

# Meeting of ICB Board

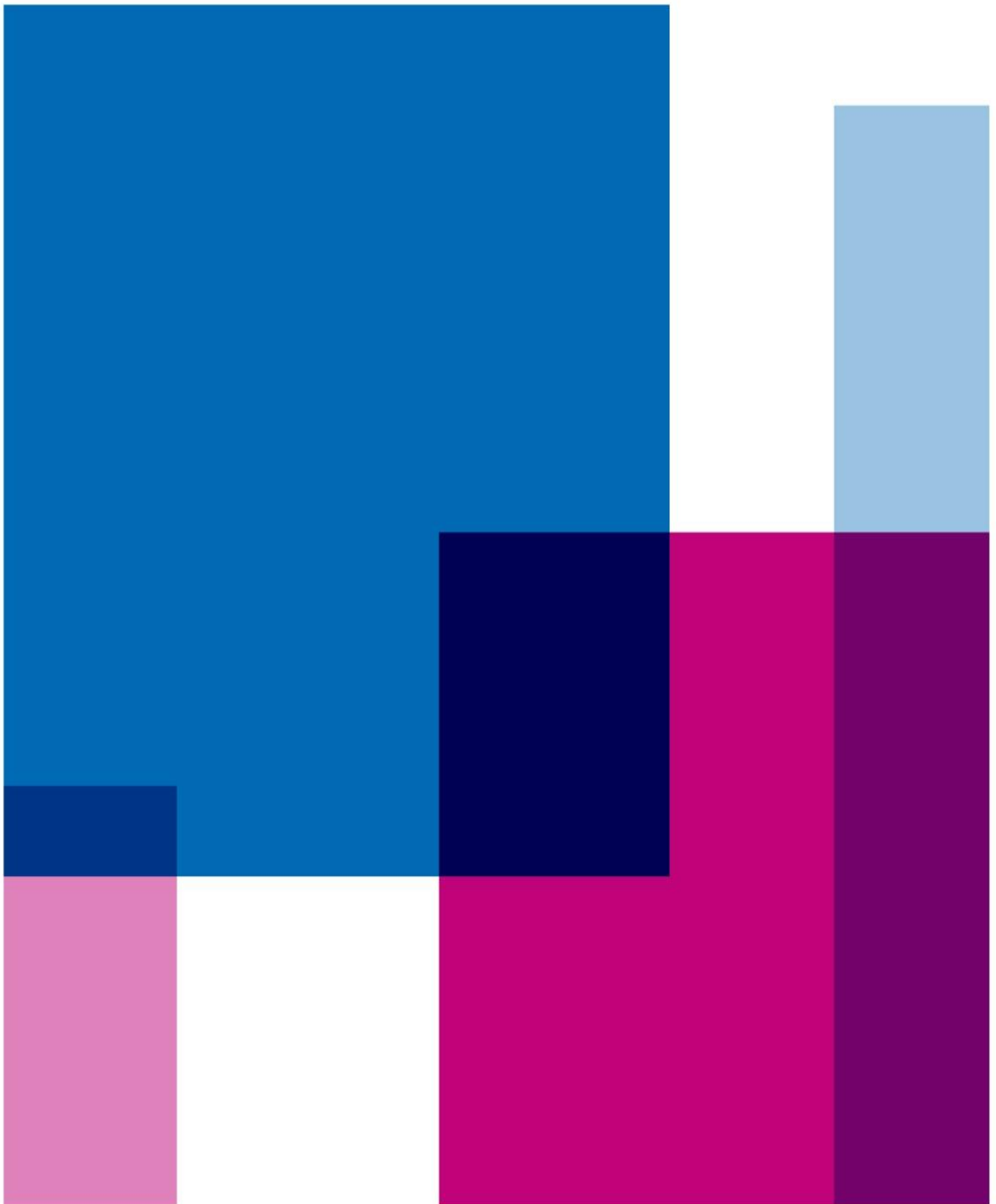
Date: Thursday 1<sup>st</sup> September 2022

Time: 11.00am

Location: University of the West of England, Enterprise Park 1, Lecture Theatre, Long Down Avenue, Stoke Gifford, BS34 8QZ

<b>Agenda Number :</b>	5	
<b>Title:</b>	Chief Executive Update – September 2022	
<b>Confidential Papers</b>	<b>Commercially Sensitive</b>	No
	<b>Legally Sensitive</b>	No
	<b>Contains Patient Identifiable data</b>	No
	<b>Financially Sensitive</b>	No
	<b>Time Sensitive – not for public release at this time</b>	No
	<b>Other (Please state)</b>	No
<b>Purpose: For Information</b>		
<b>Key Points for Discussion:</b>		
<p>The purpose of this paper is to provide the Integrated Care Board meeting with an update of key issues, from the Chief Executive's perspective, of importance to the successful delivery of the ICB's aims and objectives.</p> <p>The main areas of discussion this month are;</p> <ul style="list-style-type: none"> <li>• <b>ICB Senior Executive Recruitment and Organisational Structures</b></li> <li>• <b>Winter Planning</b></li> <li>• <b>Strategic Planning – Public Engagement</b></li> </ul>		
<b>Recommendations:</b>	<p>To note the current position with regards to recruitment</p> <p>To note the current winter planning position</p> <p>To note the position on the big conversation and to further share the information within members' networks.</p>	
<b>Previously Considered By and feedback :</b>	No other groups	
<b>Management of Declared Interest:</b>	No declared interest	

# Chief Executive Briefing – September 2022



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## Purpose

The purpose of this paper is to provide the Integrated Care Board meeting with an update of key issues, from the Chief Executive's perspective, of importance to the successful delivery of the ICB's aims and objectives.

The main areas of discussion this month are;

- **ICB Senior Executive Recruitment and Organisational Structures**
- **Winter Planning**
- **Strategic Planning – Public Engagement**

## ICB Senior Executive Recruitment and Organisational Structures

The creation of the Integrated Care System provides a fabulous opportunity to improve outcomes for our population and to truly address health inequalities. A key part of the success of the system will be an effective and efficient Integrated Care Board (ICB) as an organisation in the middle of the partnership environment.

The aims and objectives of an ICB are not the same as those of a clinical commissioning group and therefore as Chief Executive I have led a programme of structural review to ensure that the four key objectives of the ICB can be delivered. Accepting that the Integrated Care Partnership (ICP) will set the long-term vision and strategy for the system then the role of the ICB is to turn that strategy into action. To enable this to happen I proposed that there are four main functions of delivery that need to be created within the ICB.

1. Strategy
2. Innovation and Development
3. Delivery
4. Review and Improvement

These four key functions must be set in the context of the four aims of the ICS i.e. Improved Outcomes, Reducing Inequalities, Value for Money and Driving Economic and Social Development.

As per figure 1, the four proposed ICB operational functions are inherently interconnected and cyclical in nature. In other words, a good strategy will lead to innovation and development of new services however simply having both will not ensure success unless there are good vehicles for making them real and delivering value. The final part of the cycle is to critically evaluate whether the difference is being made, and evidenced, for our population. If we accept that this is the key organisational cycle of functions for the ICB then we can begin to build an organisational structure to meet this need. Therefore ensure that the form of the ICB follows the functional requirements. Figure 2 reflects the new organisational Directors that we lead on the respective functions.

Figure 1. ICB Operational Functions

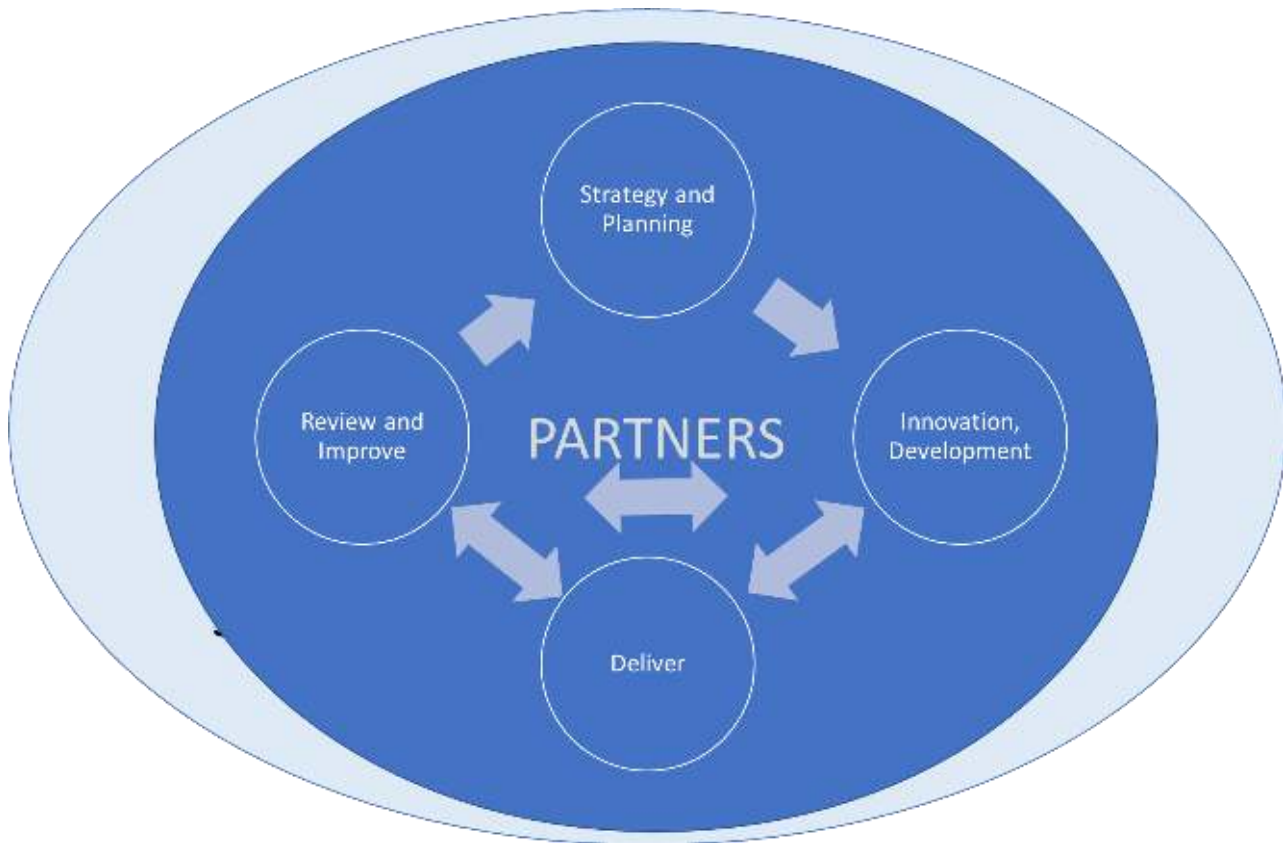


Figure 2 – Director Alignment with Functions

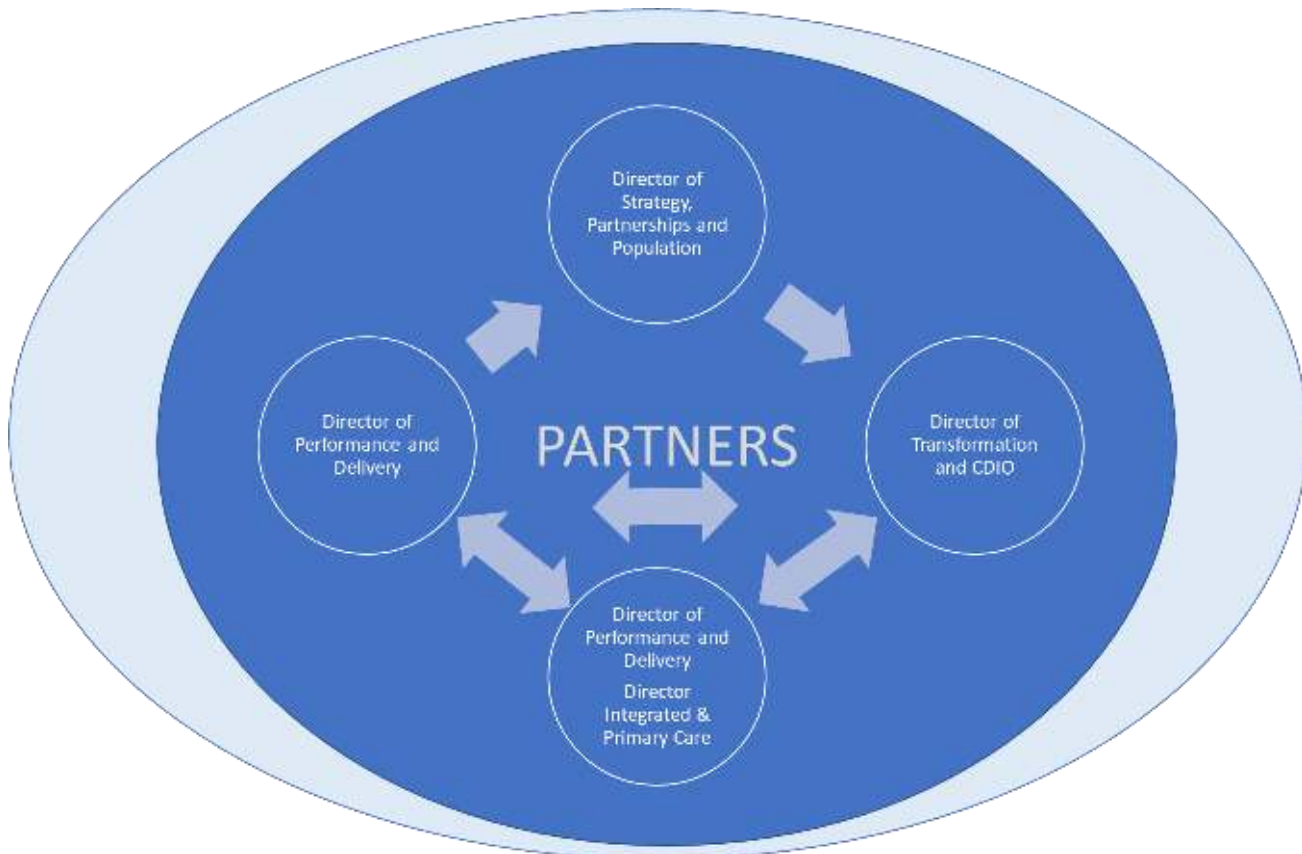
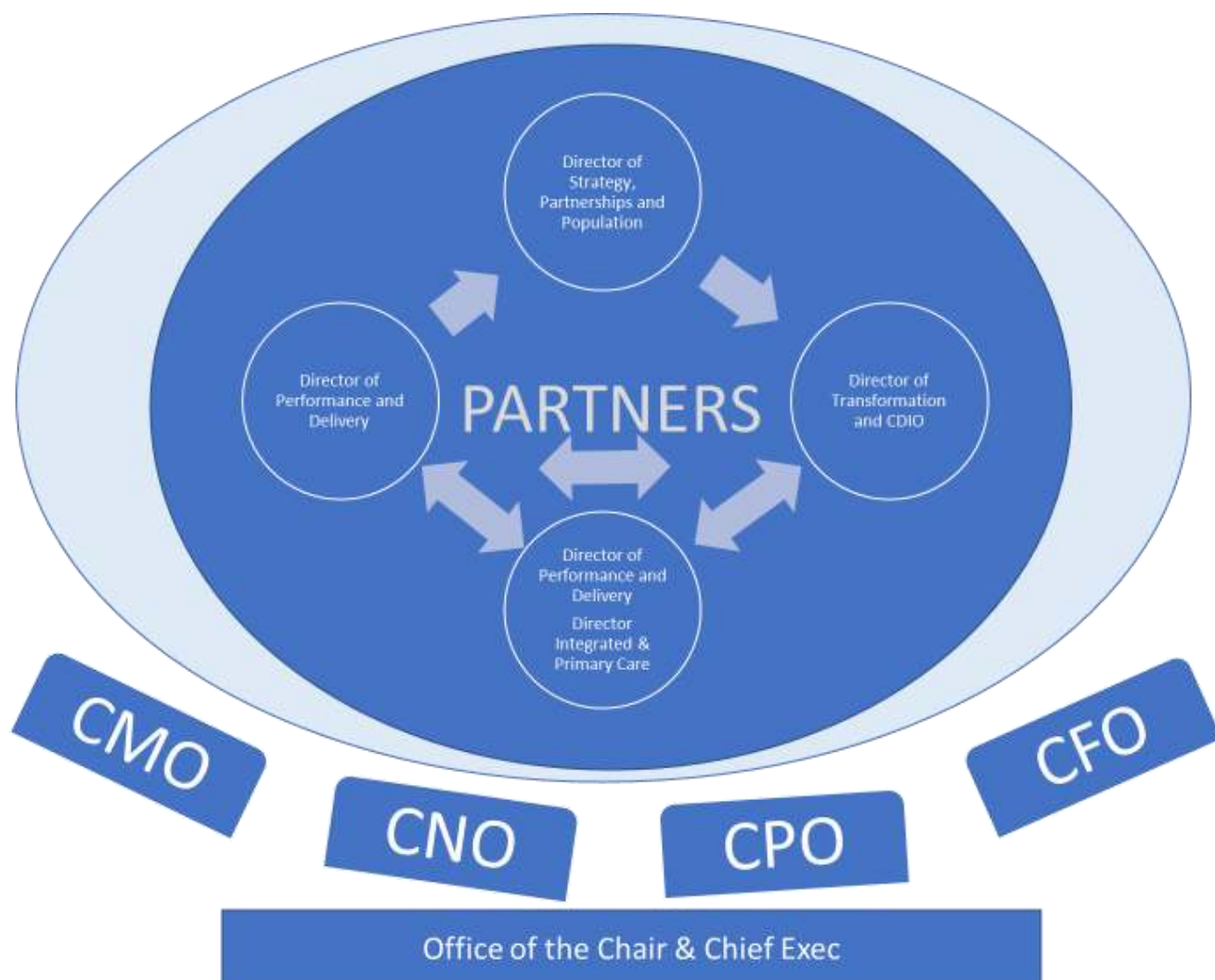


Figure 3 below represents the full executive team where the Chief Finance, Nursing, Medical and People Officers support the delivery of the four key functions.



The process of recruiting to the posts was completed in August. Following engagement with CCG post holders, and considerable discussions across the complete organisation, a process of role matching was instigated. This process allowed for existing postholders to review proposed job roles and to submit an application for their current role to be matched, in line with CCG policy, to a new role. If the new role was considered a match, through a matching panel, then the post could be filled without competition. The role of the Director of Transformation and Chief Digital Information officer was filled through this process. The role of the Chief Finance Officer was also filled through this process before the transition from CCG to ICB. All other Director posts were competed for and all but the Chief People Officer have been appointed to. We were unsuccessful in that appointment process and it will be readvertised shortly.

The next stage of the process is the realignment of functions from existing portfolios and the transformation from existing ways of working into the new functional ways described above. The complete portfolio alignment is presented overleaf

Chief Financial Officer & DCEO	Chief Medical Officer	Chief Nurse	Chief People Officer	Director of Transformation & CDIO	Director of Strategy, Partnerships & Population	Director of Performance & Delivery	Director of Integrated & Primary Care
Financial strategy, performance & recovery	Clinical leadership, development & engagement	Clinical & care professional leadership, dev. & Engagement	ICS/ICB People Strategy, planning & assurance	Single intelligence function inc. Business Intelligence	ICS Strategy lead: Development of ICS strategies e.g. mental health	Manage the service delivery unit (SDU). Performance management	Locality partnership development & implementation (ICP's)
Procurement & Contracting (inc. CSU contract)	Clinical effectiveness & transformation	Patient safety, quality & experience	ICB SPF, staff survey & engagement	Business Improvement & innovation	Community development / health improvement	SDU – elective recovery & beyond	Primary care strategy & development
Financial assurance & governance	Health inequalities	Complex children inc. SEND, CCHC, Looked after Children	OD, leadership & Talent management	Transformation hub (TH) management	Population health improvement (joint)	SDU – Unscheduled care	GP practice engagement and GP locality development
Operational planning	Clinical policies	Learning disabilities LeDeR	HR shared service	Major system transformation	System Modelling	SDU – Primary care	Intermediate care
Commissioning (except primary and community care)	Primary care strategy & development (joint)	Adult continuing healthcare	Well-led & ICS leadership & talent boards	TH – strategic development, delivery & PMO	Strategic Stakeholder Development	SDU – community providers	Primary care commissioning
Estates & sustainability strategy & plans	Population health improvement & value based care	Infection, prevention & control	ICS/ICB Workforce planning & performance	TH – Insights, design & innovation	Voluntary & community Sector Development	SDU – mental health	Primary and community workforce development
Internal & external audit	Caldicott guardian	Safeguarding	Equality, Diversity & Inclusion	TH – Transformation academy	Health & wellbeing Boards	Provider support to improve	Primary care resilience
Security management	Medicines optimisation	Regulatory interface with CQC	Optimising HR services	System digital strategy & delivery		EPRR – Emergency AO	Primary care implementation
	Research & evaluation	Personal health budgets		IM&T			

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## The new Executive Team members are:-

Sarah Truelove - Chief Finance Officer / Deputy Chief Executive

Dr Joanne Medhurst - Chief Medical Officer

Rosi Shepherd - Chief Nursing Officer

Lisa Manson - Director of Performance and Delivery

David Jarrett - Director of Integrated and Primary Care

Colin Bradbury - Director of Strategy, Partnerships and Population

Debs El-Sayed - Director of Transformation and Digital

Vacant - Chief People Officer

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## Winter Planning

On the 12 August 2022, NHS Chief Executives and Chairs received a letter from Amanda Pritchard, Chief Executive of the NHS, co signed by the Chief Operating Officer and Chief Financial Officer (Appendix 1). The letter entitled “Next steps in increasing capacity and operational resilience in urgent and emergency care ahead of winter” clearly outlined their expectations with regards to the role of ICBs in the management and delivery of safe health and care services over the winter period.

The collective core objectives and actions that we, the ICB, are now responsible for are;

- 1) **Prepare for variants of COVID-19 and respiratory challenges**, including an integrated COVID-19 and flu vaccination programme.
- 2) **Increase capacity outside acute trusts**, including the scaling up of additional roles in primary care and releasing annual funding to support mental health through the winter.
- 3) **Increase resilience in NHS 111 and 999 services**, through increasing the number of call handlers in 111 and in 999 services.
- 4) **Target Category 2 response times and ambulance handover delays**, including improved utilisation of urgent community response and rapid response services, the new digital intelligent routing platform, and direct support to the most challenged trusts.
- 5) **Reduce crowding in A&E departments and target the longest waits in ED**, through improving use of the NHS directory of services, and increasing provision of same day emergency care and acute frailty services.
- 6) **Reduce hospital occupancy**, through increasing capacity by the equivalent of at least 490 general and acute beds, through a mix of new physical beds, virtual wards, and improvements elsewhere in the pathway.
- 7) **Ensure timely discharge**, across acute, mental health, and community settings, by working with social care partners and implementing the 10 best practice interventions through the ‘100 day challenge’.
- 8) **Provide better support for people at home**, including the scaling up of virtual wards and additional support for High Intensity Users with complex needs.

Working in partnership the ICB is currently developing a set of proposals to address the objectives however it is expected that this will require considerable partnership working, new resources and a rethink of our approach to risk across the system.

In addition to the eight objectives the letter was also explicit with regards to the role of the ICB to performance manage the system. The letter is explicit in that ICBs are now accountable for ensuring that their system providers and other partners deliver their agreed role in their local plans and work together effectively for the benefit of the populations they serve.



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It is proposed that both the final systems winter plan and an enhanced approach to performance management and improvement will come to the ICB Board Meeting in October for approval.

## Strategic Planning – Public Engagement

On the 1<sup>st</sup> July this year, as the Integrated Care Board came into statute, we launched a significant public engagement exercise. The 12-week period of public and partner engagement is now well underway, and will inform the development of the ICS strategy by enhancing our understanding of what keeps people in BNSSG happy, healthy and well; what gets in the way of staying well; and priorities for wellbeing, health and care. The engagement is a critical input into our strategy development alongside a joint needs analysis being led by our public health teams.

There are a number of ways that people can get involved, and we've been heartened by the active engagement of all partners in spreading the word about the engagement and gathering views. An online survey is live, and at the time of writing, over 1,600 people in BNSSG have completed it – across all ages, areas and demographics. There are also some really important and fruitful conversations happening locally – drawing on the power of our community and partner networks. People are sharing a range of views, and you can see a snapshot of these in the video clips in the links below.

By the end of the engagement period on September 25<sup>th</sup>, we anticipate having spoken to more than 1,000 people at over 100 events; supported by our providers, VCSE partners, Local Authorities, user-led and community groups and Locality Partnerships. Crucially, the engagement is being underpinned by a robust Equality Impact Assessment, and additional focussed work with marginalised communities. It is vital that we reach out to the breadth of our communities 'where they are', and harness our collective capability to work in this way.

### How ICB Board Members can continue to help:

You remain our greatest ambassadors and conduits to communities, so please share details of the engagement through your social and professional networks. As a reminder, the link for the Have Your Say landing page is: <https://bnssghealthiertogether.org.uk/haveyoursay/>. The direct link to the survey is: <https://junglegreen.researchfeedback.net/s/tdsfh>

If you also suggest a new community conversation, or join us at an existing event. Please make contact with the team to find out more: [bnssg.communications@nhs.net](mailto:bnssg.communications@nhs.net)

Citizen video clips of the week – gathered at community events:

- Paul is concerned by the rising cost of living: <https://youtu.be/TYUd0-nBG-A>
- Asha has joined a women's football team: <https://youtu.be/RbQgLBPWshY>
- Joanne talks about GP appointments: <https://youtu.be/hAa8Zxs5s1k>

Appendix 1

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

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

**12 August 2022**

- cc.
- Regional Directors

Dear colleagues

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

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

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

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

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

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

## **Core objectives and key actions for operational resilience**

Our collective core objectives and actions are to:

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

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

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

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

### **Performance and accountability: A new approach to working together**

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

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

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

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

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

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

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

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

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

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

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

Yours sincerely,



**Amanda Pritchard**  
NHS Chief Executive



**Julian Kelly**  
Chief Financial Officer  
NHS England



**Sir David Sloman**  
Chief Operating Officer  
NHS England

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

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

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

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

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

### **2. Demand and capacity**

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

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

In community care:

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

In primary care:

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

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

In mental health, cancer, and elective care:

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

### **3. Discharge**

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

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

### **4. Ambulance service performance**

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

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

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

## **5. NHS 111 performance**

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

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

## **6. Preventing avoidable admissions**

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

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

## **7. Workforce**

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

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



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

## **8. Data and performance management**

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

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

## **9. Communications**

We are undertaking the following actions to enable strong communications:

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