West Midlands Ambulance Service
University NHS Foundation Trust

AGENDA

TITLE OF MEETING: Meeting of the Board of Directors

Monday 20 December 2021 at 09:00 hours
To maintain the Trust's policy on social distancing this meeting will be convened by electronic means through Microsoft Teams software.

Membership

Prof. I Cumming*	Chair	Non Executive Director (Chairman)
Prof. A C Marsh*	CEO	Chief Executive Officer
Ms W Farrington Chadd*	WFC	Non Executive Director (Deputy Chair)
Ms C Beechey	CB	People Director
Prof. L Bayliss-Pratt*	LBP	Non Executive Director
Mr C Cooke*	CC	Director of Strategic Operations and Digital Integration
Mr M Docherty*	MD	Director of Nursing and Clinical Commissioning
Mr M Fessal*	MF	Non Executive Director
Mrs C Finn*	CF	Director of Finance
Mr M Khan*	MK	Non Executive Director
Mr V Khashu	VK	Strategy & Engagement Director
Mrs N Kooner*	NK	Non Executive Director
Mr M MacGregor	MM	Communications Director
Dr A. Walker*	AW	Medical Director

* Denotes a voting member appointed pursuant to the Constitution of the West Midlands Ambulance Service NHS Foundation Trust

Directors are reminded to submit their apologies in advance of the meeting.

In attendance

Ms K Freeman	KF	Private Secretary – Office of the Chief Executive
Mr J Brown	JB	Integrated Emergency & Urgent Care Director
Mr P. Higgins	PH	Governance Director & Trust Secretary
Ms R Farrington	RF	Staff Side Representative

All attendees to this meeting must be aware that access may be given to all minutes and associated documents under the Freedom of Information Act 2000.

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Item No	Description	Lead	Paper No/ Comments
01	Welcome, apologies and Chairman's matters	Chairman	Verbal
02	Declarations of Interest		
	To enable declarations of any conflict of interest members may have in relation to any matters contained within the agenda for this meeting.	Chair	Verbal
03	Any Questions from the Public relating to matters to be discussed at this Board of Directors meeting.	Chair	Verbal
04	BAF and High Risks (Coversheet and Report)	Director of Nursing and Clinical Commissioning	Paper 01
05	Ambulance Providers Capital Mandate Transfer Funds a. Coversheet b. Letter from Department for Health and Social Care setting out the award of Public Dividend Capital c. Report seeking approval to procure equipment using the funding allocation	Director of Finance	Paper 02a Paper 02b Paper 02c
06	Letter from NHS England & NHS Improvement – Preparing the NHS for the Potential Impact of the Omicron variant & other Winter Pressures	Chief Executive Officer	Paper 03
07	New or Increased Risks Arising from the Meeting		
08	Any Other Business (previously notified to the Trust Secretary)	Chair	
09	Date and time of the next meeting: The next meeting will be on Wednesday 26 January 2022 at 09:00 hours	Chair	

Please note: Timings are approximate.
Preferred means of contact for Any Other Business items:
Phil Higgins, Trust Secretary (phil.higgins@wmas.nhs.uk)

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WEST MIDLANDS AMBULANCE SERVICE
UNIVERSITY NHS FOUNDATION TRUST

REPORT TO EXTRAORDINARY MEETING OF THE BOARD

AGENDA ITEM: 04 MONTH: December 2021 PAPER NUMBER: 01

BAF and High Risks	
Sponsoring Director	Executive Director of Nursing and Clinical Commissioning
Author(s)/Presenter	Head of Risk
Purpose	The Board is asked to note the risks and discuss any actions and mitigations required to control and reduce those risks
Previously Considered by	EMB, HSREG, QGC
Report Approved By	Executive Director of Nursing and Clinical Commissioning

Executive Summary

The board assurance framework (BAF) brings together in one place all of the relevant risk assessment information on the threats to the achievement of the board's strategic objectives. The effective application of board assurance arrangements and continued site of the BAF will assist management and the board to collectively consider the process of securing assurance and promoting good organisational governance and accountability.

The BAF will now show the latest updates rather than all historical changes in the "reviewed comments" for ease of review

Changes to the BAF since the last Board review are;

Strategic Objective 1 –

EOC-016 (previously PS-128) - Increase in stacking of calls during times of high demand – both 111 & 999 calls, delay to patient treatment and performance failure - Following submission of report to EMB, it has been agreed to increase the score of the assessment to 25 (Consequence = 5, Catastrophic x Likelihood = 5, Almost Certain) This is the highest risk level available and follows the Board decision to recently increase the Hospital Delay Risk Assessment, because of the belief that patient harm is almost certain in these cases.

The impact has been seen with escalation to REAP Level 4 from September 2021 where the Trust has remained since. This has also had a significant impact on SURGE levels and since July 2021, the Trust has been at SURGE Level 4 31 times, with 27 of these being in October and November, showing a continued and consistent increase over the recent months. Unfortunately, there have been several cases where severe patient harm has occurred due to the awaiting allocation of dispatch resulting in several SI's.

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By having large numbers of incidents unallocated, undoubtedly the greatest risk is to patients in the community who cannot receive a timely and appropriate ambulance response. This is because of ambulances being unable to handover their patient at hospital, preventing further deployment.

PS-074 - Risks associated with extensive Hospital Breaches, Delays and Turnaround times resulting in patient delay and harm, lack of resources to respond and serious incidents – Recruitment of winter HALOs has increased provision and allows greater coverage and support at each site, often providing 7-day cover. Ongoing work with UHB and SATH (Shrewsbury and Princess Royal) group to develop "streaming" system - which allows ambulances to be screened and directed to other wards on arrival and not solely ED – this is to reduce footfall in ED and to spread resources across the Acute site to promote more efficient offloading and reduce pressure in ED's. This work was prompted following Walsall Manor's success in reducing handover delays with the streaming method.
The Trust has secured co-horting areas at several sites, which enables a single Crew to cohort up to 6 patients, releasing the other 5 crews to ensure greater response to patients waiting in the community – this is supported by HALO.
Daily attendance at multiagency meetings continues where discussions centre around current demand, activity, and progress on current actions as well as ideas for greater improvements.

EP-019 - Impact on all Trust functions because of Pandemic Influenza (updated to reflect COVID-19) including staff sickness, infection transmission, resourcing, performance and demand level management. - On 28th November information was released regarding a new variant of COVID-19 which emerged from South Africa. As it stands there is a level of uncertainty regarding the impact this will have in the U.K and on our Staff and Patients. At this time the national IPC cell has confirmed that there are no changes to IPC guidance (PPE, Decontamination etc) however the Trust has reinforced its message regarding prolonged handovers, and patient management, as well as necessary precautions. This will be monitored accordingly.

EOC-001 - Clinical validation for Cat 3 and Cat 4 incidents - Risk assessment reviewed, and actions updated. Risk remains and further action is ongoing around update of protocols and procedures as identified in the recent IEUC thematic SI review. Current ongoing recruitment continues for clinical validators.
Work started on reducing re-contacts and call backs where relevant e.g., ensuring referral success/outcomes Board paper in progress for future funding. Since inception circa 18% Hear and Treat, which has increased from 4% prior to CVT.

Strategic Objective 2 –
No changes

Strategic Objective 3 –

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No Changes

Strategic Objective 4 –

ORG-082 - Devolution of resources to place and PCN level, for example around transformation funds and how the ambulance trusts engage – Awaiting update on whether still relevant?

ORG-083 - **Investment in digital capability for ambulance services often benefits from a regional approach** – Awaiting update on whether still relevant?

Strategic Objective 5 –

ORG-084 - The opportunity for "collective accountability" on performance could be helpful in addressing issues – Awaiting update

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Related Trust Objectives/ National Standards	There is a national requirement for WMAS to have a Board approved Board Assurance Framework
Risk and Assurance	The board assurance framework (BAF) brings together in one place all of the relevant information on the risks to the board's strategic objectives. It is an essential tool for boards and the effective application of board assurance arrangements to produce and maintain a BAF will help management and the board to consider collectively the process of securing assurance using a formal process that promotes good organisational governance and accountability.
Legal implications/ regulatory requirements	The completion of a BAF and ensuring risks are managed appropriately is an issue of good corporate governance
Financial Implications	There are no direct financial implications for the Committee to consider, however the BAF does address organizational financial risk – there may be requirements to provide additional funding if it is believed that this may reduce certain risks identified which may threaten achievement of strategic objectives e.g. increasing resourcing and overtime opportunities
Workforce & Training Implications	There are no direct workforce implications, however the BAF does address workforce issues. It may be considered appropriate to increase resourcing/staffing to reduce certain risks, which will have an impact on workforce. Health and Wellbeing, morale and productivity may also be impacted (specific risks are detailed on relevant assessments)
Communications Issues	The BAF will need to be communicated to colleagues in the organisation via regular channels. Relevant changes/updates may be required to be communicated via Press. Possible increased Press and Media interest
Diversity & Inclusivity Implications	This is addressed, where appropriate in the risks identified and mitigating actions.

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REPORT TO EXTRAORDINARY MEETING OF THE BOARD

AGENDA ITEM: 04 MONTH: December 2021 PAPER NUMBER: 01

Quality Impact Assessment	This is addressed, where appropriate in the risks identified and mitigating actions.
Data Quality	The information in the BAF is sourced from the WMAS Risk Register

Action required

Board is asked to review, discuss, and agree the changes to the BAF and consider where further mitigation may be required (finance, resourcing, workforce etc)

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West Midlands Ambulance Service University NHS Foundation Trust Board Assurance Framework

Strategic Objective 1 :Safety, Quality and Excellence
Lead Director: Mark Docherty

Strategic Objective	1: Safety, Quality and Excellence	**Risk Description** *What might happen if the risk materialises*	**Current Risk Score** With Controls and Assurances in Place (Consequence x Likelihood)	**Mitigated Risk Score** After Applying all Mitigating Actions (Consequence x Likelihood)	**Target Risk score** *(if deemed appropriate upon Board review)*
Principal Risks		**SR-1** - Failure to achieve Operational Performance Standards	5x4=20	5x3=15	5x2=10
		PS-074 - Risks associated with extensive Hospital Breaches, Delays and Turnaround times	5x5=25	5x4=20	5x3=15
		HS-012 - Risk of staff suffering serious injury because of stab / ballistic weapons	5x3=15	5x2=10	5x2=10
		EP-019 – Pandemic Influenza	4x5=20	4x5=20	4x3=12

Lead Committee	Health, Safety, Risk and Environment Group
Last Reviewed	December 2021 (Board)
Review comments	**EOC-016 (Previously PS-128)** - Increase in stacking of calls during times of high demand – both 111 & 999 calls, delay to patient treatment and performance failure **PS-074** - Risks associated with extensive Hospital Breaches, Delays and Turnaround times resulting in patient delay and harm, lack of resources to respond and serious incidents **EP-019** - Impact on all Trust functions as a result of Pandemic Influenza (updated to reflect COVID-19) including staff sickness, infection transmission, resourcing, performance and demand level management. **EOC-001** - Clinical validation for Cat 3 and Cat 4 incidents

	EP-027 – Risks associated with Terrorist Threats	5x3=15	5x2=10	5x2=10		
	ORG-003 – Failure to complete SI investigations within timescales	4x4=16	4x3=12	4x2=8		
	IPC-032 PTS Staff at risk of conveyance of suspected infectious Patients including COVID-19	4x3=12	4x2=8	4x2=8		
	ORG-081 – Outbreak of COVID-19	4x5=20	4x5=20	4x4=16		
	IPC-035 -Risks associated with bird/vermin droppings on Trust sites	4X4=16	4X3=12	4X1=4		
	EOC – 016 (Previously PS-128) - Stacking of incidents at times of high demand	5x5=25	5x4 = 20	5x3=15		
	IPC-002 - Regulatory concerns due to non-compliance with Clinical Waste Management	4X3=12	4X2-8	4X1=4		
	ORG-093 - Utilisation of surge contingency as a result of COVID-19 and increased demand, and its impact on 2021/22 resourcing, training, finance and ultimately performance and potential patient delays and harm	5x3=15	5x2=10	5x1=5		
	ORG-094 - Easing of national COVID-19 restrictions resulting in potential risks to staff and patients, possible harm, litigation, and performance	4x5=20	4x5=20	4x5=20		
	ORG-095 - Management of changes to isolation guidance and impact on WMAS staff, to manage demand, improve resources and ensure patient delays and harm are minimised	5x3=15	5x10	5x1=5		
	ORG-096 - Clinical validation for Cat 3 and Cat 4 incidents	4x4=16	4x3=12	4x2=8		
	ORG-102 - Patients held on the back of an Ambulance awaiting hospital handover for prolonged periods resulting in harm and potential litigation and adverse publicity	5X3=20	5X2=10	5X1=5		
	ORG-103 – Risks associated with IEUC dual role resulting in patient delay and harm, staff sickness and performance	5X3=15	5X2=10	5X1=5		

Strategic Objective 2 :A great place to work for all
Lead Director: Carla Beechey

Strategic Objective	2: A great place to work for all	Risk Description *What might happen if the risk materialises*	Current Risk Score With Controls and Assurances in Place (Consequence x Likelihood)	Mitigated Risk Score After Applying all Mitigating Actions (Consequence x Likelihood)	Target Risk score *(if deemed appropriate upon Board review)*
Principal Risks		**ORG-078** - COVID-Secure in the Workplace	4X3=12	4X2=8	4X2=8

Lead Committee	People Committee
Last Reviewed	November 2021 (EMB)
Review comments	

Strategic Objective 3 :Effective Planning and use of resources
Lead Director: Claire Finn

Strategic Objective	3: Effective planning and use of resources	Risk Description *What might happen if the risk materialises*	Current Risk Score With Controls and Assurances in Place (Consequence x Likelihood)	Mitigated Risk Score After Applying all Mitigating Actions (Consequence x Likelihood)	Target Risk score *(if deemed appropriate upon Board review)*
Principal Risk		**SR-2** The Trust fails to meet its financial duties	4X3 = 12	4X3=12	4X2=8
		FI-009 - Patient activity varies at a rate that cannot be contained within the Trust's cost base	3X4=12	3X4=12	3X4=12
		FI-018 - Adequate procurement controls are not in place for Tenders, Waivers and SFI and SO compliance	4x3=12	3x3=9	3x2=6
		FI-020 - The change in planning and commissioning of services on a national basis, particularly with reference to STPs, could destabilise the Trust's current business model.	4X4=16	4x3=12	4x3=12
		FI-022 - Implementation of the IFRS 16 standard for leasing of assets	3X4=12	3X3=9	3X3=9
		FI-026 - The new nationally agreed pay award is not fully funded for the Trust	5X4 = 20	5X3=15	5X3=15

Lead Committee	Audit Committee
Last Reviewed	November 2021 (EMB)
Review comments	

Strategic Objective 4 :Innovation and Transformation
Lead Director: Craig Cooke

Strategic Objective	4: Innovation and Transformation	Risk Description *What might happen if the risk materialises*	Current Risk Score With Controls and Assurances in Place (Consequence x Likelihood)	Mitigated Risk Score After Applying all Mitigating Actions (Consequence x Likelihood)	Target Risk score *(if deemed appropriate upon Board review)*	Lead Committee	Health, Safety, Risk and environment Committee
Principal Risk		**ORG-082 -** Devolution of resources to place and PCN level, for example around transformation funds and how the ambulance trusts engage (220 PCNs across the Midlands region)	4x3 =12	4x2 = 8	4x1 = 4	**Last Reviewed**	December 2021 (Board)
		ORG-083 - Investment in digital capability for ambulance services often benefit from a regional approach, however again devolution of monies to individual ICS may challenge us.	4x3 = 12	4x2 = 8	4x1 = 4	**Review comments**	Awaiting update on whether these Risk Assessments are still required

Strategic Objective 5 :Collaboration and Engagement
Lead Director: Vivek Khashu

Strategic Objective	5: Collaboration and Engagement	Risk Description *What might happen if the risk materialises*	Current Risk Score With Controls and Assurances in Place (Consequence x Likelihood)	Mitigated Risk Score After Applying all Mitigating Actions (Consequence x Likelihood)	Target Risk score *(if deemed appropriate upon Board review)*	Lead Committee	Workforce Development Group
Principal Risk		**ORG-084 -** The opportunity for "collective accountability" on performance could be helpful in addressing issues - how this would work though is ill defined	4x3 = 12	4x2 = 8	4x2 = 8	**Last Reviewed**	December 2021 (Board)
		ORG-087 - Proposed changes to Urgent and Emergency Care Quality and Access Standards	5X3 = 15	5X2 = 10	5X2 = 10	**Review comments**	Awaiting update on whether ORG-084 is still required

Appendices

Strategic Objective 1 :Safety, Quality and Excellence
Lead Director: Mark Docherty

	Risk Description *What might happen if the risk materialises*	**Assurance** ***Evidence that the controls are effectively implemented***	**Gaps in Assurance**	*Mitigating Actions*	**Board Review – Tolerance and Appetite**	**Action Required (with timescale to complete)** *Gaps in Controls or Assurance*
EOC-016 (previously PS-128)	Increase in stacking of calls during times of high demand – both 111 & 999 calls, delay to patient treatment and performance failure	To focus on finding alternative pathways for waiting patients, all clinical personnel within EOC as part of the validation team are solely carrying out re-triage of the category 3 and 4 calls that are viable. As there is no mandated requirement to undertake welfare calls of patients awaiting a response, the decision has been made to concentrate the efforts of dispatch to effectively deploy Ambulances to patients which need them the most. On a regular basis, the validation clinicians are achieving 18% Hear and Treat, which effectively reduces the requirement to respond to patients by finding alternatives pathways and enabling availability of an ambulance resource.	Call stacking remains a significant challenge with October continuing the trend with REAP Level 4 and Surge Management. Hospital delays remain the biggest factor in impacting our ability to respond to calls, and this has been raised at Board, where the risk score has been raised to 25. As the risk continues to increase, which is seen in the number of SI's, Patient delay and harm and whilst actions are taken to mitigate and reduce, these are not having the desired effect currently because of the sheer volume of hospital delays being experienced. It is therefore appropriate to consider raise this risk to a 25 as with the hospital delay risk.	As per RA	Risk grading raised to 25 - Identify and agree any actions	
PS-074	Risks associated with extensive Hospital Breaches, Delays and Turnaround times resulting in patient delay and harm, lack of resources to respond and serious incidents	Recruitment of winter HALOs has increased provision and allows greater coverage and support at each site, often providing 7-day cover. Ongoing work with UHB and SATH (Shrewsbury and Princess Royal) group to develop "streaming" system - which allows ambulances to be screened and directed to other wards on arrival and not solely ED – this is to reduce footfall in ED and to spread resources across the Acute site to promote more efficient offloading and reduce pressure in ED's. This work was prompted following Walsall Manor's success in reducing handover delays with the streaming method. The Trust has secured cohorting areas at several sites, which enables a single Crew to cohort up to 6 patients, releasing the other 5 crews to ensure greater response to patients waiting in the community – this is supported by HALO.	Hospital delays a significant risk to the Trust	As per RA	Risk grading raised to 25 - Identify and agree any actions	

EOC-001	Clinical validation for Cat 3 and Cat 4 incidents	On 28th November information was released regarding a new variant of COVID-19 which emerged from South Africa. As it stands there is a level of uncertainty regarding the impact this will have in the U.K and on our Staff and Patients. At this time the national IPC cell has confirmed that there are no changes to IPC guidance (PPE, Decontamination etc) however the Trust has reinforced its message regarding prolonged handovers, and patient management, as well as necessary precautions. This will be monitored accordingly		As per RA	Identify and agree any actions	
EP-019 -	Impact on all Trust functions because of Pandemic Influenza (updated to reflect COVID-19) including staff sickness, infection transmission, resourcing, performance and demand level management.	On 28th November information was released regarding a new variant of COVID-19 which emerged from South Africa. As it stands there is a level of uncertainty regarding the impact this will have in the U.K and on our Staff and Patients. At this time the national IPC cell has confirmed that there are no changes to IPC guidance (PPE, Decontamination etc) however the Trust has reinforced its message regarding prolonged handovers, and patient management, as well as necessary precautions. This will be monitored accordingly			Identify and agree any actions	

Strategic Objective 2 :A great place to work for all
Lead Director: Carla Beechey

	Risk Description *What might happen if the risk materialises*	**Assurance** ***Evidence that the controls are effectively implemented***	**Gaps in Assurance**	*Mitigating Actions*	**Board Review – Tolerance and Appetite**	**Action Required (with timescale to complete)** *Gaps in Controls or Assurance*

Strategic Objective 3 :Effective Planning and use of resources
Lead Director: Claire Finn

	Risk Description *What might happen if the risk materialises*	**Assurance** ***Evidence that the controls are effectively implemented***	**Gaps in Assurance**	**Mitigating Actions**	**Board Review – Tolerance and Appetite**	**Action Required (with timescale to complete)** *Gaps in Controls or*

						Assurance

Strategic Objective 4 : Innovation and Transformation
Lead Director: Craig Cooke

	Risk Description *What might happen if the risk materialises*	**Assurance** ***Evidence that the controls are effectively implemented***	**Gaps in Assurance**	**Mitigating Actions**	**Board Review – Tolerance and Appetite**	**Action Required (with timescale to complete)** *Gaps in Controls or Assurance*
ORG-082	Devolution of resources to place and PCN level, for example around transformation funds and how the ambulance trusts engage (220 PCNs across the Midlands region)		Awaiting update from Senior Finance Team			N/A
ORG-083	Investment in digital capability for ambulance services often benefit from a regional approach, however again devolution of monies to individual ICS may challenge us.		To be discussed and drafted with Executive Director of Strategic and Digital Integration			N/A

Strategic Objective 5 : Collaboration and Engagement
Lead Director: Vivek Khashu

	Risk Description *What might happen if the risk materialises*	**Assurance** ***Evidence that the controls are effectively implemented***	**Gaps in Assurance**	**Mitigating Actions**	**Board Review – Tolerance and Appetite**	**Action Required (with timescale to complete)** *Gaps in Controls or Assurance*
ORG-084	The opportunity for "collective accountability" on performance could be helpful in addressing issues - how this would work though is ill defined		Awaiting update			N/A

WEST MIDLANDS AMBULANCE SERVICE UNIVERSITY NHS FOUNDATION TRUST

REPORT TO BOARD OF DIRECTORS

AGENDA ITEM 05 DATE December 2021 PAPER NUMBER 02a

Winter Fleet Ambulance Providers Capital Funding	
Sponsoring Director	Director of Finance
Author(s)/Presenter	Director of Finance
Purpose and action required	a. To notify Board of capital funding which has been made available to support winter fleet capacity and set out the criteria for use of the funding. b. To seek approval for the procurement of equipment using the allocated funding.
Previously Considered by	Not applicable
Report Approved By	Director of Strategic Operations and Digital Integration

Summary/Key Issues relevant to this committee

Revenue funding has been made available to the ambulance sector to support the provision of additional capacity required for the increased pressures expected throughout the winter period.

All ambulance Trusts were also requested to bid for additional capital funding to support the increased capacity during the winter period. WMAS identified and submitted a bid for fleet equipment at a total cost of £1.34m.

WMAS has been notified that the submission has been approved and the criteria on the use of funding outlined. Funding must be spent by the 31st March and only on the schemes which were identified as part of the submission.

The board briefing attached as appendix A sets out how the Trust intends to utilise the funding and seeks approval to procure the medical equipment set out in the report by means of the funding.

Related Trust Objectives Is it contributing to the Trust Objectives:	Please tick relevant objective
SO1 – Safety Quality and Excellence (our commitment to provide the best care for patients)	X
SO2 – A great place to work for all (Creating the best environment for all staff to flourish)	
SO3 - Effective Planning and Use of Resources (continued efficiency of operational and financial control)	X
SO4 - Innovation and Transformation (Developing the best technology and services to support patient care)	
SO 5 – Collaboration and Engagement (Working in partnership to deliver seamless patient care)	

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WEST MIDLANDS AMBULANCE SERVICE UNIVERSITY NHS FOUNDATION TRUST

REPORT TO BOARD OF DIRECTORS

AGENDA ITEM 05 DATE December 2021 PAPER NUMBER 02a

Is the proposal required to enable the Trust to meet national standards? If yes state which.	The Trust must be compliant with national standards, the use of the funds to procure this equipment is in compliance with the Trusts strategic objectives as an Ambulance provider. The purposes of capital funding is to support keeping additional ambulances on the road during winter by funding the purchase of the additional equipment required
Risk and Assurance	This funding is provided only for the financial year 2021/22 and there is no provision for carry forward to future years. If slippage in the scheme does occur, this will be at the risk of the Recipient. The draw of funding is expected to be made in line with expenditure being committed by the 14 March 2022, at the latest. Resulting assets should be created in the financial year of the PDC Draw and on, or before, 31 March 2022. Any slippage or underspends against the award must be identified as soon as possible and the Authority and NHS England and NHS Improvement informed to allow for this resource to be potentially allocated elsewhere to support other Trusts
Legal implications/ regulatory requirements	Legal advice has not been sought and the report is submitted to firstly advise the Board of the Capital allocation for the purposes set out in the letter and to approve the procurement of the medical equipment at set out in the report submitted on the grounds that the the level of spending requires Board approval..
Financial Implications	To support the purchase additional medical equipment to keep additional ambulances on the road during winter 21/22 a capital allocation has been made of £1,341,000.00 To enable the access of funds, the Recipient must submit a Utilisation Request and a capital cash flow statement to NHSE&I. The form must be signed by two authorised signatories, duly authorised to do so under the Trust's Standing Financial Instructions, and scheme of delegation. The Trust is required to meet any revenue costs associated with this capital award from its own funds.
Workforce & Training Implications	Not directly applicable

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AGENDA ITEM 05 DATE December 2021 PAPER NUMBER 02a

Communications Issues	Not directly applicable
Diversity & Inclusivity Implications	Not directly applicable
Quality Impact Assessment	A quality Impact Assessment is not required as this proposal is compliant with the Trust's strategic objectives.
Data Quality	The procurement information is held by the Director of Strategic Operations and Digital Integration

Action required

a. To notify Board of £1.34m of capital funding which has been made available to support winter fleet capacity and set out the criteria for use of the funding.
b. To approve the procurement of the medical equipment using the funding allocation.

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Department of Health & Social Care

DHSC Ref: CENT/MISC/RYA/2021-11-15/A

Award of Public Dividend Capital (PDC) made in Nov 21 between:

1) The Department of Health & Social Care (The Authority), and

2) West Midlands Ambulance Service University NHS Foundation Trust (The Recipient)

PURPOSE OF AWARD

The Authority will allocate PDC to the Recipient for the purposes of capital funding to support keeping additional ambulances on the road during winter by funding the purchase of the additional equipment required

PAYMENT OF AWARD

PDC will be made available to the Recipient who will have ownership of the resulting capital asset. Capital funding is only available to be spent on items that can be classified as capital expenditure according to the recipient's local accounting rules. In addition to the PDC the Recipient will also receive, if appropriate, an increase to their Capital Resource Limit (CRL) and External Financing Limit (EFL).

It has been agreed to make available Public Dividend Capital (PDC) to invest the following amounts in the Financial Year 2021-22:

Reference	Description	**£**
Ambulance Winter Pressure Support	Support to purchase additional medical equipment to keep additional ambulances on the road during winter 21/22.	£1,341,000
-		
-		
-		
-		
-		
	Total	**£1,341,000**

Central capital funding is provided only for the financial year 2021/22 and there is no provision for carry forward to future years. If slippage in the scheme does occur, this will be at the risk of the Recipient. The draw of funding is expected to be made in line with expenditure being committed by the 14 March 2022, at the latest. Resulting assets should be created in the financial year of the PDC Draw and on, or before, 31 March 2022.

Any slippage or underspends against the award must be identified as soon as possible and the Authority and NHS England and NHS Improvement informed to allow for this resource to be potentially allocated elsewhere to support other Trusts.

The issue of PDC is conditional on the advances being held in the Recipient's Government Banking Services account until payments are made. The Authority reserves the right to ask the Recipient to repay cash that has been drawn but not spent in the financial year that the cash draw occurred.

A cash limit will be set against the schedule of the Recipient's anticipated cash requirements. It is against this limit that requests for PDC will be assessed. In due course, a unique PDC reference number will be allocated, to be used in all correspondence between parties on this matter.

PDC is issued by the Authority on a Monday. All capital draw requests (Utilisation Request) must be submitted via the NHSE&I Capital & Cash Team in the first instance (NHSI.CapitalCashQueries@nhs.net). Where requests are submitted directly to the Authority, these will be referred to NHSE&I before any action is taken.

To enable the access of funds, the Recipient must submit a Utilisation Request and a capital cash flow statement to NHSE&I. The Utilisation Request is the official request to release the funds into the recipient's Government bank account. The form must be signed by two authorised signatories, duly authorised to do so under the Trust's Standing Financial Instructions, and scheme of delegation. The capital cash statement details the planned spend for the initiative as well as confirming that the cash is not being drawn in advance of need. The Recipient will submit these forms in accordance with standard practice to the NHSE&I Capital & Cash Team.

The Authority shall be entitled to repayment of payments incorrectly claimed by the Recipient or issued by the Authority.

The amount of the Award shall not be increased in the event of any overspend by the Recipient in its delivery of the Project.

CONDITIONS OF AWARD

The capital funding will be made available as PDC. Funding can only be spent on items that score as capital expenditure in Trust accounts.

The Recipient set out in its application to this fund plans for meeting the revenue costs associated with this capital award from its own funds.

The Recipient shall use this award only for the delivery of the Project as set out in 'Purpose of Award'.

The Director of Finance must sign and return a copy of this letter to the Authority (agreeing to the conditions of the award and in due course also complete the Utilisation Requests as required). PDC requested will be assessed against the limit set for this award.

The Director of Finance will nominate a lead person who shall act as a point of contact between the Recipient and the Authority in all matters connected with the award.

The Recipient shall keep all invoices, receipts and accounts and any other relevant documents relating to the expenditure of the award for a period of at least six years following the receipt of any monies to which they relate. The Authority shall have the right to review accounts and records that relate to the award and shall have the right to take copies of these records.

MONITORING AND REPORTING

The Recipient shall closely monitor the delivery and success of the scheme(s) to ensure that the purpose of the award is being met. The Recipient is to regularly report implementation progress to the NHSE& I regional teams on a monthly basis and ensure delivery of the scheme's benefits in accordance with this agreement. The Authority and NHSE&I shall have the right to request the recipient to provide details on implementation and commissioning of the scheme on more regular intervals if required.

The Recipient shall on request provide the Authority with such further information, explanations and documents as the Authority may reasonably require in order for it to establish that the Award has been used properly in accordance with this Agreement.

The Recipient shall permit any person authorised by the Authority such reasonable access to employees, records, premises or facilities for the purpose of validating the status and progress of the planned work.

Signed on behalf of The Secretary of State (sign and date below)

Date: 15/11/2021

Name: Victoria Cave

Position: Deputy Director – Infrastructure Strategy and Capital Funding

Signed on behalf West Midlands Ambulance Service University NHS Foundation Trust (sign and date below)

Date:

Name: Claire Finn

Position: DoF

E-mail address: Claire.finn@wmas.nhs.uk

Lead Contact at West Midlands Ambulance Service University NHS Foundation Trust for all matters connected with the scheme(s)

Name: Paul Jarvis

Position: **Head of Strategic Finance**

E-mail address: Paul.jarvis2@wmas.nhs.uk

Telephone Number:

WEST MIDLANDS AMBUALNCE SERVICE UNIVERSITY NHS FOUNDATION TRUST

REPORT TO THE BOARD OF DIRECTORS

Subject: Ambulance Providers – Additional Capital Allocation 2021/22

Date: 20TH December 2021

WMAS has received an additional Central Capital allocation for Ambulance Services to assist with the current operational pressures this year (2021/22). This additional capital allocation of £1.3m has been allocated based on the Trusts ability to expend this money before 31 March 2022.

Medical and Ambulance Equipment will be purchased for the Emergency Ambulance Fleet which will be fully operational in 2022/23. The equipment items will be procured and purchased using current procurement frameworks available and therefore the Fleet Department has raised the required Purchase Orders which the Finance Director and Chief Executive have approved for ordering of the following equipment assets:

40x Stryker Stretcher and Rescue Stair Chair

40x Ferno Carry Chair / Scoop Rescue Stretcher and Immobilisation Long Board

40x Zoll X-series 12lead ECG Defibrillators

40x ParaPac Emergency Portable Ventilators

40x Mangar Elk Lifting Device

The orders for this equipment have been placed. At the time these orders were placed, suppliers indicated they were able to mobilise and provide the required equipment to WMAS in Q4 2021/22 as per the funding requirement.

The total cost for this equipment including VAT will be £1,340,988.64 which has been fully funded by this additional capital income.

A business case for this requirement was presented to the Capital Control Group and subsequently agreed at EMB.

OFFICIAL - Business data that is not intended for public consumption. However, this can be shared with external partners, as required.

To:
- Chief executives of all NHS trusts and foundation trusts
- CCG accountable officers
- GP practices and PCNs
- Providers of community health services
- NHS111 providers
- PCN-led local vaccination sites
- Vaccinations centres
- Community pharmacy vaccination sites
- ICS and STP leads

cc.
- NHS regional directors
- NHS regional directors of commissioning
- Regional incident directors
- Regional heads of EPRR
- Chairs of ICSs and STPs
- Chairs of NHS trusts, foundation trusts and CCG governing bodies
- Local authority chief executives and directors of public health

NHS England and NHS Improvement
Skipton House
80 London Road
London
SE1 6LH

13 December 2021

Dear Colleagues,

Preparing the NHS for the potential impact of the Omicron variant and other winter pressures

Thank you for everything you and your teams have done since the COVID-19 pandemic began to treat those with the virus, including over half a million people who have needed specialist hospital care, as well as delivering the largest and fastest vaccination programme in our history. This is while maintaining urgent non-COVID-19 services and now working to recover the backlogs that have inevitably built up, providing around 90% of pre-pandemic levels of activity this year, despite continuing to care for thousands of hospital inpatients with COVID-19 over that period.

The discovery of the Omicron variant once again requires an extraordinary response from the NHS. Last night, the Prime Minister announced the new vaccination challenge which will see the NHS deliver more vaccines over the coming weeks than ever before, and will require us to prioritise activities to deliver this.

However, even with the additional protection that vaccine boosters will give, the threat from Omicron remains serious. The UK chief medical officers on 12 December increased their assessment of the COVID-19 threat level to 4, and advice from SAGE is that the number of people requiring specialist hospital and community care could be significant over the coming period.

In light of this, we are again **declaring a Level 4 National Incident**, in recognition of the impact on the NHS of both supporting the vital increase in the vaccination programme and preparing for a potentially significant increase in COVID-19 cases.

This letter therefore sets out important actions we are now asking every part of the NHS to put in place to prepare for and respond to the Omicron threat.

These will:

- Ensure the successful ramp up of the vital COVID-19 vaccine programme.
- Maximise the availability of COVID-19 treatments for patients at highest risk of severe disease and hospitalisation.
- Maximise capacity across acute and community settings, enabling the maximum number of people to be discharged safely and quickly and supporting people in their own homes.
- Support patient safety in urgent care pathways across all services and manage elective care.
- Support staff, and maximise their availability.
- Ensure surge plans and processes are ready to be implemented if needed.

1. Ensure the successful ramp-up of the vital COVID-19 vaccine programme

You will be aware of the Prime Minister's announcement yesterday outlining the latest situation with regards to the Omicron and other variants. The Prime Minister launched an urgent national appeal calling for people to get vaccinated and set out the commitment that all adults in England would be offered a booster jab by the end of the year.

In just over a year since the vaccination programme was launched, more than 100 million jabs have been given. In their December update, the UKHSA estimated that, as of 24 September, 127,500 deaths and 24,144,000 infections had been prevented as a result of the COVID-19 vaccination programme. This is a remarkable achievement, but the urgency of this new national mission requires the NHS to once again step up to support an immediate, all out drive to protect the health of the nation.

A separate letter will set out the immediate next steps for the vaccination programme, describing the ask of systems including:

- Clinically prioritising services in primary care and across the NHS to free up maximum capacity to support the COVID-19 vaccination programme over the next few weeks, alongside delivering urgent or emergency care and other priority services. As the Prime Minister said, this means some other appointments will need to be postponed.

- Delivering at scale whilst also retaining the focus on vaccination of those at greatest risk, including those who are housebound. Continuing to maximise uptake of first and second doses including through identifying dedicated resources to work alongside directors of public health locally.

- Creating capacity, both by maximising throughput, efficiency and opening times of existing sites to operate 12 hours per day as standard, seven days per week as well as running 24 hours where relevant for the local community, and through opening additional pop-up and new sites.

- Increasing training capacity with immediate effect to support lead employers with rapid onboarding and deployment of new vaccinators.

The letter also describes support available including a removal of the current cap on spend against the budget for programme costs, additional vaccine supply and significant expansion of volunteering and recruitment activity.

The NHS has been clear that staff should get the life-saving COVID-19 vaccination – and that is even more important now – to protect themselves their loved ones and their patients, and the overwhelming majority have already done so.

Working with NHS organisations, we will continue to support staff who have not yet received the vaccine to take up the evergreen offer of COVID-19 vaccination. NHS England has released resources on how to help engage and communicate with staff to encourage vaccine uptake within your organisations. We also recommend that CQC regulated services review the new Planning and Preparation guidance which will help organisations prepare for when the regulations (which are subject to parliamentary passage) are introduced.

Flu can be a serious illness for some people and the flu vaccine provides vital extra protection as well as minimising transmission. NHS staff should take every opportunity to encourage patients, including pregnant women, to receive their COVID-19 and flu

vaccines if they are eligible. Healthcare colleagues are asked to make every contact count this winter with pregnant women – and those planning pregnancy – to advise them of the benefits of COVID-19 and flu vaccination.

2. Maximise the availability of COVID-19 treatments for patients at highest risk of severe disease and hospitalisation

Having discovered the efficacy of dexamethasone as a treatment for COVID-19 and begun rolling it out just hours after trial results were announced, saving thousands of lives both here and across the world, the NHS is again at the forefront of new treatments for COVID-19.

The UK was the first country in the world to approve an antiviral (monupiravir) able to be taken at home. It will be available for use by patients at highest risk in the community from 16 December alongside other treatments including monoclonal antibodies. Arrangements for deployment of these treatments was set out in a letter on 9 December alongside the UK policy for use.

Local ICS teams should finalise preparations for COVID-19 Medicine Delivery Unit service implementation, working with regions on final assurance of delivery models.

Separately, the Government also announced the PANORAMIC national study for oral antivirals treatment for at-risk patients. The study will allow medical experts to gather further data on the potential benefits of oral antivirals for the UK's predominately vaccinated population. General practices can refer patients into this study as per the GP and community pharmacy letter.

3. Maximise capacity across acute and community settings, enabling the maximum number of people to be discharged safely and quickly and supporting people in their own homes

The operational imperative is to create the maximum possible capacity within acute care settings to support patient safety in the urgent care pathway, which is currently under significant pressure as the data on ambulance response times and 12 hour waits in A&E shows, to maintain priority access for elective care, particularly P1, P2 and cancer assessment, diagnostics and treatment, and to create capacity to respond to a potential increase in COVID-19 demand.

To that end, you are asked now to work together with local authorities, and partners across your local system including hospices and care homes to release the maximum number of beds (and a minimum of at least half of current delayed discharges) through:

A) An immediate focus to support people to be home for Christmas. Throughout the period between Christmas and New Year, ensure there is support in place to discharge medically fit patients across all seven days of the week.

B) Those patients who do not need an NHS bed, because they do not meet the reasons to reside criteria, must be discharged as soon as practically possible. Working with local authorities, every system will need to put in place sufficient measures in order to reduce by half their own number of patients not meeting the reasons-to-reside criteria. This will necessitate senior system leaders across the NHS and local authorities meeting daily to ensure sufficient progress is made.

C) A significant proportion of discharge delays are within the gift of hospitals to solve. Hospitals should work to eliminate avoidable delays on pathway zero, ie straight home without the need for social care support. Where necessary, this could include using personal health budgets, which has been successfully piloted in Cornwall and Lancashire; or use of hotel beds.

D) Making full use of non-acute beds in the local health and care system. NHS England has today switched back on the full use of spare hospice capacity – both beds and community contacts, through the same national arrangement with Hospice UK that was in place earlier in the year. As well as making use of personal health budgets, hotel beds, and hospices, systems can also make use of independent sector capacity in the community using the following framework. We encourage systems to explore surging community rehabilitation capacity and securing spare capacity from care homes. To support safe discharge of COVID-19 patients, DHSC will be expanding the number of designated beds from CQC accredited providers.

E) Expanding the use of virtual wards and hospital at home models with the full confidence of knowing these models will be supported in forthcoming planning guidance with significant additional funding, to enable a major expansion over the next two years.

Systems already have access to resources within core funding, COVID-19 allocations and through the Hospital Discharge Programme to fund these measures. Where systems can show further funding is necessary in addition to existing budgets then, to facilitate this drive, NHS England will fund additional costs incurred. Commissioners and providers

should notify regional teams of the estimated additional cost and bed benefit as plans are firmed up and claim the actual cost through the existing quarterly claims process.

The NHS will need to increase its effective capacity next year and we are planning on ring-fencing significant national funding for the further development of virtual wards (including hospital at home). Therefore, where steps taken now on virtual wards can have an enduring benefit to overall capacity and have recurrent costs those should be notified at the same time so that we can allow for them on top of core system allocations for 2022/23.

To facilitate this drive, and maintain it thereafter through winter and into next year:

- the Government has announced a further additional £300 million support for domiciliary care workforce, to boost capacity, on top of the existing £162 million workforce scheme.

- A new national discharge taskforce including the NHS, ADASS, national and local government, led by Sarah-Jane Marsh, has been established. Working to both DHSC and NHS England, it will focus on the local authority and NHS actions required to drive progress. This will dock with enhanced regional and local system arrangements that need to be put in place.

4. Support patient safety in urgent care pathways across all services, and manage elective care

Ambulance response: Systems must focus on eliminating ambulance handover delays in order to ensure vehicles and paramedic crews are available to respond to urgent 999 calls as set out in the letter of 26 October, and take action to see patients quickly and avoid 12 hour waits in emergency departments. Working with health, social care, voluntary sector partners and CQC, systems should take a balanced view of risk and safety across all parts of the health system, recognising that the greatest risk may be the patient waiting for an ambulance response.

Prioritising the recruitment of 999 and 111 call handling capacity will be crucial to ensure patients have rapid access into urgent and emergency care services when required. It is therefore important that Regions work closely with Ambulance Trusts and 111 providers to monitor progress on a weekly basis.

Community crisis response: Local systems should take immediate steps to maximise referrals from 999 to the two-hour Urgent Community Response services**.** Good progress has been made in developing and rolling out UCR services across England faster than

planned trajectories, with 27 ICSs now providing UCR services 8-8pm seven days a week.

Further expansion and join-up with other services is needed now, as part of a wider drive to reduce ambulance response times and support people in their own homes. Systems should:

- Where possible, accelerate coverage and capacity of UCR services in line with the 2 hour guidance, to make an impact in January. This includes supporting equipment purchases such as lifting chairs and point of care testing equipment.
- Maximise the number of patients being referred and transferred to UCR from ambulance services.
- Work together with local councils and providers of local pendant alarm/Technology Enabled Care (TEC) providers and reduce the demand on 999 ambulance services through the re-direction of appropriate patients.
- Refresh your local Directory of Services (DoS) so that NHS Service Finder profiles are accurate, up to date and are updated to show that UCR teams will accept referrals from health & social care colleagues including TEC providers.
- Ensure accurate and complete data to via the Community Services Data Set for UCR, so you can track how much the services are being used and helping reduce pressures.

Further information, webinar recordings and tools, such as legal advice, information governance documents and case studies, are available on the Urgent Community Response FutureNHS platform.

Mental health, learning disability and autism: The pandemic has had an impact on the nation's mental health, disrupting daily routines. In response, the NHS has extended mental health support, including introducing 24/7 all-age mental health crisis support lines earlier than planned, and continued to expand services to meet growing need in line with the Long-Term Plan.

Systems are asked to ensure that access to community-based mental health services and learning disability and autism services are retained throughout the COVID-19 surge to ensure that people at risk of escalating mental health problems and those who are most vulnerable can access treatment and care and avoid escalation to crisis point, with face-to-face care retained as far as possible.

Healthcare colleagues are asked to make every contact count this winter with people with SMI and LD – to ensure promotion of health checks and interventions as well as

access to COVID-19 and flu vaccination, in the context of stark health inequalities for these patients.

Managing critical care: Over the course of the pandemic, the NHS showed its determination and flexibility time and time again, not least in rapidly expanding critical care capacity. Indeed, the Health and Social Care Select Committee wrote in their recent report on lessons learned to date that it was ‘a remarkable achievement for the NHS to expand ventilator and intensive care capacity’.

We do not know what the demand from Omicron will be on critical care facilities, but it is essential that trusts familiarise themselves with existing plans for managing a surge in patients being admitted with COVID-19, with particular focus on the management of oxygen supplies, including optimising use at ward level. This work should also include a review of how critical care capacity can be expanded and of surge arrangements in critical care networks – acknowledging these will already have been activated in some parts of the country. Further guidance on surge planning will be published based on good practice from the early phases of the pandemic.

Managing elective care: As in the COVID-19 wave last winter, it is crucial that we continue to deliver elective care and ensure that the highest clinical priority patients – including patients on cancer pathways and those with the longest waits – continue to be prioritised. Once again, clinical leadership and judgement about prioritisation and risk will be essential.

There are now 6 million patients waiting for elective care, of whom 16 thousand have been waiting over 104 weeks, as a result of the inevitable disruption caused by the COVID-19 pandemic. It is therefore even more important that diagnostic, first outpatient, elective inpatient and day case capacity should be maintained as far as possible, recognising the requirement to release staff to support the vaccination programme and respond to the potential increase in COVID-19 cases. Systems and NHS trusts should work collaboratively, particularly using the provider collaborative arrangements you have in place to prepare elective contingency plans against different COVID-19 scenarios for discussion and agreement with Regions.

A key feature of plans should be the separation of elective and non-elective capacity where possible, and the use of mutual aid between trusts and across systems and regions where necessary to maintain access to urgent elective care. You should maintain your focus on eliminating waits longer than two years, as set out in H2 planning guidance as far as possible.

Independent sector (IS): Local systems need to significantly step up use of available capacity in the independent sector to help maintain services. IS capacity should be one of the main protected 'green' pathways for treating elective patients during the final quarter of this year. Systems should take action now to agree plans with your local IS providers, building on existing H2 plans, to maximise use of local IS capacity so that as many patients can be treated as possible through the IS route. This should include, where clinically appropriate, additional pathways including cancer.

Any work will be funded consistent with original H2 planning guidance.

Primary care: The vaccination ramp up is the current priority for primary care, supported by the additional funding already announced and changes to GP contract arrangements. Continued access to general practice remains essential for those who need care and the £250 million Winter Access Fund remains available through systems to support general practice capacity more generally, including through the use of locums and support from other health professionals.

Cancer: local systems should stress test their plans to confirm that the elements that helped to sustain cancer services in previous waves are in place, and to ensure that:

- rapid access, including tests and checks for patients with suspected cancer, as well as screening services, are maintained
- provision for P1 and P2 cancer surgery is prioritised
- cancer surgical hubs have been established with cancer surgery consolidated on COVID-19-protected sites, and that centralised triage is in place across local systems to prioritise patients based on clinical need
- arrangements are in place to centralise high volume or high complexity work such as upper GI or head and neck surgery
- local systems have adapted cancer pathways in line with the advice on streamlining cancer diagnostic pathways and keeping them COVID-19-protected
- local systems are maximising the use they make of IS capacity for cancer services, where clinically appropriate
- effective communications with patients and safety netting is in place, and patients are involved in decisions around their care, including when they chose to reschedule
- anyone with concerning symptoms is encouraged to come forward, in line with our 'Help us, Help You' messages.

5. Support staff, and maximise their availability

The experience of the pandemic has shown, once more, that the NHS is nothing without its exceptional staff. NHS staff have been severely tested by the challenges of dealing with the pandemic and its of vital importance that we collectively support them over the months ahead.

Support for staff to stay well and at work: We also ask you to revisit your staff wellbeing offer to ensure it has kept pace with the changing nature of the pandemic, with a continued focus on ongoing health and wellbeing conversations taking place for staff. Health and wellbeing conversations are the best route for exploring the many drivers and root causes of sickness absence and for offering individualised support to staff where it is needed, including with work pressures, worries and relationships.

Employers should be ready to communicate any changes in testing and isolation guidance associated with Omicron as we learn more, as these may well evolve, and to offer staff options wherever possible to continue to contribute when they are unable to come into work, if they are able to do so. In addition, organisations should consider contingency options for significant staff absences to ensure essential services can be maintained.

The pandemic has had a disproportionate impact on our staff from ethnic minority communities. It is therefore vital that as we prepare for this next phase, we take action to address systemic inequality that is experienced by some of our staff including by allowing staff network leads the dedicated time they need to carry out this role effectively. We will continue to collect and publish data on the experiences of our ethnic minority colleagues via the Workforce Race Equality Standard (WRES).

Mental health and wellbeing support: We have strengthened the mental health support offer for health and social care staff to ensure they can get rapid access to assessment and evidence-based mental health services and support as required.

This includes your own occupational health services as well as the 40 local staff mental health and wellbeing hubs across the country which provide proactive outreach and clinical assessment, and access to evidence-based mental health services and support where needed.

Please continue to promote the mental health hubs and the confidential helplines that are available for all staff, and in particular the bereavement helpline (0300 303 4434, 8am-8pm) to support staff who may have been affected by the death of patients and colleagues.

Workforce planning, flexibility and training: System leaders and NHS organisations should review workforce plans for the next three months to ensure that, as per your surge plan testing, you have the appropriate workforce in place to deal with an increase in the number of COVID-19 patients and are able to support the ramp up of the COVID-19 vaccination programme. Organisations should continue to use their staff flexibly to manage the most urgent priorities, working across systems as appropriate.

Where staff require particular support or training to enable their potential redeployment, including for vaccination or to support critical care services, please use the next few weeks to provide this.

Recruitment: Trusts should seek to accelerate recruitment plans where possible, including for healthcare support workers, and where possible bringing forward the arrival of internationally recruited nurses, ensuring they are well supported as they start work in the NHS.

Volunteers: Volunteers play an important part in supporting patients, carers and staff over winter months. In particular, there are a number of high-impact volunteer roles which free up clinical time for clinical tasks, improve communication with families and assist with discharge, and support staff wellbeing. Although volunteers have been active in many NHS trusts, many more experienced volunteers are willing to help yet remain inactive. Trusts are encouraged to take advantage of the available support to restore volunteering and strengthen volunteer management in ways which can contribute significantly to reducing service pressures, including NHS Reserves.

6. Ensure surge plans and processes are ready to be implemented if needed

Incident Co-ordination: In light of the move to a Level 4 national incident, systems and NHS organisations will need to review incident coordination centre arrangements, and should ensure that these are now stood up, including to receive communication and act as the single point of contact.

Surge Plans: As we have done previously, we are asking all systems and NHS organisations to review and test their incident management and surge plans to assess their number of beds (G&A, community and critical care), supplies and staffing, learning the lessons from previous waves of COVID-19, and making preparations to have the capacity in place to meet a potentially similar challenge this winter.

Systems should ensure that preparedness includes making plans to deliver the services needed to vulnerable groups within systems as well as maintaining essential services in primary, community, mental health and learning disability and autism services.

To support regional and national planning, we will ask you to submit your identified maximum capacity, including your plans for critical care capacity, by 17 December.

These plans should detail the incident coordination arrangements, including leadership roles and responsibilities, hours of operation of the incident coordination centre, including out-of-hours contact arrangements. The plans should also detail how organisations will deal with timely information/SitRep reporting.

We will keep under review the timing and scope of the regular sitrep returns and we ask for your cooperation in continuing to make timely returns as requested.

Supplies: As a result of the work undertaken over the past 18 months, nationally held stock levels are more than adequate to respond to any additional increases in demand caused by a new variant. You should maintain normal ordering patterns and behaviours. In advance of the Christmas period, you may wish to review your local current stock levels particularly oxygen supplies, medical equipment and relevant consumables and it is key that you connect into the regional incident arrangements as and when needed.

Oxygen: In addition, through the testing of your surge plans, trusts must ensure that their oxygen delivery systems and infrastructure are able to bear at least the same level of demand when COVID-19 inpatients were at their highest point, and that any improvements or adaptations identified as necessary have been put in place.

Infection prevention and control: Staff and organisations should continue to follow the recommendations in the UK Infection Prevention and Control (IPC) guidance. According to research, IPC measures prevented 760 in-hospital COVID-19 infections each day in wave 1. Organisations must ensure that application of IPC practices is monitored using the IPC Board Assurance Framework and that resources are in place to implement and measure adherence to good IPC practice.

The past two years have arguably been the most challenging in the history of the NHS, but staff across the NHS have stepped up time and time again to do the very best for the nation – expanding and flexing services to meet the changing demands of the pandemic; introducing new treatments, new services and new pathways to respond to the needs of patients with COVID-19 and those without; pulling out all the stops to recover services that have been disrupted, whilst rolling out the largest and fastest vaccination programme in our history. The Omicron variant presents a new and significant threat, and the NHS must once again rise to the national mission to protect as many people as possible through the vaccination programme whilst also now taking steps to prepare for and respond to this threat.

Thank you for everything you have done and continue to do – as we have said before, this is a time when the NHS will benefit from pulling together again in a nationally co-ordinated effort, but please be assured that within the national framework you have our backing to do the right thing in your particular circumstances.

We look forward to speaking to you at the virtual regional events later this week and will keep in regular contact over the coming weeks and months.

Yours sincerely,

Amanda Pritchard
NHS Chief Executive

Professor Stephen Powis
Chief Executive of NHS Improvement