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HEALTH & ADULT SOCIAL CARE SCRUTINY PANEL

Thursday, 18th November, 2021 at 7.00 pm in the Conference Room, Civic Centre, Silver Street, Enfield, EN1 3XA

Membership:

co : Huseyin Akpinar, Kate Anolue, Tolga Aramaz, Birsen Demirel, Chris Dey, Alessandro Georgiou, Christine Hamilton (Deputy Mayor) and Derek Levy

AGENDA – PART 1

1. WELCOME & APOLOGIES

2. DECLARATIONS OF INTEREST

Members of the Committee are invited to identify any disclosable pecuniary, other pecuniary or non-pecuniary interests relevant to the items on the agenda.

3. MINUTES OF THE PREVIOUS MEETING (Pages 1 - 4)

To agree the minutes of the previous meeting held on 16 September 2021.

4. PRESSURES IN GENERAL PRACTICE & WHO OWNS GENERAL PRACTICE

Verbal update to discuss the scope of 'Pressures in General Practice' and 'Who owns General Practice'

5. RECONFIGURATION OF THE NHS & THE IMPACT ON LOCAL SERVICES (Pages 5 - 60)

To receive a report from NHS North Central London Clinical Commissioning Group (CCG).

6. THE LONDON AMBULANCE SERVICE (Pages 61 - 84)

To consider the report from the London Ambulance Service.

7. DATE OF NEXT MEETING

To note the date of the next meeting:

Thursday 20th January 2021

MINUTES OF THE MEETING OF THE HEALTH & ADULT SOCIAL CARE SCRUTINY PANEL HELD ON THURSDAY, 16TH SEPTEMBER, 2021

MEMBERS: Councillors Kate Anolue, Alessandro Georgiou, Christine Hamilton (Deputy Mayor), Derek Levy, Jim Steven and Hass Yusuf

Officers:

Clare Duignan (HOS Integrated Care Mental Health), Jon Newton (HOS Integrated Care OP&PD) and Tony Theodoulou (Executive Director People), Jane Creer (Secretary)

Also Attending: Olivia Clymer (Healthwatch Enfield), Dr Jo Sauvage (NCL CCG Chair), Jo Murfitt (Programme Director for NCL CCG Strategic Reviews of Community and Mental Health Services) and Alex Smith (NCL CCG Director of Transformation).

1. WELCOME AND APOLOGIES

Councillor Derek Levy, Chair, welcomed everyone to the meeting and made introductions.

Apologies for absence were received from Councillor Birsen Demirel (substituted by Councillor Hass Yusuf), Councillor Chris Dey (substituted by Councillor Jim Steven), and from Councillors Tolga Aramaz and Huseyin Akpinar. Councillor Alev Cazimoglu, Cabinet Member for Health and Social Care) sent apologies she was unable to attend this meeting.

2. DECLARATIONS OF INTEREST

There were no declarations of interest.

3. MINUTES OF THE PREVIOUS MEETING

The minutes of the meeting of 28 July were agreed with the following corrections:

- Olivia Clymer represented Healthwatch Enfield.
- Date of the next meeting should have read 16 September 2021.
- Noted that the Vice Chair nomination was subject to approval by Council.

4. NORTH CENTRAL LONDON CLINICAL COMMISSIONING GROUP COMMUNITY AND MENTAL HEALTH SERVICES REVIEWS

RECEIVED the report on the progress of two strategic service reviews, one for community services and one for mental health services, that the North Central London Clinical Commissioning Group (NCL CCG) was running.

NOTED the presentation by Dr Jo Sauvage (NCL CCG Chair), Jo Murfitt (Programme Director for NCL CCG Strategic Reviews of Community and Mental Health Services) and Alex Smith (NCL CCG Director of Transformation).

Feedback, comments and questions were received from Members throughout.

1. A key priority was addressing historical complexities across the system and differential access to services. Through the Covid-19 pandemic some of the variations and the impact of inequality became even more stark. The need for a more integrated approach to address inequities in community services was clear.
2. Mental health issues had been more pronounced during the pandemic, and the terms of reference of the review had subsequently been amended. Work had started firstly on community services, but because of the impact on mental health, the reviews were being run in tandem.
3. It had been important to understand the baseline and system and core offer.
4. Work had progressed through August into September, with frontline staff, residents, and others involved in workshops regarding what people thought community and mental health services should be everywhere. The stage had been reached of a proposed core offer iteration, which would be submitted to the Programme Board for sign off at the end of this month. At the same time, each borough had been asked to map the situation in reality. There would be an impact assessment on what this meant for access, finance and resources to achieve greater consistency.
5. In response to Councillor Georgiou's queries, it was advised that there was necessarily engagement with professional clinicians, but there was an active process of listening to patients who would be affected, and looking at evidence. There was liaison with all stakeholders at multiple levels, across the boroughs, including a residents' panel. It was fundamental for the CCG to engage properly and to evidence this.
6. In response to Clare Duignan's further queries regarding specific attention for local BAME communities, assurance was given that the difficulties of particular groups accessing services was known and that those concerns would be addressed, especially in the implementation stage.
7. In response to the Chair's queries regarding the methodology of the reviews, it was confirmed there was a need to look at both reviews together. It was recognised that there were deficits and variations in both service lines and a need to look in a more confluent way. The financial methodology used was considered the most helpful.
8. In response to Councillor Hamilton's query in respect of exclusions in the scope of the review, it was confirmed that learning disabilities referred only to a cohort of funded patients from long stay assessment centres.
9. In response to Councillor Hamilton's query about the example quoted about variation in boroughs' times of acceptance of referrals, it was confirmed that the aim was to broadly have coverage that was consistent, while recognising that sometimes variations were justified. The current

arrangements around borough borders were clarified, and there were mitigations, particularly for planned services.

10. Councillor Anolue raised the issue of care staff who were resistant to accepting mandatory Covid-19 vaccination and how this would be dealt with. It was advised there had been concerted effort and conversations to support members of staff, and planning around mitigating the risks. There were also issues around staff morale, stress, sickness and retirement in the care and health sectors. In respect of care homes staff, Jon Newton advised that there was an ability to self-certify if vaccination was not possible due to health reasons for example.
11. Councillor Anolue also raised the seriousness of mental health issues, brought to prominence by the pandemic. It was confirmed that mental health had already been a priority in the NHS long term plan, and more funding had been provided to North Central London for mental health care. The money had been used to start to tackle inequities. Also, shortages in specialist roles and workforce, delivery and implementation had to be considered even as funding was unlocked.
12. Olivia Clymer welcomed the comprehensive engagement programme, but questioned whether the level of patient response was considered satisfactory, the timescale of the consultation, appropriate communication, and appropriate complaints procedures. It was agreed that the number of responses to the patient survey had been disappointing, but that the comments submitted had been consistent and had matched what had been heard elsewhere. The Residents Reference Group had around 22 members, including people from all the boroughs, a diversity of age, and those who had community health and mental health experience. An equality impact assessment had also been taken through the Residents Reference Group. Jo Sauvage would discuss issues around current patient experience further with Olivia Clymer following the meeting. Healthwatch had brought forward reports around access to GPs and patients' experience, and it was important to understand where there were gaps, and investigate poor experiences. The CCG sought to tackle unwarranted variation, and there were ways to complain which patients should be directed to use. The inequities had been recognised for a long time and it was now being identified how resources could be redistributed across the system to tackle them.
13. In response to Members' further queries, it was confirmed that the forthcoming integrated care system would mean working collectively towards solutions. The Covid-19 crisis had brought many organisations together and relationships across North London had improved as a result. There was a focus on support to care homes and a national Ageing Well programme.
14. In response to Councillor Hamilton's queries about allocation of funding across the five boroughs, it was advised that the relevant discussions across the system were just beginning, allocation should be needs-led, and decisions may be challenging regarding reallocation of existing spending. The importance of out of hospital services was highlighted and keeping people at home if safe. Resources could be released by bringing management of some long term conditions into the community. An update would be brought to a future meeting.

15. Members were thanked for their scrutiny and constructive comments.

5. DATES OF FUTURE MEETINGS

The dates of future scheduled meetings were noted, and that the next meeting would be arranged for a suitable date in November.

The meeting ended at 8.30 pm.

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Health & Social Care Scrutiny Panel

18th November 2021

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Developing the North Central London Integrated Care System

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The North Central London population

- Around 1.6 million residents, with a relatively young population in some boroughs compared to London average
- Diverse population with historic high migration – from within UK and abroad; around 25% of people do not have English as their main language
- Higher rates of deprivation than some London areas, with pockets of deprivation across all boroughs
- Significant variation in life expectancy between most affluent and most deprived areas
- Approx. 200,000 people in NCL are living with a disability

[1] Index of Multiple Deprivation, 2019

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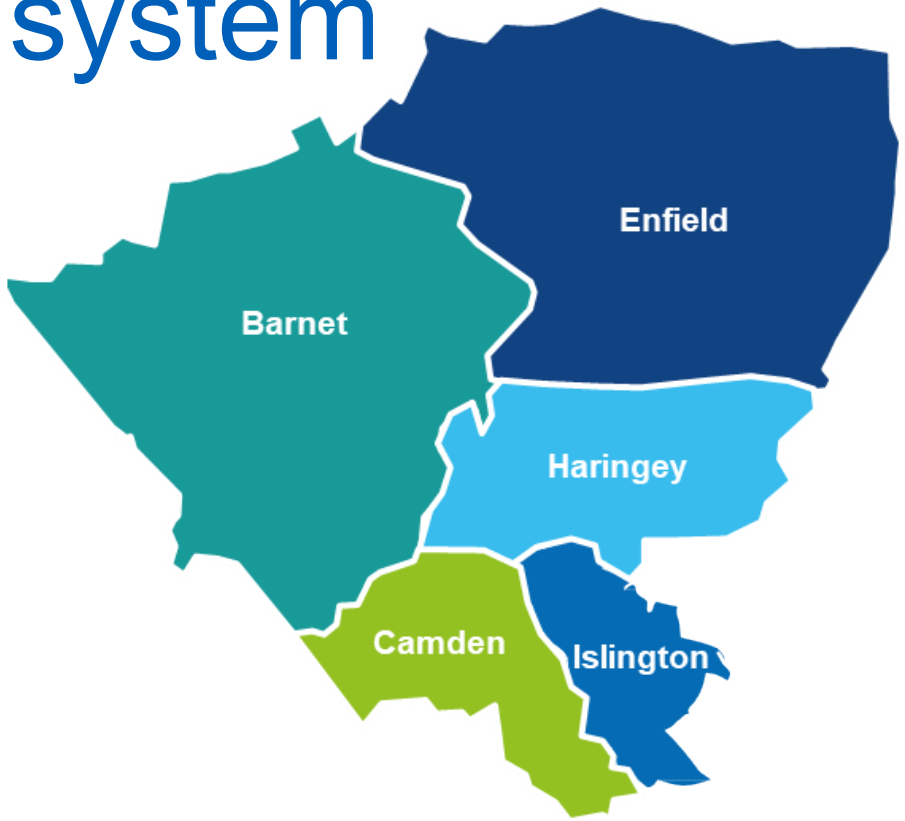
The North Central London health and care system



- 12 hospital trusts
- 5 local authorities
- One clinical commissioning group
- 200+ general practices
- 300+ pharmacies
- 200+ care homes
- Countless voluntary sector organisations and community groups providing essential care

[1] Index of Multiple Deprivation, 2019

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Building on strong NCL partnership foundations to form our ICS

The formation of Integrated Care Systems (ICS)

- The NHS Long Term Plan committed to delivering Integrated Care Systems (ICSs) across England by April 2021, to build on the lessons learnt and good work carried out by Sustainability and Transformation Partnerships (STPs).

- Integrated Care Systems (ICS) are a new form of partnership between organisations that support the health and wellbeing of local communities. Partners include the NHS and local councils alongside voluntary, community and social enterprise sector organisations

- In April, the Department of Health and Social Care published a White Paper (February 2021): *'Integration and Innovation: working together to improve health and social care for all'*.

- Government and Parliament will establish ICSs in law and remove legal barriers to integrated care for patients and communities. Decisions on legislation will be for Government and Parliament to make.

- From 1 April 2022, Integrated Care Systems (ICSs) will become fully operational as statutory organisations responsible for strategic commissioning, with a financial allocation set by NHS England. In North Central London, our ICS will operate in shadow form this financial year.

The core purpose of an Integrated Care System

- The core purpose of an Integrated Care System is to:
  - improve outcomes in population health and healthcare
  - tackle inequalities in outcomes, experience and access
  - enhance productivity and value for money
  - help the NHS to support broader social and economic development.
- Each ICS will have a responsibility to coordinate services and plan health and care in a way that improves population health and reduces inequalities between different groups.
- This way of working closely reflects how the NHS and Councils in North Central London have already been working together in recent years, to improve our population's health and reduce inequalities through greater collaboration.

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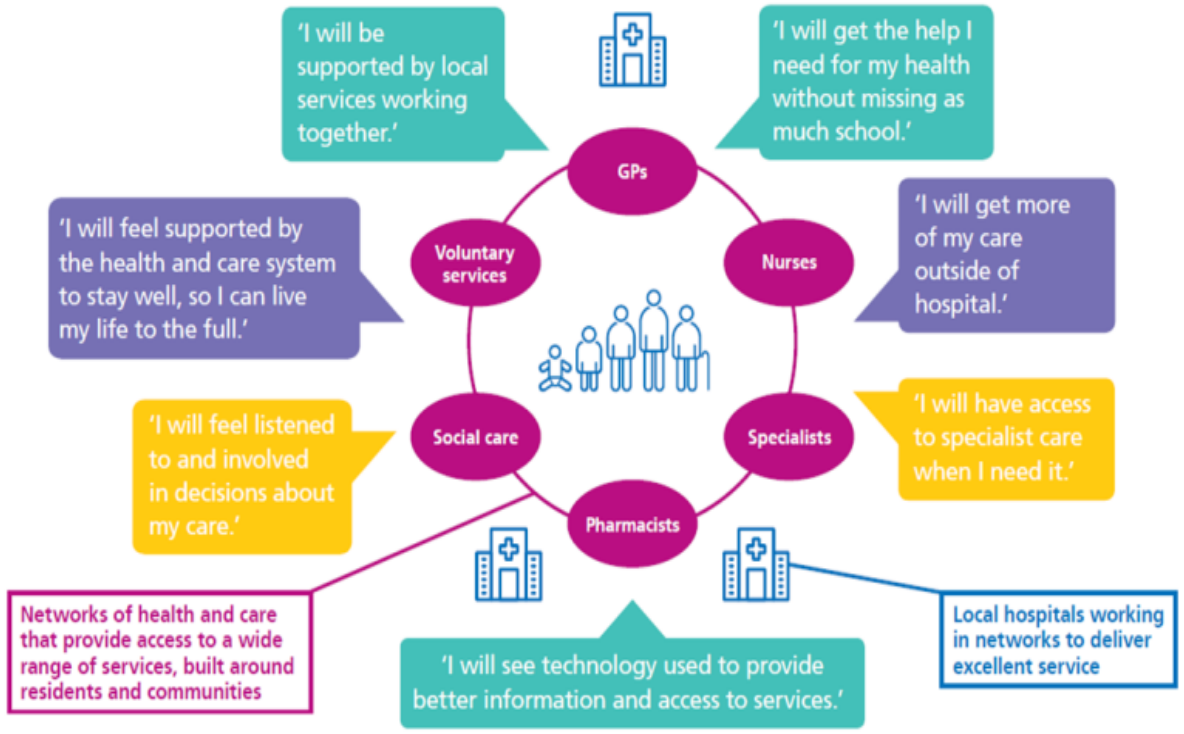
What will this mean for residents?

Faster progress towards what residents have told us they want from local services:



And an increased system-focus on the wider determinants of health and wellbeing:

- Fulfilling work
- Education and skills
- Our surroundings
- The food we eat
- Money and resources
- Transport
- Housing
- The support of family, friends and communities

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Building on strong foundations in NCL

- Whilst ICSs are new statutory organisations, we have a track record of close working between partners, NHS and LA, through the STP and other collaborative programmes of work.
- In April 2020 the five Clinical Commissioning Groups in North Central London (NCL CCGs) – Barnet, Camden, Enfield, Haringey and Islington – merged to form one CCG.
- We have strong partnerships already formed in each borough to support working at a 'place' level
- Alongside this, we have 33 thriving primary care networks across the area.
- Over the last year system partners have worked closely together, with the CCG, Councils, NHS providers, general practices, voluntary and community organisations, working to respond to the pandemic.
- There has been continued progress towards a more strategic approach to health commissioning at NCL-level, and within our borough partnerships.

Building on strong foundations in NCL

- The new legislation will mean the NHS moves away from the current way of planning and paying for healthcare.
- In the current system NHS hospitals were encouraged to compete with each other to provide the best care possible.
- This improved quality, but has meant it is harder to move money to prioritise prevention.
- The new way of working will support more collaboration and joint planning between NHS organisations with the aim of both improving quality and investing in preventative and proactive care.

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Building on strong foundations in NCL

Responding to the Covid-19 pandemic has accelerated, and consolidated, ways the system worked together to deliver for residents. Acting like an ICS already in many ways:

- **Innovative approaches to patient care -** pulse oximetry led by primary care and virtual wards led by secondary care to avoid Covid patients' admission to hospital and early discharge where appropriate
- **Accelerated collaboration -** single point of access for speedier and safe discharge from hospital to home or care homes; development of post-Covid Syndrome multi-disciplinary teams to support patients
- **Mutual planning and support -** system able to respond quickly to a significant increase in demand for intensive care beds
- **Smoothing the transition between primary and secondary care -** increased capacity for community step-down beds to ease pressure on hospitals
- **Sharing of good practice -** clinical networks to share best practice and provide learning opportunities
- **Clinical and operational collaboration -** Ensuring consistent prioritisation across NCL so most urgent patients are treated first

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Benefits of forming an ICS in North Central London

Improved Outcomes

Enable greater opportunities for working together as 'one public sector system' – ultimately delivering improved patient outcomes for our population

Working at Place

Support the further development of local, borough-based Care Partnerships and Primary Care Networks

Reduce inequalities

Identify where inequality exists across in outcomes, experience and access and devising strategies to tackle these together with our communities

Efficient and Effective

Help us build a more efficient and effective operating model tackling waste and unwarranted variation.

New Ways of Working

Accelerate our work to build new ways of working across the system to deliver increased productivity and collaboration

Economies of Scale

Help us make better use of our resources for local residents and achieve economies of scale and value for money

System Resilience

Help us become an system with much greater resilience to face changes and challenges to meet the needs of our local population by supporting each other.

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NCL Integrated Care System: our vision and principles

Our ICS purpose: To improve outcomes and wellbeing, through delivering equality in health and care services for local people. **Supporting them to Start Well, Live Well and Age Well.** We also want to support the many local people who are employed by health and social care to **Work Well.**

Our Principles:

- We will work as one system to benefit the whole population of NCL and work together to drive health equality.
- We will retain the local patient, resident and clinical voice in the commissioning and delivery of health and care, by working effectively together at the three levels of our system.
- We will value our staff, our partners and their expertise to deliver the best health and care possible for the patients and residents of North Central London.
- We will work on a population health basis, planning for population needs as a system, and through local partnerships and neighbourhoods/networks.
- We will work to deliver joined-up care for our population planning around residents not organisations
- We will emphasise the value of subsidiarity, working as locally as is feasible whilst retaining strategic, effective commissioning for North Central London

We will be guided by a shared set of objectives (an 'Outcomes Framework'), setting out the difference we will make for the population in NCL and how we will be monitoring that we are achieving our strategic aims.

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NCL focus on tackling health inequalities

Restore NHS services inclusively	• Ensuring that all analysis undertaken in relation to the restoration of NHS services specifically considers equalities dimensions, including ethnicity and deprivation E.g. in our elective recovery and waiting lists, and community diagnostics hubs • Continuing to build up our population health management platform, HealtheIntent. In six months' time, we plan to have all acute and mental health trusts on HealtheIntent, alongside GPs and Royal Free that are there now. We will have also started onboarding community trust and adult social care data.
Mitigate against digital exclusion	• Commissioning an Equalities Impact Assessment report into the causes and contributing factors to digital exclusion, views from local stakeholders, the impact of Covid, and recommendations for action to address digital exclusion. • Establishing a pilot in Haringey, as a joint initiative with North Middlesex and the local Haringey ICP, that focuses on practical steps that can reduce digital exclusion for those already in the system, i.e. purchasing of hardware. • Prioritising digital exclusion in our most deprived wards through the utilisation of NHS Charities funding.
Ensure datasets are complete and timely	• Use of our population health management platform, HealtheIntent, to understand where care teams can make improvements in recording of equalities data. • System-wide audit on the use of "other" category in ethnicity data
Accelerate preventative programmes which proactively engage those at greatest risk of poor health outcomes	• Ongoing work with NHSE/PHE to encourage commissioning and delivery of a more culturally and socially competent flu vaccination programme, with appropriate equity monitoring during the coming winter. • Using HealtheIntent for : Deploying a registry for physical health checks among people with serious mental illness, Developing a similar registry for learning disabilities, Deploying our registries for COPD, diabetes, childhood asthma and atrial fibrillation, and dashboards on population health needs, childhood immunisations, frailty and quality improvement for long term conditions. • Working closely with PHE as part of our ICPS, to identify key priorities and implement changes in line with national guidance and the recommendations of publications including Beyond the Data. For example, Enfield is focusing on their most deprived communities, and is jointly funding (with the local authority) community participatory research and community engagement to look childhood obesity.
Strengthen leadership and accountability	• A Population Health Management and Health Inequalities Committee has been established, led by our ICS Chair and with broad stakeholder engagement across local authorities, primary, community and acute services. The aim of this Committee is to embed a population health approach across the system, including a focus on reducing health inequalities.

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Priority NCL ICS Programmes for 2021/22

We have defined 9 clinical and care priorities plus four enabler programme priorities:

Elective Recovery	Mental Health	Community/ Local Care
Urgent & Emergency Care	Children, Young People & Maternity	Primary Care Recovery
Cancer Alliance	Diagnostics	Social Care

+

- Estates
- Workforce
- Digital
- Corporate

Our **Clinical and Care priorities** focus on **tackling health inequalities** and improving the **overall quality of care for our residents through service improvement and transformation -** an integral component being **recovery of services to pre-pandemic levels** in an equitable manner .

Our **enabler programmes** help establish the foundation of a truly integrated care system, and contribute to **releasing system efficiencies** that strengthen our health and care system.

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Governance and structures of the NCL ICS

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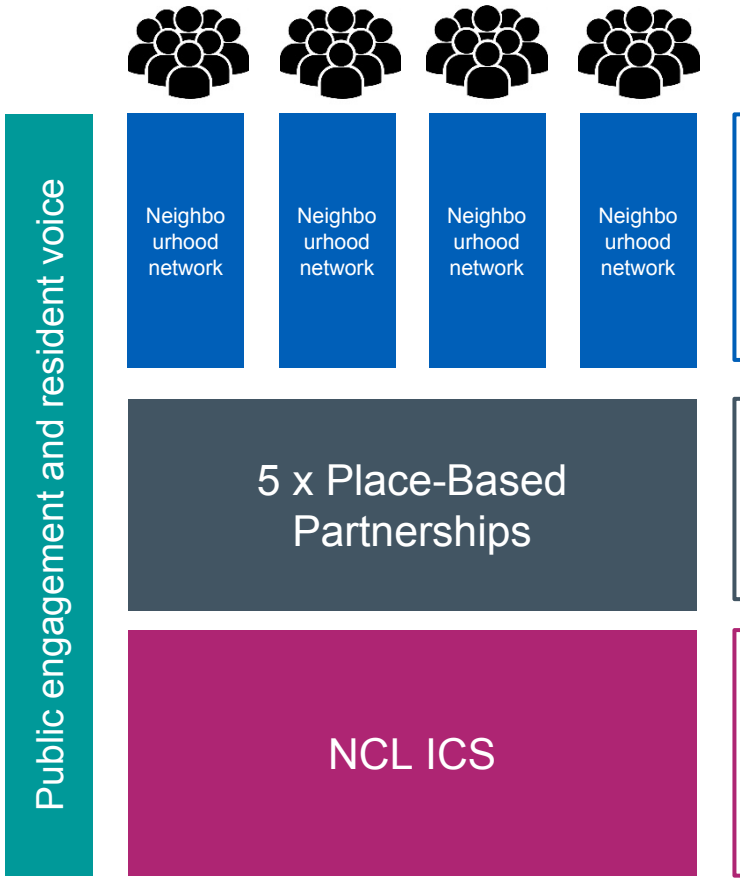
Working towards an NCL ICS

Together, system partners are designing what our Integrated Care System (ICS) will look like at neighbourhood, place and system-level



Neighbourhoods build on the core of the primary care networks and **enable greater provision of proactive, personalised, coordinated and more integrated health and social care** through multidisciplinary teams taking a proactive population based approach to care at a community level.

Boroughs are the **critical point of integration and coordination of services**. All boroughs have a **strong sense of defined population being coterminous with local authorities**. The work at borough partnerships is focussed on bringing together partners **develop and coordinate services based on agreed outcomes.**

The NCL ICS will focus on activities that are better undertaken at an NCL level **where a larger planning footprint increase the impact or effectiveness** of these functions. It will also be responsible for **system planning,** towards our goals of reducing inequalities and improving health outcomes.

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Core components of NCL ICS Governance

- There are some elements of system wide governance we will need to set up and implement to support the formation of an ICS. This is subject to legislation and further work locally on how these will work. These are set out below.
- Integrated Care will not just be at system-level but also within our boroughs, or at 'Place'.
- System partners will work together to confirm the footprint for each place-based partnership, the leadership arrangements and what functions it will carry out.

Integrated Care Partnership

Guidance to be issued by DHSC in September.

Responsible for developing integrated care strategy for whole population across partners in NCL

Forerunner of this in NCL: **Quarterly Partnership Council**

Integrated Care Boards (ICB)

Unitary (single) Boards to lead integration within the NHS.

Board membership to be outlined in legislation.

Forerunner of this in NCL: **Steering Committee**

Community Partnership Forum

Will bring together NHS, Healthwatch, local authority, VCSE and community representatives for strategic discussions.

Builds on work of the Engagement Advisory Board, established for the North Central London STP

Place-based partnerships

Functions to be exercised and decisions to be made, by or with place-based partnerships at a borough level.

ICB will remain accountable for NHS resources deployed at place-level.

All boroughs have partnerships in place

Provider Collaborative

Will agree specific objectives with one or more ICB, to contribute to the delivery of that system's strategic priorities.

NCL Provider Alliance forming with all providers and Primary Care as members

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North Central London's sustainability and transformation partnership

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Clinicians at the heart of our NCL ICS

Future clinical leadership

- Clinical leadership will remain at the centre of the NCL ICS - at system, place and neighbourhood level
- Must reflect the multidisciplinary nature of an ICS, and the diversity of our population
- Continued need for primary care clinical leadership
- Setting objectives for effective partnership working between clinical and professional leaders, officers and system partners to provide high quality health and care for NCL patients and residents

Our clinical workforce

- COVID has made us think and act in a more integrated way, aiming to deliver the best care for our population
- Development of the North Central London ICS will build on the good work done to support staff throughout the pandemic
- We are looking at the possibility of having some NHS staff based across multiple sites, to manage the demand on the system
- Working together offers the opportunity to reduce duplication, learn best practice and learn from / teach each other

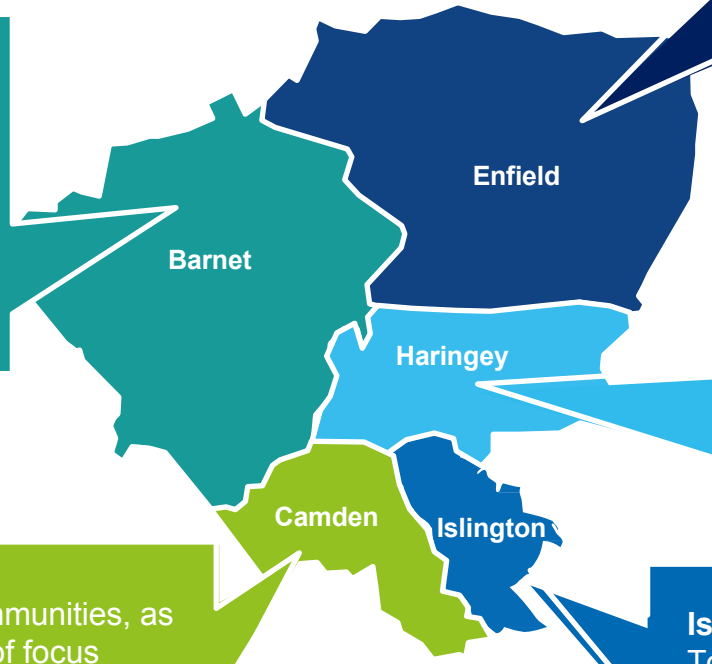
Our Place-Based Partnerships

Enfield - COVID has helped accelerate integrated working. Priorities have been expanded from an initial focus areas following success around flu and Covid vacs. Provider Integration Partnership oversees delivery

- 10 'organisations' represented (25+ members of delivery board)
- 4 PCNs (not geographical – neighbourhoods within @ 50k)

Barnet - Older population gives rise to focus on proactive care, same day urgent care and support to remain independent.

- 10 + 'organisations' represented (25+ members of delivery board)
- 7 PCNs



Haringey –Focused on expansion of community based care models, MH, wider determinants and inequalities and a local strengths based approach that also addresses risks driven by deprivation.

- 15+ 'organisations' represented (25+ members of delivery board)
- 8 PCNs

Camden – Strong focus on CYP, MH, citizen's engagement/coproduction & dialogue with families & communities, as well as a developing Neighbourhood model. New areas of focus include accelerating provider developments at PCN and borough level and connecting with local communities.

- 303,267 registered population
- 15 + 'organisations' represented (30+ members of ICP/8 PCNs)

Islington – active multiagency partnership under banner of 'Fairer Together' with input from all statutory agencies (incl police, fire, housing). Senior leadership from Islington Council & CCG. Emphasises joint commissioning, operational joint working & expansion of neighbourhood level delivery. New Delivery Board estbalished to drive key workstreams:

- 15+ 'organisations' represented (25+ members of delivery board)
- 5 PCNs

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Place-Based Partnership priorities

- Covid-19 and flu vaccine programme
- Tackling Inequalities: in outcome, in access, in experience, for deprived communities, for BAME communities
- Mental health and mental wellbeing – for all but especially population groups historically less engaged
- Community joint working and the voluntary and community sector (VCS)
- Health inclusion groups – homeless, asylum and refugee
- Children, Young People and families – support to deliver key outcomes and address the impact of the pandemic 20/21
- Access – inclusive, appropriate, timely – focus on specific groups e.g. people with learning disabilities, serious mental illness, refugees
- Digital inclusion/exclusion
- Wider determinants including employment and housing
- Priority outcomes and populations, including those groups at risk of disadvantage/worse outcomes during the pandemic
- Proactive and Personalised care in the community – including use of technology, expansion of social prescribing models
- Urgent community response – in particular joint working across primary, community and social care supported by VCS

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Building resident and community voices at the heart of our ICS

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Community involvement and representation

Health and Wellbeing Boards

Health and Wellbeing Boards are linked to all borough partnerships:

- Most boroughs have updated their Health and Wellbeing Board ToR to include a link to the Borough Partnerships.
- Cllrs are largely engaged through the HWBB although there is increasing interest in direct involvement.
- HASCs also regularly request reports on the development of integrated care locally.

Patient & resident involvement & engagement

Patient and resident engagement is being undertaken in different forms across borough partnerships:

- All partnerships have their local Healthwatch as members on their partnership groups.
- Some Healthwatch members leads on specific areas of focus/priorities within the partnership.
- Most ICPs have engagement groups (e.g. Haringey Citizen Health & Care Advisory Board, Camden Citizens Assembly, Islington conducts regular community engagement events).
- Some CCG borough teams also support a patient engagement forum, with resident and VCS representation.
- CCG Community Members sit on many of our committees and support wider engagement work.

Engaging the VCS

Voluntary & community sector organisations play a role in all partnerships:

- VCS is represented on all partnership groups across all boroughs. In some, VCS leads on priorities areas (for example MIND in Camden alongside CIFT).
- In all others they are “plugged into” the work and have played an increasingly significant role in delivery of partnership plans (social prescribing, mental health and wellbeing support, delivery of equipment, support to access services, support to comms campaigns such as flu).

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Principles for communication and engagement

Effective communication and engagement across partnerships will be key to the ICS development and implementation. The key principles we will work to are included below.

Shape a programme of collaborative work between CCG, Council and Provider comms and engagement team – to build shared processes and ways of working for the future ICS, focused on:

- Building shared approaches to engagement, co-production etc.
- Models to bring together resource (staff and budgets) from across partner organisations
- Regular opportunities to share practice and make connections on engagement work across organisations
- Processes to centrally collect and report on insights to inform plans and decisions
- Shared evaluation models to demonstrate impact of engagement / community involvement
- Workforce training – develop skills to work with communities and VCSE, and build understanding that this is part of everyone's role in tackling health inequalities.

ICS Community Partnership Forum

- Established to oversee ICS resident engagement and involvement – to be aligned strategically with the ICS Quarterly Partnership Council and ICS Steering Committee.
- An expert reference group on community engagement as well as a forum for discussion and debate on emerging proposals and strategies.
- The Forum met for the first time in October 2021, and will meet quarterly.
- Current membership includes:
  - North Central London ICS Chair
  - North Central London Provider Alliance Chair
  - North Central London Executive Director of Strategic Commissioning
  - North Central London Executive Director of ICS Transition
  - Healthwatch representatives from the five boroughs
  - Council of Voluntary Services representatives from the five boroughs
  - Patient representatives from the five boroughs
  - Communication and Engagement reps from NCL Clinical Commissioning Group

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Community involvement and representation

Strong resident, patient and VCS involvement (at system, place and neighbourhood level) is critical. Over the next six months we will seek views, including the below areas of focus - from the ICS Community Partnership Forum, CCG Patient Public Engagement and Equalities Committee, Council Leaders, elected members, our Healthwatches and VCS, and wider audiences.

Ongoing Work to do at System-Level:

- Ensure transparent governance – public board meetings; resident, service user and carer representatives in governance etc.
- Developing shared principles and methods for involving people and communities, and co-production
- Capturing insights to build a picture of resident priorities and needs, and acting on this as a system
- Develop a shared approach to involvement / decision making with VCSE, supporting a resilient third sector

Ongoing Work to do at Place-Level

- Develop place-based partnership approaches on engagement and involvement, linked to ICS framework
- Ensure partnership links with HOSCs, HWBB, Healthwatch and VCSE sector are strong and effective
- Support Primary Care Networks and neighbourhood team links into communities
- Make every contact count to signpost residents to services and support

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Key stakeholders

Organisation	Stakeholder group
North Central London CCG	Governing Body, Executive Management team, Extended Executive Management team, Clinical Leads, union reps, all staff
Local authority (Barnet, Camden, Enfield, Haringey and Islington)	Council leaders, Chief executives, health and social care leads, Directors of adult social care / services, directors of public health, directors of children's social care / services, comms leads, council staff
NHS providers (incl mental health trusts, acute trusts and community trusts)	Chairs, Chief executives, Chief operating officers, Medical directors, nursing leads, comms leads, Trust staff
Primary care	LMC, Federation leads (chairs / chief execs / chief operating officers), PCN clinical directors, GPs, practice managers, practice staff
Cross-cutting groups	Health and Wellbeing Board representatives, Joint Health Overview and Scrutiny Committee members, borough Health Overview Scrutiny committees (HASC / HOSC)
Elected members	MPs (x 12); Councillors
VCSE	Healthwatch (x5) – Chief executives, Chairs, comms leads; NHS charities; VCSE organisations aligned to priorities (including but not limited to): mental health, children and young people, aged care and ageing, long term conditions; cancer; maternity and women's health
Patient / resident groups	Resident health panel, CCG patient groups (organised by borough), strategic review reference groups, Trust patient reference groups, Council patient reference groups, VCSE groups

Barnet, Camden, Enfield, Haringey and Islington residents and communities

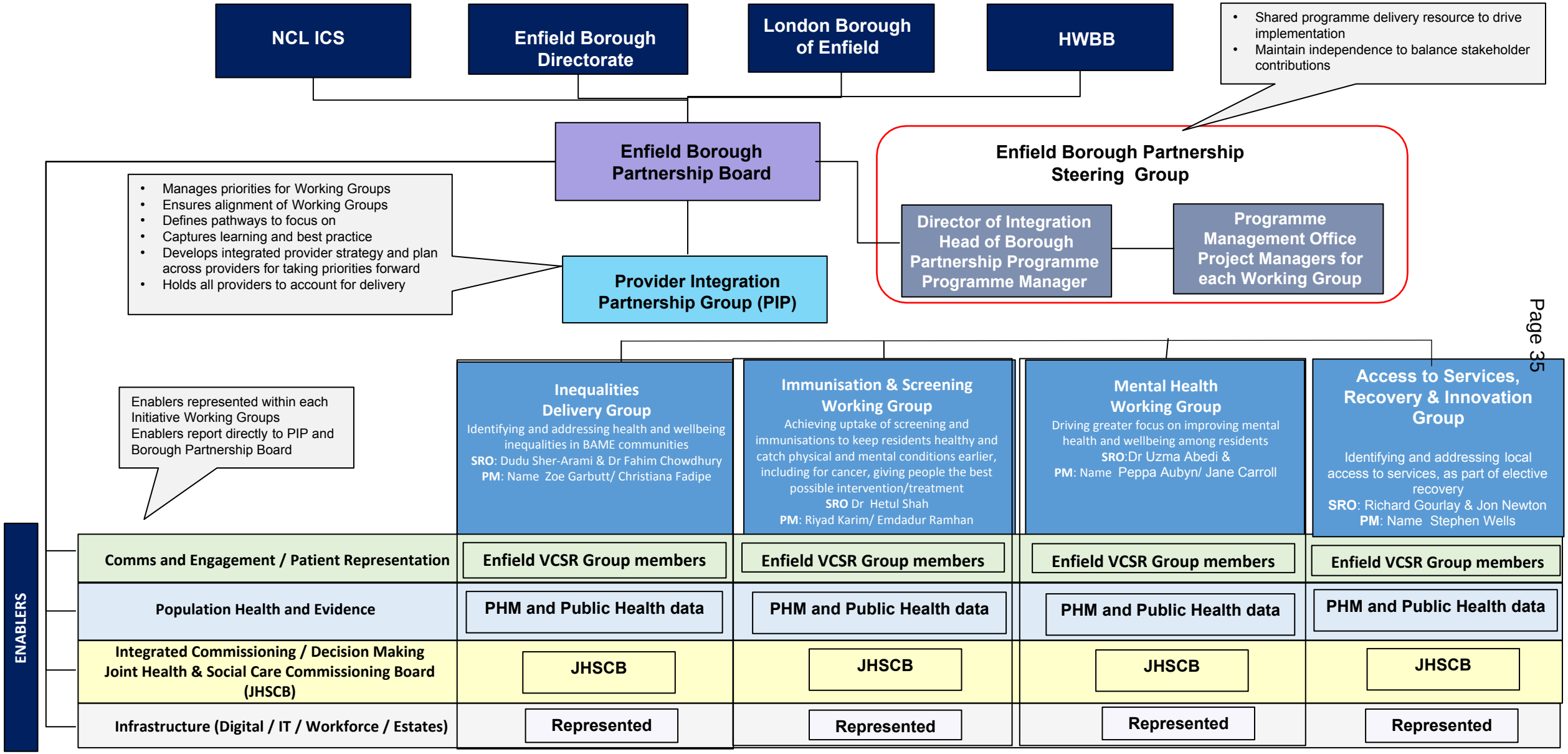
If you have a question about our transition to an Integrated Care System in North Central London, please contact us at northcentrallondonics@nhs.net in the first instance.

Enfield Borough Partnership

Progress Update
Health & Social Care Scrutiny Panel

18th November 2021

Enfield Borough Partnership Governance structure



Enfield Borough Partnership Priorities 22201/ 22

Partnership Priority outcomes

1. Achieving screening and immunisations uptake including Flu and Covid vaccination and uptake to the national Cancer screening programmes
2. Identifying and reducing inequalities where they exist
3. Improved Mental Health outcomes
4. Improving Access to Services, Recovery and Innovation

Wider Partnership Working

- Access to Services, Recovery & innovation inc. Collaboration with RNOH to develop MSK services on the High Street proof of concept pilot and engaging with local residents in accessing local services with an initial focus on primary care
- Long Term Conditions Programme inc. GP Federation/ PCNs with CVS organisations i.e. Enfield Voluntary Action and Health Champions,
- Enfield Joint Health & Social Care Commissioning Board – focus on Adults & CYP, Mental Health, LD, SEND, Better care Fund and Section 75 priorities
- Flu and Covid Vaccination Programme – multi-organisational approach involving All Borough Partnership stakeholders
- Key enablers: Estates, Workforce and IT/ Digital

Core Projects

- Mental Health - developing community integrated mental health pilot in SE Enfield
- Inequalities - childhood obesity and community participatory research
- Access to Services, Recovery & Innovation – identifying where the Borough Partnership can support improvement in local access to services i.e. primary care
- Screening & Immunisation Uptake - including national cancer screening programmes, Childhood immunisations, flu and Covid

Enfield Integrated Care Partnership:

Provider Integration Partnership Meeting

Highlight Reports:
Mental Health
Inequalities
Seasonal Vaccination
COVID Vaccination Inequalities

October 2021

The Enfield ICP Mental Health Steering Group: October21

ICP MH Steering Group Agreed Priorities	ICP MH Steering Group Agreed Priorities (Cont.)
Strengthened Governance ICP Sub group meetings continue to maintain a firm engagement as a forum to address key priorities and focus. Additional workshops planned to support: Co-production, collaboration development on key population segments across primary and secondary care alongside, caseloads and hub structure. Review of meeting agenda and attendees completed 15th Oct. **SOP (Standard Operating Policy)** Development of SOP for the community teams which will incorporate the VCS pathways and is iterative process as we progress the Co-production with partners. First draft complete and share with partners for review. Involvement of partners with clinical pathways development ongoing. Planned Persona's workshops expected to take place in end of October. **Clinical Pathway Development** First draft of Co-production clinical pathway (EIS, Recovery College and front door/ Personality Disorder Therapy / CRT PH/ SM Substances / Mental Health Service for Older People) is completed, with next steps to invite further stakeholder feedback. Pathway presentation to wider audience with Service Users, Carers, VCS and PCN Clinical Directors expected in November. **Early intervention in psychosis** Ongoing reviews of EIP services to support actions and development trajectory to achieve level 3.	**Staffing/ Recruitment** The Trust is continuing to recruit for the new core teams. Enfield recruiting additional 34 posts to support core functions through transformation programme. Currently 9 posts have been recruited, 7 under offer and 20 posts currently in the recruitment stage. VCS posts in recruitment stage. **ARRs roles** ARRS attracted 12 application, with offers to 3 candidates made. Start date pending. **VCS Tender** Ongoing regular Mobilisation meeting with lead VCS partner MIND (supported by EVA, Enfield Saheli and Alphacare). New VCS JDs agreed with partners. Communication Plan under review. Discussion and agreement on staff location and induction process to be firmed up in November. **KPI and Outcome** Ongoing review of and implementing KPIs which would be signed off by BEH and NHSI. Progress updat will be shared with the ICP steering group shortly. **Community Asset Mapping** Asset mapping (Enfield Borough wide Mental Health service) complied by clinical project lead and shared with ICP partners. Asset mapping to compliment the Council's directory of mapped the local contracted offers.

Issues for Escalation to PIP AND/OR ICP BOARD	
1	None at present

Risk/Issues	RAG*	Mitigating Actions
1. Engagement with clinicians, staff, public	At Risk	Enfield continued excellent comms support with an interactive approach to support staff involvement and programme roll out. Additional support provided to the borough by OD lead.
2. Ongoing pressures/challenges re resourcing and operational pressures	At Risk	Continued prioritisation of programme plus additional support. 1 x PMO support and 1 x Divisional Clinical PM 8a in post. Borough sub-structures focussed.
3. Incurring significant recruitment challenges	At Risk	Recruitment strategy ongoing

Mental Health Steering Group: October 2021

NEXT KEY MILESTONES

MH Steering Group	Milestone / product	Due date	RAG Status
PCN led proposal to improve SMI health checks	PCN/ Federation led proposal to improve SMI health checks that provides outreach and targets hard to reach group commenced on 26th of April. KPIs have been agreed and we will develop an evaluation to test outcomes achieved. The pilot is currently being evaluated. High level outcomes are that there has been a 29% improvement in uptake of health checks and 93% satisfaction rate during the pilot reporting period. The Pilot has been extended for the remainder of 21/22.	Mid April	
	NCL MH ICS Board has agreed commissioning arrangement for 21/22 and funding placed under the CCG Single Offer Framework. KPIs and outcomes are being agreed as part of the evaluation process; agreed that as a minimum the LTP target will be achieved and we will strive to increase uptake of hard to reach groups; those that have not engaged within the last 12-24 months, EIP and Wellbeing Clinic cohort.	July	
Procurement for Enablement under MDT model	VCS provider onboard, with MIND as lead partner in collaboration with EVA, Enfield Saheli and Alphacare. Mobilisation meeting ongoing on regular basis.	October	
	Next steps are to devise workforce model at PCN level and agree co-location of Multi-Agency Teams. Including IPS employment support services for SMI cohort	November	
Continue to develop new model of care for the Enfield Community Framework	Via Steering Group and sub groups with continuous input from the NCL Community Framework Steering Group . Focus is on whole person care which means moving beyond secondary caseloads to review SMI population needs. Steering group and sub-groups co-production of access to services, referrals and interfaces first draft completed. Service Users and partners review expected in November.	November	
Dialog /+ Development	Enfield has trained four Dialog + leaders in the pioneering Core Community team. Two training session undertaken. Following slippage of installation on system of device, activation of account, piloting of system with three staff and five service user each is underway with feedback expected in November.	November	
Milestone Plan	Milestone progress continuing at pace across all streams work including staff recruitment, caseload review, implementing Estates improvement works and Standard Operating procedure Core Community Team caseload	October	
Enablers: Areas for Consideration	The NCL Mental Health Service Review		
	NCL Community Framework Steering Group and Core Offer development		

The Enfield ICP Inequalities T&FG: October 2021

ICP Agreed Priorities	Impact of COVID
Governance The Delivery Group met in October. Regular attendance at VCS Reference Group which has improve engagement by extending meeting invitation to smaller organisations and coproduction of inequalities work. Governance was established for the inequalities group to hold other ICP work streams to account around inequalities. Also, continue to working on a series of events with the VCS around wider determinants that will feed into the ICP programme. **Inequalities Fund phase 1** Overall good progress are being made on the seven bids with a total of £652,156 were approved. Schemes are now being mobilised. Development of MOU and STW are underway. Will develop Inequalities evaluation methodology with an academic partner **Inequalities Fund phase 2** Further funds are available for schemes to the end of March 2023, VCS engagement workshop to develop bids. Membership of VCS meeting in September was expanded to ensure full representation by all stakeholders. Bids to be reviewed at Delivery Group in October finalised early November. Worked with ICP programme lead and organised ICP engagement to sign off of bids. **Inequalities Programme** Enfield Council have commissioned community participatory research to provide insights for the community health champions and community chest. Steering groups for the programmes took place in October. Successfully awarded funding for NHS Charities Together Grant £700k that will be spent across the boroughs of Enfield and Haringey in view of the higher deprivation and health inequalities in those areas.	Inequalities exposed and experienced through covid has informed the programme of work of this work stream. The inequalities fund phase 2 will further consider the impact of covid for example opportunities for local employment.

Issues for Escalation to PIP AND/OR ICP BOARD	
1	None at present

Risk/Issues	RAG*	Mitigating Actions
1. Delays in confirmation of funding for inequalities schemes will delay delivery	At Risk	CCG in communication and reassurance to all leads. Formal confirmation due mid-November .
2. Ongoing pressures/challenges re resourcing and operational pressures	At Risk	Continued prioritisation of programme plus additional support from communities team.

Seasonal Vaccination Programme: October 2021

ICP Agreed Priorities (PRE-Covid)	Impact of COVID
Achieve National Flu Target: Over 65s – 75% Under 65s at risk – 55% Pregnant Women – 55% 2/3 year olds – 50% Actual Performance 2020/21 : Over 65s – 73.0%, Under 65s at risk - 45.1%, Pregnant Women – 26.8%, 2/3 years olds – 48.7%	Increased target to 75% across all cohorts Additional 50-64 cohort Services delivered in covid compliant facilities/ increased time to deliver vaccine.

Risk/Issues	RAG*	Mitigating Actions
1. Pregnant women flu uptake in Maternity units below target	R	NCL below target. Engaging with Maternity Departments on recovery plans
2. Failed EMIS data extractions (no metrics supplied by Immform till further notice)	R	Managed by NHS England
3. Supplier Vaccine delivery delays	R	National Stock coming online for under 65s cohort

*RAG status based on Likelihood & Impact

Issues for Escalation to PIP AND/OR ICP BOARD	
1	Engage Acute Maternity providers to improve flu uptake amongst pregnant women.
2	

Highlight Report: October 2021

Develop Immunisation & Screening programme	Set up of Flu Task and Finish Group following release of National Flu Letter. Review lessons learned with PCNs by May 2021 and preparation for 2021/22 seasonal flu vaccination.	Date June 2021 Completed
	• Agree approach to improving flu uptake by patient cohort groups informed by 2020/21 position and work towards national target of 75%. • Continued commissioning of 2/3 year children Flu LCS via the Enfield Single Offer. • Working with Maternity services to improve flu uptake amongst pregnant women. • Reporting monthly commences from September onwards through to March - delayed • Continued use of Healthentent to support work targeting hard to reach groups and identify additional cohorts with low uptake - delayed	Date June - September 2021 Ongoing
PCN engagement	Work with national programmes, to align resources and support flu uptake, in addition to enhanced services in GP Contract.	Date : Ongoing
100 Day Plan	To develop a 100-day plan to: a) Implement a pre-seasonal task and finish group to plan for the flu season; Updates to be included with Covid inequalities group b) Review acute maternity mums to be recovery plan with NMUH; c) National Stock being made available ordering from 18/10/2021; d) Clarify changes in vaccines eligible for reimbursement by the NHS, in particular aTIV changing to aQIV vaccine; confirm whether children are eligible for QIVc/e on non clinical grounds (i.e. porcine); - **Confirmed QIVc eligible for those opposing nasal spray but providers are requested to order supplies from Immform for this batch: Flu poster** 2021382 Flu vaccines for the 2021 to 2022 season poster - Health Publications e) Complete a NCL communication and engagement project request form to enlist NCL communications resources for the flu programme.	Date June - October 2021 a) Completed b) In progress c) Ongoing d)Completed e)Completed

COVID Vaccine Inequalities: Oct 2021

ICP Agreed Priorities (PRE-Covid)	Impact of COVID
(National target) At least 75% coverage for all JCVI cohorts – including health, social care and care home staff • Overall uptake in over 12s = 64% - second in North Central London after Barnet at 68% • 96% of care home staff are now vaccinated with at least one dose, 93 of 2,160 care staff not vaccinated – all need to be fully vaccinated by 11 Nov • Higher than 75% uptake in all cohorts above 50s • Higher than 75% uptake in all over 12s in Highlands, Grange and Town	NA
(Aligned to NHSE Local Borough Plan submitted and agreed March 2021) Aspiration of 95% vaccine coverage for all JCVI cohorts	NA
Limit inequality in vaccine uptake between areas of high and low deprivation, different ethnic groups, Under 40s and other groups experiencing deprivation (e.g. GRT, Black African and Caribbean, homeless)	NA

Risk/Issues	RAG*	Mitigating Actions
1.Below 75% vaccine coverage (or <95%) in some geographic communities, ethnic groups and other communities experiencing inequality (e.g. homeless, GRT) • Age group: Uptake not yet at target in younger populations: 12% in 12-15s, 34% in 16 -17s, 51% in 18-29s, 56% in 30-39, 69% in 40-49 • Wards: Uptake (over 12) particularly low in Lower Edmonton (53%), Upper Edmonton (53%) and Edmonton Green (55%) • Ethnicity: Low uptake in White Gypsy Traveller residents (30%), Black African (52%) and Black Caribbean (49%) in over 12s • Language spoken – low uptake Bulgarian (21%), Romanian (27%) and Polish (39%)	amber	• Culturally competent conversations in hesitant areas • Tailored social media engagement campaigns • Partnership working with local authorities and the voluntary sector • ICP Vaccine Workstream activity informed by intelligence provided by Public Health Team. (Fortnightly **Phase 3 COVID and Flu Vaccination Group** continues this work and includes PCN and community pharmacy sites and stakeholders) • Ongoing communication and engagement for communities with sub optimal uptake and Under 40s cohort • Continued targeted comms in low uptake areas • Black African & Caribbean targeted work; Eastern European communities

Issues for Escalation to PIP AND/OR ICP BOARD	
1	Continued integrated focus on sub optimal vaccine uptake in Black African and Caribbean, Eastern European and GRT communities and under 40s cohort incl schools

Enfield Integrated Care Partnership

Access to Services, Recovery & Innovation Working Group

Co-chaired by Richard Gourlay, NMUH and Jon Newton, LBE

Scope and Purpose of the Working Group

ICP Access to Services, Recovery & Innovation is one of four local workstreams within the ICP programme that will work to ensure access to health care, social care, and community and voluntary organisation services for the residents of Enfield, engaging with all local stakeholders to inform the delivery of agreed local priorities and solutions to recover access to services in the post pandemic context.

The success of this work will depend on the mutual desire to understand how each of our organisations work, by:

- Recognising and being prepared to understand our partners' drivers
- Ensure we are looking at innovation and measures that support commitment to change the way we deliver services and make a real difference the patient's experience
- Ensure resident views and patients experience is feeding into the work of the group i.e. access to services, development of MSK services, etc.
- We recognise as a group we represent a range of different providers/ settings/ capacity and we must ensure we have an open culture that builds trust, openness and respect to enable everyone to contribute, respect their and to encourage genuine contribution to shape the way we can work effectively by collaboration
- To make best use of effort, resources etc. and ensuring that each partner plays it part to maximise the success of the Borough Partnership
- To accept that each stakeholder has different drivers, targets and frameworks, and acknowledging how these can complement each other, enabling services to go forward in a different way
- To recognise what we do well, and to identify areas that need to be improved. Use the expertise of all partners to achieve a better, more integrated way of working and delivery services to local residents
- Ensure members of the group can raise issues or concerns in relation to the transition to the NCL ICS/ Borough Partnership arrangements given the pace of change to establish new organisational arrangements from April 2022

Primary Care Access - Developing Communication material for local residents: Key Themes

1. **Valuing the primary care workforce** – abuse of staff is increasing. NCL have adopted Leeds CCG campaign (GP intranet). We have fed back comments about potential additional messaging around face masks – changing art work and some of the messaging . A national campaign is also coming out in the Autumn about this same topic
2. **Rise in feedback** – there is a lot of feedback coming into NCL about access to primary care that has not gone through the right routes – e.g. practices or the complaints process. This feedback is being given to the CCG and not in a format that can be shared with our member practices to understand the access pressures. We recognise that we may need to do some education work with patient groups, VCS and key stakeholders possibly with the support of our PPGs about how to feedback compliments, concerns or complaints – what the correct route is, what information your practice needs e.g. time of day that you tried to call and if this is a multi-organisational concern/complaint, how this is handled under the NHS complaints policy. We are thinking of how we can best support feedback and help with a better understanding of the system or a way that "problems" can be reported with a solution suggested at the same time.
3. **Perception that receptionists are triaging**. We recognise that receptionists are under a lot of pressure and they are not triaging but trying to help their practices with the workload and direct patients to the best clinician to help them e.g. practice nurse or pharmacist. Not all patients need to be seen by a doctor, and in Enfield we are under doctored too, which means we need to be resourceful in how we plan primary care services.
4. **Workforce roles** – lots of new roles have been introduced into PCNs and during the pandemic, many patients have now had appointments with clinical pharmacists, physician associates etc. We want to do a comms campaign about these new roles and how they are working in practices to deliver patient care.
5. **PPGs** – they want to help member practices and the CCG to broker a conversation with patients about access with a focus on supporting their practices and understanding the needs of patients. The PPGs have this on their work plan and we may look to bid for funding to support a special piece of work that is PPG led.
6. **While the focus is on primary care, there are system wide issues and this may also put pressure back on primary care. e.g. elective waiting lists**. We need to compliment anything about primary care by reinforcing the system wide messaging around things like winter pressures, surgical centres etc.

NORTH LONDON PARTNERS in health and care
North Central London's sustainability and transformation partnership

NHS

Proactive Integrated Teams (PITs)

Aims

- Form a PCN-based MDT who will proactively support patients on the elective waiting list to improve their health and wellbeing
- Holistic and personalised approach to care which will tackle gaps in care and optimise health and wellbeing before a procedure
- Driven by risk stratification approach using pop health data aiming to tackle inequalities
- **3 month pilots** delivered as part of NCL's elective recovery accelerator programme.
- Will place PITs in areas of greatest needs and inequalities – risk stratifying and prioritising patient lists by need and inequalities

Context

- Funding for the PITs work has been awarded from NCL's elective recovery accelerator funding
- Commitment to focusing on areas of greatest inequalities within the waiting lists in additional to raw patient numbers
- This work reports to the NCL interface steering group alongside other primary care / triage focused accelerator projects
- Elective waiting list ranges from 50 – 1100 per practice with greater numbers in areas which predominantly refer to Royal Free

Creating a proactive waiting list model to support Elective Recovery

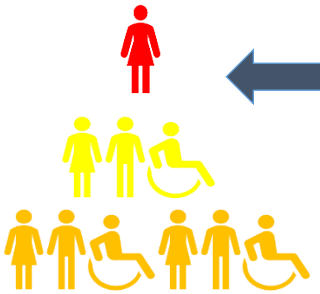
1 Aggregated Patient Tracking List (PTL)

2 HealtheAnalytics Dashboard

Insights from combined PTL and Integrated Patient Record

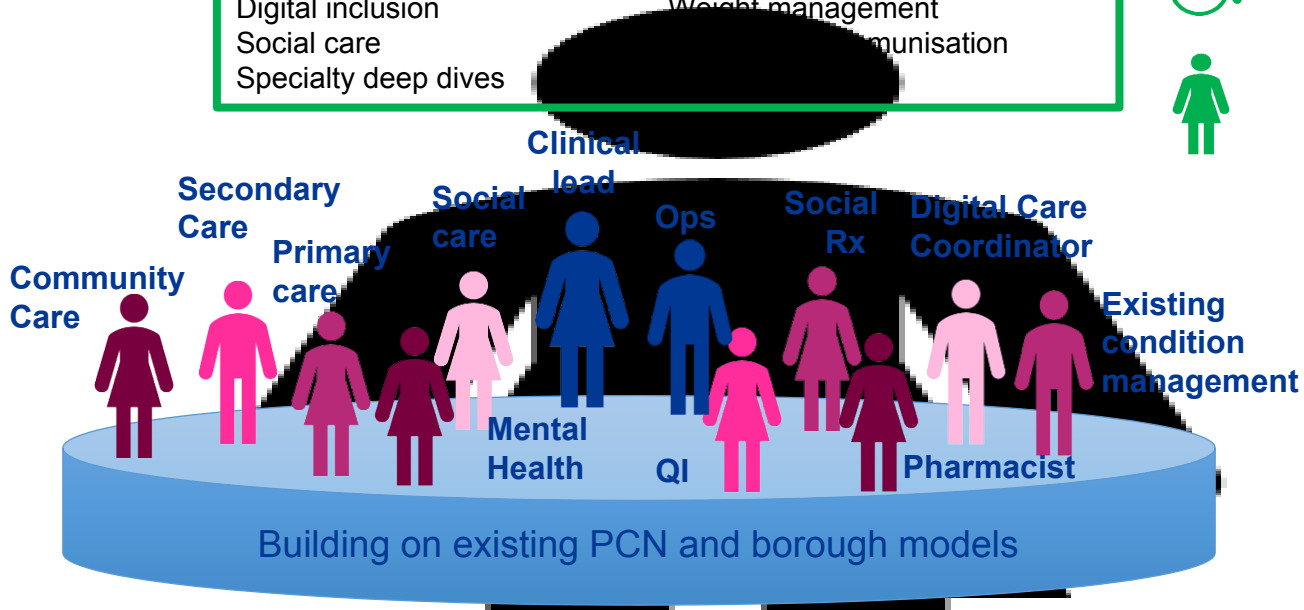
- inequalities and inequities in access & outcomes
- clinical and demographic information

3 HealtheIntent Stratified List by inequality & clinical profile



5 Personalised Proactive Care and Support

Shared Decision Making	Medicines optimisation
Strengths-Based Approach	Falls prevention
Case management	Speciality MDT
Care coordination	Clinical Advice &Guidance
Health Coaching	Community & Voluntary Services
Remote monitoring	Smoking cessation
Digital inclusion	Weight management
Social care	munisation
Specialty deep dives	



4 Proactive Integrated Teams (PITs)

personalised, coordinated impr alth and well-being of those or ele

- Improve health status, coordinatio outcor waiting
- Personalised care and support planning to confirm elective care is still appropriate and re-prioritisation
- Coordinate individual care between primary/community/secondary care
- Tackle health inequalities by personalising care to individual preference and linking to voluntary services
- Improve health literacy, reducing long-term inequalities in access and waits

6 Outcomes

Shorter Term

- Increased use of personalised approaches to address health inequalities
- Improved management of medical conditions
- Reduction in numbers waiting
- Increased alternative interventions to reduce numbers waiting and demand (O/P, Dx and Tx)
- Reduction in risk of crises & escalation
- Streamlined primary/secondary interface

Medium Term

- Improved population health
- Reduction in health inequalities
- Improved equity in access to elective care
- Reduction in LOS
- Reduction in crisis admissions
- Reduction in long-term CHC & social care needs
- Further refinement of system proactive care model

Enfield Borough Collaboration with Royal National Orthopaedic Hospital

MSK on the High Street- Enfield Proof of Concept pilot

Bringing Expert MSK Care to the High Street

Royal National Orthopaedic Hospital NHS Trust

The 'High Street' Community MSK Health Hub will be an innovative pilot that provides a novel approach to attacking the current issues in MSK. The pilot will learn from Ophthalmology which has built pathways around High Street provision as an entry point to services

Therapist led holistic MSK care including 'First Contact Practitioner'

Focus on solving system issues in collaboration with partners

Underpinned by digital technology, and high quality research

Patients first, *always* | Excellence, *in all we do* | Trust, honesty and respect, *for each other* | Equality, *for all*

What will be delivered

Royal National Orthopaedic Hospital NHS Trust

There are four tranches of patients that can be serviced through the 'Community MSK Hub' encompassing the MSK journey. Innovative clinical models will provide access to high quality care with the right healthcare professional at the right time

Patients awaiting Orthopaedic Consultant review	Patients listed for surgery but facing long waits	Primary Care	Rehabilitation
• Advanced MSK practitioners assess, organise diagnostics and pathway manage patients • Diagnostic and interventional ultrasound procedures delivered onsite • Significant pressure taken from secondary care	• Pre-optimization of patients physical and mental health prior to surgery • Improved outcomes post surgery • Potential reduction in patients requiring surgery	• First Contact Practitioner Model accessed directly on the High Street • Supporting Long term management of chronic conditions • Reducing the pressure on primary care services	• Providing rehabilitation for patients • Traditional Physiotherapy supplemented with Occupational Therapists, Dieticians and Nurse Specialists to address co-morbidities

Phase 1 work has commenced

Phase 2 co-creation to start in September

Patients first, *always* | Excellence, *in all we do* | Trust, honesty and respect, *for each other* | Equality, *for all*

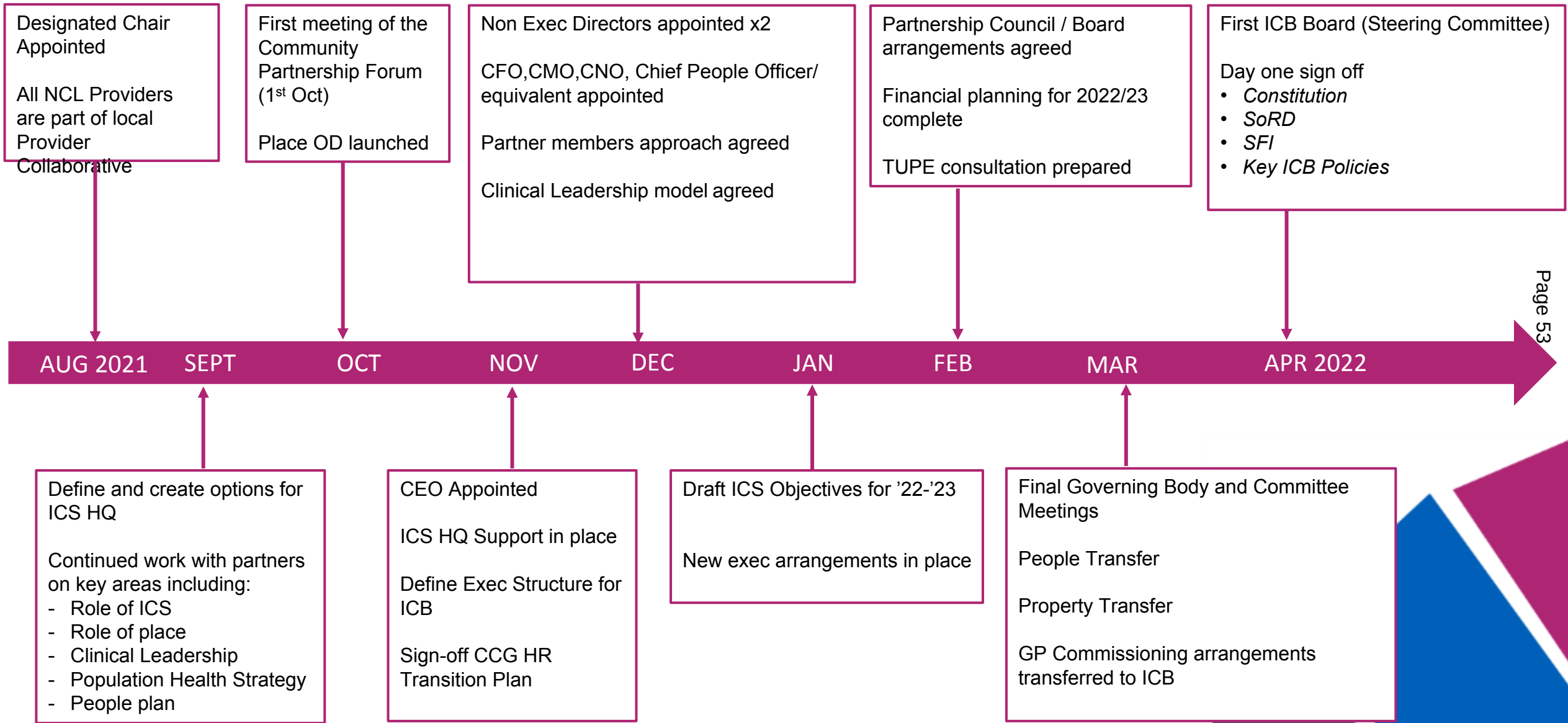
Enfield Integrated Care Partnership:

Provider Integration Partnership Meeting

ICS Development Plan

October 2021

NCL ICS Transition timeline – to April 2022



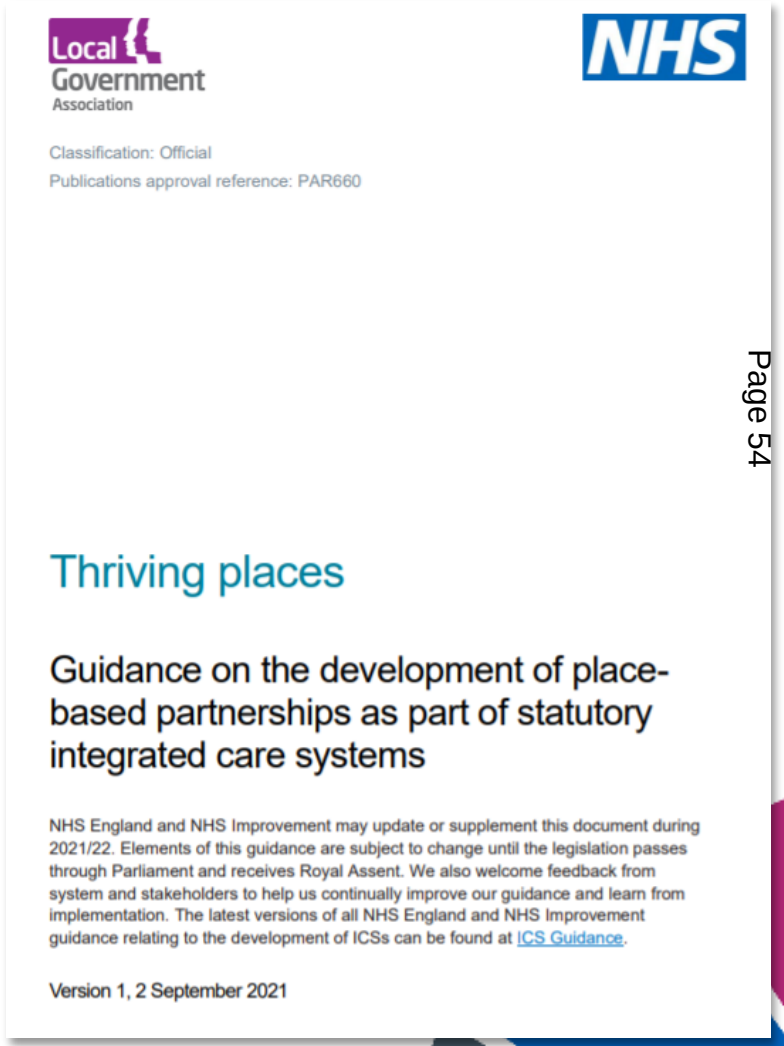
National Guidance

A range of documents has been published and summaries have been produced by NCL CCG. Key docs include ***Thriving Places: guidance on the development of place-based partnerships as part of statutory integrated care systems***, jointly developed by LGA and NHSE/I.

Key points:

- ✓ Place-based partnerships are collaborative arrangements formed by the organisations responsible for arranging and delivering health and care services in a locality or community.
- ✓ Place-based partnerships will remain as the foundations of integrated care systems as they are put on a statutory footing (subject to legislation), building on existing local arrangements and relationships.
- ✓ **Permissiveness.** It will be for system partners to determine the footprint for each place-based partnership, the leadership arrangements and what functions it will carry out.
- ✓ This document describes the activities placed partnerships may lead, capabilities required and potential governance arrangements.

Recently an **Integrated Care Partnership (ICP) engagement document** was published capturing the statutory role of this NCL-wide partnership in the development of integrated care locally - found here


Local Government Association

NHS

Classification: Official

Publications approval reference: PAR660

Thriving places

Guidance on the development of place-based partnerships as part of statutory integrated care systems

NHS England and NHS Improvement may update or supplement this document during 2021/22. Elements of this guidance are subject to change until the legislation passes through Parliament and receives Royal Assent. We also welcome feedback from system and stakeholders to help us continually improve our guidance and learn from implementation. The latest versions of all NHS England and NHS Improvement guidance relating to the development of ICSs can be found at ICS Guidance.

Version 1, 2 September 2021

NORTH LONDON PARTNERS in health and care

NHS

Priority system actions to April 2022

- ✓ **Progressing the key requirements of the new statutory model** including:.
  - Confirming key appointments – Chair, CEO, roles required for the ICB e.g. chief medical officer, chief nurse
  - Establishing key committees and forums
  - Technical transition from CCG model to ICS – legal, financial, staff TUPE
  - Recruitment of other senior NCL ICS Development of system discussion papers on specific aspects of the transition – covering e.g. Place, Clinical & Care Professional Leadership, Population Health
- ✓ **Continuing to 'build by doing'** through our joint work including e.g. winter planning and delivery, Inequalities Fund, Covid vaccination and Flu programmes, population health development, asylum and refugee response, elective recovery programme, care home support.
- ✓ **Developing our Borough Partnerships –** ensuring we have a clear position for April & forward plan around scope, role, capacity, boundaries, leadership, membership, governance & oversight
- ✓ **Developing provider alliances** – as vehicles to support provider collaboration, resilience, mutual aid and delivery
- ✓ **Developing and convening with Councils the ICS Partnership Council**, to sit alongside the NHS Statutory Board and ensure progress against key outcomes and objectives
- ✓ **Developing our Clinical & Care Professional leadership model –** ensuring we have a clear position for April & forward plan
- ✓ **Design and organisational development** with support and facilitation for local partners. Focusing in particular on Borough Partnerships and PCNs as the foundations of the system and level at which outcomes are improved for patients and residents

NORTH LONDON PARTNERS in health and care

NHS

Community involvement and representation

Strong resident, patient and VCS involvement (at system, place and neighbourhood level) is critical. Over the next six months we will seek views, including the below areas of focus - from the ICS Community Partnership Forum, CCG Patient Public Engagement and Equalities Committee, Council Leaders, elected members, our Healthwatches and VCS, and wider audiences.

Ongoing Work to do at System-Level:

- Ensure transparent governance – public board meetings; resident, service user and carer representatives in governance etc.
- Developing shared principles and methods for involving people and communities, and co-production
- Capturing insights to build a picture of resident priorities and needs, and acting on this as a system
- Develop a shared approach to involvement / decision making with VCSE, supporting a resilient third sector

Ongoing Work to do at Place-Level

- Develop place-based partnership approaches on engagement and involvement, linked to ICS framework
- Ensure partnership links with HOSCs, HWBB, Healthwatch and VCSE sector are strong and effective
- Support Primary Care Networks and neighbourhood team links into communities
- Make every contact count to signpost residents to services and support

Enfield Integrated Care Partnership:

Provider Integration Partnership Meeting

Development of Place (Thriving Places)

October 2021

The Leadership Centre and Traverse will support workshops that encompass:

- work with each borough and across NCL to deliver independent support to place-based design and the ongoing development of partnership working locally.
- work with CCG staff and joint teams so they are informed and supported as our ICS and borough partnerships develop.

The Leadership Centre and Traverse have clear expertise and experience and they will will focus on:

- Developing our narrative around what the ICS is about and how the ICS and place-based partnerships will accelerate integrated care.
- Developing the practice of system leadership, community engagement and partnership working.
- Being enquiry led and working with issues and challenging myths to support sustainable change.
- Embracing lived experience and shifting power to communities via co-design and collaboration.
- Drawing on the experience of our people.
- Exploring how we (individually and collectively) make the ICS work for local people.

Key Questions:

- How will the NCL ICS develop collaborative arrangements between NHS bodies and LAs - given the need to work with elected members as well as development of joint posts in the Borough Partnerships focused on service development/ delivery?

- Future role of borough HWBBs alongside the NCL: ICS and the transition of the new Public Health arrangements i.e. regional vs/ local PH teams – how will this be aligned with both NCL ICS requirements vs Borough based work?

- Governance – which of the 5 governance models will be the best fit for the Borough Partnerships in NCL ICS?

Thriving Places Guiding Principle 4: governance arrangements

Option	Definition	Benefits	Risks
1. Consultative forum	A collaborative forum to inform and align decisions by relevant statutory bodies, such as the NCL ICB or local authorities, in an advisory role. In this arrangement, the decisions of statutory bodies should be informed by the consultative forum.	-Helpful for engaging the widest range of partners to discuss and agree shared strategic direction together. Many places have found it useful to establish forums for developing shared visions and priority setting. -One current option is HWBs, which are a collaborative body bringing together the clinical, professional, political and community leadership. Other local areas have established place boards to fulfil this consultative forum function.	Perceived limited power and credibility within the system
2. Individual executives or staff	Statutory bodies may agree to delegate functions to individual members of staff to exercise delegated functions, and they may convene a committee to support them, with membership that includes representatives from other organisations.	-Helpful for engaging partners in the decision-making of statutory bodies, while retaining a single SRO for decisions. -A named individual could become the SRO for the place in their body, enabling budgets to be defined for the committee and managed through their internal management and reporting arrangements. In addition to the decision-makers, there can also be individuals in attendance who do not have decision-making authority but can participate in the discussion in the forum setting. -Equally, the individual director could be a joint appointment, between the ICB and local authority, or statutory NHS provider, and may have delegated authority from those bodies.	-Potential for missed opportunities for engagement and co-production -Perceived limited power and credibility within the system - Potential additional costs into the system
3. Committee of a statutory body	A committee provided with delegated authority to make decisions about the use of resources. The terms of references and scope are set by the statutory body and agreed to by the committee members. A delegated budget can be set to describe the level of resources available to cover the remit of the committee.	-Helpful for making decisions based on a range of views, while facilitating delegated authority for the use of resources. -For a committee of the ICB or LA, in both instances, there is an expectation that there are joint working arrangements with partners to embed collaboration. -The committee may appoint representatives of non-statutory providers to participate in the committee or attend meetings to take part in discussions without being members, but only where the convening statutory bodies consider it appropriate. HWBs are constituted as committees of local authorities and are charged with promoting greater integration and partnership between bodies from the NHS, public health and local government, and can also exercise functions delegated to them by their local authority.	-Potentially bureaucratic and slow decision making process to deliver change at pace -Does not signal true partnership working -Could create challenging and cumbersome governance across the system

Option	Definition	Benefits	Risks
4. Joint committee	A committee established between partner organisations, such as the ICB, local authorities, statutory NHS providers or NHS England and NHS Improvement. The relevant statutory bodies can agree to delegate defined decision-making functions to the joint committee in accordance with their respective schemes of delegation. A budget may be defined by the bodies delegating statutory functions to the joint committee, to provide visibility of the resources available to deliver the committee's remit.	-Helpful for making joint decisions between relevant partners. -The committee may include participation from representatives of non-statutory providers, but only where the convening statutory bodies consider it appropriate. -To date, we have seen that NHS and/or local government functions can be integrated using S.75 (of the NHS Act 2006) arrangements, creating a Joint Committee to manage the arrangements. Equally, section 65Z5 of the 2006 Act, inserted by clause 60 of the Health and Care Bill, allows the setting up of joint committees between a LA and an ICB.	-Could take longer time to establish -Potentially difficult to add partners as partnerships develop
5. Lead provider	A lead provider manages resources and delivery at place-level, as part of a provider partnership, under a contract with the ICB and/or local government, having lead responsibility for delivering the agreed outcomes for the place (including national standards and priorities) for the defined set of services.	-Helpful for giving provider leaders greater ownership and direction around the delivery and co-ordination of services. -The lead provider would subcontract other providers within the scope of the place-based delivery partnership. They can agree how resources are spent within the payment envelope agreed with the statutory body, complying with the terms of the contract, and establish governance with partnering providers to support delivery. - The Integrated Care Provider (ICP) Contract is one of the available options for systems to enable joined-up decision-making and integration of services. It will enable a single contract to be awarded to a provider that is responsible for the integrated provision of general practice, wider NHS and potentially local authority services.	-Providers do not map to geography -Could become the forum for the lead provider priority - Missed opportunities for engagement and co-production

Key questions:

1. Which approach would provide the right balance between the delivery of change at pace and the continuity and development of the existing local partnership?
2. Do we need to consider the approaches that will allow the arrangements to develop over time – short, medium and long term?

London Ambulance Service
NHS Trust

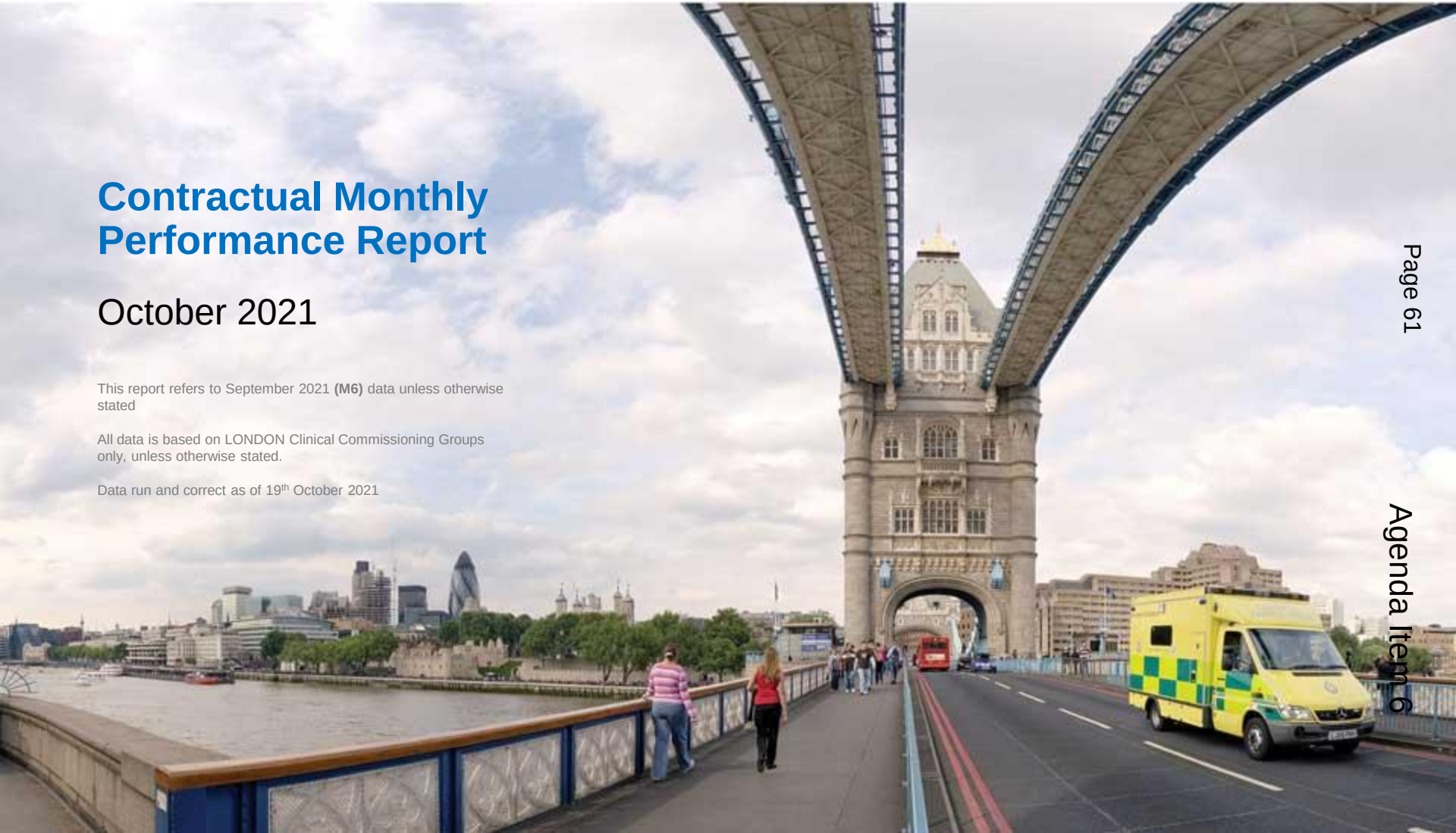
Contractual Monthly Performance Report

October 2021

This report refers to September 2021 **(M6)** data unless otherwise stated

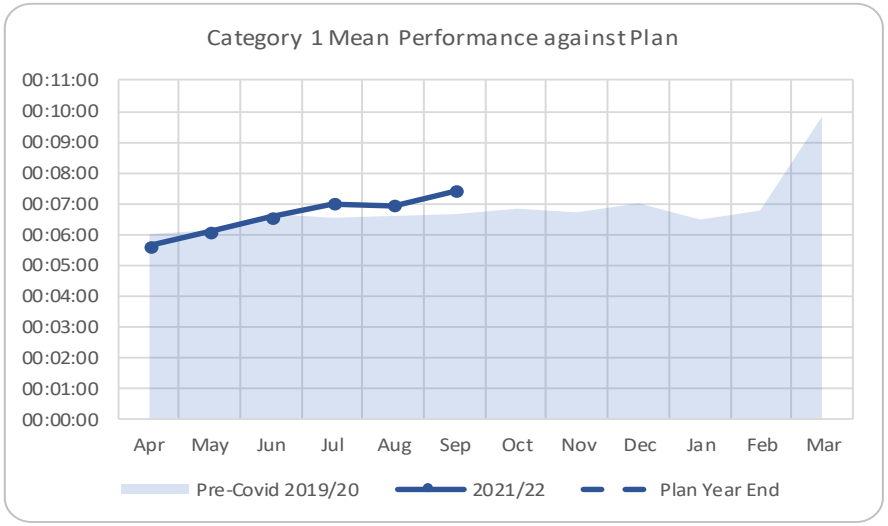
All data is based on LONDON Clinical Commissioning Groups only, unless otherwise stated.

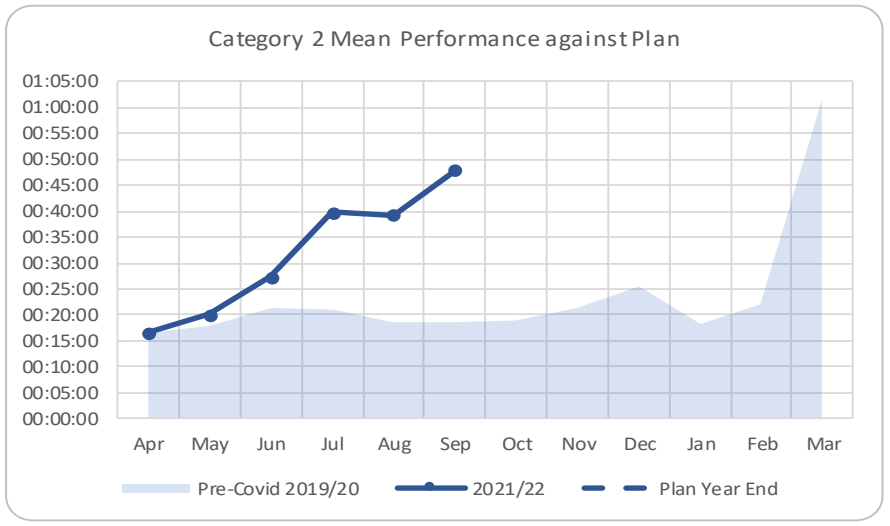
Data run and correct as of 19th October 2021



EXECUTIVE SUMMARY
Performance Summary

LAS Performance Variance to National Standard	C1 Mean (00:07:00)	Variance	C1 90th Centile (00:15:00)	Variance	C1T Mean (00:19:00)	Variance	C1T 90th Centile (00:30:00)	Variance	C2 Mean (00:18:00)	Variance	C2 90th Centile (00:40:00)	Variance	C3 Mean (01:00:00)	Variance	C3 90th Centile (02:00:00)	Variance	C4 90th Centile (03:00:00)	Variance
Previous month (M4)	00:06:59	00:00:01	00:11:49	00:03:11	00:10:49	00:08:11	00:18:43	00:11:17	00:39:50	00:21:50	01:26:27	00:46:27	01:45:05	00:45:05	04:27:15	02:27:15	07:47:25	04:47:25
Previous month (M5)	00:06:57	00:00:03	00:11:47	00:03:13	00:11:01	00:07:59	00:18:49	00:11:11	00:39:15	00:21:15	01:24:35	00:44:35	01:43:07	00:43:07	04:13:07	02:13:07	07:35:49	04:35:49
Last month (M6)	00:07:25	00:00:25	00:12:40	00:02:20	00:12:12	00:06:48	00:21:18	00:08:42	00:47:56	00:29:56	01:44:07	01:04:07	01:53:13	00:53:13	04:41:56	02:41:56	08:23:59	05:23:59
Current YTD (2021/22) * 1Apr - 30 Sep 21	00:06:40	00:00:20	00:11:22	00:03:38	00:10:37	00:08:23	00:18:16	00:11:44	00:31:44	00:13:44	01:12:05	00:32:05	01:22:35	00:22:35	03:28:41	01:28:41	07:00:27	04:00:27
2020/21 (M6)	00:05:45	00:01:15	00:09:49	00:05:11	00:09:00	00:10:00	00:15:31	00:14:29	00:16:53	00:01:07	00:33:42	00:06:18	00:47:18	00:12:42	01:53:42	00:06:18	03:14:10	00:14:10





* Incident data is correct as of 19th October and is subject to change due to data validation.

EXECUTIVE SUMMARY
Performance Summary

Demand

- 88,110 incidents were provided with a face to face response in September 2021. This is a 7.2% decrease compared to September 2019 (Disregarding September 2020 due to Covid)
- Category 1 incidents increased by 11.8% in September 2021 compared to September 2019 (disregarding September 2020 due to Covid)
- High acuity incidents (C1 & C2) increased by 1.5% when compared to September 2019

Performance

- The C1 Mean performed above the 7 minute National Standard for the first time since April 2020 (at the height of Covid).
- All the other Performance metrics deteriorated slightly compared to the previous month

Outliers

- The table opposite shows the outlier areas with long responses for the C4 90th centile measure. The table shows the top chief complaints and the number of incidents per area.
- This month all of these long responses were categorised as 111 Transfers.

NHS 111 Transfer is a chief complaint that is directly transferred from the 111 system into the LAS 999 call taking system. As these calls can not be re-triaged no further diagnostic information is available.

CCG Name	Chief Complaint	Total
NHS Enfield CCG	NHS 111 Transfer	41
NHS Hillingdon CCG	NHS 111 Transfer	24
NHS Islington CCG	NHS 111 Transfer	19
NHS Waltham Forest CCG	NHS 111 Transfer	12

* Incident data is correct as of 19th October and is subject to change due to data validation.

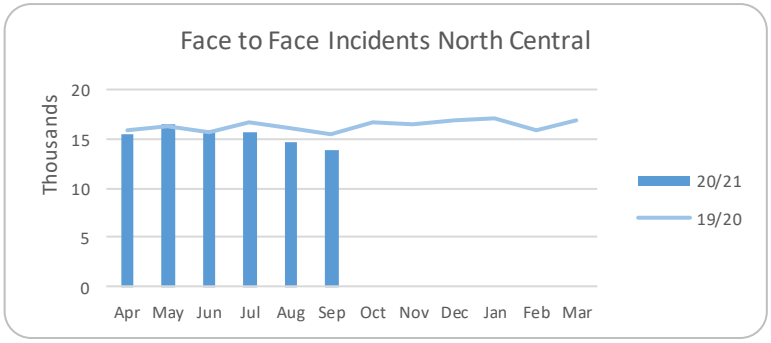
EXECUTIVE SUMMARY
North Central CCG Summary

- **Performance**

North Central CCG	C1 Mean		C1 90th Centile		C2 Mean		C2 90th Centile		C3 Mean		C3 90th Centile		C4 Mean		C4 90th Centile	
	20/21	19/20	20/21	19/20	20/21	19/20	20/21	19/20	20/21	19/20	20/21	19/20	20/21	19/20	20/21	19/20
Sep-21	00:07:50	00:06:49	00:13:19	00:11:34	00:57:15	00:19:28	02:00:20	00:39:13	02:14:31	01:04:39	05:22:11	02:39:29	04:18:18	01:28:45	08:45:43	03:18:22
Aug-21	00:07:15	00:06:40	00:12:41	00:11:16	00:46:25	00:18:41	01:39:48	00:37:29	02:01:41	00:59:47	04:51:32	02:30:30	03:51:31	01:28:28	07:40:20	03:21:58
Jul-21	00:07:26	00:06:40	00:12:28	00:11:14	00:47:36	00:22:42	01:43:57	00:47:47	02:06:08	01:19:53	05:13:18	03:24:33	04:02:16	01:53:49	08:12:43	03:44:48

- **Demand**

North Central CCG	C1		C2		C3		C4		HCP/IFT	
	20/21	19/20	20/21	19/20	20/21	19/20	20/21	19/20	20/21	19/20
Sep-21	1,677	1,501	8,880	9,706	2,458	3,296	225	360	272	534
Aug-21	1,563	1,729	9,500	9,905	2,766	3,436	245	320	314	557
Jul-21	1,714	2,138	10,290	10,284	2,853	3,186	266	333	281	519



- **Top 5 Chief Complaints**

The most often presenting complaints recorded at the call taking stage per month for the above named CCG. (The presenting complaints shown have been shortened)

North Central

Presenting Complaint	Sep-21	Presenting Complaint	Aug-21	Presenting Complaint	Jul-21
NHS 111 Transfer	2,880	NHS 111 Transfer	3,326	NHS 111 Transfer	3,497
Pandemic / Epidemic /	1,396	Pandemic / Epidemic /	1,567	Pandemic	1,596
Falls	1,046	Falls	1,090	Falls	1,159
_unknown	892	Unconscious / Fainting (Near)	960	Unconscious / Fainting (Near)	1,038
HEALTH CARE PROFESSIONAL	876	HEALTH CARE PROFESSIONAL	911	Chest Pain / Chest Discomfort	927

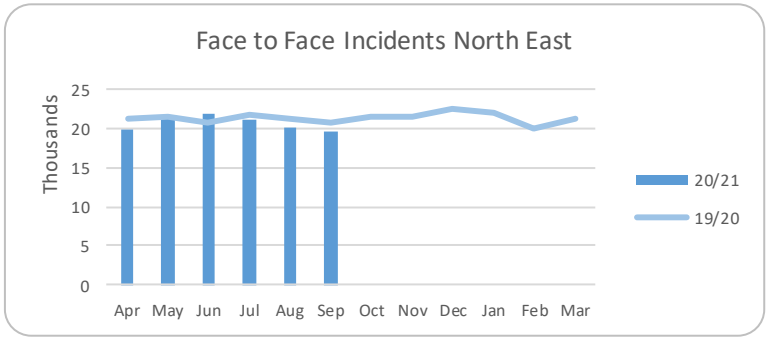
EXECUTIVE SUMMARY
North East CCG Summary

- **Performance**

North East CCG	C1 Mean		C1 90th Centile		C2 Mean		C2 90th Centile		C3 Mean		C3 90th Centile		C4 Mean		C4 90th Centile	
	20/21	19/20	20/21	19/20	20/21	19/20	20/21	19/20	20/21	19/20	20/21	19/20	20/21	19/20	20/21	19/20
Sep-21	00:07:45	00:06:29	00:12:39	00:10:42	00:55:03	00:17:45	01:58:09	00:35:03	02:01:48	00:59:17	05:15:19	02:26:59	04:26:42	01:28:23	09:12:01	03:23:53
Aug-21	00:07:02	00:06:18	00:11:45	00:10:32	00:47:31	00:17:03	01:39:09	00:34:07	01:55:48	00:55:00	04:48:53	02:09:09	03:49:00	01:36:36	07:36:51	03:31:35
Jul-21	00:07:07	00:06:27	00:11:57	00:10:45	00:47:16	00:19:56	01:41:27	00:40:47	01:51:26	01:07:51	04:53:47	02:44:33	04:02:07	01:42:39	08:41:55	03:50:40

- **Demand**

North East CCG	C1		C2		C3		C4		HCP/IFT	
	20/21	19/20	20/21	19/20	20/21	19/20	20/21	19/20	20/21	19/20
Sep-21	2,395	2,024	13,143	13,227	3,046	4,389	226	467	345	460
Aug-21	2,298	2,385	13,534	13,125	3,350	4,782	251	430	280	418
Jul-21	2,443	2,875	14,472	13,308	3,299	4,518	239	399	327	519



- **Top 5 Chief Complaints**

The most often presenting complaints recorded at the call taking stage per month for the above named CCG. (The presenting complaints shown have been shortened)

North East

Presenting Complaint	Sep-21	Presenting Complaint	Aug-21	Presenting Complaint	Jul-21
NHS 111 Transfer	4,419	NHS 111 Transfer	4,507	NHS 111 Transfer	4,675
Pandemic / Epidemic /	1,921	Pandemic / Epidemic /	2,068	Pandemic	2,246
Chest Pain / Chest Discomfort	1,367	Falls	1,461	Unconscious / Fainting (Near)	1,499
Falls	1,360	Chest Pain / Chest Discomfort	1,397	Falls	1,436
Breathing Problems	1,351	Unconscious / Fainting (Near)	1,264	Chest Pain / Chest Discomfort	1,379

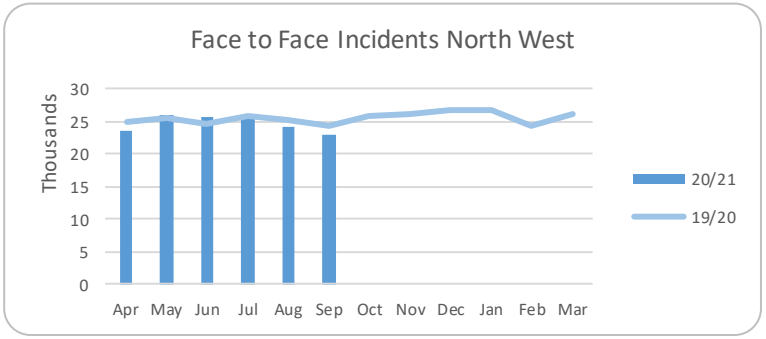
EXECUTIVE SUMMARY
North West CCG Summary

- **Performance**

North West CCG	C1 Mean		C1 90th Centile		C2 Mean		C2 90th Centile		C3 Mean		C3 90th Centile		C4 Mean		C4 90th Centile	
	20/21	19/20	20/21	19/20	20/21	19/20	20/21	19/20	20/21	19/20	20/21	19/20	20/21	19/20	20/21	19/20
Sep-21	00:06:55	00:06:47	00:12:05	00:11:34	00:48:04	00:17:51	01:42:49	00:35:45	01:55:24	00:51:19	04:46:27	02:03:02	04:24:40	01:15:55	09:17:06	03:02:47
Aug-21	00:06:51	00:06:36	00:11:15	00:11:01	00:33:01	00:18:15	01:08:42	00:37:10	01:37:00	00:52:06	04:00:28	02:01:45	03:44:18	01:18:53	07:56:18	03:01:10
Jul-21	00:06:41	00:06:33	00:11:12	00:10:59	00:34:42	00:21:35	01:13:03	00:44:25	01:40:27	01:06:30	04:19:50	02:44:01	03:55:17	01:38:51	07:54:10	03:49:17

- **Demand**

North West CCG	C1		C2		C3		C4		HCP/IFT	
	20/21	19/20	20/21	19/20	20/21	19/20	20/21	19/20	20/21	19/20
Sep-21	2,576	2,303	15,185	14,760	3,838	5,528	289	590	504	837
Aug-21	2,395	2,570	15,751	14,936	4,700	5,771	359	578	529	863
Jul-21	2,549	3,201	16,839	15,387	4,684	5,384	384	586	542	930



- **Top 5 Chief Complaints**

The most often presenting complaints recorded at the call taking stage per month for the above named CCG. (The presenting complaints shown have been shortened)

North West

Presenting Complaint	Sep-21	Presenting Complaint	Aug-21	Presenting Complaint	Jul-21
NHS 111 Transfer	4,680	NHS 111 Transfer	4,924	NHS 111 Transfer	5,039
Pandemic / Epidemic /	2,380	Pandemic / Epidemic /	2,444	Pandemic	2,659
Falls	1,738	Falls	1,920	Unconscious / Fainting (Near)	1,833
Unconscious / Fainting (Near)	1,634	Unconscious / Fainting (Near)	1,764	Falls	1,809
HEALTH CARE PROFESSIONAL	1,490	HEALTH CARE PROFESSIONAL	1,600	HCP Protocol	1,648

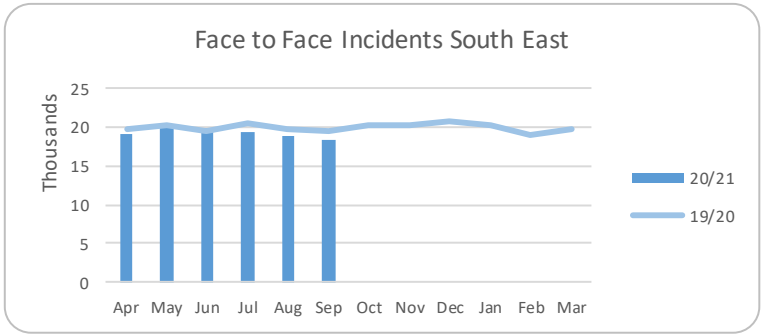
EXECUTIVE SUMMARY
South East CCG Summary

- **Performance**

South East CCG	C1 Mean		C1 90th Centile		C2 Mean		C2 90th Centile		C3 Mean		C3 90th Centile		C4 Mean		C4 90th Centile	
	20/21	19/20	20/21	19/20	20/21	19/20	20/21	19/20	20/21	19/20	20/21	19/20	20/21	19/20	20/21	19/20
Sep-21	00:07:08	00:06:40	00:12:24	00:11:17	00:37:37	00:18:43	01:22:32	00:38:47	01:38:23	00:53:08	03:58:49	02:09:35	03:13:48	01:10:55	06:23:11	02:34:54
Aug-21	00:06:45	00:06:42	00:11:41	00:10:54	00:34:30	00:19:26	01:15:08	00:40:29	01:34:02	00:59:22	03:47:23	02:27:27	03:03:54	01:31:12	06:41:52	03:28:41
Jul-21	00:06:46	00:06:35	00:11:23	00:10:51	00:34:08	00:20:51	01:13:39	00:44:05	01:34:12	01:00:32	03:51:41	02:23:31	03:04:15	01:24:04	06:15:49	03:21:23

- **Demand**

South East CCG	C1		C2		C3		C4		HCP/IFT	
	20/21	19/20	20/21	19/20	20/21	19/20	20/21	19/20	20/21	19/20
Sep-21	1,897	1,798	12,060	11,474	3,425	4,761	232	528	465	642
Aug-21	1,958	2,084	12,162	11,664	3,741	4,740	269	448	458	655
Jul-21	1,975	2,549	12,657	11,896	3,730	4,598	272	460	473	731



- **Top 5 Chief Complaints**

The most often presenting complaints recorded at the call taking stage per month for the above named CCG. (The presenting complaints shown have been shortened)

South East

Presenting Complaint	Sep-21	Presenting Complaint	Aug-21	Presenting Complaint	Jul-21
NHS 111 Transfer	3,804	NHS 111 Transfer	3,924	NHS 111 Transfer	4,127
Pandemic / Epidemic /	1,821	Pandemic / Epidemic /	1,869	Pandemic	1,939
Falls	1,580	Falls	1,617	Falls	1,539
_unknown	1,315	Unconscious / Fainting (Near)	1,257	HCP Protocol	1,275
Unconscious / Fainting (Near)	1,203	HEALTH CARE PROFESSIONAL	1,193	Unconscious / Fainting (Near)	1,269

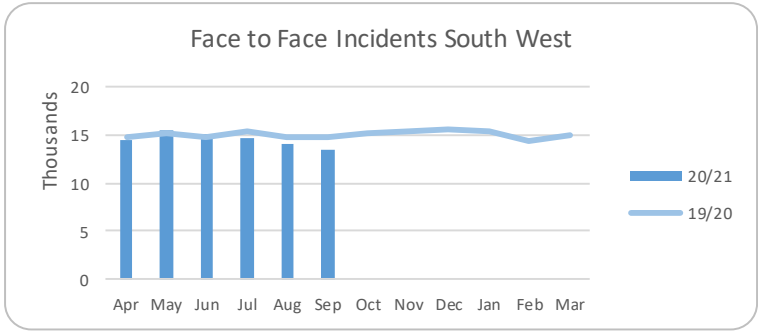
EXECUTIVE SUMMARY
South West CCG Summary

- **Performance**

South West CCG	C1 Mean		C1 90th Centile		C2 Mean		C2 90th Centile		C3 Mean		C3 90th Centile		C4 Mean		C4 90th Centile	
	20/21	19/20	20/21	19/20	20/21	19/20	20/21	19/20	20/21	19/20	20/21	19/20	20/21	19/20	20/21	19/20
Sep-21	00:07:39	00:06:42	00:13:20	00:11:01	00:41:37	00:19:11	01:31:28	00:38:53	01:39:12	00:53:36	04:01:01	02:05:56	03:41:57	01:13:34	07:19:43	02:55:07
Aug-21	00:06:58	00:06:45	00:12:12	00:11:28	00:36:30	00:19:27	01:21:03	00:40:38	01:32:25	00:52:17	03:45:35	02:03:07	03:18:07	01:27:19	07:01:38	03:30:54
Jul-21	00:07:02	00:06:40	00:12:09	00:11:02	00:36:46	00:20:53	01:20:21	00:43:10	01:38:44	01:00:24	04:05:20	02:22:28	03:02:13	01:25:33	06:55:09	03:15:36

- **Demand**

South West CCG	C1		C2		C3		C4		HCP/IFT	
	20/21	19/20	20/21	19/20	20/21	19/20	20/21	19/20	20/21	19/20
Sep-21	1,489	1,350	8,620	8,783	2,568	3,330	188	453	395	644
Aug-21	1,464	1,535	8,814	8,727	2,904	3,394	192	420	446	623
Jul-21	1,516	1,797	9,297	8,855	2,964	3,485	196	386	489	659



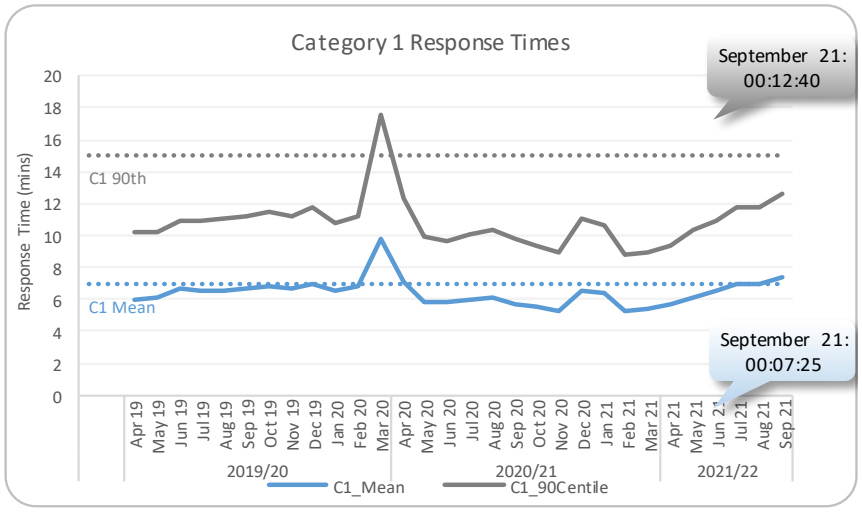
- **Top 5 Chief Complaints**

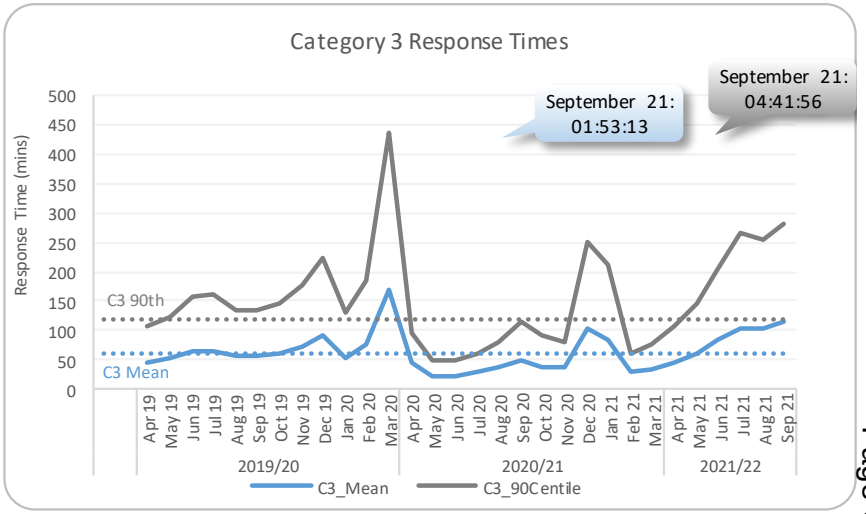
The most often presenting complaints recorded at the call taking stage per month for the above named CCG. (The presenting complaints shown have been shortened)

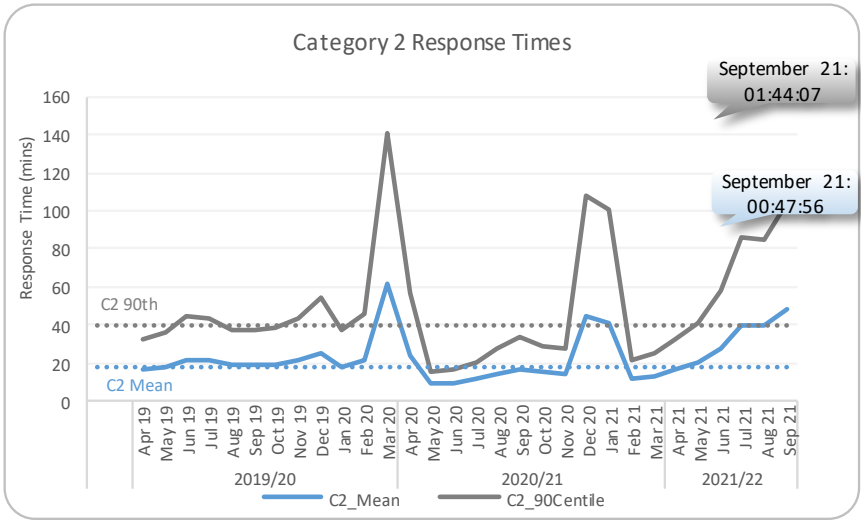
South West

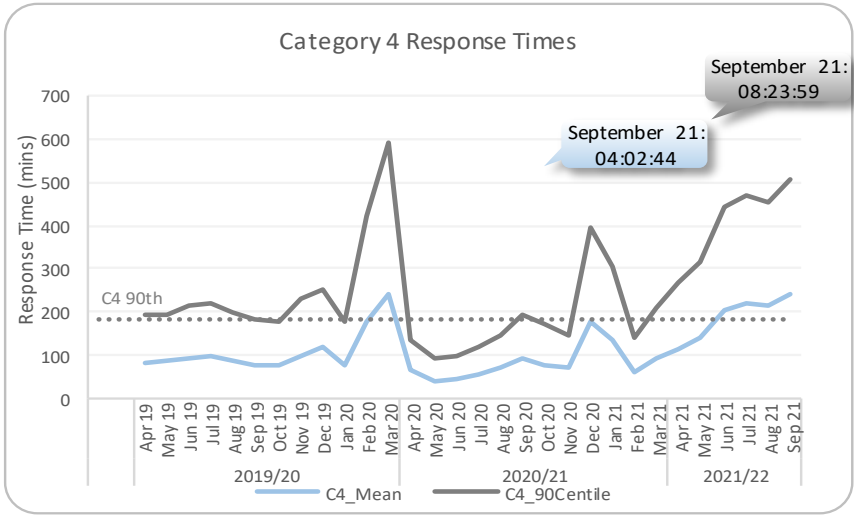
Presenting Complaint	Sep-21	Presenting Complaint	Aug-21	Presenting Complaint	Jul-21
NHS 111 Transfer	2,811	NHS 111 Transfer	2,933	NHS 111 Transfer	2,936
Pandemic / Epidemic /	1,340	Pandemic / Epidemic /	1,359	Pandemic	1,446
Falls	1,166	Falls	1,237	Falls	1,299
HEALTH CARE PROFESSIONAL	1,057	HEALTH CARE PROFESSIONAL	1,107	HCP Protocol	1,158
Unconscious / Fainting (Near)	897	Unconscious / Fainting (Near)	922	Unconscious / Fainting (Near)	961

Performance Overview
Response Times by Category

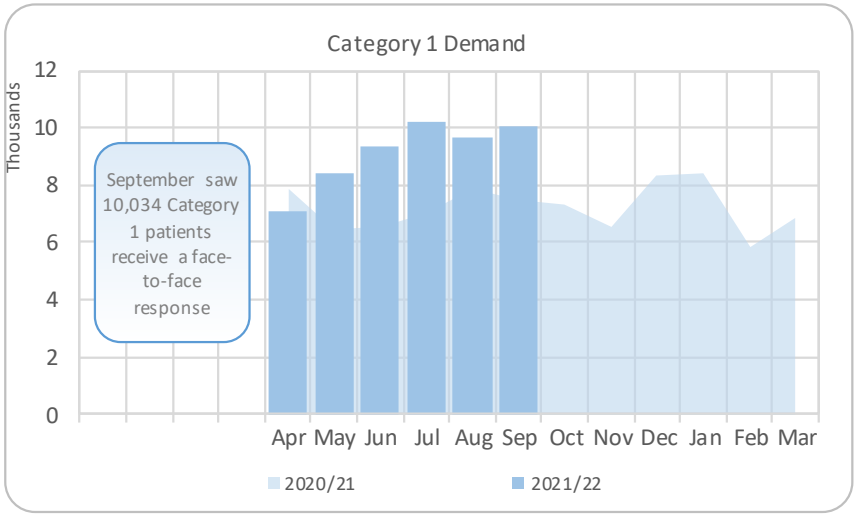


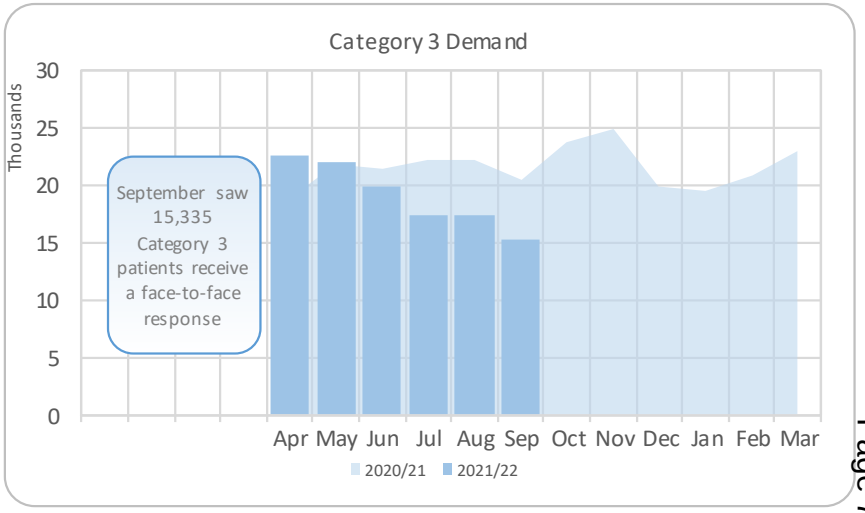


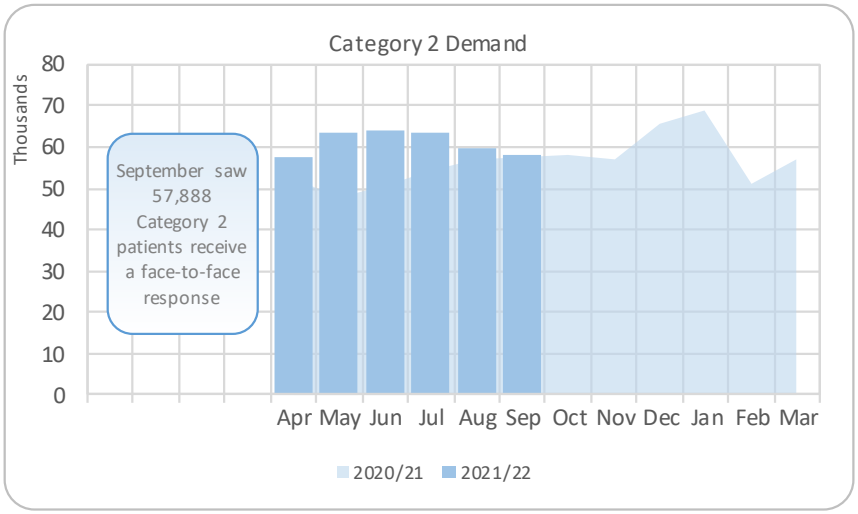


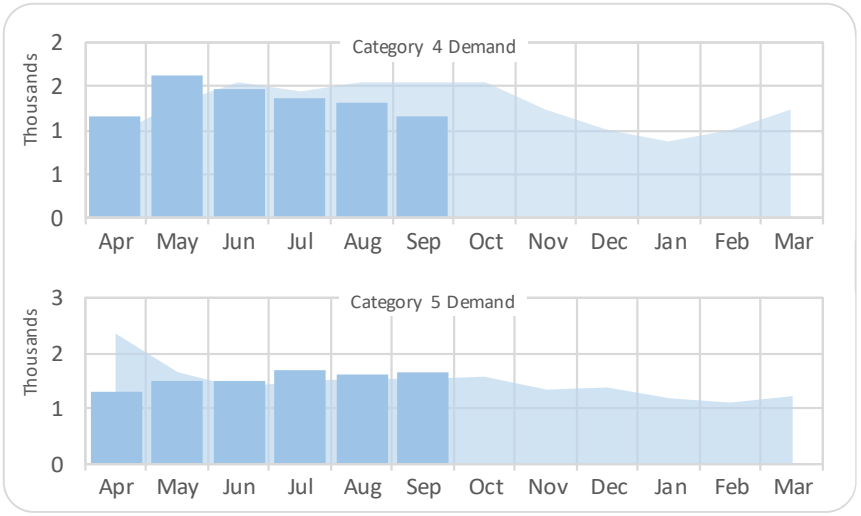


Performance Overview
Demand by Category









* Incident data is correct as of 19th October and is subject to change due to data validation.

Performance Overview
90th Centile Performance

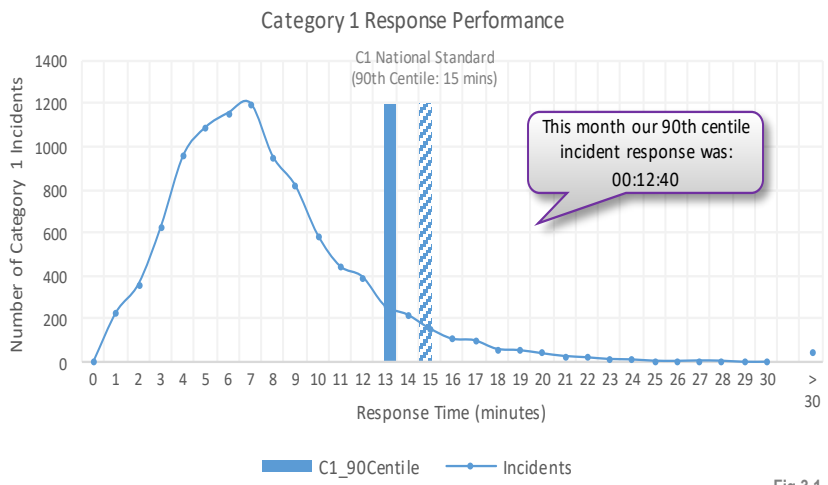


Fig 3.1

- Fig 3.1 Demonstrates the response distribution for Category 1 incidents.

The 90th centile response time in September was 00:12:40 minutes, within the 15 minute National Standard as set out in the guidelines by NHSI.

Of the 10,034 incidents requiring a Category 1 response, 9,030 incidents received a face to face response within 00:12:40

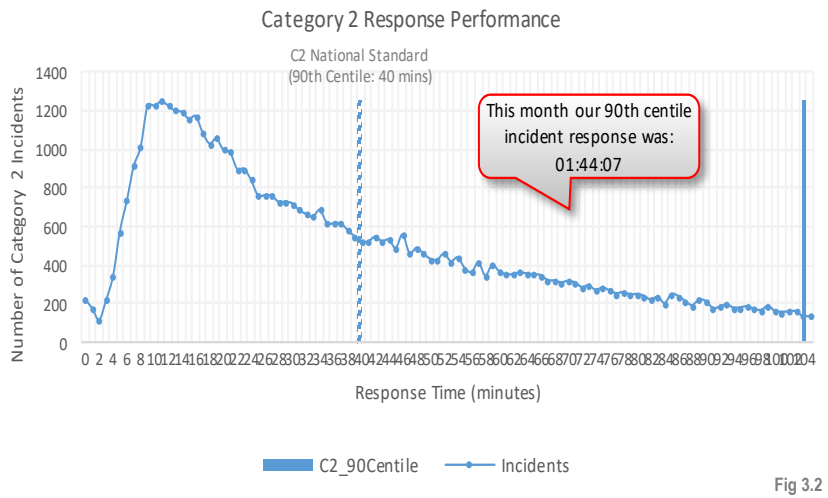


Fig 3.2

- Fig 3.2 Demonstrates the response distribution for Category 2 incidents.

The 90th centile response time in September was 01:44:07, above the 40 minute National Standard as set out in the guidelines by NHSI.

Of the 57,888 incidents requiring a Category 2 response, 52,100 incidents received a face to face response within 01:44:07

Performance Overview
90th Centile Performance

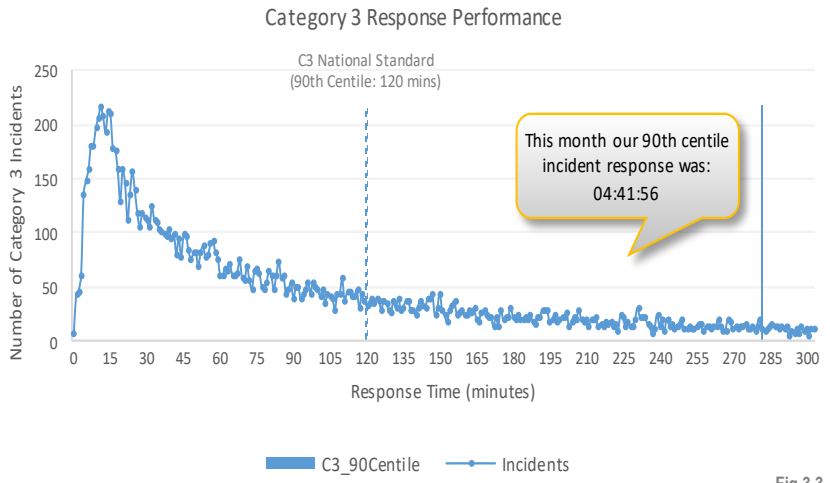


Fig 3.3

- Fig 3.3 Demonstrates the response distribution for Category 3 incidents.

The 90th centile response time in September was 04:41:56, above the 2 hour National Standard as set out in the guidelines by NHSI.

Of the 15,335 incidents requiring a Category 3 response, 13,881 incidents received a face to face response within 04:41:56

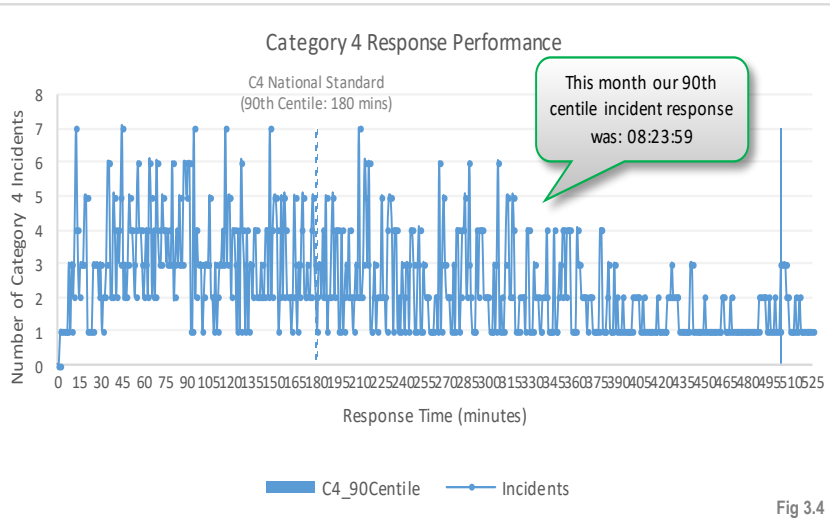


Fig 3.4

- Fig 3.4 Demonstrates the response distribution for Category 4 incidents.

The 90th centile response time in September was 08:23:59, above the 3 hour National Standard as set out in the guidelines by NHSI.

Of the 1,160 incidents requiring a Category 4 response, 1,044 incidents received a face to face response within 08:23:59

Performance Overview
Benchmarking - National Picture

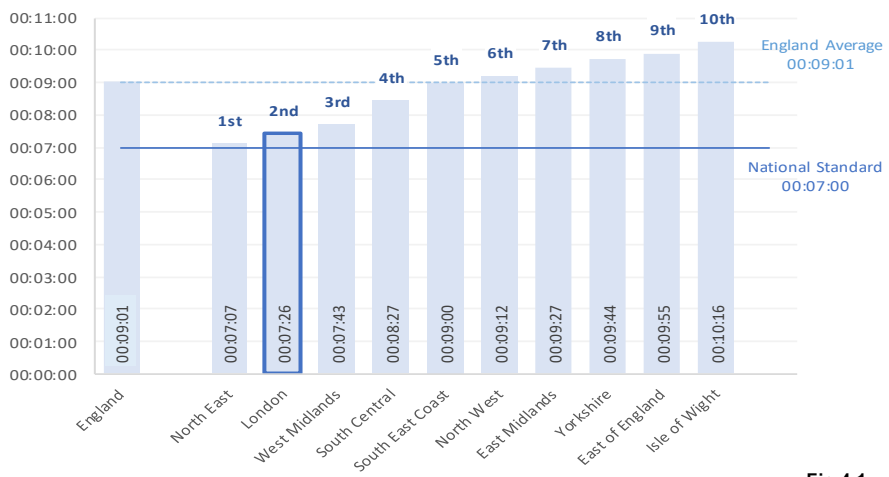


Fig 4.1

- Fig 4.1 Illustrates the Category 1 Mean Response Performance for Ambulance Trusts across England.

Additional information also displayed :

- The National Standard
- The average for England
- The ranking position for each Trust

- LAS achieved 7 minutes 26 seconds for the mean response time for Category 1 patients. This is above the 7 minute national standard.

- LAS performed within the England average.

Fig. 4.2 Displays the seven key ARP performance measures for each Ambulance Trust across England.

- LAS ranked 2nd in the Category 1 Mean performance measure, compared to the other Trusts.

- LAS also ranked 2nd in the Category 1 90th Centile measure, compared to the other Trusts.

	Mean		90th Centile		Mean		90th Centile		Mean		90th Centile		90th Centile	
September 2021	**Category 1**		**Category 1**		**Category 2**		**Category 2**		**Category 3**		**Category 3**		**Category 4**	
National Standard	00:07:00		00:15:00		00:18:00		00:40:00		01:00:00		02:00:00		03:00:00	
England	00:09:01	Rank	00:15:56	Rank	00:45:30	Rank	01:38:03	Rank	02:35:45	Rank	06:23:17	Rank	06:58:14	Rank
East Midlands	00:09:27	(7)	00:17:01	(8)	00:52:36	(9)	01:53:36	(9)	03:18:03	(10)	08:00:52	(10)	09:15:05	(9)
East of England	00:09:55	(9)	00:17:57	(9)	00:48:34	(8)	01:44:51	(8)	02:30:37	(7)	06:11:12	(6)	09:02:04	(8)
London	00:07:26	(2)	00:12:40	(2)	00:47:54	(7)	01:44:07	(7)	01:53:05	(2)	04:41:51	(3)	08:23:59	(6)
North East	00:07:07	(1)	00:12:21	(1)	00:43:34	(6)	01:29:53	(6)	02:22:29	(5)	06:17:23	(7)	03:40:30	(2)
North West	00:09:12	(6)	00:15:35	(5)	00:57:12	(10)	02:06:26	(10)	03:46:43	(11)	09:25:36	(11)	-	(-)
South Central	00:08:27	(4)	00:15:31	(4)	00:28:17	(2)	00:58:48	(2)	02:03:02	(4)	04:40:09	(2)	05:42:44	(3)
South East Coast	00:09:00	(5)	00:16:25	(6)	00:30:58	(3)	01:00:37	(3)	03:07:15	(9)	07:12:48	(8)	09:19:10	(10)
South Western	00:11:04	(11)	00:20:21	(11)	01:06:12	(11)	02:25:55	(11)	02:55:20	(8)	07:56:38	(9)	08:59:36	(7)
West Midlands	00:07:43	(3)	00:13:30	(3)	00:30:59	(4)	01:07:01	(4)	02:27:18	(6)	05:59:51	(5)	06:29:24	(4)
Yorkshire	00:09:44	(8)	00:16:47	(7)	00:37:56	(5)	01:21:03	(5)	01:58:54	(3)	04:50:53	(4)	06:41:07	(5)
Isle of Wight	00:10:16	(10)	00:18:41	(10)	00:28:01	(1)	00:56:56	(1)	01:27:29	(1)	03:12:47	(1)	03:35:14	(1)

Fig 4.2

Performance Overview
Performance by CCG & Locality

	(M6)	00:07:00	00:15:00	00:18:00	00:40:00	01:00:00	02:00:00	03:00:00
	Areas (formerly known as CCGs)	C1 Mean	C1 90th centile	C2 Mean	C2 90th centile	C3 Mean	C3 90th centile	C4 90th centile
North Central	Barnet	00:07:13	00:12:22	00:54:53	01:55:21	02:16:11	05:27:07	08:50:47
	Camden	00:07:13	00:11:44	00:45:15	01:43:06	01:40:11	04:12:20	08:07:35
	Enfield	00:08:32	00:14:11	01:07:00	02:12:52	02:47:49	06:05:53	09:02:33
	Haringey	00:07:54	00:13:31	01:06:53	02:14:10	02:18:16	05:24:18	07:53:19
	Islington	00:08:14	00:12:44	00:50:37	01:42:52	02:01:03	04:50:48	08:19:08
	Total	**00:07:50**	**00:13:19**	**00:57:15**	**02:00:20**	**02:14:31**	**05:22:11**	**08:45:43**
North East	Barking and Dagenham	00:07:17	00:11:49	00:55:33	01:56:47	01:59:07	05:06:22	05:49:23
	City and Hackney	00:07:22	00:11:47	00:46:05	01:40:31	01:43:15	04:44:40	09:50:02
	Havering	00:07:44	00:13:29	00:53:38	01:51:46	01:57:47	04:34:58	07:26:30
	Newham	00:08:11	00:11:48	00:56:40	02:06:13	02:06:11	05:11:57	09:05:57
	Redbridge	00:07:51	00:12:04	00:56:40	01:58:20	02:11:09	05:29:17	08:49:38
	Tower Hamlets	00:06:49	00:11:46	00:46:25	01:45:16	01:54:16	05:19:37	10:23:48
	Waltham Forest	00:09:14	00:14:38	01:11:56	02:34:30	02:28:57	06:52:07	10:25:15
	Total	**00:07:45**	**00:12:39**	**00:55:03**	**01:58:09**	**02:01:48**	**05:15:19**	**09:12:01**
North West	Brent	00:06:41	00:11:18	00:44:38	01:31:06	01:53:22	04:29:34	06:36:59
	Central London (Westminster)	00:05:49	00:10:49	00:43:55	01:35:48	01:28:42	03:59:07	09:47:25
	Ealing	00:07:37	00:13:00	00:53:02	01:51:38	02:12:02	05:07:41	08:10:11
	Hammersmith and Fulham	00:06:12	00:11:27	00:48:04	01:41:47	01:54:25	04:49:27	08:57:17
	Harrow	00:07:36	00:13:10	00:42:49	01:29:13	01:52:49	04:35:05	07:08:06
	Hillingdon	00:07:41	00:13:24	00:52:11	01:59:09	01:58:07	04:53:23	07:37:47
	Hounslow	00:06:50	00:11:41	00:51:11	01:47:02	01:58:23	04:56:55	09:37:05
	West London	00:06:34	00:11:02	00:45:44	01:36:27	01:58:31	04:55:57	10:47:23
	Total	**00:06:55**	**00:12:05**	**00:48:04**	**01:42:49**	**01:55:24**	**04:46:27**	**09:17:06**
South East	Bexley	00:08:06	00:14:20	00:42:45	01:28:45	01:47:04	04:16:45	07:04:01
	Bromley	00:08:14	00:13:55	00:41:13	01:30:49	01:38:58	03:59:19	04:49:47
	Greenwich	00:07:18	00:12:16	00:41:58	01:31:03	01:37:52	03:52:11	06:21:35
	Lambeth	00:06:03	00:11:02	00:29:51	01:04:58	01:30:45	03:40:22	06:48:52
	Lewisham	00:07:03	00:12:34	00:42:21	01:28:09	02:00:02	04:44:46	08:17:36
	Southwark	00:06:31	00:10:57	00:30:15	01:06:59	01:22:13	03:17:49	05:18:28
	Total	**00:07:08**	**00:12:24**	**00:37:37**	**01:22:32**	**01:38:23**	**03:58:49**	**06:23:11**
South West	Croydon	00:08:32	00:15:40	00:49:11	01:42:03	01:48:14	04:19:20	06:25:43
	Kingston	00:07:00	00:12:00	00:39:46	01:29:08	01:34:24	04:17:57	07:07:08
	Merton	00:07:08	00:11:22	00:35:30	01:12:41	01:36:15	03:50:00	08:34:20
	Richmond	00:06:55	00:11:09	00:44:24	01:39:36	01:23:59	03:30:28	05:58:03
	Sutton	00:07:53	00:13:27	00:38:06	01:19:38	01:35:15	03:53:12	07:42:45
	Wandsworth	00:07:03	00:11:29	00:36:18	01:21:20	01:43:13	04:09:48	06:25:26
	Total	**00:07:39**	**00:13:20**	**00:41:37**	**01:31:28**	**01:39:12**	**04:01:01**	**07:19:43**

Performance Overview
Performance by CCG & Locality

	YTD 2021/22 Areas (formerly known as CCGs)	00:07:00 C1 Mean	00:15:00 C1 90th centile	00:18:00 C2 Mean	00:40:00 C2 90th centile	01:00:00 C3 Mean	02:00:00 C3 90th centile	03:00:00 C4 90th centile
North Central	Barnet	00:06:50	00:11:36	00:35:18	01:17:48	01:33:29	03:45:32	06:21:28
	Camden	00:06:28	00:10:58	00:28:59	01:07:36	01:24:18	03:38:09	08:00:58
	Enfield	00:07:27	00:12:49	00:43:55	01:39:41	01:54:13	04:46:20	09:02:59
	Haringey	00:07:07	00:11:50	00:42:30	01:37:28	01:51:34	04:41:01	07:29:57
	Islington	00:07:04	00:11:28	00:32:59	01:14:52	01:28:51	03:34:12	06:35:07
	Total	**00:07:01**	**00:11:53**	**00:37:06**	**01:25:13**	**01:38:39**	**04:08:33**	**07:39:37**
North East	Barking and Dagenham	00:06:40	00:11:05	00:36:08	01:21:50	01:22:33	03:29:37	06:14:52
	City and Hackney	00:06:35	00:11:01	00:33:58	01:17:37	01:33:51	04:15:59	08:57:35
	Havering	00:07:13	00:11:48	00:35:32	01:20:55	01:18:12	03:16:29	05:36:17
	Newham	00:07:01	00:11:27	00:36:43	01:22:31	01:35:29	04:07:26	08:16:21
	Redbridge	00:06:52	00:11:23	00:37:51	01:25:55	01:35:23	04:00:54	06:35:14
	Tower Hamlets	00:06:07	00:10:40	00:33:02	01:17:08	01:27:34	03:55:08	08:24:54
	Waltham Forest	00:07:48	00:12:45	00:44:20	01:39:40	01:53:53	04:56:12	09:44:42
	Total	**00:06:52**	**00:11:28**	**00:36:42**	**01:23:42**	**01:31:58**	**03:58:40**	**07:48:15**
North West	Brent	00:06:32	00:11:13	00:28:59	01:01:58	01:26:34	03:32:14	06:35:07
	Central London (Westminster)	00:05:30	00:09:52	00:26:36	01:01:25	01:09:52	02:59:49	07:54:55
	Ealing	00:06:48	00:11:24	00:30:04	01:04:56	01:23:22	03:26:19	06:56:07
	Hammersmith and Fulham	00:05:30	00:09:52	00:25:59	00:58:36	01:19:49	03:30:17	07:55:39
	Harrow	00:06:43	00:11:36	00:28:41	01:01:59	01:21:04	03:23:55	06:32:18
	Hillingdon	00:06:55	00:11:43	00:32:14	01:13:14	01:15:45	03:12:58	06:43:15
	Hounslow	00:06:01	00:10:14	00:29:05	01:04:28	01:17:17	03:09:13	07:23:26
	West London	00:06:18	00:10:12	00:26:05	00:59:18	01:20:11	03:24:56	07:41:50
	Total	**00:06:21**	**00:10:54**	**00:28:51**	**01:04:04**	**01:19:36**	**03:21:04**	**07:16:52**
South East	Bexley	00:07:20	00:12:51	00:33:03	01:13:10	01:20:41	03:19:33	06:48:07
	Bromley	00:07:17	00:12:24	00:27:27	01:01:33	01:02:26	02:29:17	04:22:52
	Greenwich	00:06:35	00:11:19	00:30:13	01:09:00	01:18:24	03:17:30	06:31:23
	Lambeth	00:05:50	00:10:07	00:24:09	00:53:17	01:14:02	03:03:06	06:37:02
	Lewisham	00:06:21	00:11:10	00:29:47	01:06:32	01:21:39	03:26:46	06:00:36
	Southwark	00:05:58	00:09:48	00:22:48	00:50:18	01:06:18	02:45:05	05:36:18
	Total	**00:06:29**	**00:11:13**	**00:27:38**	**01:02:10**	**01:13:14**	**03:02:33**	**06:01:07**
South West	Croydon	00:07:19	00:13:05	00:34:15	01:18:05	01:26:58	03:32:40	06:13:09
	Kingston	00:06:25	00:11:18	00:25:45	00:58:08	01:01:32	02:25:04	05:00:33
	Merton	00:06:42	00:10:50	00:24:32	00:54:56	01:06:50	02:46:17	05:53:28
	Richmond	00:06:05	00:10:17	00:28:29	01:02:36	01:03:58	02:34:12	04:35:55
	Sutton	00:07:12	00:12:03	00:27:28	01:00:43	01:10:48	02:57:32	07:07:42
	Wandsworth	00:06:18	00:10:16	00:26:32	00:58:52	01:13:14	03:00:12	06:21:13
	Total	**00:06:47**	**00:11:35**	**00:28:50**	**01:05:38**	**01:13:18**	**03:01:56**	**06:09:29**

Performance Overview
Call Answering Performance

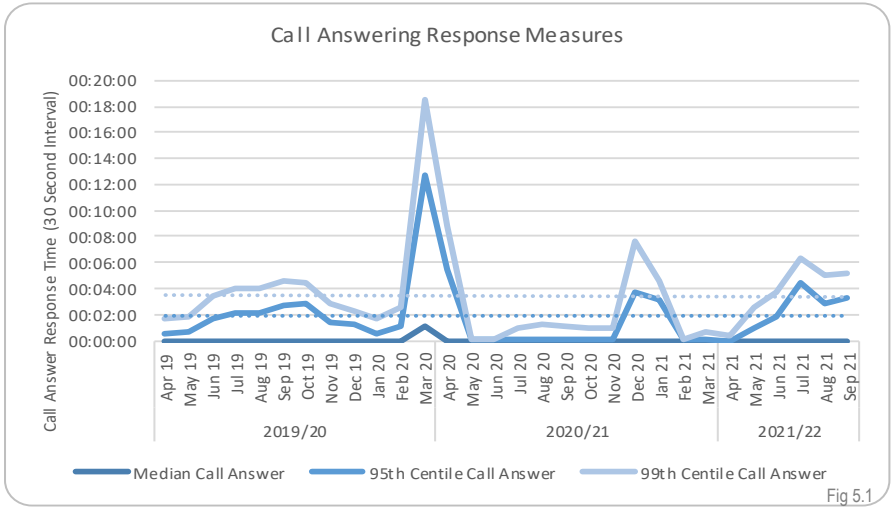


Fig 5.1

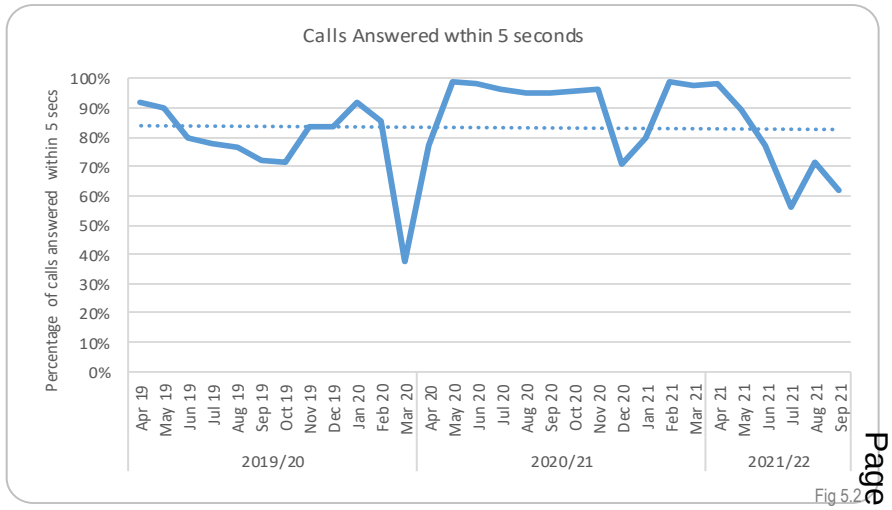


Fig 5.2

- Figure 5.1 demonstrates three key measures for call answering under the Ambulance Response Programme (ARP).

- 151,685 calls were received into the EOC in September 2021 (M6).
  - 844,490 calls have been received into the EOC for the YTD.

- During September the median call answering was zero seconds.
  - This means 50% or half of all calls received into the Emergency Operations Centre (EOC) were answered immediately.

- The 95th centile was 195 seconds. (approx. 3 minutes)
  - In other words 95 out of every 100 calls were answered in less than 195 seconds.

- Figure 5.2 shows the percentage of calls answered within five seconds.

- 88,110 incidents received a face-to-face response in September 2021 (M6).
  - 567,400 incidents received a face-to-face response for the YTD.

However, to illustrate the graph shows the daily call taking performance in the month.

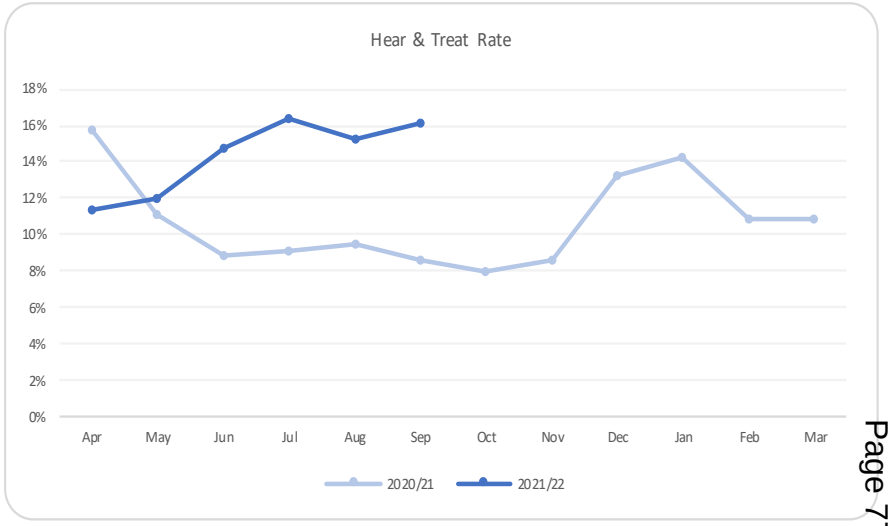
- In September 62% of all calls received into the EOC were answered within five seconds.

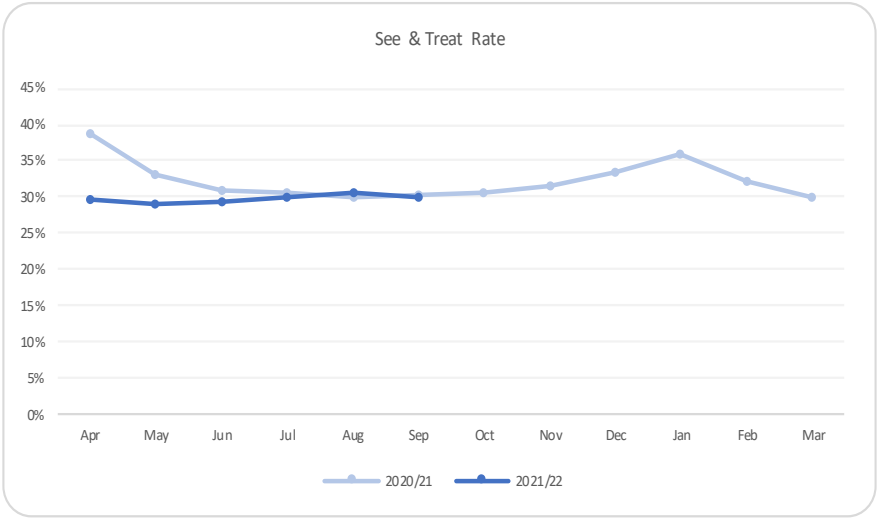
The "answered within 5 seconds" metric was previously part of the National Ambulance Performance Indicators, it's shown here for historial context.

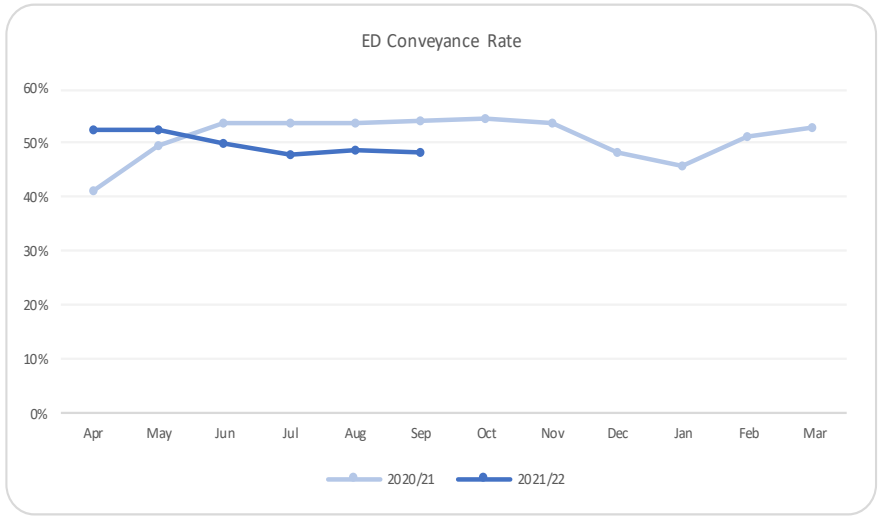
* Incident data is correct as of 19th October and is subject to change due to data validation.

Activity Overview
Activity vs. Profiles

		in-month Sep-21	*cumulative* Year To Date	Year-end Target
Hear & Treat %	%	16.14%	14.33%	
	(n)	16,953	94,907	
See & Treat %	LAS	30.03%	29.84%	
	Target	-	-	
See & Convey to Other % (Excl. HASU & Cath Lab)	LAS	4.06%	4.51%	
	Target	-	-	
ED conveyance % (Excl. HASU & Cath Lab)	LAS	48.37%	49.91%	
	Target	-	-	
See & Convey to Other % (HASU & Cath Lab)	LAS	1.40%	1.40%	
	Target	-	-	-







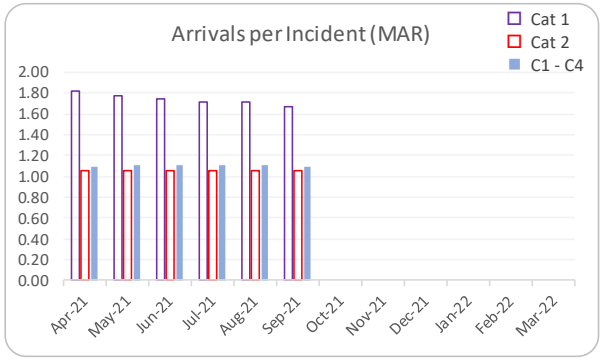
* Incident data is correct as of 19th October and is subject to change due to data validation.
Overall Activity here is all Hear & Treat and to Face to Face incidents.

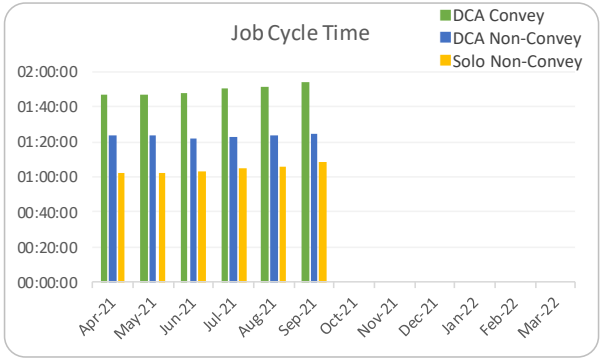
Hospital Handover Summary
Hospital Conveyance Lost Hours

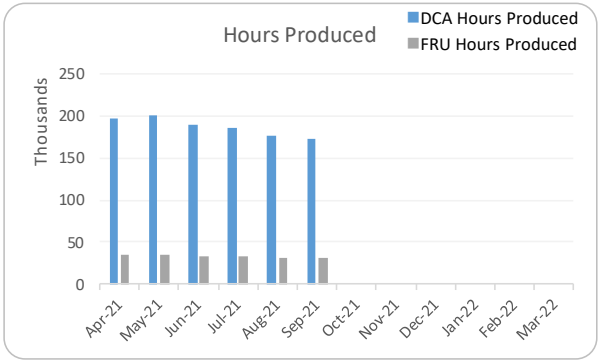
	September 2021	Non-blue calls. Arrival at hospital to patient handover								Non-blue calls. Patient Handover to Green							
		Arrived to Handover								Handover to Green							
		Total Conveyances	Total Handovers	Handovers exceeding 15 mins	% over 15 mins	Overrun per breach (mins)	Total time lost over 15 mins (hrs)	Handovers exceeding 30 mins	Handovers exceeding 60 mins	Total Conveyances	Total Handovers To Green	Handovers exceeding 14 mins	% Over 14min	Overrun Per Breach (Mins)	Total Time Lost Over 14 Minutes (Hrs)	Handovers exceeding 30 mins	Handovers exceeding 60 mins
North Central	Barnet ED	1189	1118	1040	93%	28	491	466	163	1189	1118	651	58%	11	117	130	16
	North Middlesex ED	2036	1904	1665	87%	24	665	991	178	2036	1904	1123	59%	11	199	222	26
	Royal Free ED	1297	1130	1047	93%	20	346	458	104	1297	1130	599	53%	10	98	104	10
	University College ED	1318	1232	689	56%	11	128	133	36	1318	1232	793	64%	12	156	186	8
	Whittington ED	1194	1075	881	82%	12	172	252	15	1194	1075	614	57%	10	102	122	7
North East	Homerton ED	1272	1125	659	59%	7	78	76	5	1272	1125	662	59%	10	108	116	7
	King Georges ED	1090	959	934	97%	32	500	635	117	1090	959	606	63%	10	96	101	12
	Newham ED	1534	1259	1150	91%	23	434	600	125	1534	1259	685	54%	9	105	115	11
	Queens Romford ED	2005	1725	1664	96%	40	1115	1217	303	2005	1725	1066	62%	9	168	146	26
	Royal London ED	1828	1553	1273	82%	11	233	265	11	1828	1553	918	59%	11	170	178	22
	Whipps Cross ED	1277	1059	873	82%	36	519	416	195	1277	1059	613	58%	10	104	118	11
North West	Charing Cross ED	1060	991	272	27%	4	19	7	0	1060	991	627	63%	8	84	68	8
	Chelsea & West ED	1284	1109	639	58%	7	69	40	2	1284	1109	709	64%	10	120	112	11
	Ealing ED	1176	1126	437	39%	13	95	106	22	1176	1126	656	58%	8	88	69	7
	Hillingdon ED	1652	1524	853	56%	12	177	228	24	1652	1524	833	55%	7	103	74	12
	Northwick Park ED	2950	2805	1375	49%	23	524	583	173	2950	2805	1657	59%	8	230	196	12
	St Marys ED	1511	1382	960	69%	13	202	261	20	1511	1382	831	60%	9	132	121	10
	West Middlesex ED	1764	1690	895	53%	8	124	136	4	1764	1690	975	58%	7	119	80	7
South East	Kings College ED	1820	1641	1363	83%	15	330	506	36	1820	1641	983	60%	9	142	125	11
	Lewisham ED	1289	1113	836	75%	17	239	284	85	1289	1113	634	57%	7	76	66	3
	Princess Royal ED	1506	1270	855	67%	30	421	342	158	1506	1270	738	58%	8	98	77	8
	Queen Elizabeth II ED	2182	1951	638	33%	13	142	94	45	2182	1951	1091	56%	7	122	99	12
	St Thomas' ED	1976	1782	1202	67%	11	212	251	20	1976	1782	1045	59%	8	140	121	4
South West	Croydon ED	1947	1791	1484	83%	11	274	239	45	1947	1791	1140	64%	8	154	112	12
	Kingston ED	1460	1280	897	70%	11	166	182	19	1460	1280	789	62%	8	107	84	10
	St Georges ED	1743	1391	1026	74%	13	220	344	13	1743	1391	868	62%	10	138	123	14
	St Helier ED	1181	1042	822	79%	11	156	165	25	1181	1042	600	58%	9	85	69	12
	LAS TOTAL	42,541	38,027	26,429	70%	17	8049	9,277	1,943	42,541	38,027	22,506	59%	9	3359	3,134	309

Resourcing
Capacity & Efficiency

	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22
Cat1 Arrivals per Incident (MAR)	1.81	1.78	1.74	1.71	1.71	1.67						
Cat2 Arrivals per Incident (MAR)	1.05	1.06	1.06	1.05	1.06	1.05						
Cat1-Cat4 Arrivals per Incident (MAR)	1.10	1.10	1.10	1.10	1.10	1.10						
JCT - Conveying DCA (hh:mm:ss)	01:47:19	01:47:24	01:48:16	01:50:41	01:51:20	01:54:04						
JCT - Non Conveying DCA (hh:mm:ss)	01:23:56	01:23:34	01:22:14	01:23:15	01:23:45	01:24:19						
JCT - Non Conveying Solo (hh:mm:ss)	01:02:28	01:02:33	01:03:12	01:04:46	01:06:07	01:08:22						
OOS % of Hours Lost	8.4%	8.8%	9.3%	9.3%	9.2%	9.5%						
DCA Hours Produced	196,336	200,261	190,330	185,077	176,132	173,375						
FRU Hours Produced	34,819	34,759	33,162	33,109	30,889	30,335						
PAS/VAS Hours Produced	4,628	5,553	4,693	4,842	4,302	3,965						
Non-Patient Facing Hours Produced	41,804	43,439	41,636	41,970	42,427	41,276						







Resourcing
Plan vs. Actual

Vehicle Hours	Responder Type	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22
Planned Resource Level ^	DCA	180,721	186,607	180,557	186,777	186,543	180,593						
	FRU *	44,941	46,405	44,944	46,430	46,420	44,940						
Current Resource Level (GRS)	DCA	191,840	196,165	186,597	181,639	172,224	169,529						
	FRU *	34,313	34,281	32,669	32,645	30,253	29,901						
Current Resource Gap	DCA	11,118	9,558	6,041	-5,138	-14,320	-11,065						
	FRU	-10,628	-12,123	-12,275	-13,784	-16,167	-15,039						

Fig 6.1

- Figure 6.1 shows a breakdown of resource levels, in patient facing vehicle hours.

- The **Planned Resource Level** is the ORH plan for patient facing vehicle hours. This is profiled by responder type.

- The **Current Resource Level (GRS)** are the actual patient facing hours produced profiled by responder type.

- The **Current Resource Gap** is shown to demonstrate the gap in resourcing for these responder types each month.

GRS data shows scheduled hours and as such it does not include pre or post shift overtime hours.

* Including MRU

^ ORH plan

Hospital Handover Summary
Ambulance Turnaround

The table below shows the hospital handover measures for ambulance turnaround

- The Patient Handover to Green measure, demonstrates the percentage of handovers **within** 15 minutes

- The Data Completeness measures, demonstrate the accuracy of the data recorded on the PRF for conveyed patients

Ambulance Turnaround	(M1)	(M2)	(M3)	(M4)	(M5)	(M6)	(M7)	(M8)	(M9)	(M10)	(M11)	(M12)	YTD 2021/22
Patient Handover to Green (15 mins)	45.2%	44.7%	43.8%	42.9%	42.9%	43.2%							43.8%
Data Completeness (arrival)	99.5%	99.4%	99.3%	99.4%	99.4%	99.3%							99.4%
Data Completeness (green)	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%							100.0%

Glossary

Abbreviations / Acronyms Explained

ARP	Ambulance Response Programme
JCT	Job Cycle Time
DCA	Double Crewed Ambulance
FRU	Fast Response Unit
PAS/VAS	Private Ambulance Service / Volunteer Ambulance Service
MRU	Motorbike Response Unit
ORH	Operational Research in Health
GRS	Global Rostering System
MAR	Multiple Attendance Ratio
OOS	Out Of Service
EOC	Emergency Operations Centre

Commonly used Terms Explained

Hear & Treat	The outcome of a call where clinical advise was given over the phone and no vehicle response was sent
See & Treat	The outcome of a call where a vehicle response was sent, that resulted in a non-conveyance
See & Conveyed	The outcome of a call where a vehicle response was sent, that resulted in a conveyance
ED Conveyance	The outcome of a call where the patient was conveyed to an Emergency Department
See & Conveyed to Other	The outcome of a call where the patient was conveyed to a NON Emergency Department

For further detailed definitions please see link below
https://www.england.nhs.uk/statistics/wp-content/uploads/sites/2/2019/09/20190912-AmbSYS-specification.pdf

Glossary

These are the National Standards issued to all Ambulance Trusts by NHS England

Category	National Standard	How long does the ambulance service have to make a decision?	What stops the clock?
Category 1	• 7 minutes mean response time • 15 minutes 90th centile response time	The earliest of: • The problem being identified • An ambulance response being dispatched • 30 seconds from the call being connected	The first emergency vehicle that arrives on scene stops the clock (there is an additional Category 1 transport standard to ensure that these patients also receive early ambulance transportation).
Category 2	• 18 minutes mean response time • 40 minutes 90th centile response time	The earliest of: • The problem being identified • An ambulance response being • dispatched • 240 seconds from the call being connected	If a patient is transported by an emergency vehicle, only the arrival of the transporting vehicle stops the clock. If the patient does not need transport, the first emergency vehicle arriving at the scene of the incident stops the clock.
Category 3	• 60 minutes mean response time • 120 minutes 90th centile response time	The earliest of: • The problem being identified • An ambulance response being • dispatched • 240 seconds from the call being connected	If a patient is transported by an emergency vehicle, only the arrival of the transporting vehicle stops the clock. If the patient does not need transport, the first emergency vehicle arriving at the scene of the incident stops the clock.
Category 4	• 180 minutes 90th centile response time	The earliest of: • The problem being identified • An ambulance response being • dispatched • 240 seconds from the call being connected	Category 4T: If a patient is transported by an emergency vehicle, only the arrival of the transporting vehicle stops the clock.

These standards are intended to:

- Prioritise the sickest patients quickly to ensure they receive the fastest response.
- Ensure national response targets to apply to every patient for the first time – so ending ‘hidden waits’ for patients in lower categories.
- Ensure more equitable response for patients across the call categories.
- Improve care for stroke and heart attack patients through sending the right resource first time.

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