Public Document Pack

Telford & Wrekin COUNCIL

Shropshire Council

Addenbrooke House Ironmasters Way Telford TF3 4NT

JOINT HEALTH OVERVIEW & SCRUTINY COMMITTEE

Date	**Monday, 22 November 2021**	Time	**2.00 pm**
Venue	**Ramada Telford Ironbridge Hotel, Forgegate, Telford, TF3 4NA**		

Enquiries Regarding this Agenda		
Democratic and Scrutiny Services	Lorna Gordon	01952 384978
Media Enquiries	Corporate Communications	01952 382406

Committee Membership:	**Telford & Wrekin**	**Shropshire**
	Councillor Jayne Greenaway	Kate Halliday, Shropshire Council
	Councillor Stephen Reynolds	Councillor Heather Kidd
	Councillor Derek White, Telford & Wrekin Health Scrutiny Chair	
Co-Optees	Hilary Knight	David Beechey (Shropshire Co-Optee)
	Janet O'Loughlin	
	Dag Saunders	Ian Hulme (Shropshire Co-Optee)

AGENDA

1. **Apologies for Absence**

2. **Declarations of Interest**

3. **Minutes of the Previous Meeting** 3 - 16
   To confirm the minutes of the meetings held on 19 November 2020, 15 April 2021, and 14 October 2021.

4. **Shropshire, Telford & Wrekin CCGs Urgent & Emergency Care Improvements and Winter Preparedness** 17 - 58

5. **Phlebotomy Review** 59 - 66

6. **Proposed Changes to In-patient Cardiology Services** 67 - 94

7. **Co-Chair's Update**

Continued…

This page is intentionally left blank

JOINT HEALTH OVERVIEW & SCRUTINY COMMITTEE

Minutes of a meeting of the Joint Health Overview & Scrutiny Committee held on Thursday, 19 November 2020 at 12.30 pm in

Present: Councillors H Kidd, M Shineton, S J Reynolds and D R W White (Co-Chair).

Co-optees: I Hulme, H Knight, J O'Loughlin and D Saunders

Also Present: Councillors Andy B, Cabinet Member for Health & Social Care (Telford & Wrekin Council), A McClements, Chair Children & Young People Scrutiny Committee (Telford & Wrekin Council) and P Mullock, Chair of Shropshire Children's Scrutiny Committee (Shropshire Council)

In Attendance: Z Bowden, Chair of Shropshire Parent & Carer Council and West Midlands Regional Representative for Parent Carer Forums across England, K Bradshaw, Director of Children Services (Shropshire Council), J Dean, Service Manager Special Educational Needs and Disabilities (Shropshire Council), J Galkowski, Democratic Services and Scrutiny Officer (Telford & Wrekin Council), H Jones BeeU Quality and Governance Lead Emotional Health services (MPFT), Dr A Maclachlan, Consultant Clinical Psychologist and Clinical & Care Director, Shropshire and Telford & Wrekin Care Group (MPFT), Cllr K Middleton, Health & Wellbeing Specialist representing 3rd sector professional group, C Parrish, Service Manager BeeU Service & Urgent Care Adult Pathway,Shropshire and Telford & Wrekin (MPFT), E Pearce, Project Manager, Pods Parent/Carer Forum,Telford & Wrekin , C Riley, Managing Director Shropshire and Telford & Wrekin Care Group (MPFT), J Stevens, Strategic Coordinator, Pods Parent/Carer Forum, S Thomas, Participation Coordinator for Shropshire Parent Carer Council (PAC), Dr S Waheed, Consultant Child & Adult Psychiatrist and Medical Lead for BeeU Service (MPFT), D Webb, Overview & Scrutiny Officer (Shropshire Council), Stacey Worthington, Senior Democratic and Scrutiny Services Officer (Telford & Wrekin Council)

Apologies:

None

JHOSC1 Declarations of Interest

None

JHOSC2 Minutes of the Previous Meeting

To follow

JHOSC3 Children Mental Health Services

The Managing Director, Midlands Partnership Foundation Trust presented a report to the Committee on the BeeU service commissioned in 2017. A partnership between CAMHS and Partners. The service provided an Emotional Health and Wellbeing service for children and young people up to 25 years of age. The Committee heard that new referrals were taken up to the age of 18 and supported up to the age of 25 though service users could transfer to adult services earlier if they wished to do so. The report noted the I-Thrive Model & Partners, a stepped framework which started with self-support, moving to advice guidance and consultation then onto getting help and getting more help. The report also covered Poly-Pharmacy. Services had been reviewed in line with NICE guidance, with the creation of a standard operating procedure for repeat prescribing and the setup of a weekly physical health clinic. A case study was presented which highlighted the changes made in prescribing medication, offering behavioural therapies and also the psycho-educational groups for parents.

Members asked a number of questions and received responses as follows:

What services has CAMHS provided, what was the evidence for the service and what was the profile of its need?

Low level support was provided by way of a text service, specialist CAMHS access point, clinical triage, signposting for all age access to adult practitioners and CAMHS specialist professionals and online CBT (Cognitive Behavioural Therapy). A core part of the workforce for BeeU service was predominantly medical and nursing led to meet prescription demands. This had been changed over the last few years. Speech & language therapists, occupational therapists, psychological practitioners, CBT therapists and specialist trauma therapists had been employed as part of the workforce and had been linked into improvements. A wider range of therapies were offered including a number of pathways such as learning disabilities and ASD (Autism Spectrum Disorder) diagnostic pathway. These changes were commissioned by the CCG (Clinical Commissioning Groups) and added to the funding to develop the ASD pathway. The ADHD (Attention Deficit Hyperactivity Disorder) pathway previously had long waiting lists, at the time of the meeting only 29 people were waiting to be seen, a reduction from 100. Children had been seen and started on a pathway. The Committee heard that there had been difficulties nationally.

They had created two separate teams who looked at those who had waited over 12 months and also new referrals. A waiting list initiative was completed in the recommended 6 week time frame. A link with local authority and schools was introduced in Telford so that any schools that had any concerns around child mental health/developmental went to a school panel MDT (Multi-Disciplinary Team). Additionally, mental health support teams were going into schools to help early identification of those that needed help. The same

format was planned for Shropshire. Members noted that what may work in Telford may not always be appropriate for such a different area as Shropshire.

What communication was there between schools, GPs, parents and other agencies?

Where any child is seen, the information is documented and communicated by letter back to the GP. Every letter is copied back to the GP.

Could further detail of the current staff level, skills shortages and recruitment concerns be provided?

There have been a huge array of disciplines to recruit from. However, members decided that being limited on the meeting time constraints, written questions could be posed as there would be a workshop in the future where these could be addressed.

Was there uniformity in the commissioning and services provided across Shropshire and Telford and Wrekin?
There was the same service specification from the two CCGs and the Local Authority contributed to the income received but not the detail or split. It was confirmed that there was uniformity and that it had improved with the new tender.
How near were they to meeting the structure the British Psychological Society has set? How many trained mental health practitioners in post were from diverse backgrounds and were they focused on schools of high deprivation or was it a blanket service?
When the bid was placed there was specific criteria about what schools were targeted. The service worked with the Local Authority and looked at schools that had the highest level of deprivation, highest referrals into early years programmes and also the highest exclusions. At the time of the meeting there was a group going through training to qualify in December. It was a 12 month training programme. There were band five and six practitioners spread equally across Telford & Wrekin and Shropshire. In terms of diversity, there was a diverse background of various ethnic groups that work across Telford and Wrekin and Shropshire.

What factors were considered when looking at rurality and accessing Pharmacies during COVID restrictions?

The CAMHS service had defined resources. More video consultation was used which allowed the service to reach different people in different communities. This was not fit for all and in those situations they connected through telephone and face to face interactions. Working with system population health needs the service was waiting for more information to understand how resources linked to particular PCN areas. They had worked closely with PCNs and developed plans for the 18-25 age group. As the service progressed, it was hoped that there would be further working with other PCNs.

How would the service work with rural primary schools that can be quite isolated? PCNs don't quite fit the format here though school development groups could be worked with rather than just the individuals.

The Anna Freud link project were working with schools across the county, led by the local authority and schools. Mental Health teams are also working in schools across rural areas. Further information on the school development groups would be gratefully received to see how that could be taken forward.

How did the service utilise strategic pathways to support teams and the community effectively? How confident were staff that strategic opportunities with shaping the footprint in the county ensured services were properly supported?

The ASD service was not clearly commissioned from when they received initial funding and it had taken up to the meeting to be funded. It was acknowledged that this resolution came too late for many service users. However, the next development would be the parent support group 'Rollercoaster'. Parent link programmes and service users would be involved in developing feedback for transition. Feedback surveys were reviewed but it was acknowledged that there was still some way to go to involve people more and earlier on in the process.

What was the demand for the service?

The Committee were informed that the CCG would be able to provide more in depth demographic information to answer this question and it was noted that this would be looked at, at the next meeting.

How did the service engage with the groups appropriately?

Engagement with the parents was the next planned move. The CCG was working around commissioning of post diagnostic referral provision, but this was with other providers and not the BeeU service.

How did the level of funding of CCG for Shropshire and Telford & Wrekin apply to the CAMHS service? How did it compare to other areas that had commissioned services from BeeU?

IST reported benchmarking around the workforce showed to be lower than other areas when compared to CAMHS and it was noted that this service goes up to age of 25.

What was the typical wait time for assessment?

There was no waiting list for the main BeeU service. However the waiting list for newer developmental pathways was inherited and was considerable. Though it had greatly reduced (at the time of the meeting to just 20). The ADHD clinic had helped work through those on the list to get help they needed

and it was hoped those remaining would shortly be cleared. ASD still had a large waiting list which was being worked through with the funding to get to an 18 week wait plan. This would meet NICE guidance target of 3 months. It was hoped that the funding could be applied to new referrals again to meet NICE guidance.

It was requested that the criteria for referral was provided to help understand if it was still fit for purpose in the current climate. The request was recognised but it was noted that the upcoming workshop covered this.This meeting was perhaps not the most appropriate format. The workshop with users involvement could look at the needs of the service/users.

What are wait times for ASD?

For ADHD there were 29 waiting to be seen. For ASD there were 120 waiting for assessment, but since the funding had been finalised, this would be addressed.

Where were the gaps in staffing?

Recruitment of substantive CAMHS consultants had been a struggle since very few came off the development line. There were two locum doctors within the BeeU service. Speech and language/diagnostic areas were also difficult to recruit to due to being so specialised, especially in rural areas.

How were the crisis provisions locally coping?

The crisis service was available 9am to 5pm. During COVID-19 there was national requirement to create an urgent telephone line for crisis response. This had been created for adult services but had also been requested for children and young people. From the end of January this was being implemented following funding for a 24 hours a day 7 days a week service. It was deemed likely this service would see higher demand from young people due to a lack of tier 4 beds. There were only a small number of providers and these were mostly private providers. Previously when that happened, children could be stuck waiting for a tier 4 bed with only BeeU service support. For older children assessments, if it was a serious incident they could be admitted to adult Mental Health wards. Where this was deemed unsafe a health based place of safety was converted to a ward to hold those people and care for them. There was no alternative for teenagers to health based places of safety. Winter funding would add to the service. This was viewed to be a serious issue for the service.

Were these not known to the service previously?

There were a mixture of new and previously known users. It was noted that those with eating disorder referrals did not come early enough to the service though the service was able to respond well to the referrals.

With the identified shortages and areas of gaps what was being done?

There was a paper on behalf of the group taken to CCG to demonstrate the lack of tier 4 beds. The CCG still had a responsibility under Mental Health act to ensure alternative bed provision. Due to the specialist needs and specialist workforce required this was not an easy problem to address. Although tier 4 beds have been paid for, they have not been getting allocated.

If we've been exporting children to areas with lack of support and help they're already making difficult adjustments why can't we have a local solution?

Tier 4 beds are not commissioned by the CCG but by a specialised commission. The CCG try to influence that but they still have a responsibility to provide alternative arrangements to those in need where they can't get hold of them.

Who is in charge of the specialised commissioning?

NHS EI in charge of specialised commissioning.

JHOSC4 Co-Chair's Update

Time did not allow taking the agenda any further. The remaining items were suspended.

It was noted that the attendees from MPFT would hopefully return participate at the next meeting to continue from where the agenda was halted.

The meeting ended at 2.00 pm

Chairman: .....

Date: Tuesday, 24 November 2020

JOINT HEALTH OVERVIEW & SCRUTINY COMMITTEE

Minutes of a meeting of the Joint Health Overview & Scrutiny Committee held on Thursday, 15 April 2021 at 2.00 pm in Remote Meeting

Present: Councillors K Calder (Co-Chair (Shropshire Council)), H Kidd (Shropshire Council), M Shinetone (Shropshire Council), S J Reynolds and D R W White (Co-Chair).
Co-optees: H Knight, J O'Loughlin and D Saunders

In Attendance: A Holyoak (Committee Officer (Shropshire Council)), J Galkowski (Democracy Officer (Scrutiny) (Telford & Wrekin Council)), T Jones (Deputy Director Partnerships, Shropshire, Telford & Wrekin CCG), Nicky O'Connor (STP Programme Director, Shropshire Telford & Wrekin STP), K Robinson (Democracy Officer (Scrutiny) (Telford & Wrekin Council)), R Robinson (Director of Public Health (Shropshire Council)), J Rowe (Executive Director: Adult Social Care ,Health Integration and Wellbeing (Telford & Wrekin Council)), D Webb (Overview and Scrutiny Officer (Shropshire Council))

Apologies: Councillor D Beechey (Shropshire Council)

JHOSC1 Declarations of Interest

None.

JHOSC2 Minutes of the Previous Meeting

RESOLVED - that the minutes of the meeting held on 22 October 2020 be approved.

RESOLVED - that the minutes of the meeting held on 24 November 2020 be approved.

JHOSC3 End of Life Care Update

Members received the update report of the Deputy Director: Partnerships, Shropshire, Telford & Wrekin CCG.

The Committee were informed that the report was an update on a previous report received by the Committee and that it covered the achievements of the review of end of life care to date and the next steps of the review.

The Deputy Director provided Members with an overview of the report. The first section of the report covered the background to the review. In the second section, the methodology of the review was laid out. The original idea had been to shortlist focus areas from data but there had been a decision to open up one of the focus areas to influence from the feedback received from those with lived experience. There was a desire to include symptom control as a

focus. Section 3 of the report covered the four areas that formed the key areas of focus, while Section 4 set out the regional focus on palliative and end of life care. Section 5 focussed on next steps, in which working groups would seek to deliver change. Finally, Section 6 summarised where the review was.

Following the presentation, a discussion followed. Members asked a number of questions:
Who sat on the Community and Place Board?
Representatives from the main health providers, HealthWatch, and social care colleagues. The hospice was not involved but a representative was the Chair of the End of Life Group, so the hospice was involved.

Did the hospice contribute as an individual stakeholder?
It did.

Why had a generalist approach been favoured in the report to a specialist one?
Generalists needed support in end of life care as it was not something they usually dealt with. This would improve end of life care more broadly.

Could the term generalist be defined?
Generalists were staff that did not work in a specialist end of life care role.

Where was the CCG at with the Advanced Care Plan (ACP)?
This was outside of the area of expertise; however, the work was being led by the hospice in conjunction with oncologists from SATH. It was looking at producing an ACP.

Was the review of end of life care underpinned by a holistic approach?
The report was the result of engagement, holistic was not a term used in the report but the review was being approached holistically.

How close to fruition were information systems that shared data to avoid repetition of questioning patients?
Shared care records were not a part of the review, however, that work was progressing at pace.
For those who wished to die at home, there was an issue around support from GPs and district nurses. Was there anything in the report around supporting that choice?
In terms of the reviews, this was a routine end of life commissioning question. In those instances where individuals were unable to access the necessary equipment it was necessary to speak to service providers to find out why as equipment was commissioned. This was not an area fed back by service users as a particular issue.

Would Phase 2 of the review be able to influence equipment provision and the delivery and recovery of equipment from a patient's home?
In each of the four key areas there would be a task and finish group established, COVID had enabled rapid change across a wide area as clinicians came together to examine the problem and had found active ways

of solving it. Equipment could feature in a number of the task and finish groups' conversations, looking at a solution focussed approach. Separately, issues around commissioned services, such as equipment, had to be reported and actioned as individual cases. Where people did not receive the equipment needed, they should report this to the CCG.

Who would be taking part in the task and finish groups?
For each area, there would be a lead clinician and a lead manager, membership would then be opened up; looking at healthcare providers, people with lived experience, HealthWatch members, and non-statutory areas involved in the specific area. It would depend on the area being looked at but a broad membership would be pursued.

Occupational therapists appeared to be in short supply but appointments with them were necessary prior to receiving equipment. Would occupational therapists be a part of the review?
The review and its outcomes would depend on the collective discussions about the questions posed. The therapy base in Telford & Wrekin was being assessed by the Telford & Wrekin Integrated Place Partnership. The review looked at how to improve experience but other pieces of work were looking at those other issues Members had raised such as the availability of therapists and the rapid response team.

Post-COVID with the build-up of waiting lists, staff shortages, and major financial problems in the health economy, were there any fears about the impact of these challenges on the end of life care process?
There had been concerns, but continued work on the paper had been secured at the Community and Place-Based Board in spite of those challenges.

Regarding Generalists, would they be able to identify gaps in the review? How would they feed that in? How long would the grace period for identifying gaps in service be?
The working group looking at that issue would generate the answer to that question.

Members expressed their intention to invite Professor Derek Willis to the Committee at the next stage of the process.

Members recommended revisiting this matter in September.

Resolved that –

i. The completion of Phase One of the Review and the collaborative identification of the 4 areas of focus be noted.

ii. The change of CCG leadership of the End of Life Review as it entered Phase Two and the continued commitment of system partners to engage in the improvement workstreams to address the four key areas, including clinical leadership for all four key areas be noted.

iii. The regional NHSEI requirements regarding local system PEoLC group whose membership would include representatives from the voluntary sector and people with lived experience be noted.

iiii, The agreement that this refreshed PEoLC would act as the programme board for the four key improvement projects and report into the Community and Place based Board which in turn would report directly to the shadow ICS Board, thus ensuring prominent line of sight on the progress of the 4 working groups be noted.

iiiii. The JHOSC would receive a report on the EOL task and finish group progress in September 2021.

JHOSC4 Shropshire, Telford & Wrekin Integrated Care System

The Committee received the presentation of the STP Programme Director from Shropshire, Telford & Wrekin STP.

It was expected that the legislation would begin the parliamentary process in May 2021 with integrated care systems (ICS) becoming statutory bodies from April 2022. The proposal would be that there would be two bodies forming the ICS – a statutory body made up of the existing NHS bodies and local authorities and another, broader, partnership bringing together partners from across the system. The second body would likely be focussed on population health.

There were four purposes of an integrated care system:

1. Improving health outcomes in the general population
2. Tackling inequalities in outcomes, experience, and access
3. Enhancing productivity and value for money
4. Helping the NHS to support broader social and economic development

System pledges had been drafted as an integrated care system on areas to improve. There was the potential to work together with the Committee to improve things. In terms of place based working, people had worked together locally to generate ideas on how to improve. A commitment had been made to tackle ill health and health inequalities as well as to improve mental health services.

Commitments had been made with local government on working together on climate change and to regenerate economies.

The sense was that the legislation intended for work to be undertaken locally as much as possible.

Members posed a number of questions:
Concern was expressed at the creation of a two tier integrated care system in which democratic bodies, such as the Joint Health Overview & Scrutiny Committee, formed the lower tier.

The primary body would be the partnership board, the one including the democratically elected; it would then be for the statutory body to take the nucleus of what they asked for into action.

There was an engagement and accountability plan due in March 2021, where could that be found?
This had been delayed; it was expected in May 2021. However, the individual responsible would likely be interested in consulting with the Committee on how to pull that report together.

In terms of integrated care systems, would you agree that the system should be simple, local, and evolutionary?
Yes.

Does the workforce stream look at all workforce (including nursing staff, care staff) or just within the NHS?
This may be something to consider in a specific session, as a standalone item. Conversations on the issue were ongoing; workforce strategy covered all of the health and care workforce.

Given the challenges faced by the local health economy, are you confident that you can move forward in the way presented?
The pledges aimed to address these challenges; working together presented an opportunity to achieve goals.

Was there an agreed understanding of what health inequalities were within Shropshire, Telford & Wrekin?
In the next steps for place-based working, health inequalities were central. They were categorised in three ways, what could be done at a civic level? What intervention could be made in communities? And what could be done around services to improve them?

When would the ICS meet in public?
Board meetings would be held in public but work was being done on how they would be held. Initial plans were for an annual general meeting in September 2021.

How did you ensure that departments all speak to one another?
There was a long way to go on this issue, people needed to be enabled to work closer. Digital working was key. A digital work stream was in place, but pump priming was needed. Sharing of information was critical to success.

What was being done to help primary care be a part of this?
Primary care had a mandated seat on the board, but they needed to be enabled to engage and attend. It was critical that primary care were at place based boards, which they were, as this was where they could have most impact on what was happening on the ground. The place-based boards would be where real change could be made, not the ICS. The ICS would be policy and strategy focussed.

Did place based boards meet in public?
No.

Was there an opportunity to take part in the place-based boards for members of the public and elected Members?
They developed from local health and care staff working together and were chaired by senior individuals. They were ultimately, where pathways of care would be determined, informed by what was happening in primary care networks and the health and care issues in specific communities. HealthWatch and the voluntary sector were involved.

Where did scrutiny fit in? How could scrutiny play a part?
There were officers on the board from both authorities, as well as Councillors and they had served to link the board up to date.

Could the Committee see the board minutes?
Yes, this could be arranged.

How would SEND sit within ICS?
An outline governance schematic was within the presentation, that would evolve, but there was a children's and young people's delivery board proposed. SEND would be central to that.

On wider determinants of health, education and housing for example, was there a platform for those areas and professions to be involved?
There was.

Members made clear that they believed scrutiny's role in the new system had to be clearly identified and enhanced.

There was a consultation document out for review on the accountability of the ICSs; it was felt that local authorities should assess and respond to the document.

Members thanked the STP Programme Director for their attendance.

RESOLVED that –

- **The Committee request both local authorities draft a response to the Government consultation document.**
- **The Committee write to the LGA to ask for their response to the consultation.**

JHOSC5 Co-Chair's Update

Councillor White thanked the Committee's Co-Chair, Councillor Calder, for their work on the Committee.

The meeting ended at 4.00 pm

Chairman: _____

Date: 22 November 2021

This page is intentionally left blank

Shropshire, Telford & Wrekin
Integrated Care System

REPORT TO: **Joint Health Overview Scrutiny Committee**
22 October 2020

Item Number:	Agenda Item:
	Shropshire, Telford & Wrekin CCGs Urgent & Emergency Care Improvements and Winter Preparedness

Executive Lead (s):	Author(s):
Sam Tilley - Director of Planning Sam.tilley2@nhs.net	Sam Tilley - Director of Planning Sam.tilley2@nhs.net

Action Required (please select):										
A=Approval		R=Ratification		S=Assurance		D=Discussion		I=Information	X

History of the Report (where has the paper been presented):		
Committee	**Date**	**Purpose (A,R,S,D,I)**
N/A	15 November 21	I

Executive Summary (key points in the report):
The NHS is currently experiencing unprecedented levels of demand and as we begin to move into the winter phase it is anticipated that these pressures will continue. This paper sets out work that is already underway to develop our approach to the delivery of urgent and emergency care (UEC), to progress improvements where they are needed and implement service transformation where it will benefit our patients. Alongside this, this paper sets out the particular work we have undertaken in relation to winter preparedness

Recommendations/Actions Required:
JHOSC is asked to: 1. Note and support the contents of the report.

Shropshire, Telford & Wrekin
Integrated Care System

Urgent and Emergency Care Improvements and Winter Preparedness

Sam Tilley, Director of Planning, Shropshire, Telford & Wrekin CCGs

1.1 Context

The Shropshire, Telford & Wrekin system has experienced a number of challenges over a period of time in relation to the delivery of Urgent and Emergency Care (UEC). This has been exacerbated recently by unprecedented levels of demand, not only in UEC but across the health and care sector. As we move into the winter phase it is anticipated that these pressures will continue. It is important to note that this year we are facing a unique set of challenges across health and social care and the Shropshire, Telford and Wrekin (STW) system is no exception. This includes a set of distinct but interdependent issues including: The ongoing impact of Covid19, the expected resurgence of other infectious diseases, the ongoing recovery of services, significant workforce capacity pressures and an already emergent increase in demand on all services

This report focuses on two specific areas, firstly our ongoing UEC improvement work and secondly our preparations for winter

1.2 UEC Improvements

As part of our aspiration to make improvements to the delivery of UEC in STW, the system came together in early 21/22 to develop a set of focused work streams to do this. The vision for urgent and emergency care in STW is to transform our services into an improved, simplified and financially sustainable 24 hour/7 day model; delivering the right care, in the right place, at the right time for all of our population. Much of our local approach is modelled on the national UEC policies and guidance. In particular, in September 21 NHS England (NHSE) published its UEC Recovery 10 Point Action Plan (attached) to which the system has aligned its work streams

In undertaking this improvement work we are guided by a set of principles

- To provide better signposting to all the urgent care services available, such as walk-in services, pharmacy care and A&E departments
- To make sure that we're using technology to help us to offer the most up to date services and treatments
- To work as a network so that care is given at the right time by the right staff in the right place with the right equipment
- To reshape services where necessary to provide the best patient care and experience
- To ensure the appropriate links between Urgent and Emergency Care Transformation and Community Service Transformation, working closely with primary care colleagues and community teams to meet the needs of patients close to their home/where they live to make sure that only the people most in need will go to hospital.

In particular the STW UEC Improvement work focuses on:

- Pre-Hospital Improvements and Alternatives to Admission
- Ambulance Handovers and NHS 111
- Discharge
- Mental Health
- Primary Care
- Communications

Pre-Hospital Improvement and Alternatives to Admission (mapped to NHSE action point 2, 3, 4, 7)
The STW system recognises the important role that pre-hospital services play in managing demand in Urgent and Emergency Care. The system is therefore working on a number of schemes to support improvements and develop capacity in this area.

The CCG has funded additional same day capacity in Primary Care which will result in over 22,000 additional GP and allied health professional appointments between October and March.
We are about to commence a detailed review of a range of services including our GP out of Hours Service, Care Co-ordiantion Centre, Minor Injuries Units and Urgent Treatment Centres to determine the best configuration of these services to meet the needs of patients in the future. The aim of this work is to ensure that these service elements work seamlessly together without overlap or duplication in a way that offers the best outcomes for patients and appropriately relieves pressure from our Emergency Departments

The system is part way into a 5 year plan to transform community service that will include a focus on proactive prevention, development of the community respiratory model to include greater virtual support options and intravenous therapy in the community. A review of the “Positive Lives” Service is underway (previously the High Intensity Service User Service) to provide equity of access and one consistent service across the county

The implementation of Alternative to Hospital Admission schemes includes the roll out of the 2 hour rapid response service across the county with recruitment underway to support this. The expanded model (7 days a week 8am-8pm) will ensure a 2 hour response service is available across the whole county to all patients requiring urgent care by March 22. The service is delivered by multi-agency Multi Disciplinary Team ensuring access to a range of expertise is available to support community based alternatives

In addition, the CCG has funded additional support over the winter for patients with respiratory conditions to assist them in managing their own conditions at home and reducing the impact of potential exacerbations

Ambulance Handovers and NHS 111 (mapped to NHSE action point 1)
STW, along with many other areas nationally, is experiencing increasing delays in ambulances being able to handover their patients when they arrive at an acute Trust. Our system sentiment is that the occurrence of ambulances having to wait outside Emergency Departments is not acceptable and we are committed to doing all we can to improve this situation. The causes of ambulance handover delays are multi-factorial and as such all elements of our UEC improvement work will help to improve this position. However, there are a number of specific programmes of work, set out below, aimed at addressing this particular issue.

West Midlands Ambulance Service (WMAS) are increasing their capability to manage greater proportions of 999 calls without the dispatch of a paramedic with an increasing number of calls not resulting in a conveyance to hospital. WMAS continue to maximise the use of ‘Hear and Treat’ and ‘See and Treat’ Pathways for 999 demand.

We continue to work with WMAS to develop attendance avoidance initiatives. In particular in early October 21 we activated direct access for paramedics to our Medical Same Day Emergency Care (SDEC) facility. The take up of this has been good and as a result we will now go live with direct access to our surgical SDEC in late November. In late October 21 we initiated a single point of access for paramedics to our four Minor Injury Units (MIUs) hosted by Bridgnorth MIU.

For patients arriving at hospital by Ambulance we continue to make good use of the Hospital Ambulance Liaison Officer (HALOs) provided by WMAS and we use intelligent conveyancing between sites and across boundaries to manage pressures as they develop.

Via the CCG's Winter Scheme funding we have initiated an attendance avoidance intervention for elderly patients with dementia utilising the expertise of Midlands Partnership Foundation Trust (MPFT)

We are keen to continue to increase the utilisation of 111 bookable appointments and we are working with WMAS to increase the numbers of patients booked directly into appointments in A&E, Urgent Treatment Centres (UTC), Minor Injury Units (MIU) and Primary Care via this route. Locally, utilisation of NHS111 bookable appointment has been lower that we would like and we are working with WMAS to understand the reasons for this and to develop mitigations.

In partnership with Healthwatch we are currently undertaking a survey with the local public regarding their experiences of using NHS111 and why they may choose to walk in to A&E when other services are available. The survey is currently live and will run until the end of November. The outputs will then be used to inform further service improvement work. (The survey can be accessed via the following link: https://www.healthwatchshropshire.co.uk/urgent-medical-care-survey)

Although staffing has proved to be a challenge in previous attempts, work is ongoing to review the operating hours of our UTC and to map this against utilisation data with a view to operating for extended hours if possible.

With support from NHSE we are working on the implementation of a Screening and Redirection tool in our Emergency Departments. This will commence with the screening element going live in January 2022. This tool will be in situ as walk in patients arrive at the Emergency Department and will assist in determining if that is the most suitable venue for their care or if they would be served better accessing care elsewhere.

We have now received confirmation of NHSE funding to support a system Urgent Care Single Point of Access which will support all referring clinicians with one point of contact in relation to urgent care pathways. We have commenced the work on implementation which we will endeavour to do at pace and anticipate this being in place by mid December

Via the GP Winter Access fund we have also submitted a bid to support GP Streaming at the Emergency Department front door as another way of ensuring only those who need assessment and treatment in that setting access it there and that others are redirected to more appropriate services, therefore ensuring patients get the right support in the most timely way, avoiding demand bottlenecks and long waits.

Discharge (mapped to NHSE action point 6)

In order to support improved hospital discharge we are not only focusing on specific discharge related activity but also on improvements that can be made to the flow of patients through the hospital once they have been admitted.

To complement our Discharge Lounge at Princess Royal Hospital (PRH), after some recruitment challenges, we have now been able to recruit sufficient staff to permanently open our Discharge Lounge facility at Royal Shrewsbury Hospital. This will greatly assist with managing the preparation for discharge and flow out of the hospital for patients identified as discharge ready.

Shrewsbury and Telford Hospital NHS Trust (SaTH) have recently carried out a "Flow Fortnight" discharge improvement initiative with its wards. This has identified refinements that can be made to internal processed and we are beginning to see tangible benefits as a result of this initiative.

Via the CCG's Winter Schemes funding we have initiated a number of specific schemes which will run over the winter period to support discharge including:

- Enhancements to voluntary sector support,
- increased pulmonary rehabilitation capacity,
- increased therapy support to Care Homes,
- increased capacity in the Integrated Discharge Team and
- additional beds in the community

In addition we have secured a further cohort of Designated Care Home beds to specifically assist with flow of Covid19 positive patients out of our acute and community settings. These will come into effect from 22 November

The CCG has this week approved a further package of funding to support further discharge specific enhancements including:

- An expansion to Domiciliary Care capacity including block purchasing care for specific runs
- Increased social work and administrative support to the Integrated Discharge Team to further enhance capacity
- Social work support to our newly commissioned Designated Care Home beds
- Shropshire Trusted Assessors Pilot – focused on working with community partners to undertake low level prevention work supporting at pace discharges in the community specifically for pathways zero and two

We continue to work at pace on enhancing our Virtual Ward capabilities and have been working with NHS colleagues and drawing in clinical input from across the region and utilising this expertise to further develop our model.

Mental Health (mapped to NHSE action point 7)
The system recognises the interdependency between mental health service provision and Urgent and Emergency Care. We maintain good channels of communication with our MPFT colleagues who are engaged operationally in supporting with the provision of appropriate assessment support in A&E and the facilitation of onward movement where more specialist interventions are required.

As part of the winter planning a proposal was supported for the system to fund a limited time winter scheme for enhanced community focused admission avoidance for frail older people with mental health problems and older people with dementia. Isolation and underlying health conditions impact on older people with mental health problems particularly during winter. Older people with functional mental health issues (i.e. anxiety/ depression) often go undiagnosed and issues manifest in physical health conditions often further exacerbating mental ill health. The scheme will support this group as an alternative to hospital admission/ A&E attendance and to support earlier discharge from acute without the need for an acute mental health bed, supporting the system by increasing bed capacity. The scheme will provide additional staff to support the current hospital avoidance service operating 08:00-20:00 providing assessment and treatment to older people with mental health problems following referral. Interventions will focus on maintaining people in their own home or usual place of residence and on facilitating early discharge from hospital.

Primary Care (mapped to NHSE action point 2)
As noted above the CCG has funded additional capacity in primary care over the winter period and we continue to work with practices to support increasing the use of 111 bookable appointments in primary care as well as working with GP practices whose patient groups have high levels of Emergency Department attendance to understand how these patients can be better supported to access care in different settings

Again to reiterate information provided earlier, via the GP Winter Access fund we have also submitted a bid to support GP Streaming at the Emergency Department front door as another way of ensuring only those who need assessment and treatment in that setting access it there and that

others are redirected to more appropriate services therefore ensuring patients get the right support in the most timely way, avoiding demand bottlenecks and long waits.

Communications with the public and patients (mapped to NHSE action point 5)
The system has acknowledged the important role that communication with our public, patients and staff plays in the management of Urgent and Emergency care demand. We have seen the significant role that communications has played during the pandemic in relaying important public service and public health information and we are committed to working as a system to use the communications tools at our disposal to inform and advise our population during this time of high UEC demand and as we navigate our way through winter

System partners have local communication plans in place and are delivering key messages as part of their business as usual. However, we will also utilise our resources as a collective in the acknowledgement that consistent messages are vital to make sure that service users and communities understand what is happening, how to access appropriate services and how to look after themselves and those that they care for. We have a system communications infrastructure in place to ensure that all partners work together to a common goal, can access shared resources and are able to alert one another to local system pressures and escalation situations.

At system level, we will be focusing particularly on the following areas:

1. **Prevention**
- Reducing avoidable hospital admissions by promoting health and wellbeing with a focus on people with respiratory illnesses, especially those who have recovered from COVID-19.
- This includes the **Covid booster campaign**, **flu vaccination programme** and Public Health's - **Better Health Campaign**

2. **Signposting**
- Reducing inappropriate attendances by helping people choose self-care and the right service, linking to the national "Help Us Help You" campaign across pharmacies, extended GP access, voluntary and community services and **NHS 111** alongside appropriate use of ambulatory services.
- NHSE are launching an integrated campaign communicating the importance of both vaccines **'Boost your immunity this winter'**. There will be activity to bust myths, overcome barriers and promote the benefits of the vaccines.
- Flu vaccination and Covid-19 boosters will be critical to protecting lives, livelihoods and the NHS.

3. **Managing expectations**
- We will communicate with staff and the public about how the system is preparing for winter and what public and stakeholders can expect from services during this period.
- There will be messages in relation to changes in the way services are accessed as a consequence of the COVID-19 virus, but also due to flu, norovirus and the service pressures.
- A clear message will also be that services are working differently and to assist in managing patient expectations these will include; access to GPs and voluntary/community services, planned care, outpatients, referrals to acute care, access to A&E, out of hours services, and changes to how patient discharges are managed .

We are keen to secure the support of our public and patients in assisting us to manage the increasing demand on services by making the right choices in accessing support should they need it.

Winter Preparedness
Winter 2021/22 will see an unprecedented set of challenge across the NHS and the Shropshire, Telford and Wrekin (STW) system will be no exception. The impact of Covid-19 including the national requirements to continue to rollout the vaccination programme will be ongoing. This will be

alongside the circulation of other infections and viruses that were not prevalent last winter where we are expected to experience a resurgence, e.g. influenza and pneumonia. The NHS continues to work at pace on the recovery of services following the height of the pandemic and the system continues to balance the requirements of service recovery with the pressures winter brings to Urgent and Emergency Care.

The system has been challenged in relation to workforce for a number of years and continues to work to address issues around recruitment and retention. The availability of workforce that meets the needs of the system will continue to create pressure over the winter period for a combination of reasons including; annual leave, sickness absence, Covid19 isolation and recruitment and retention challenges. The expected impact of high Covid19 infection rates will also affect availability of healthcare staff across the system.

The modelling the system has undertaken to date indicates that demand for services will remain very high over the winter period and against the context set out above, this presents a unique and unprecedented challenge over this period.

In order to ensure the right preparations are carried out for the increase in service demands over the winter it is customary that the system assesses its preparedness and takes steps to put arrangements in place to meet additional service demands winter brings. We have endeavoured as a system to bring the process forward this year in recognition that this planning is often completed quite late in the summer/ winter cycle and also in recognition of the likely scale and complexity of the challenges we will face this winter. This work has included all system partners and has focused on all elements of service provision including primary care, community care, urgent and emergency care and elective care.

Existing Arrangements that will be relied upon at times of extreme pressure

Our preparedness work has included reviews of current policies, procedures, protocols and actions that are not winter specific but would be enacted or enhanced over the winter period to provide support to the system if the situation renders them necessary. This would include the Protocol for the Management of Emergency Pressures and a Hospital Full Protocol which are designed to support safety and quality across all areas when a hospital is under pressure.

All NHS Hospitals have been asked during the pandemic to support each other in relation to Critical Care Capacity and as such SaTH is part of an Adult Critical Care network that provides mutual aid where hospitals are experiencing Critical Care pressures. These arrangements will continue to be utilised throughout winter.

Within our local system we have, across our partnership, agreed arrangements for mutual support, including arrangements to share staff flexibly where one part of the system finds itself with escalating demand. We have built on the successful arrangements that we deployed at the height of the Covid19 pandemic to support our arrangements for meeting winter demand if necessary.

The earlier part of this report sets out a number of work streams focused on improving the provision of local Urgent and Emergency Care. We will continue to work to implement these improvements during winter and whilst this work will continue to provide benefits to patients regardless of the level of service pressure, they will become particularly important in assisting us to manage additional pressures.

Winter Specific Programmes

Our winter specific approach has centered around:

- assessing the specific challenges we believe we will face this winter
- assessing our previous approaches to winter and what has worked well
- allocating funding to schemes that will have the maximum impact for winter

Assessing the specific challenges we believe we will face this winter

As noted earlier in this report, we anticipate a unique set of inter-related challenges this winter including

- Ongoing impact and management of Covid19
- resurgence of winter illnesses such as flu, norovirus and Respiratory Viral Infections
- Ongoing delivery of the Covid19 vaccination programme and an enhanced flu vaccination programme
- Staffing shortages
- Escalating demand for all services
- Ongoing recovery of services following the eight of the pandemic

The work we are undertaking regarding winter preparedness continues to focus on addressing and working in the context of the above.

The first part of this paper sets out several areas of work aimed at relieving pressure in our system and ensuring people are accessing care in the right place. We continue to focus on Covid19, particularly working to ensure that we maintain good infection Prevention and Control arrangements within all of our health and care setting and are able to offer advice and support across the sector when issues arise. We have maintained an ongoing system Covid19 Management Group to ensure we continue to bring together expertise and best practice to enable us to manage Covid19 in the best way possible, maintaining appropriate patient pathways and delivering Covid19 specific services and flexing current services to meet need as required.

Our flu and Covd19 vaccination programmes continue at pace. For those yet to receive a Covid19 vaccine our “Evergreen” offer remains available. We are actively encouraging eligible members of the public to get both the flu and Covid19 vaccinations to give themselves, their families, friends and colleagues the best protection this winter. Community Covid19 prevalence rates remain high across Shropshire Telford and Wrekin and we encourage people to adhere to the “Hands, Face, Space” guidance and to wear a mask where they are able.

In addition, we have seen Covid19 positive admissions to hospital increase in recent weeks. This presents particular challenges for SaTH in maintaining the necessary distinct pathways for Covid19 and non-Covid19 patients and balancing creating the necessary space for Covid19 positive admissions whilst maintaining other service provision. The system has worked together to mitigate these risks and whilst Covid19 admissions are now starting to reduce this remains an ever present challenge

Modelling from other part of the world, particularly Australia, has shown the potential for an increase in Respiratory Viral Infections in young children over winter. In light of this we have reviewed our service provision and made adjustments and contingency plans should cases escalate beyond seasonal norms. Although we have seen a small number of cases presenting earlier in the season than usual, we have not yet seen a rise in cases beyond what we would usually expect. Our plans are in place however, should we need to rely on them

We continue to work collectively across partner organisations to manage significant workforce challenges. These challenges are a combination of issue relating to general staff illness, Covid19 related sickness and isolation, annual leave and other absence, exacerbated by legacy workforce recruitment challenges. Our system workforce infrastructure continues to work innovatively to look at solutions including agile and flexible working, how we use our staff and utilise skills sets creatively whilst maintaining safety and quality, sharing staff flexibly across the system where appropriate, building on the Bring Back Staff scheme initiated during the height of the pandemic and continuing to work at pace on our international recruitment programmes.

The issues of escalating demand for all of our services across health and care have been set out in the earlier part of this paper along with a range of mitigations that we are implementing. Alongside addressing these pressures we continue to balance this with the recovery of service provision following the height of the pandemic.

Assessing our previous approaches to winter and what has worked well

In early 2021 the STW system commenced a piece of work to improve our approach to winter planning, utilising independent expertise (via Prism Improvement) supported by NHSE. This work focused on a range of areas including: our use of data within the urgent care arena, our governance and decision making processes, our escalation processes and our approach to developing winter schemes in order to maximise their impact and clarify the outcomes we wanted to achieve.

As part of the process of developing our approach to winter schemes, we undertook a review of system member's experiences of previous winters within Shropshire, Telford and Wrekin and the success of previous arrangements to identify what lessons the system could learn to improve this year's winter preparedness. Using clinical expertise we identified a clear set of objectives by which we could evaluate winter schemes and established that the system was keen to ensure our winter planning was done earlier in the year. Alongside this we reviewed what winter looks like for our system, utilising data to understand the activity that we might see.

The outcomes of this process coupled with what the data was telling us indicated that we should focus on:

1. Respiratory conditions for both adults and children
2. Supporting families of children and young people to avoid A&E attendances and admissions
3. Providing alternatives for keeping patients away from A&E
4. Increasing capacity in primary care to prevent patients accessing A&E

On this basis the CCG invited bids from system partners for the delivery of schemes across the winter months that would deliver an impact in the areas set out above.

Allocating funding to schemes that will have the maximum impact for winter

As a result of this process the CCG approved £1.4m of spend to support winter specific schemes as follows:

- Implementation of a Hospital avoidance scheme for Older people with dementia
- Enhancing capacity for voluntary sector support
- Creating additional capacity for Children and Young People's Early intervention
- Creating additional capacity in Pulmonary Rehabilitation provision
- Increased therapy support to care homes
- In reach capacity to support the acute Interdisciplinary Team
- Increased community bed capacity via our two Local Authorities
- Additional same day capacity in Primary Care

We were keen to support schemes that were well developed and could be mobilised quickly. The above schemes will be/ have been implemented between October and November 21 and will run until March/ April 22. They are all subject to ongoing monitoring throughout their operational period to ensure we can maximise impact and understand what works well

In Q1 2022/23 we will begin the process of a full evaluation of these schemes to inform our approach to winter 2022/23

Conclusion

As you will see from the detail of this report there is a significant amount of work currently being undertaken to both prepare for winter in the shorter term and to improve the delivery of UEC in both the shorter and longer term. This process is iterative and will continue to develop. This report provides a point in time position regarding the work in hand to addres immediate issues an pressures as well as our aspirations for the future

UEC Recovery 10 Point Action Plan – Implementation guide

Working together to ensure urgent and emergency care recovery

NHS England and NHS Improvement

Introduction

This year has seen significant pressure put on urgent and emergency care (UEC) services. As demand has returned to pre-pandemic levels, managing this activity whilst impacted by, for instance, staff isolation and Infection prevention and control measures has constrained the capacity within the system to manage this demand.

There are further, complex, reasons for the current challenges within UEC which mean that it will take all parts of the system working together to ensure a strong recovery across urgent and emergency care services.

The NHS has a plan on how the whole system will work together to ensure UEC services have resilience, by:

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

Purpose

Our plan builds on many conversations that have taken place with leaders across UEC at both national and local level to agree consensus on how we, as a system, can recover services and ensure patients receive a clinically appropriate response in the necessary timeframe.

The purpose of this document is to share the immediate and medium term actions we can collectively take. It highlights what you can expect from the NHS England and Improvement national team – as well as setting out actions for regional NHS England and Improvement teams and at ICS and provider level. Full recovery of UEC will take time and require actions beyond this plan; this recovery plan is by necessity focused on the actions intended to be taken with immediate effect to mitigate against the current pressures felt across systems and improve performance in all settings. A key enabler to support implementation of the plan, and associated benefits, will be the collaboration with social care colleagues at every level of our organisation.

With support from both regional and national teams, ICSs will co-ordinate and lead the implementation of these actions, working with providers and system partners across the health and social care sector. There is a critical role for ICSs in leading local assessment of demand in all settings, and ensuring that plans are in place to match demand with capacity.

We recognise that as ICSs develop towards full capability by April 2022 there may be some fluidity between the actions of the region, the ICS and other system partners. It is imperative that the following actions are translated effectively across individual ICS footprints in a collaborative and comprehensive manner.

Addressing Health Inequalities

COVID-19 has highlighted the urgent need to prevent and manage ill health in groups that experience health inequalities, as outlined in the NHS Long Term Plan. It is important that as systems take both short and longer term actions to restore UEC services that they do so inclusively, with a particular focus on deprivation and ethnicity. Guidance is set out at NHS England » 2021/22 priorities and operational planning guidance: Implementation guidance, and systems should be mindful of the five key priorities for tackling health inequalities:

- Restoring NHS Services Inclusively;
- Mitigating against digital exclusion;
- Ensuring datasets are timely and complete (e.g. ethnicity coding);
- Accelerate preventative programmes (annual health checks for LD, SMI, Continuity of Maternity Carer); and
- Ensure Leadership and Accountability.

We would advise systems to cut UEC data by indices of multiple deprivation and ethnicity. This presents a powerful lens to understand e.g. acuity of attendances at A&E and subsequent outcomes by deprivation. Systems can use this information to understand local barriers, or perceived barriers, to access and consider whether targeted communication, or specific services, in the community are required to better meet patient need and avoid attendance and / or emergency admissions.

We will offer further advice on UEC and tackling Health Inequalities in the future; an early priority is to explore UEC pathways for people experiencing homelessness.

1. Supporting 999 and 111 services.

National commitments: what you can expect from us

111 funding and CAS capacity – addressing operational pressures

To support both 999 and 111 services it is critical that local systems understand demand and have commissioned suitable alternatives to referral and / or conveyance for appropriate patients.
111:

- We will work, through regions, to support ICSs and commissioners to ensure baseline funding is increased to support 111 and ensure there is sufficient capacity.
- We offer guidance and support on the uptake of recent NHS Pathways licence easements to facilitate remote clinical supervision, call handlers homeworking and increased training throughput.
- We will offer technical support around the deployment of homeworking technology to mitigate against high levels of staff abstraction resulting from positive testing and isolation requests.
- We will roll out the use of Video Consultation offering “eyes on” for clinicians to improve outcomes reduce referrals, and IUC providers should be maximising utility of this offer.
- We propose further automation of elements of the call flow such as demographics capture to reduce the reliance on human resources.
- We ask systems to support greater pooling of resources at regional level increasing economies of scale and more cross regional buddying arrangement.

Supporting NHS 111.

System commitments: what we expect from you

Actions at regional level

111:

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

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

Ensure continued implementation of NHS 111 First.

Implement Further, Faster (where applicable).

Consider regional networked call handling.

Actions at system/ICS level

111:

Demonstrate system leadership across UEC.

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

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

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

Actions at provider level

111:

Ensure performance and quality of service.

Spend funding appropriately to maximise resource.

Plan for forthcoming winter.

Supporting 999 and 111 services.

National commitments: what you can expect from us

999 funding and CAS capacity – addressing operational pressures

To support both 999 and 111 services it is critical that local systems understand demand and have commissioned suitable alternatives to referral and / or conveyance for appropriate patients
999:

- We will support the ongoing roll out of the £55m winter funding made available to all ambulance services to stabilise and improve performance by delivering increased call handling and operational response capacity, clinical support, and e.g. HALO support for acute trusts with continued challenges in handover of patients.
- We have set out national guidance and support ambulance trusts on clinical validation to support the implementation of C3/4 999 clinical validation changes for lower acuity ambulance calls, safely fast tracking key learning from the ongoing pilot sites.
- We will support cross-system work on reducing hospital handovers i.e. minimise patient safety risks and enable crews to turnaround vehicles more rapidly.
- We will provide a national escalation point as required to increase ambulance service capacity according to local requirements e.g. through identifying and deploying or coordinating national levers and organisations e.g. St John's; and, issuing revised self isolation advice
- NHSE/I People Directorate will lead work with HRDs, AACE and Unions to optimise the health and wellbeing of the existing workforce
- We will nationally review options to manage demand for lower acuity ambulance dispositions from NHS 111.

Supporting 999 services.

System commitments: what we expect from you

Actions at regional level

999

Ensure the £55m allocations are spent through ICSs.

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

Actions at system/ICS level

999

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

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

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

Actions at provider level

999

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

Ensure C3/4 validation amends are implemented as needed.

Make sure capacity issues are escalated rapidly.

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

2. Supporting primary care and community health services to help manage the demand for UEC services.

National commitments: what you can expect from us

Improving primary and community care access and moderating downstream demand – Part 1

We know that primary care is key to supporting UEC recovery through demand management; this should reflect a balance between making best use of technology and offering face to face appointments.

- We will maximise workforce capacity through:
  - additional staff resource for vaccination (£20m support over June and July).
  - General capacity funding at £120m during the first half of 2021-22 (TBC for H2).
  - Driving ongoing PCN recruitment through the ARRS and improving GP recruitment and retention.
- We will maximise the use of community pharmacies as part of integrated care pathways by:
  - Optimising referrals from NHS 111, 999, IUC CAS, UTC and ED to manage low-acuity activity and support access to urgent medicines supply as part of the NHS Community Pharmacist Consultation Service (CPCS).
  - Optimising referral from General Practice to CPCS for low acuity conditions to manage demand in primary care.
  - Comms push planned for CCGs and practices to drive up referral rates to the GP CPCS, aligned with IIF indicator going live on Oct 1st. Inclusion of requirements in winter planning and planning guidance.
  - Optimising referral from acute services into the Discharge Medicines Service (DMS) to reduce re-admission for patients discharged on multiple medicines.

Continued . . .

2. Supporting primary care and community health services to help manage the demand for UEC services.

National commitments: what you can expect from us

Improving primary and community care access and moderating downstream demand - Part 2

- We will prioritise urgent dental care delivery through maintaining a system for UDCs.
- We will support practices and PCNs through the Access Improvement Programme.
- Improvements will be made to remote triage/online consultation access.
- We will Improve direct booking functionality from 111 into practices and extended/enhanced access services .
- We will optimise access models through extended access including new arrangements via the network contract DES from April 22.
- Cancer – PCNs should use data provided to them on the 36k people who have not come into cancer services to support GP practices to identify patients who may have cancer.
- We will continue to support systems and providers with the roll out of two-hour crisis response (UCR) services at scale, ensuring provision is 7 days a week and a minimum of 8am until 8pm, along with enabling and diversifying referral routes into two-hour services from 111, 999 and other services to support admission avoidance and care in the right place. This includes the investment of £273.4 m in 21/22 to support community transformation.

Supporting primary care to help manage the demand for UEC services.

System commitments: what we expect from you

Actions at regional level

Workforce

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

Access

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

Dental

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

Actions at system/ICS level

Workforce

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

Access

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

Actions at provider level

At Trust Level

Workforce

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

At PCN level:

Access

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

At Practice level:

Access

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

Workforce:

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

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

System commitments: what we expect from you

Actions at regional level

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

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

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

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

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

Actions at system/ICS level

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

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

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

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

Actions at provider level

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

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

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

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

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

3. Supporting greater use of Urgent Treatment Centres (UTCs).

National commitments: what you can expect from us

Urgent Treatment Centres (Type 3 & 4 services)

- We will, where asked, work with regions and systems to explore the suitability of the UTC model locally, including co-located UTCs alongside ED to manage demand.
  - Alternatives may be other forms of primary care provision in the community, or forms of enhanced streaming and / or triage at the front door of ED.
- We have set clear expectations on what a UTC should offer through the published UTC standards.
- We will work with NHS Digital and NHS X to support and implement direct booking of appointments in all UTCs
- We will support the adoption of the national information booking standard, Care Connect, which aims to standardise appointment booking in urgent care.
- We will promote the adoption of referral pathways into UTCs from NHS 111 and 999.

Supporting greater use of Urgent Treatment Centres (UTCs).

System commitments: what we expect from you

Actions at regional level

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

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

Actions at system/ICS level

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

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

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

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

Actions at provider level

Deliver the UTC model and support implementation of new pathways.

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

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

4. Increasing support for Children and Young People.

National commitments: what you can expect from us

Children and Young People

- We will work with our key partners, including PHE/DHSC on national and targeted messages, alerting parents to symptoms and appropriate management for common seasonal illnesses.
- With DHSC, provide a 1.8m fund for Voluntary, Community and Social Enterprise (V.C.S.E) organisations to support self management and provide tailored information to targeted groups of children, young people, families and carers (including the most vulnerable) and carers with seasonal illness in 21/22. The bidding process for this funding will begin in August.
- Issue guidance and case studies to support CCGs / ICSs who wish to establish an Adult and Paediatric (all ages) out of hospital Respiratory Clinical Assessment Services (RCAS) to manage the likely increase in respiratory infections.
- HEE have produced a 'Respiratory Surge in Children programme – e – learning programmes. This includes modules for recognition, management and escalation for CYP across settings.
- We have worked with the Joint Committee on Vaccination and Immunisation (JCVI), partners and the palivizumab manufacturer to mobilise an early programme to identify and protect those at risk of severe complications from RSV.
- We will develop the role of the paediatric workforce to reduce pressure on UEC by **piloting** a national paediatric CAS in 111. This builds on previous work undertaken to place paediatricians into local CAS services. Learning will be shared with local systems.
- We will establish a National Cell specifically to manage actions for Children and Young People.

Increasing support for Children and Young People.

System commitments: what we expect from you

Actions at regional level

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

Actions at system/ICS level

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

Actions at provider level

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

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

National commitments: what you can expect from us

National communication activity and campaigns

- **Immediate action:** we will undertake a number of activity strands to:
  - Push lower acuity cases to NHS 111 online through a campaign via social media and digital channels (incl. video on demand)
  - Ensure good signposting on nhs.uk.
  - Create a template press release for ambulance services re: pressures.
- **Immediate action:** we will create a suite of materials aimed at people holidaying in England as well as covering when to use NHS 111, GP practices and pharmacy as well as encouraging people to stock up on prescriptions before they go away.

- We will plan and develop a schedule of national communications campaigns and activity to guide patients to access UEC services appropriately (whether online, telephone, face to face).

- We will roll out a campaign to support reducing long hospital stays:
  - With the aim of empowering the patient to being confident to ask questions about their care;
  - as well as push the previous staff engagement campaign to enable better flow within hospitals and understanding system pressures.

- We will develop materials to promote understanding among clinicians of what Same Day Emergency Care (SDEC) services can offer and encourage peer-to-peer conversations/referrals.

Using communications to support the public to choose services wisely.

System commitments: what we expect from you

Actions at regional level

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

Amplify national campaigns and cascade regionally.

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

Ensure local campaigns are consistent with national messaging.

Actions at system/ICS level

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

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

Actions at provider level

Ensure promotion of length of stay campaign within your trust.

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

6. Improving in-hospital flow and discharge.

National commitments: what you can expect from us

Improving in-hospital flow and discharge

Same Day Emergency Care:

- We will support systems to maximise SDEC provision through restoration of workforce and estate to pre-pandemic levels as a minimum, develop further guidance and promote direct access for all appropriate patients (e.g. paramedic referral).
- Working with systems to support acute providers develop short -long term plans for staffing models, estate and facilities to embed this model of care and avoid usage of SDEC areas as a bedded ward.

To support flow in Emergency Departments (CRS):

- We will work through regions to support providers and ICSs to improve patient flow through hospitals; from arrival to discharge.
- We will offer technical and operational support for all providers to adopt the Clinical Review of Standards and the principles of Clinically Ready to Proceed (CRTP), requiring trust wide adoption of and engagement to 'own' ED flow issues.
- We ask systems to support every aspect of seven day working to ensure all patients are seen promptly by a senior clinical decision maker.
- We will work through regions to reduce 12 hour stays in ED, linking ambulance offload difficulties, clinically ready to proceed delays and 12-hour delays.
- We will provide guidance to support for frequent attenders and rough sleepers and people experiencing homelessness to ensure continuity of care and reduced attendances.

Improving in-hospital flow and discharge.

National commitments: what you can expect from us

Improving in-hospital flow and discharge

To support early discharge and reduce in hospital length of stay:

- We will continue working with systems to reduce in-hospital length of stay to levels which remain clinically appropriate and make more efficient use of NHS resources eg utilise data to focus on trusts that are above the mean average for LoS on 21 and 14 days and have greatest potential release of capacity.
- We will continue to drive clinical leadership and engagement to support Discharges and reduce LOS.
- We will support systems to implement the National Operational Hospital Discharge policy.
- We will continue working with systems to maximise flow over seven days, including increasing weekend discharges.
- We will continue working with systems to embed the Discharge to Assess model and ensure that people are efficiently discharged on the correct pathway when they no longer meet the Clinical Criteria to Reside, with a view that the average length of stay in acute care will continue to reduce.
- Nationally we will continue to monitor availability of critical care and specialist beds and support regions and providers in the availability and management of these beds, using the Critical Care Capacity Panel as required to provide strategic oversight and support.
- We will provide guidance to systems on non-emergency patient transport services, this will support rapid discharge and assist in embedding other good practice (rapid access to pharmacy and deployment of cleaning teams).
- We will support systems to increase appropriate referrals to the community pharmacy discharge medicines service (DMS), which is now available in all community pharmacies in England. All NHS Acute, community and Mental Health Trusts can refer into the NHS DMS. Based on the evidence, for every 30 completed NHS DMS referrals, one 30-day re-admission can, on average, be avoided.

Improving in-hospital flow and discharge (SDEC).

System commitments: what we expect from you

Actions at regional level

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

Actions at system/ICS level

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

Actions at provider level

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

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

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

Avoid usage of SDEC as a bedded ward overnight.

Ensure acute Frailty SDEC Provision 70hrs + per week.

Improving in-hospital flow and discharge (CRS).

System commitments: what we expect from you

Actions at regional level

Assure system plans to measure:

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

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

Actions at system/ICS level

Drive system culture and leadership plans to support CRS.

Drive best practice sharing, peer reviews and case studies.

Own improvement programmes with ongoing monitoring.

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

Develop/strengthen governance arrangements to support collaboration.

Actions at provider level

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

Improving in-hospital flow and discharge (reducing length of stay).

System commitments: what we expect from you

Actions at regional level

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

Actions at system/ICS level

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

Develop/strengthen governance arrangements to support collaboration.

Actions at provider level

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

7. Supporting adult and children's mental health needs.

National commitments: what you can expect from us

Addressing Mental Health Pressures

• We will continue to increase investment in mental health, with clear published expected investment profiles for each ICS, to:
- improve access and capacity in community based mental health crisis services and alternatives to A&E for children and adults;
- improve access and capacity in adult mental health liaison and CYP equivalent services in ED and general hospital wards; and
- increase dedicated MH capacity in ambulance services to reduce avoidable conveyance to ED.
• Data and analysis: We will develop and share specific mental health data reports from ECDS, split by age at region, ICS and provider level on total attendances, and 12h waits in ED for mental health patients. Intended to bring transparency benchmarking and identify systems with highest mental health pressures for the first time at national.
• We will ensure that all CCGs/providers in England have s.140 compliant MH bed management protocols in place, and all regions have clear MH escalation process.
• We will develop and issue national guidance on open access community MH crisis services, including expectations for access to urgent mental health care via NHS 111 and delivery against proposed new standards.
• We will develop and issue national guidance on adult acute mental health inpatient care (including flow and discharge).
• We will explore strengthening national mechanisms to support integration of NHS/LA mental health services (eg BCF, DHSC social care plan).
• We will work with CQC in relation to closures of CAMHS beds to better align bed capacity and bed demand at system level.
• We will improve integration between CYPMH and acute trusts (with particular focus on supporting the paediatric workforce) through ensuring there are clear pathways and guidance to support joint working, and integration, across physical and mental health.
• We will continue the roll out of CYPMH provider collaboratives.

Supporting adult and children's mental health needs.

System commitments: what we expect from you

Actions at regional level

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

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

Sharing systems together to share learning.

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

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

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

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

Actions at system/ICS level

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

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

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

Allocate share of local capital funding for MH capacity pressures.

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

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

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

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

Put in place s.140 compliant bed escalation protocols.

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

Actions at provider level

Invest in staff wellbeing initiatives.

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

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

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

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

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

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

8. Reviewing Infection Prevention and Control (IPC) measures to ensure a proportionate response.

National commitments: what you can expect from us

Changes to IPC guidance

Social/physical distancing measures have impacted capacity and operational flow. A review of the IPC guidance is in progress, this should provide an evidence based, proportionate approach to service restoration that protects patients and staff whilst releasing capacity within established estate requirements.

Whilst we await outcomes of this review, we must reiterate the following principles:

- There should be an expectation of no corridor care.
- Patients should not be left waiting in ambulances for handover to emergency departments.
- Patients and staff in the UEC pathway experience parity of safety with other parts of the health system.

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

System commitments: what we expect from you

Actions at regional level

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

Actions at system/ICS level

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

Actions at provider level

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

9. Reviewing staff COVID self isolation rules.

National commitments: what you can expect from us

Staff isolation policy

- COVID-19 absences due to Test & Trace and Self-Isolation in England had been steadily rising from the beginning of June 2021. Guidance for NHS and social care staff was issued 19 July 2021 to address this and has been further updated in August 2021.

Reviewing staff COVID self isolation rules.

System commitments: what we expect from you

Actions at regional level

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

Actions at system/ICS level

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

Actions at provider level

Ensure Compliance with updated Staff Isolation guidance.

10. Ensuring a sustainable UEC workforce.

National commitments: what you can expect from us

Workforce

- We will work with the Royal Colleges and other stakeholders to ensure we improve the pipeline for the future by having a long-term plan for workforce across the UEC pathway.
- We will develop new models of acute medicine - such as the increasing utility of SDEC and acute frailty services, as well as the need for increasing consultant presence at the front door to support admission decisions.
- We will address short term staff capacity pressures felt in all patient facing workforce groups, exacerbated by additional time donning and doffing PPE.

Ensuring a sustainable UEC workforce.

System commitments: what we expect from you

Actions at regional level

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

Actions at system/ICS level

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

Actions at provider level

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

Plan recruitment across 111 services.

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

This page is intentionally left blank

Shropshire, Telford & Wrekin
Sustainability and Transformation Partnership

Phlebotomy Update

JHOSC

November 2021

Phlebotomy Review Scope/Objective

Programme Scope:

- Whole system review of all out-patient phlebotomy services across Shropshire, Telford and Wrekin. Based upon the principles of:-
  - Patients should have **local access to phlebotomy** irrespective of the person requesting the blood test
  - Adults and children should all have their **blood taken by someone with specialist skills** making it as painless as possible
  - The whole programme is **co-produced with stakeholders**. This includes people that use the service, clinicians that require blood tests as part of an outpatient/primary care pathway of care, clinicians in primary care that are commissioned to provide phlebotomy services

Programme Objective:

- To ensure consistent commissioning of phlebotomy across STW for adults and paediatrics, reduce variation in service access and improve quality and patient experience

Review progress – phases complete

Phase 1 - information gathering (January - July)

- Activity analysis - demand modelling
- Engagement work – current experience, what's important
- Finance and contracting – how we contract and what we currently invest in phlebotomy

Phase 2 - Clinical Design (August-September)

- Taking the information from phase 1, develop a set of core service requirements
- Having reference to the core set of requirements, system stakeholders (including current provider clinical leads, patient rep and Healthwatch) co-produce a long list of options for the future service model

Phase 3 - Long List Options Viability Appraisal (November)

- Workshop held on 1st November to undertake a high level assessment of the options, their risks and benefits against the core service requirements to determine if there are any at this stage which should not be carried forward as they do not sufficiently meet the core service requirements. Outcome paper to Strategic Commissioning Committee on 17th November for approval to move to the next stage.

Review progress – next phases

Phase 4 - Work up the options in detail (delivery model, workforce, estate, finance etc) and develop the phase 5 communication and engagement plan

Phase 5 - Public Consultation or Engagement Exercise

- Paper to JHOSC seeking approval of comms and engagement plan
- Public consultation or engagement exercise

Phase 6 - Shortlist to Preferred Option

Phase 7 - Preferred Option Business Case Approval

Phase 8 - Commission/contract the new model and mobilise

TIMELINE: The aim is for the new service to be mobilised Q1 2022/23

Current Phlebotomy service provision position

- **Global Blood tubes supply shortage** - The current situation with the consumables is stable, however, NHSEI still have measures in place for both primary and secondary care, focus is on demand management of requests, monitoring stock levels and the re-introduction of monitoring bloods over a period of time. It is anticipated these measures will be in place until spring next year.
- **Demand for the service** remains extremely high.
- **Protected appointments are available for urgent bloods** within 48 hrs of the request being made and Warfarin patients. This is similar to the waits seen by the service in the weeks before the global shortage of blood collection products. Waiting time for routine bloods is 4-6 weeks due to the backlog from the suspension of routine blood testing in response to the global blood tube supply issue.
- **SATH are currently taking on average 600 bookings per day**, a combination of online and telephone bookings. The feedback from patients is that they would use the online booking however there are no appointments in the timeframe that they want. Booking line staff are continuing to support more callers to use online booking wherever feasible and restore online booking levels to previous levels in excess of 60%. Aspiration is to achieve 80% of patients booking their appointments online booking within the next 6 months.
- **General Practice** who have signed up to deliver an in house service continue to provide this service

Current Phlebotomy service provision position

- **Additional capacity at PRH** – Additional clinic rooms have been made available at PRH, already seeing a reduction in wait times from 5 weeks to 18 days. Awaiting further equipment to open up more sessions – early December 2021.
- **Additional capacity at RSH** – SaTH in discussion with Severnfields Medical Practice to open up some sessions there.
- **Additional capacity at Whitchurch** – week commencing 15th November, some additional morning sessions to be opened to reduce waiting times
- **Additional capacity at Bridgnorth** – discussions are underway to increase capacity at Bridgnorth
- **SaTH have secured additional funding for staff for 4 months** to support the back log of patients for blood tests, envisage start mid November 2021 (enable a further 240 bookings to be made on line to start with for RSH).

Current Phlebotomy service provision position

Current position - waiting times week of 8th November 2021

Site	Urgent blood availability	Routine bloods	Warfarin availability	Paediatrics
RSH	Within 48hrs	28 Days	Within 24hrs	5 Days
PRH	Within 48hrs	18 Days	Within 24hrs	8 Days
Whitchurch	Within 48hrs	13 Days	Not applicable	Not applicable
Bridgnorth*	Within 48hrs	20 Days	Not applicable	Not applicable

This page is intentionally left blank

The Shrewsbury and Telford Hospital NHS Trust

Cardiology Inpatient potential service change

Background

The Shrewsbury and Telford Hospital NHS Trust

- Currently inpatient Cardiology services are provided at the Royal Shrewsbury Hospital (RSH) on ward 24 and Ward 6 at the Princess Royal Hospital (PRH).
- At RSH there are 20 beds including 8 Acute Coronary Care Unit (ACCU) beds.
- At PRH there are 25 beds including 5 ACCU beds.
- For a number of years there have been workforce issues on both hospital sites within Cardiology. Historically the service has had challenges with medical workforce recruitment, however more recently the recruitment of trained cardiac nurses has also been an issue.
- Due to the nurse recruitment issues, the inpatient service has found it challenging to provide the required staffing levels. The department has now reached minimal staffing levels and any episode of sickness is putting the service at risk.

Background

The Shrewsbury and Telford Hospital NHS Trust

- The majority (70%) of the cardiology service which comprises diagnostic, interventional procedures, Cath lab and outpatient services are currently located at PRH.
- Patients from RSH who require diagnostic or interventional procedures, often have an increased length of stay as they are required to be transferred and for a bed to be available and allocated on the PRH site. Although the department facilitate a treat and return facility within PRH this is often hampered by the availability of specialist transport.
- On an average 10 patients per week are needing to be transferred from RSH for diagnostic/intervention procedures. RSH patients can wait 5-6 days to be transferred and for some more specialist intervention this wait can be longer. This is primarily down to transfer time frames and bed availability.
- Due to the delays in patient transfers the Cath Lab is not being used to full capacity. The result of this is delay to the patient in obtaining treatment and empty capacity on lists allocated for inpatient support.
- During COVID there are Amber and Green pathways and patients on these pathways must remain separate at all times. As a result of this there is a reduced trolley recovery capacity within the Cardiac Day Unit, for example there is a reduction of two trollies when facilitating an amber patient from RSH.

HTP – The Future of Cardiology

The Shrewsbury and Telford Hospital NHS Trust

- Cardiology services are allocated on the Acute site (RSH) within the Hospital Transformation Programme (HTP).
- The move of all cardiology inpatient services to PRH is a temporary change and once HTP progresses services will be relocated in a new facility at RSH
- The temporary move of all inpatient cardiology services to PRH will support the service until the changes and help the team evolve into a single site model.
- It is hoped that the earlier move to a one site model will greatly enhance the patients experience of the Cardiology Inpatient Service.

Reasons for change

The Shrewsbury and Telford Hospital NHS Trust

- The majority (70%) of the cardiology service which comprises diagnostic, interventional procedures, Cath lab and outpatient services are currently at PRH.
- A significant number of cardiology inpatients admitted to RSH are then required to be transferred to the PRH site for a diagnostic or cardiac procedure as part of their inpatient stay.
- Having a bed available at PRH for the transfer is a challenge when the escalations levels in the hospital are at level 3 and 4.
- As a result of COVID and the need to keep green and amber patients separate has had a significant impact on the ability to transfer patients from RSH to PRH to perform interventions in the Cath Lab.
- Specialist workforce is currently split across two hospital sites – issues with sickness absence etc.
- Please note that most serious heart attack cases are currently transported directly to either Wolverhampton or Stoke

Proposal

The Shrewsbury and Telford Hospital NHS Trust

As an interim measure until HTP is progressed, it is proposed that all Cardiology inpatient services are moved to PRH. The reasons for this are:

- To support the fragile workforce issues
- To prevent delays in diagnostic and interventional procedures for cardiology inpatients
- To support the COVID-19 pathways
- The outpatient service provided by Cardiology, Cardiorespiratory and Cardiac Rehab at RSH would continue.

Proposal

The Shrewsbury and Telford Hospital NHS Trust

We would do this by:

- Transfer ward 24 cardiology inpatient beds (RSH) to ward 7 at PRH. Ward 7 is next door to our current cardiology ward (ward 6).
- Cardiology would have 15 beds for cardiac patients on ward 7. These beds are currently General Medicine beds, which currently are regularly used by Cardiology outliers.
- Under the new proposal the remaining 13 beds on ward 7 would be used for Endocrine.
- This would give Cardiology a total 38 beds over 2 wards. This bed base would comprise of 28 general cardiology, 8 ACCU beds and 2 high telemetry side rooms.
- The 20 bed released at RSH would then become General Medicine beds.
- On average this will affect up to 25 cardiology inpatients per week.

Key benefits

The Shrewsbury and Telford Hospital NHS Trust

- Patients will see an improved inpatient service with timely access to diagnostics and intervention. In particular patients who would have previously been admitted to the RSH site and then transferred to PRH would have quicker access to diagnostic and interventional procedures.
- Reduction in the length of stay, which in turn will improve outcomes for cardiology patients.
- The department sees an improved recruitment, retention and sickness position for all staffing groups.
- It supports training for student nurses, junior doctors and middle grades, helping to develop the cardiac staffing models of the future.
- Risks held within the inpatient service around staffing and estate are addressed.
- Greater bed base for general medicine patients on the RSH site.

Issues

The Shrewsbury and Telford Hospital NHS Trust

There is a requirement to upgrade the telemetry system at PRH (planned for 2021 before decision to move) and undertake some estates work within the cardiology base.

There will be a requirement to facilitate direct pathways to the PRH site liaising with the ambulance services. Conversations are already underway.

Some patients care will be delivered further away from their home which could potentially in the future impact on visiting (currently there is restricted visiting at our hospitals due to COVID19)

What next - Timescales

The Shrewsbury and Telford Hospital NHS Trust

Changes in the service will require approval by the Trust Board and a decision is expected before winter.

All staff are fully aware and have had regular updates in person from the Centre Manager and Matron since the initial discussions in July 2020.

EQIA was completed and presented last year. This will be reviewed again with patient and public input.

If the service move was to go ahead we would review this after 6 months with patient and public involvement.

Regular updates on the proposal, move and subsequent consolidated service will be given through the community members update email.

Contact details of who to contact if you want to email/telephone feedback –

Debbie Houliston, Centre Manager – Debbie.houliston@nhs.net or

Donna Moxon, Operations Manager – Donna.moxon2@nhs.net

Engagement Plan

The Shrewsbury and Telford Hospital NHS Trust

- We held a Stakeholder Event on Thursday 2nd September which had representatives from:
  - Healthwatch (Shropshire, T&W)
  - CHC
  - Members of Health Overview and Scrutiny Committee (HOSC)
  - Members of the Health and Wellbeing Boards (HWBB)
  - Local and National Cardiology patient groups
  - Local Patient groups (e.g Telford Patient First and Shropshire Patient Group)
  - Following the meeting we have sent the presentation slides and the draft EQIA to all who attended to share with their groups and provide any feedback.
- We have a website page which has a copy of the presentation, a question and answer sheet and the draft EQIA – this is accessible to all members of the public
- We have written the following:
  - MP's
  - HOSC
  - HWBB
  - We included a copy of the presentation and EQIA

Attendance at events to discuss the proposal:

- Quarterly Community Meeting – 22nd September 2021
- Powys Services Planning Committee – 21st September 2021
- Montgomeryshire Local Committee – Thursday 14th October 2021
- Telford Patient First - Wednesday 1st December 2021

This page is intentionally left blank

NHS
The Shrewsbury and Telford Hospital
NHS Trust

Engagement Report

Proposed changes to Cardiology Inpatient Services

Julia Clarke, Director of Public Participation

Hannah Roy, Head of Public Participation

Background

The Shrewsbury and Telford Hospital NHS Trust

- This presentation outlines the engagement that has been undertaken with our local communities around the potential service change of cardiology inpatient services at RSH and PRH
- Currently inpatient Cardiology services are provided at the Royal Shrewsbury Hospital (RSH) on ward 24 and Ward 6 at the Princess Royal Hospital (PRH).
  - At RSH there are 20 beds including 8 Acute Coronary Care Unit (ACCU) beds.
  - At PRH there are 25 beds including 5 ACCU beds.

  The cardiac catheterisation lab is based at the Princess Royal site
- For a number of years there have been workforce recruitment issues on both hospital sites, as well as nationally, within Cardiology. Historically the service has had challenges with medical workforce recruitment, however more recently the recruitment of trained cardiac nurses has also been an issue.
- Due to the nurse recruitment issues, the inpatient service has found it challenging to provide the required staffing levels. The department has now reached minimal staffing levels and any episode of sickness is placing great pressures on the service.
- COVID-19 pathways have also placed an additional constraint on the service
- The senior consultants in cardiology and more widely have developed a medium-term plan to strengthen cardiology services which has the full support of all the workforce.

Proposed Change

As an interim measure until HTP is progressed, it is proposed that all Cardiology inpatient services are moved to PRH. The reasons for this are:

- To strengthen the cardiology workforce
- To prevent delays in diagnostic and interventional procedures currently experienced by RSH cardiology inpatients
- To support the COVID-19 pathways
- The temporary move of all inpatient cardiology services to PRH will support the service until the changes and help the team evolve into a single site model. This is an interim measure until HTP progresses. Under the HTP model Cardiology services are co-located with the ED at RSH.
- It is hoped that the earlier move to a one site model will greatly enhance the patients experience of the Cardiology Inpatient Service.
- The outpatient service provided by Cardiology, Cardiorespiratory and Cardiac Rehab at RSH would continue.
- To see the full proposal click here: Cardiology Inpatient Service - Temporary Service Change - SaTH

Reasons for Change

The Shrewsbury and Telford Hospital NHS Trust

- Currently the majority (70%) of the cardiology service which comprises diagnostic, interventional procedures, Cath lab and outpatient services are located at PRH.
- Inpatients from RSH who require diagnostic or interventional procedures, often have an increased length of stay as they need to be transferred to PRH when a bed becomes available
- On an average 10 patients per week are transferred from RSH for diagnostic/intervention procedures. RSH patients can wait 5-6 days to be transferred and for some more specialist intervention this wait can be longer. This is primarily down to transfer time frames and bed availability. It also means that the cardiology diagnostic facilities are not being fully utilised
- During COVID there are Amber and Green pathways and patients on these pathways must remain separate at all times. This impacts on the effective operation of the Cardiac Day Unit.

Engagement Process

The Shrewsbury and Telford Hospital NHS Trust

- As an NHS Provider organisation we have a legal duty under Section 242 of the Health and Social Care Act 2012, to ensure that patients and/or the public are involved in certain decisions that affect the planning and delivery of NHS services. (Staff have been engaged through separate processes)

- As an organisation we believe its is important that we engage with our communities and stakeholders, prior to any decisions being made

- This report outlines how we have engaged with our communities and have informed and involved them in the discussion around the proposed service change.

- From the discussions we have had with our communities we can address any issues prior to implementing any changes in services

Stakeholder Forum

- On Thursday 2nd September we held a stakeholder event with attendance from the following organisations:
  - Healthwatch (Shropshire, T&W)
  - CHC
  - Members of Health Overview and Scrutiny Committee (HOSC)
  - Members of the Health and Wellbeing Boards (HWBB)
  - Local and National Cardiology patient groups
  - Local Patient groups (e.g Telford Patient First and Shropshire Patient Group)
- A presentation giving an overview of current service provision and the potential service change was given by Dr Tom Ingram (Consultant Cardiologist), Debbie Houliston (Centre Manager) and Sarah Kirk (Matron for Cardiology)
- Feedback from stakeholders was provided at the meeting and a discussion regarding further engagement with our community was discussed
- Following the meeting we have sent the presentation slides and the draft EQIA to all who attended to share with their groups and provide any feedback. Please see Appendix 1 for presentation slides and Appendix 2 EQIA.

Engaging our Stakeholders

The Shrewsbury and Telford Hospital NHS Trust

- As part of our s242 engagement plan the following organisations/individuals have been contacted to advise of the proposal and a copy of the Equality Impact Assessment
  - Local MP's
  - Health Overview and Scrutiny Committee
  - Health and Wellbeing Board

We welcomed feedback and comments from any organisation and contact details of the Cardiology Centre Manager and Operational Manager were provided in the presentation pack

- Our Operational Team have also discussed the proposed service changes with the ICS Shropshire, Telford and Wrekin CCG and Powys Teaching Health Board

Engaging with our Communities

The Shrewsbury and Telford Hospital NHS Trust

- The Trust has a community membership of over **2500** members. Every month an **email update** goes to all community members, and an article on the proposed changes was part of the September update. Our email gave a link to our webpage which provided members with more information.

- The proposed service change was presented at the Trust's **Quarterly Community Update meeting** on 22nd September 2021. This meeting is open to all members of the public and to community groups and organisations. Questions were received from the public and were answered by the clinical and operational teams

- Throughout our engagement we have offered to attend any public meeting to discuss the potential service change, and as a result we have attended or are due to attend the following meetings:
  - Powys Services Planning Committee – 21st September 2021
  - Montgomeryshire Local Committee – Thursday 14th October 2021
  - Ludlow Community Connectors – Tuesday 9th November
  - Telford Patient First - Wednesday 1st December 2021

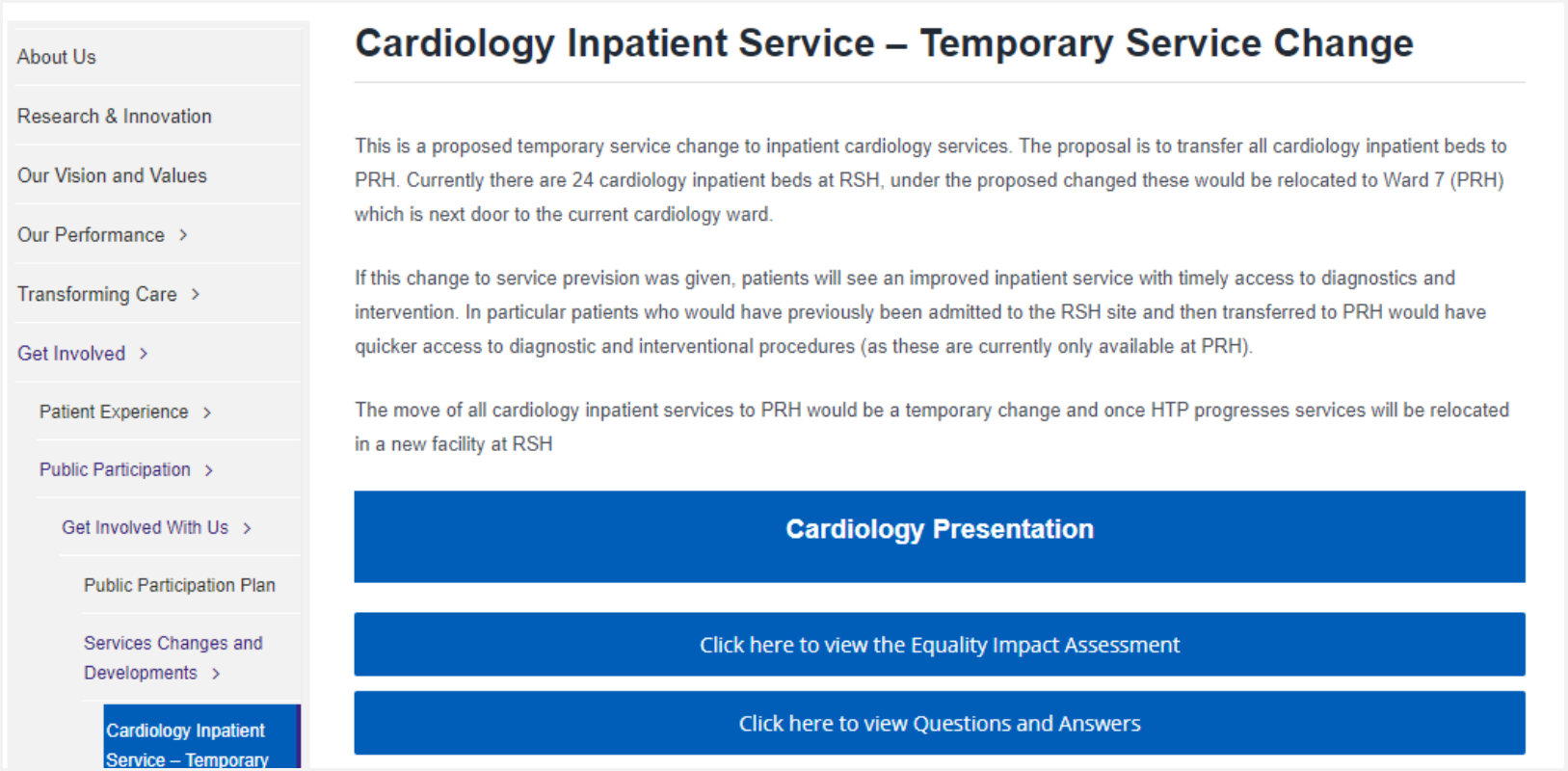
SaTH Website

The Shrewsbury and Telford Hospital NHS Trust

There is a dedicated webpage on our public website www.sath.nhs.uk regarding the potential service change to cardiology inpatient services.

This page is available to the public and the website has the functionality to change the language, and alternative formats to support accessibility.

- The webpage outlines the proposed service change and has links to the following documents:
  - Cardiology presentation
  - Equality Impact Assessment
  - Questions and Answers document



Previous Engagement (2020)

The Shrewsbury and Telford Hospital NHS Trust

- In July/August 2020 the Trust engaged with the public about the repatriation of Trauma and Orthopaedic services, from Robert Jones and Agnes Hunt Hospital, following the services being temporarily relocated there as part of the local response to COVID-19 and the centralisation of cardiology inpatient service at PRH
- Whilst the proposals for inpatient cardiology services did not progress at that time, the following engagement was carried out:
  - Stakeholder Forum (17th August 2020) – with representatives from Healthwatches, Community Health Council and local patient groups
  - Attendance and presentation at the SaTH Equality, Diversity and Inclusivity Patient Group meeting (Thursday 13th August 2020)
  - EQIA Assurance meeting with Healthwatches, CHC (Thursday 13th August 2020)
- The proposed changes to inpatient cardiology services discussed in 2020, have not changed from the proposed service we are currently engaging on.
- The proposed changes were supported by our communities in 2020 however due to the lapse in time, the Trust decided that it was important to re-engage with our communities again around these proposed changes.

Key Themes

The Shrewsbury and Telford Hospital NHS Trust

From the Stakeholder engagement, key themes were identified from the questions and comments given by our stakeholders and communities, these are:

Key Theme	Comment/Issue	Response
Accessibility and Transport	• Concerns for those living the further away, and transport to PRH	• Nearly all inpatient admissions are by ambulance. The most serious heart attacks are currently transported directly to Stoke or Wolverhampton • For patients admitted to RSH they will be transported by ambulance to PRH
	• Has the impact on relatives visiting patients who are further away been addressed?	• It was acknowledged that the current proposal may impact on relatives visiting patients, particularly those who live further away from PRH. However currently there is restricted visiting at both sites due to COVID-19 guidelines. It was acknowledged by the public that the reduced length of stay created by a single site service would be beneficial to patients and relatives. There is also now a bus service between both hospital sites which could also be utilised.
	• What happens when I get discharged from hospital?	• When patients are discharged, arrangements will be made with the individual and their carers to ensure they return safely (e.g. via patient transport, relatives etc.) and outpatient follow-up, cardiac rehab etc will continue on both sites

Key Theme	Comment/Issue	Response
Hospital Transformation Programme	• How do these current proposes fit with the Hospital Transformation Plan?	• Under the Hospital Transformation Programme, Cardiology inpatient services will be on the Acute site (RSH)
	• Will the HTP programme for Cardiology still go ahead?	• The move of all cardiology inpatient services to PRH is a temporary change and once HTP progresses inpatient services will be relocated in a new facility at RSH
	• How long will it take for HTP to come into place?	• Currently HTP plans are progressing and a business case has been submitted. There has been no date identified yet for services to move.
Fragility of current services	• Are current services safe?	• Current staffing levels are fragile at both hospital sites, and are reviewed regularly. The current proposal is to address the fragility of the service, however if staffing levels become unsafe the move to single site would need to be implemented on safety grounds.
	• How soon can these changes happen?	• There is a process which we need to follow, which includes taking our proposal to the HOSC and approval by Trust Board. The plan is for them to be introduced before winter
Which cardiology services which would be affected by the change	What cardiology services would be impacted by this proposed service change?	• The proposed service change would only affect Cardiology inpatient services • Cardiorespiratory and Cardiac Rehab would continue on both sites

Feedback from our communities

The Shrewsbury and Telford Hospital NHS Trust

- Overall all organisations we have engaged with have been supportive of the plans to centralise Cardiology inpatient services at PRH
- The key benefits of reduced length of stay for patients and having a robust and specialised workforce were highlighted by many individuals.
- For many, these benefits outweighed the additional distance that patients/carers would need to travel. It was also acknowledged that currently acute cardiac cases were being taken to Stoke or Wolverhampton.
- For many members of our community it was also important to acknowledge this was proposal was a temporary change of service until HTP progresses.

Equality Impact Assessment (EQIA)

The Shrewsbury and Telford Hospital NHS Trust

- An Equality Impact Assessment was completed by our Operational Team.
- A meeting with the Healthwatches and CHC was held to review the EQIA.
- Additional feedback given in this meeting highlighted the following:
  - Under the new proposal care will be provided in several single sexed areas and side rooms allowing for individual needs to be met. This was highlighted to have an positive impact on those may feel more comfortable receiving their care in a single room. The example provided by the group was for those individuals who identify as non-binary or transgender.
- The EQIA has been sent out to stakeholders for comment and is available on our website.

Next Steps

The Shrewsbury and Telford Hospital NHS Trust

- Take our service change proposals to HOSC for approval of our engagement activities to date within our local communities
- Approval by Trust Board is required for this service change to go ahead

- If the service changes are approved the Trust will continue to keep our communities informed and engaged, this will include:
  - Communications regarding the service change (local media, social media, through our membership and organisations we link with)
  - Ensure that any patients who are impacted by this change are kept informed
  - Ensure that all staff are kept informed and receive regular updates from the Centre Manager and Clinical leads
  - Regular updates on the proposal, move and subsequent consolidated service will be given through the community members update email.
  - If the service move was to go ahead we would review this after 6 months with patient and public involvement.

PACT Partnering · Ambitious Caring · Trusted

Our Vision: To provide excellent care for the communities we serve

This page is intentionally left blank