This document is our response and details the action that we will take to deliver the 6 key priorities for the ICB over the next period, specifically:

- Protecting people from COVID-19 and Influenza
- Supporting people in their own home
- Providing an urgent response for those most in need
- Enhancing the resilience of General Practice
- Reducing discharge delays from hospital

- Reducing the backlog for elective and cancer care

3. Alternative Options Considered

3.1. Alternative options were not considered.

4. Implications

4.1 We go into this winter on the back of a spring and summer period which has seen key aspects of health and care service provision operating at full capacity and levels of escalation like the last winter period – with little opportunity to reduce.

4.2 This is an unpreceded situation, with:

- The level of 'exit-block' from our acute hospitals being the key structural issue which is driving front end acute pressures (over-crowding, long waits for admission and ambulance delays in the ED) and a has a direct opportunity cost of lost elective operating time.

- General practice delivering more appointments than any previous period recorded – with close to half of this output servicing on the day demand.

- Community Nursing Teams are serving more demand of a complex nature.

4.3 Whilst this plan is not focussed on the actions that are necessary to put these services, and others, on a more sustainable trajectory in the long term, it is focussed on creating a greater level of operational resilience over winter which hopefully provide a springboard going into 2023/24.

4.4 An assessment of our position against the key deliverables this winter is as follows:

Those areas where our plan is compliant to the ask of NHS England and there is sufficient confidence of delivery:

Requirement	Rationale
Rolling out the C-19 booster vaccination to c43,000 people.	We are ahead of trajectory in terms of vaccination numbers.

Matching last year's influenza uptake rate.	Confidence level based on the quality of our historic performance.
Ensuring that at least 70% of the urgent community response referrals are responded to within 2 hours.	Confidence is rated as high as we are currently within target range.
Implementing a universal community-based falls recovery service.	Impact is rated as high given the plan to deal with a large majority of the demand for level 1 and 2 falls that EMAS are currently dealing with. The confidence level is based on the specificity of the plan and the fact that it doesn't rely on a significant number of new staff.

4.4.1 **Areas where we have set out a compliant position, but there are issues of confidence in relation to delivery:**

Requirement	Rationale
Reducing the number of 78+week waits for general elective care to 0 by March 2023	Whilst we have set out a compliant plan with the expected level of impact, there is uncertainty on deliverability, particularly given that (i) the number of 78+ weeks wait is currently on an upward trajectory and (ii) we don't have a fully mitigated G&A bed position which therefore poses risk to our ambition to ringfence elective beds.
Increasing community capacity	Whilst we plan to increase community step down capacity, it is not of a sufficient level to meet demand and have a significant impact on reducing discharge delays - particularly P1 package of cares. Confidence is rated as medium given that sourcing staff has a degree of uncertainty to it.
Increasing general practice capacity	A 10% increase in on-the-day appointment capacity is sizable, particularly given the level of demand which is displaced to other parts of the system which is much less than this. Furthermore, the 'standing-up' of acute respiratory hubs, meets NHSE's requirements and will play an important role in enhancing the resilience of general practice over the winter. Confidence is rated as medium given that sourcing staff has a degree of uncertainty to it.

4.4.2 **Areas where we have set out a compliant position, but there are issues of confidence in relation to delivery:**

Requirement	Rationale
Reduce the 62+ day cancer waiting list to the pre-pandemic level by the end of the winter period	The number of 62+day waits is on a downward trajectory but impact of new referral demand on capacity not yet understood.
Improve category II 999 response times	Given the size of the gap between current category II response times compared to target, it is highly unlikely that we are to overturn the deficit in performance. This is based on two factors (i) EMAS are unable to source new crew capacity and (ii) there is insufficient evidence at this stage as to what level of crew capacity the new push model will release by reducing ambulance delays.

4.5. There are several risks which the ICB will be managing this winter:

Theme	Risk
Workforce	- **Ability to recruit** – which is pertinent to key initiatives within this plan e.g., the virtual ward programme and staffing community surge beds. - **Increased sickness absence** – no significant change to current absence rates has been assumed in provider plans. - **Staff availability due to industrial action** – no adverse impacts assumed in provider plans. - **Stability of the PVI sector** – there is a degree of uncertainty about the resilience of this sector over winter.
COVID-19	- **Burden of COVID-19 on bed occupancy** – current plans are predicated on COVID-occupancy being at between 5-8% over the winter period.
Safety	- **Clinical risk due to delays in accessing care** – Given that we are not anticipating seeing a material impact on category 2 response times, cancer long waits and delayed discharges, the risk to clinical safety associated within these issues has not been mitigated.

5. Consultation and Engagement

5.1. Raising awareness of the additional pressures this winter is vitally important. We are seeking to maximise every opportunity to communicate and engage with our public and patients, our staff, our partners and stakeholders and others to explain what we are doing together as a health and care system in response to the significant challenge that winter presents. This includes our investment in programmes of work which will help to mitigate the impact of increased winter pressures. Alongside this, we are also seeking to convey messages on areas where see increased risk across winter and to promote ways in which people can help to manage and limit their own risks through changes they can make for themselves.

5.2. There are three core communications priorities defined by, and in support of regional and national approaches to winter/surge communications and these are:

- Preparation - working to prepare for winter – how we're doing things differently
- Prevention / behaviour change – what you can do to help
- Performance - reputation management during winter – the NHS is here for you

5.3. We already have a strong and collaborative cross system approach and the communications and engagement functions across all system partners are working together to deliver priority messages and to encourage take up of initiatives and services. The following are examples of campaigns which are already live or planned to take place over winter:

- Covid autumn vaccination booster campaign – already underway
- Flu campaign – already underway
- Urgent Treatment Centres campaign to encourage people to choose wisely and attend the service most appropriate for their needs – launched 8 November
- NHS 111 campaign to encourage people to go to the NHS 111 telephone and online services – this is a year round, rolling campaign but will be amplified during the winter months.
- Emerging initiatives such as Virtual Wards and patient discharge messages to better support people at home – these are in development.

- Cost of living challenges and winter warm campaigns – these are local authority led and have been amplified by health partners since launch which will continue across winter.

- Workforce information and health and wellbeing messaging – this is a continual development programme of work to support colleagues with information on from both personal and professional perspectives.

The full winter campaign plan is described in the table below and to note that some of the phasing of the campaigns may change in response to changing or new winter pressures:

Campaign	Theme	Timeline
Covid booster	Nationally set but localised messaging	September to March
Flu vaccination	Nationally set	October onwards
Winter scene setting media	Link to weather	Early November
Investment in services PR campaign	Outline plans at winter outset to build upon over time	Early November
NHS 111 phase 1	Link to national and agree local themes	November to December
Urgent Treatment Centre 1	Position as alternative to ED unless life threatening - shorter waits, parking, live waits info	8 November launch
GP roles	Link to GP access messages	November to December
Condition management – know your numbers	Encourage self care - initial focus on heart (BP) but to include respiratory	November to January
Self-care (Health)	Complements LA activities	November - March
Discharge phase 1	Pre-Christmas discharge	December
Bank holiday	Repeat prescriptions	December to early January
Falls (Strictly no falling)	Link to weather	January to February
GP access	Post New Year surge	January to March
Urgent Treatment Centre 2	Shorter waits, parking, live waits	January to March
NHS 111 phase 2	To reflect current priorities - potential bad weather	February to March

Pharmacy	Build on access and 111 messaging	February to March
Discharge phase 2	Continued messaging linking to priorities	February to March
Mental health (24/7)	Helpline promo plus other services	Tbc
Severe weather	Reactive response and themed according to conditions at the time	Reactive
Potential and pipeline campaigns and budgets		
Reconditioning	SORG led - to build on CRH approach across the system	Tbc
Virtual Wards	Awaiting further detail and timescales and then quickly to development phase	Tbc
We Are The NHS	Nationally led recruitment campaign	Tbc
Rolling campaigns not ICB led or budget requirement		
Cost of living	Rolling – working with local authorities to amplify the messaging through system partner channels	September launch
Winter warm	Rolling – working with local authorities to amplify the messaging through system partner channels	Links to cost of living

We will be using a range of channels to reach our shared audiences and the collaborative approach of system partners is key to this to maximise our reach through both broad and targeted routes.

5.4. Our main channels include free organic channels such as media releases, website updates, social media, copy in partner publications and also paid for channels to include targeted social media, radio campaigns, online advertising, posters and other emerging innovative channels.

5.5. In addition to the traditional campaign routes, our Place networks, partner and stakeholder channels are particularly powerful ways of reaching into our communities and sharing key messages. This networking approach forms a cornerstone of our communications and engagement activities and as we progress with our campaigns across the winter, we will be providing key messages and toolkits for our partners to share.

5.6. An evaluation of the performance of all our campaigns will take be conducted throughout via a series of impact measures and analytics to enable us to measure success to inform our winter activities for this year and in the future.

6. Background Papers

None

7. Appendices

- Appendix 1 – Executive Summary – Winter Plan
- Appendix 2 – *Next steps in increasing capacity and operational resilience in urgent and emergency care ahead of winter* – NHS England, August 2022.
- Appendix 3 – *Going further on winter resilience plans* – NHS England, October 2022.

8. Recommendation(s)

That the Committee:

a) note the current state of the ICB's plan for winter.

9. Reasons for Recommendation(s)

9.1 To provide assurance and transparency on work that is being done to respond to the demands of winter.

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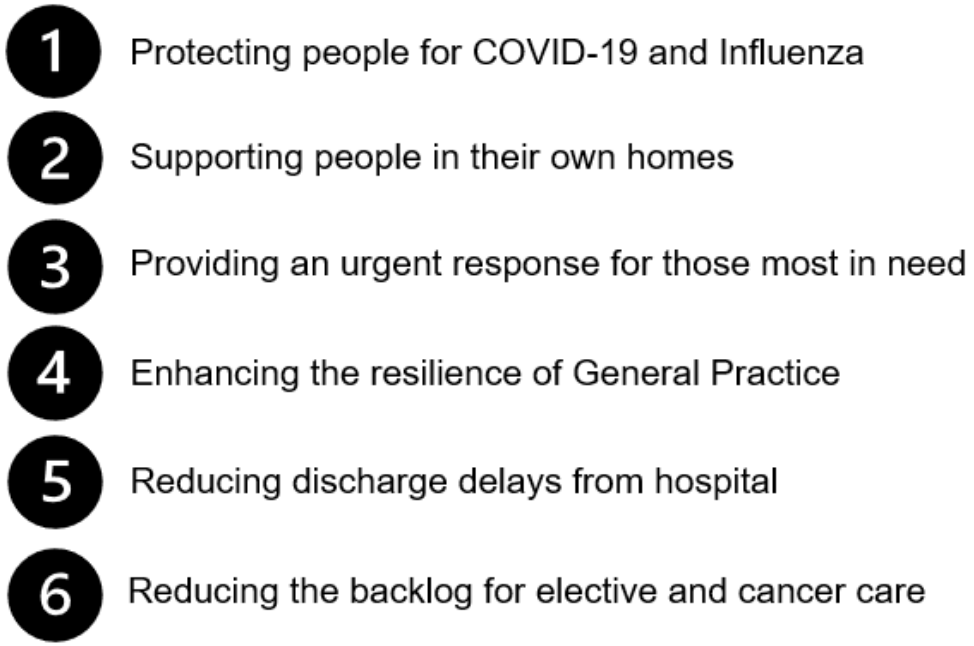
Our plan for the winter

November 2022 – March 2023

Executive Summary

Context

- We go into this winter on the back of a spring and summer period which has seen key aspects of health and care service provision operating at full capacity and levels of escalation similar to the last winter period – with little opportunity to reduce.
- This is an unpreceded situation, with:
    - The level of ‘exit-block’ from our acute hospitals being the key structural issue which is driving front end acute pressures (over-crowding, long waits for admission and ambulance delays in the ED) and a has a direct opportunity cost of lost elective operating time.
    - General practice delivering more appointments than any previous period recorded – with close to half of this output servicing on the day demand.
    - Community Nursing Teams are serving more demand of a complex nature.
- Whilst this plan is not focussed on the actions that are necessary to put these services, and others, on a more sustainable trajectory in the long term, it is focussed on creating a greater level of operational resilience over winter which hopefully provide a spring board going into 2023/24.
- In August 2022, NHS England published its expectations on how Integrated Care Boards (ICBs) should be increasing capacity and operational resilience in urgent and emergency care ahead of this winter. This was supplemented with extra guidance in October 2022, focussing on further action that ICBs should be taking.
- The plan is our response to these documents and details the action that we will take to deliver the 6 key priorities for the ICB over the winter period.



What happens if we ‘do nothing’:

Some of the impacts of the do nothing scenario...

- Both hospitals will continue to use >200 more overnight G&A beds than we planned for. This will make it increasingly difficult for us to deliver our elective operating objectives.
- Our community ‘discharge to assess’ services will continue to operate with a deficit level of capacity – short of ~45 step down nursing beds with rehabilitation and reablement and short of ~460 packages of home support per month.
- We will continue to lose around 36 hours of productive paramedic time per day because of ambulance handover delays.
- Opportunities for improving secondary prevention of disease will be missed – specifically for diabetes, hypertension, dementia and poor physical health outcomes for people with severe mental illness.

So what action will we take?

1 Protecting people for COVID-19 and Influenza

- ~43,000 people across Derby and Derbyshire receiving a C-19 booster vaccination.
- 100% of the eligible population offered an influenza vaccination, with uptake at least matching he high levels of uptake achieved in 2021/22 .

2 Supporting people in their own homes

- The **Urgent Community Response Service** will see around 800 people per month, with 70% of referrals being responded to within 2 hours – which represents an improvement on current performance levels.
- The PCN led **Home Visiting Service** will increase its reach across Derby and Derbyshire, delivering a minimum of 2,000 visits to some of the most vulnerable housebound people.
- We will implement an **enhanced community falls service**, with full geographic coverage, operational by the end of December. This will focus on responding to 90% of the see and treat incidents that EMAS are currently dealing with and at least 50% of the see, treat and convey incidents as well
- We will improve the diagnosis of **dementia**, with at least 65% of the relevant population being correctly diagnosed, an improvement on the 62% level currently seen.
- We will improve the diagnosis of **hypertension**, where we will close the gap between observed and expected diagnosis rate by 2.5% by the end of the winter period.
- We will refer more people who are **pre-diabetic** to the Diabetes Prevention Programme – moving from 62% of population referred to at least 75% by the end of the period.
- We will see a 10% improvement in the proportion of people with a **Severe Mental Illness** receiving a physical health check by the end of the winter period.

What action will we take?

3 Providing an urgent response for those most in need

- A new **‘push’ operating model will be implemented at both acute hospitals**, with the guiding principle of reducing ambulance handover delays and freeing up crews - so as to reduce clinical risk in the community as well as decompressing Emergency Departments.
- The construct of the model will be based on the following parameters:
  - Early MFFD for pathway 0 patients with early discharge (Home or discharge lounge) No patient on a pathway 0 to occupy ward bed after 12:00.
  - Hourly movement from the Emergency Department to Assessment Units continuously over the 24-hour period irrespective if there is a bed available.
  - Every hour between 08:00 and 20:00, Hourly movement from Assessment units will be transferred to the wards totalling the medical take
  - By 22:00 each evening the Assessment units have an agreed number of empty beds
- Continue to operate Crisis House, Safe Haven and Crisis cafe within Derby for people who are in need of support, and promote the use of the mental health helpline and support service, 24/7 for those in emotional and mental health CRISIS.
- Ensure effective utilisation of resources within Crisis Resolution Teams/Home Treatment Teams, providing intensive home treatment, ensuring effective gatekeeping of inpatient capacity and supporting the discharge process.

4 Enhancing the resilience of General Practice

- We will see a **10% increase** on the number of on-the-day appointments that we have delivered to date.
- 4 county wide **Acute Respiratory and Infection Hubs** will be implemented, to reduce the burden of acute respiratory illness on primary care and reduce nosocomial transmission.
- There will be renewed focus on **simplifying working arrangements across the primary – secondary care interface** to include: (i) removing non-value adding steps to the consultant to consultant referral process (ii) fit notes (iii) supply of medicine on discharge (iv) reducing patients bouncing between sectors when it comes to the testing/diagnostic process.
- Capital investment in **cloud-based telephony services** across General Practice – currently subject to NHSE review/approval.

What action will we take?

5 Reducing discharge delays from hospital

- We will **increase step-down capacity** – including:
  - Contracting with CHS Healthcare to provide the clinical workforce necessary to staff 14 beds at the Ilkeston Hospital.
  - Opening 23 beds at the Florence Nightingale Community Hospital.
  - Opening 10 interim beds across Derbyshire County Council estate.
  - Opening 4 additional beds at the Ashgate Hospice.
  - Putting 200 virtual beds into operation by April 2023, with 120 coming on line through December and the remaining 80 throughout quarter 4.
  - Contracting CHS Healthcare to provide supported discharge capacity to the RDH and CRH.
- It is anticipated that the cumulative effect of these measures will help reduce the demand on General and Acute overnight beds - equivalent to around 72 over the period.
- We will also enhance medical and surgical **Same Day Emergency Care (SDEC) services and frailty assessment services** at both acute sites, with the anticipated benefit of reducing demand on beds – equivalent to around 14 over the period.

6 Reducing the backlog for elective and cancer care

- We will use **clinical urgency** (based on the P1-6 construct) and **chronology** (amount of time waited) as the two prime criteria for deciding who receives elective care.
- We will **reduce the number of 78 week waits to 0 by the end of March 2023, by protecting a minimum of 100 overnight elective beds** across both acute sites, fully protecting the use of day case units and continuing to operate full outpatient services.
- Whilst we **will not reduce the 62+ day cancer waiting list** to the pre-pandemic level by the end of the winter period, we will continue to reduce it and maintain performance against the 28 day faster diagnosis standard over the winter period at the very least.

Does it meet NHS England's expectations?

Key deliverables	Compliance *Does our plan meet NHSE's requirements?*	Planned impact *What is the scale of planned impact?*	Degree of confidence *In terms of delivery*	Rationale – planned impact and degree of confidence
Reduce the number of 78 week waits to 0 by the end of March 2023				Whilst we have set out a compliant plan with the expected level of impact, there is uncertainty on deliverability – particularly given that (i) the number of 78+ weeks wait is currently on an upward trajectory and (ii) we don't have a fully mitigated G&A bed position (see page 9) which therefore poses risk to our ambition to ringfence elective beds.
Reduce the 62+ day cancer waiting list to the pre-pandemic level by the end of the winter period				The number of 62+day waits is on a downward trajectory but impact of new referral demand on capacity not yet understood.
Roll out the booster vaccination to the eligible population				We are ahead of trajectory in terms of vaccination numbers.
At least match last year's high uptake rate for the influenza vaccination				Confidence level based on the quality of our historic performance.
Ensure 70% of urgent community response referrals are responded to within 2 hours				Planned impact rated high given that we are submitting a compliant plan. Confidence is rated as high as we are currently within target range.
Implement a community based falls service				Impact is rated as high given the service plans to deal with a large majority of the demand for level 1 and 2 falls that EMAS are currently dealing with. The confidence level is based on the specificity of the plan and the fact that it doesn't rely on a significant number of new staff.

Does it meet NHS England's expectations?

Key deliverables	Compliance *Does our plan meet NHSE's requirements?*	Planned impact *What is the scale of planned impact?*	Degree of confidence *In terms of compliance and/or planned impact*	Rationale – planned impact and degree of confidence
Increase community capacity				Whilst we plan to increase community step down capacity, it is not of a sufficient level to meet demand and have a significant impact on reducing discharge delays - particularly P1 package of cares. Confidence is rated as medium, given that sourcing staff has a degree of uncertainty to it.
Increase the number of virtual wards in operation				Whilst there is a reasonable level of confident that some provision will be in place from December, there is uncertainty as to the scale of what will be available given that the initiative relies on recruitment of c85 WTEs and many posts are still out for advert.
Improve category II 999 response times				Given the size of the gap between current category II response times compared to target, it is highly unlikely that we are to overturn the deficit in performance. This is based on two factors (i) EMAS are unable to source new crew capacity and (ii) there is insufficient evidence at this stage as to what level of crew capacity the new push model will release by reducing ambulance delays.
Increase general practice capacity				A 10% increase in on-the-day appointment capacity is sizable, particularly given the level of demand which is displaced to other parts of the system which is much less than this. Furthermore, the 'standing-up' of acute respiratory hubs, meets NHSE's requirements and will play an important role in enhancing the resilience of general practice over the winter. Confidence is rated as medium given that sourcing staff has a degree of uncertainty to it.

What are the risks?

1 Workforce

- Ability to recruit – particularly pertinent to the VW initiative and staffing community surge beds.
- Increased sickness absence – no significant change to current absence rates have been assumed.
- Staff availability due to industrial action – no adverse impacts incorporated into Provider plans.
- Stability of the PVI sector – degree of uncertainty particularly given financial constraints.

2 COVID-19

- Burden of COVID-19 on bed occupancy exceeds plan. Current plans are predicated on COVID occupancy being at between 5-8% over the winter period.

3 Safety

- Given that this plan does not make a material impact on category II response times, cancer long waits and delayed discharges, the risks to clinical safety associated with this has not been fully mitigated.

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To:
- Integrated Care Board Chief Executives and Chairs
- NHS Foundation Trust and NHS Trust:
  - Chief Executives
  - Chairs

NHS England
Wellington House
133-155 Waterloo Road
London
SE1 8UG

12 August 2022

cc.
- Regional Directors

Dear colleagues

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

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

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

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

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

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

Core objectives and key actions for operational resilience

Our collective core objectives and actions are to:

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

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

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

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

Performance and accountability: A new approach to working together

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

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

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

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

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

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

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

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

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

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

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

Yours sincerely,

Amanda Pritchard
NHS Chief Executive

Julian Kelly
Chief Financial Officer
NHS England

Sir David Sloman
Chief Operating Officer
NHS England

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

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

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

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

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

2. **Demand and capacity**

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

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

In community care:

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

In primary care:

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

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

In mental health, cancer, and elective care:

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

3. Discharge

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

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

4. Ambulance service performance

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

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

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

5. NHS 111 performance

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

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

6. Preventing avoidable admissions

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

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

7. Workforce

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

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

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

8. Data and performance management

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

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

9. Communications

We are undertaking the following actions to enable strong communications:

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

To:
- ICB chief executives
- All NHS Foundation Trust and Trust:
  - Chief executives
  - Medical directors
  - Chief nursing officers
  - Chief people officers and HR directors
- All GP practices
- PCN Clinical Directors

cc.
- ICB chairs
- NHS Foundation Trust and Trust Chairs
- All local authority chief executives
- NHS regional directors

NHS England
Wellington House
133-155 Waterloo Road
London
SE1 8UG

18 October 2022

Dear colleagues,

In August we set out a number of steps to boost capacity and resilience, with funding ahead of winter, including providing extra bed capacity and better support for staff. Thank you to you and your teams for the incredible hard work that is ongoing to make progress and deliver these focused actions, which remain crucial.

More than eight million people have already had their autumn booster COVID-19 vaccination in just over a month. However, we continue to be in a Level 3 incident, and services are under continued, significant pressure, with challenges including timely discharge of patients impacting on patient flow within hospitals, alongside ongoing pressures in mental health services.

Over the past few weeks this has been exacerbated by an increase in the number of COVID-19 inpatients and related staff absences. We continue to prepare for the possibility of high prevalence of flu, based on the evidence from other countries and advice from public health experts.

We therefore all need to be prepared for things to get even tougher over the coming weeks and months. We will support you in doing your best under these very difficult circumstances, including as you work with and support clinical leaders to ensure risk is managed appropriately across local systems. We are working with the relevant regulators to support this.

This clinical risk management is especially important to support the ongoing work to improve ambulance handovers and response times. Many of you already have access to the data platforms that you will need to drive performance or will be getting access in the coming weeks. These data platforms will inform national, regional, and local oversight, including the NHS Oversight Framework.

Going further on our winter resilience plans

In August we set out key actions to improve operational resilience, built in partnership with you. Following further engagement with systems over recent weeks we are now setting out a necessary expansion of these plans. These actions have been co-created with systems and clinical leaders and build on best practice that you have shared with us. They have been selected based on this evidence showing that they will make the biggest additional impact. In particular we want to work with you to ensure the NHS can:

- **Better support people in the community** – reducing pressures on general practice and social care, and reducing admissions to hospital by:
    - Putting in place a community-based falls response service in all systems for people who have fallen at home including care homes
    - Maximising the use of virtual wards, and actively considering establishing an Acute Respiratory Infection (ARI) hub to support same day assessment
    - Providing additional support for care homes through reducing unwarranted variation in ambulance conveyance rates

- **Deliver on our ambitions to maximise bed capacity and support ambulance services** – bed occupancy continues to be at all-time highs, and we need to take all opportunities to make maximum use of physical and virtual ward capacity to increase resilience and reduce delays elsewhere in the system. This includes:
    - Supporting delivery of additional beds including previously moth-balled beds
    - All systems setting up a 24/7 System Control Centre to support system oversight and decision making based on demand and capacity across sites and settings
    - Ensuring all ambulance services deploy 24/7 mental health professionals in emergency operation centres and on-scene

- **Ensure timely discharge and support people to leave hospital when clinically appropriate** – more than 10,000 people a day are clinically ready to leave hospital but can't be discharged, and this causes significant and fundamental issues for patient flow. In addition to maintaining focus on the high impact actions from the 100 day challenge, the Government recently announced £500m to support social care to speed up discharge across mental and physical health pathways. More details about distribution of this fund will be shared with you when available.

Winter Improvement Collaborative

In August we committed to launching new improvement initiatives to support ambulance handover and response times, in addition to the focussed work that we are continuing to do with the 10 most challenged systems and providers.

Providers, systems, and regions have done a significant amount of work on these issues, but we have heard that we need to work with you on a faster way of identifying good practice and helping you to spread it at scale. We will therefore establish a new national Winter Improvement Collaborative by the end of October. We will review the effectiveness of this programme after 10 weeks and are committed to learning and iterating the approach to ensure it has maximum benefit. This will focus on the root causes of delay in each area. It will support teams to identify, evaluate, quantify, and scale innovation and best practice in improving handover delays and response times and reducing unwarranted variation at pace, supported by a single set of metrics.

We wish to learn from providers and systems who are tackling these issues successfully and are asking all systems to participate. The collaborative will be clinically-led, and we will work in partnership with staff using an Adapt and Adopt approach.

Continuing to support elective activity

We have proved we can deliver the ambitions set out in the elective recovery delivery plan with the virtual elimination of 2 year waits in July. Now we are in the second phase of the elective recovery plan, we need to continue to have a strong operational grip across both overall long waits and care for patients with suspected cancer. It is essential that all elective procedures go ahead unless there are clear patient safety reasons for postponing activity. If you are considering cancelling significant levels of elective care you should continue to escalate to your Regional Director for support and mobilisation of mutual aid where possible. We will be writing shortly on the next steps in recovery of elective and cancer services for our most challenged providers.

We are asking every Trust providing elective and cancer services to have their Board review the relevant performance data and delivery plans for the coming months. The Board should reflect on whether the assurance mechanisms are effective and in line with your elective recovery plan. Delivery should be managed in line with the plans and trajectories that have been agreed with NHS England regional teams. These plans should also be shared with your ICB.

On cancer, the key drivers of the cancer 62-day backlog are clear. The hard work of GPs and their teams has meant that the proportion of cancers diagnosed at Stage 1 and 2 has now fully recovered and is higher than pre-pandemic. Urgent cancer referrals are at 118% of pre-pandemic levels, while cancer treatment and diagnostic activity levels are nearer 100% of pre-pandemic levels. Three pathways (Lower GI, Skin and Urology) make up two-thirds of long waiting patients and have seen the largest increases.

Given this context, there are priority actions we are asking you to implement:

1. Faecal Immunochemical Testing (FIT) in the Lower GI pathway including for patients on Endoscopy waiting lists
2. Best Practice Timed Pathway for prostate cancer including the use of mpMRI
3. Tele-dermatology in the suspected skin cancer pathway
4. Greater prioritisation of diagnostic and surgical capacity for suspected cancer.

Infection prevention and control (IPC) measures and testing

Existing UKHSA guidance on the management of COVID-19 patients remains in place, along with the appropriate IPC measures detailed in the IPC Manual. Ahead of winter, providers should self-assess their compliance with this guidance using the IPC board assurance framework.

This guidance will continue to be reviewed based on advice from UKHSA, in line with the latest scientific evidence including the impact of COVID-19 and other respiratory diseases in the coming months. Local healthcare organisations, with clinically appropriate advice, may also continue to exercise local discretion to test specific individuals or cohorts in line with broader IPC measures.

Symptomatic testing is continuing for patients and staff, based on the current list of symptoms. Symptomatic staff should test themselves using LFDs at the earliest opportunity. Staff testing positive should follow UKHSA's return to work guidance.

Staff vaccination

It is important that health and social care workers receive both the COVID-19 and flu vaccines to protect themselves and their patients; the viruses can be life-threatening and getting both flu and COVID-19 increases the risk of serious illness. The vaccines offer the best protection for staff to better support patients and the people we care for.

All frontline healthcare workers should be offered both vaccines by their employer. Employers will confirm where both vaccines can be received, either at place of work, or, at a neighbouring provider. Health and Social Care workers can also book on the National Booking System by visiting www.nhs.uk/get-vaccination or calling 119.

Systems should continue to look at sections of their community where vaccine uptake is lower and focus significant efforts with partners to ensure community-based support is provided, building on approaches that have proved successful in the past. Trusts should also ensure that those attending for other reasons are signposted or offered vaccination.

Oversight and incident management arrangements

We will work with ICBs to ensure that oversight arrangements and associated support are appropriately focused on winter resilience and the delivery of elective recovery, including cancer, as set out above. This includes updating the NHS Oversight Framework metrics to reflect those set out in the Board Assurance Framework.

The NHS continues to operate at Level 3 Incident Response. Local systems will have their own response arrangements in place, and it is important that these continue, with robust escalation processes. There will be an opportunity to test these arrangements with a desktop exercise on winter pressures and escalation planned for November. This will be led by Regions working with ICBs, though participation will be open to all local partners. Seven day reporting against the UEC sitrep will start from Monday 31 October. Arrangements for the COVID-19 sitrep remain unchanged.

Thank you again to you and your teams for your continued hard work, and the leading role ICBs are playing in strong partnership working across the system. Since we published the winter plan in August, you have shared excellent examples of best practice

taking place across the country, and this good work has been used to inform the actions set out in this letter. The coming weeks and months will be difficult, but we will continue to support you in these challenging circumstances to ensure that we collectively deliver for patients and support our staff.

Amanda Pritchard
NHS Chief Executive
NHS England

Julian Kelly
Chief Financial Officer
NHS England

David Sloman
Chief Operating Officer
NHS England

Appendix A – Further Actions Ahead of Winter

Relevant service specifications for the actions outline in the letter can be found here.

New variants of COVID-19 and respiratory challenges

- *Systems should actively consider establishing Acute Respiratory Infection (ARI) hubs as part of preparing for managing increased ARI in the community.*

Demand and capacity

We will work with local systems to:

- *Support delivery of additional beds available to admit patients to across England to reduce the number of patients waiting in ED for a suitable bed, ambulance handover delays, and ambulance response times.*

- *Deliver their agreed contribution to the winter planning ambition of delivering an additional 2,500 Virtual Ward (VW) beds. VW capacity must be included within overall bed capacity plans and monitoring and all local VW providers must submit timely, high-quality data through the national sitrep by 24 October 2022. Systems should ensure that virtual wards are effectively utilised both in terms of addressing the right patient cohort and optimising referrals.*

- *Ensure all systems establish 24/7 System Control Centres (SCCs). SCCs will balance the risk across acute sector, community, mental health, and social care services with an aim of ensuring that clinical risk is appropriately dispersed across the whole ICS during periods of surge. SCCs will need to be supported by senior operational and clinical decision-makers to proactively manage clinical risk across the country in a 24/7 format for 365 days per year. The expectation is that systems will develop the operating model for approval via the BAF and that all systems will have an operational SCC by 1 December 2022.*

- *Improve the accuracy of information provided in the capacity tracker. The accuracy of information submitted to the capacity tracker will be key to ensuring that we can effectively manage demand and capacity at a system, regional and national level. We will work with regional teams to ensure that all providers have plans in place to submit accurate data to the capacity tracker, and that updates are submitted in line with the collection timetable.*

- *Continue to invest into acute-workforce training in managing mental health need (including paediatric acute) and embed the integration framework with associated resources for systems to support children and young people with mental health needs within acute paediatric settings.*

Discharge

- *We know that discharge challenges are causing significant issues for flow and are impacting emergency care for patients. The 100-day challenge work will continue, as local systems continue to embed the 10 best practice interventions. We will work with regions to understand the specific actions where national support is*

required to go further, and a similar programme will be extended to community and mental health trusts. Intensive discharge support will also continue for a small number of our most challenged systems and Trusts. A national data focus, beginning with a drive to improve data quality, will support real-time operational decisions.

- *We are working with cross-government colleagues through the National Discharge Taskforce to explore further options to reduce delays to discharge. This includes supporting the £500m fund to recruit and retain more care workers and speed up discharge. Looking ahead to next year, with colleagues in DHSC and DLUHC we are selecting a number of discharge Frontrunners to identify radical, effective and scalable measures for improving discharge processes and joint working between and adult social care.*

- *Mental health remains a challenge for UEC activity and delayed discharge. It is important that systems continue to invest in mental health as planned in crisis alternatives, community transformation, primary care, and liaison services in acute hospitals, and that 12 hour delays are avoided.*

Ambulance service performance

We will work with local systems to:

- *Ensure all ambulance services deploy 24/7 mental health professionals in emergency operation centres and on-scene and implement new models of improving flow out of emergency departments. Staff may be employed on a rotational or joint basis with mental health trusts. This additional capacity will prevent unnecessary mental health related ambulance trips to A&E and enable more people in mental health crisis to access the right support in their community. Further guidance will be shared shortly.*

Preventing avoidable admissions

All local systems should:

- *Have a community-based falls response service in place between 8am and 8pm for people who have fallen at home including care homes. The service should be in place by 31 December 2022 and be available as a minimum 8am-8pm 7 days per week.*

- *Address unwarranted variation in ambulance conveyance rates in care homes working collaboratively with care homes to identify and access alternative interventions and sources of support.*

- *Consider targeted, proactive support for people who have high probability of emergency admission, sometimes called High Frequency Users. For example, work in one area identified that 1% of people (~600 people) accounted for 1,925 ED attendances and 54,000 GP encounters over a 12 month period.*

Workforce

In July we wrote to you asking you to prioritise five high impact actions to maximise the retention and experience of nursing and midwifery staff. Significant progress has already been made and we are asking you to continue working across key areas, including:

1. **Nursing and midwifery retention self-assessment tool** – completed self-assessment tool and retention improvement plans should be shared with your ICS retention lead or equivalent.
2. **National Preceptorship Framework** went live on 10 October. The framework includes a core set of standards and a gold standard for organisations wanting to further develop their preceptorship programmes.
3. **Flexible working –** Your staff should be made aware and encouraged to explore flexible working options. Information and tools are available on the NHS Futures site.

We are now extending our workforce support by:

- *Re-launching the National NHS reserve campaign to bolster local surge capacity.*
- *Launching a staff offers hub to support spread of local good practice over winter.*
- *Providing a full list of recommended workforce solutions for Integrated Care Boards.*
- *Providing targeted support teams to any region or system that falls into difficulty.*