To: System Resilience Group Chairs

CC: CCG Accountable Officers,
Acute Trust Chief Executive Officers,
Ambulance Trust Chief Executive Officers,
Mental Health Trust Chief Executive Officers,
Tripartite ALB Regional Directors

11 August 2015 NHS England Publications Gateway reference: 03815

Dear colleague,

Preparation for winter 2015/16

Since we wrote to you regarding resilience planning on 24 April 2015, we are aware that there has been a great deal of work done to progress resilience planning, preparations for winter, and wider transformational changes in line with the Urgent and Emergency Care Review.

We expect all systems to have robust plans in place for winter, and we are now writing to set out the next steps and goals for the rest of the year. This will cover System Resilience Group (SRG) assurance, support available, development of mental health services, surge management, this years' winter marketing campaign, and flu preparation.

As discussed previously, with money now in CCG baselines there is no additional resilience funding for this year and the focus is now on implementation.

System Resilience Group assurance

Recognising that SRGs are maturing and evolving, assurance has been underway since operational plans were submitted in May. We would now like to assess progress that has been made to ensure resilience planning is in a stronger position than last year.

As part of the assurance, SRGs are asked to provide the following updates:

- Progress on implementation of the eight high impact resilience interventions (following communication of these in the letter of 24 April)
- A baseline assessment of plans to implement the nine high impact actions to improve ambulance performance

- Acute and out of hospital capacity and demand projections ahead of winter, building on work already underway with regional teams
- A baseline assessment of plans to implement 24/7 liaison mental health services in A&E departments
- Key actions being taken to improve upon last year's resilience plan

A number of resources have been developed to support this, and to progress all of the above your regional contacts will be in touch shortly to discuss the next steps, timescales, and exact expectations based on risk stratification. This will build on processes that are already underway, and will conclude in mid-September.

This process will help SRGs to determine where the gaps in service and planning exist locally against nationally identified priorities, and to then produce plans to address these gaps. Please send any queries regarding assurance to the following e-mail address:

england.nonelectiveperformance@nhs.net

This letter also confirms that the remit of SRGs should be explicitly expanded to cover operational performance on the cancer waiting time standards, in particular the 62 day cancer standard given the need to drive better and sustained performance. Specifically, SRGs will be responsible for taking forward the recommendations of the national Cancer Waiting Times Taskforce and the Cancer Waits Action Plan.

High impact actions to improve ambulance performance

Similar to the 'high impact interventions' for general operational resilience, a set has been developed for ambulance services. We expect every ambulance trust to address these, in partnership with local SRGs. These are set out at Annex A.

They have been developed from the good practice in *Safer, Faster, Better*, (upcoming best practice guidance on delivering urgent and emergency care) which will be published by NHS England shortly. It is expected that all organisations will be clear, through the SRG arrangements, about their responsibility for delivering all or any part of any of these services, and will have taken these into account in their planning. Progress on these will be addressed through wider SRG assurance.

Capacity and demand

Capacity and demand planning remains a critical part of preparing for winter pressures, and there is an expectation that all systems will conduct an exercise to gauge acute and non-acute capacity and demand ahead of winter. The first phase of this work is already underway, and you will be contacted again in the next few weeks by regional teams to complete a more detailed return.

We have been working with KPMG and small number of SRGs to develop a capacity and demand tool for use by SRGs. We will now be testing roll-out and support with a wider group of SRGs and the Urgent and Emergency Care (UEC) Vanguard sites. Phase two of development on this will take place over the autumn before we issue the tool for use more widely alongside the planning round.

24/7 Liaison mental health (LMH) services in A&E

More than 25% of people admitted to acute hospitals have a mental health co-morbidity (rising to 60% for older adults), with a 45-75% increased cost per patient. We also know that people with mental ill health have double the emergency department (ED) attendance rate of the general population. CQC's recent thematic review into crisis care revealed significant variation, with considerable progress needed. Improving mental health crisis care is also a key priority in the Government's Mandate to NHS England.

CQC reported 'unacceptable' findings for people experiencing mental health crisis who present at A&E, with only 36% of people reporting that they felt respected by A&E staff. Adequate provision of LMH services in ED settings is essential not only for ensuring that people with urgent mental health needs receive a timely and skilled assessment, but also for ensuring that all staff working in EDs become confident in working with people with mental health needs.

CQC will now have a specific focus on ensuring adequate 24/7 LMH services in acute hospital settings, supporting the expectation set out in the planning guidance that by 2020 all acute trusts will have in place LMH services for all ages across all pathways appropriate to the size, acuity and specialty of the hospital.

It is anticipated that, from 2016/17, an access standard for 24/7 LMH services in ED settings will be introduced, for implementation from April 2017.

To aid preparation this year in advance of the introduction of LMH access standards, £30m non-recurrent, ring-fenced funding will be made available, which will be in addition to resilience monies already in baselines. This will be allocated to CCGs by regional teams on a targeted basis. Part of this money will also to be apportioned directly to the UEC Vanguard sites. Funding will be allocated in September, but regional teams will be in contact in August to discuss the next steps and the basis of their targeted approach, expectations, and tracking.

Crisis Care Concordat (CCC)

Every SRG and UEC Network is expected to have mental health representation as a core part of their membership and their resilience plans. As well as LMH, all SRGs will be expected to ensure:

- 24/7 community-based crisis response and assessment (through Crisis Resolution and Home Treatment Teams);
- adequate provision of health-based places of safety to ensure that people experiencing mental health crisis (especially children and young people) are not detained in police cells;
- that local 111 directories of service (DoS) include a complete and up-to-date list of mental health crisis services for all ages.

Every CCG has signed up to a local CCC action plan, which is being overseen by a local CCC group. We would expect all SRGs and UEC Networks to work closely with their local group, who are already seeking to implement actions that will form part of the SRG assurance process.

A mapping of contacts for every area will be made available as part of the SRG assurance resources made shared by regional teams.

Enhanced support team

To assist the most challenged urgent and emergency care systems, we are developing a programme of support that will run over winter 15/16. It will expand and enhance the improvement work already being done by the existing Emergency Care Intensive Support Team (ECIST) by:

- Expanding the ECIST team and supplementing it with experts from other parts of the urgent care pathway, including social care;
- Creating four learning collaboratives, where trusts can come together with their peers to share improvement knowledge and provide mutual support;
- Matching up challenged systems with higher performing ones in buddy arrangements, similar to those already developed for local government; and
- Providing additional capacity, where necessary, to help systems embed and sustain performance improvements.

In addition, the programme will look for ways to share across the sector information, tools and any other resources developed as part of its work to help all systems identify and implement improvements to the way they deliver urgent care.

More information on this programme will be sent out in September.

Delayed Transfers of Care

To provide clarity on definitions and responsibilities around delayed transfers of care (DToC), NHS England alongside the Department of Health and the ECIST, will be updating the technical definitions and guidance on DToC to provide clarity and share best practice. This is currently under development, and will be published (alongside supporting materials) later in August. The launch of this refreshed guidance will be supported by regional workshops teaching good practice on discharge being run by ECIST.

Communications and marketing campaign

For 2015/16, NHS England, the NHS Trust Development Agency, Monitor, Public Health England (PHE), and the Department of Health are joining up our winter campaigns. This will bring together PHE's successful flu vaccination, 'Catch it, kill it, bin it' and "Keep Warm, Keep Well", with NHS England's effective 'Feeling under the weather' campaign and materials to promote NHS 111, into one combined strategy.

This focused behaviour change programme will be developed through a single campaign approach, covering a variety of media including television, radio, outdoor and social media, as well as materials for local teams to use.

To ensure that this campaign is as effective as possible, it is important that all organisations use nationally consistent messaging to guide patients and the public. SRGs and CCGs are requested to align their local activity with the national campaign rather than initiating individual campaigns, therefore making best use of resources and avoiding duplication. National materials can be adapted for local use as needed.

Campaign materials will be available at the beginning of September through NHS Comms Link and PHE's campaign resource centre**.** These will include posters, leaflets, campaign designs, and toolkits. The national campaigns will begin in September 2015.

Please send any queries to england.marketing@nhs.net.

Declaring a Critical Incident or Emergency

All providers of NHS funded care are encouraged to communicate early over pressures faced, keeping in mind that:

- Business continuity arrangements are put in place for circumstances which organisations are able to manage within their own internal capacity; and

- As outlined in the EPRR framework, incidents that cannot be managed within routine service arrangements are planned for and as such will have trigger points in place locally to instigate escalation.

Emergencies (major incidents) are defined in the EPRR framework and the Civil Contingencies Act as instances which represent a serious threat to the health of the community or cause such numbers or types of casualties, as to require special arrangements to be implemented. NHS organisations should be confident of the severity of any incident that may warrant a major incident declaration, particularly where this may be due to internal capacity pressures, if a critical incident has not been raised previously through the appropriate local escalation procedure.

To assist consistency and clarity over definitions across the country we are currently in the process of revising the EPRR framework which will be published in October 2015 along with examples of communications messages for use in critical incidents.

Almost any critical incident for the NHS will generate media interest, and therefore requires close working between communication colleagues. NHS England regional media teams should be contacted for further support and guidance at the earliest available opportunity.

National Flu Programme

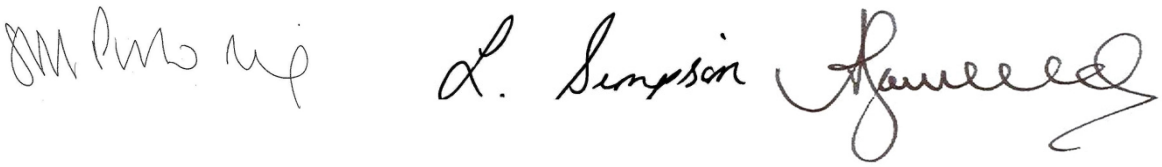
NHS England working with PHE has a well-defined delivery and action plan for the 2015-16 seasonal flu programme, integrated into the communications and marketing plan discussed earlier. The flu programme will be launched on 5 October and for the first time, this year it will include a national contract for community pharmacy for eligible over 18 year olds, which will help to reduce the variation of access across England, and play a part in reducing the burden on general practice.

Although continuing activity for the over 18 year olds is key, the programme plans to achieve a step change in population protection by focussing on the childhood programme, as vaccination rates for older people and clinical risk groups have reached a steady state. Planned activity includes engagement with CCGs, and staff within general practice, targeting the 2 to 4 year olds and a national roll out of delivery to all school children in year's 1 and 2. CCGs will be asked to ensure that messages and resources are shared within their practice nurse and GP forums.

The expectation continues that all NHS organisations will work towards improving the uptake of flu vaccinations amongst their workforce. All organisations should be working towards a minimum coverage rate of 75% for staff vaccinations. Improvement support will be focused on organisations with low rates from previous years.

We would like to thank you again for your continued efforts. We look forward to our continued work together, and to ensuring the system is in as strong a position as possible ahead of winter.

Yours sincerely,



Sarah Pinto Duschinsky	**Lyn Simpson**	**Adam Sewell–Jones**
NHS England	NHS TDA	Monitor

Annex A – High Impact Actions to Improve Ambulance Performance

Introduction

The ambulance service is a core component of the NHS in England; trusted by patients to provide a timely and effective response to sudden illness and injury at any time of the day or night. However as demand continues to increase in a resource-constrained environment all ambulance services in England are experiencing ongoing challenges in meeting operational performance standards.

NHS England is addressing this in a number of ways, including the introduction of new models of care, as outlined in the "Five Year Forward View", the implementation of the Urgent and Emergency Care Review and an extension of work to examine the impact of "dispatch on disposition" and related initiatives on clinical outcomes, operational efficiency and performance.

As a result of these initiatives a number of actions have been identified that have the potential to improve performance within the ambulance service. Implemented together they will reduce A&E conveyance and hospital admission, improve the availability of ambulance resources and increase operational efficiency and performance. These actions are outlined below, and recognise in particular that the ambulance service is part of a much wider system, which should be fully embedded in the Urgent and Emergency Care Networks that are currently being established throughout England.

Nine high impact actions

Action	Description
1. Establishing urgent care clinical hubs	All services to progress Clinical hub development – with wider MDT and specialist input. The expertise accessible through an urgent care clinical hub, on a 24/7 basis, could include (but is not limited to): pharmacy; dental; midwifery; mental health crisis and liaison psychiatry; end of life care; respiratory (including COPD); paediatrics; care of the elderly; drug and alcohol services; social care; secondary care expertise including general medicine and general surgery.
2. Improving access to community health and social care rapid response, including falls services.	Ambulance services should have (or have plans to put in place) direct access to these services, through simple routes of referral (e.g. a single point of access for professionals/single phone call) as an effective alternative to A&E conveyance and/or hospital admission.
3. Increasing direct referral to all other components of the Urgent and Emergency Care Network	Registered healthcare professionals in the employment of ambulance services (e.g. paramedics and nurses) should be empowered and supported to refer patients that they have assessed in person to all other components of the urgent and emergency care network. This includes referral to primary care and hospital-based expertise, combined with conveyance to non-A&E destinations including urgent care centres, assessment units and ambulatory emergency care units.
4. Enhanced working with community	Ambulance services should work with SRGs, commissioners, community mental health teams and other system partners to

mental health teams	improve access to early triage and assessment by mental health professionals following referral from the ambulance service. This should be supported by timely access to crisis care at home and in community-based settings.
5. Enhanced working with primary care	In addition to the referral and transport actions outlined under point 3 above, consideration should be given to: paramedic practitioners undertaking acute home visits on behalf of GPs, to avoid unnecessary admission and admission surges; 'call back' schemes whereby in-hours and out-of-hours primary care staff follow-up patients who have been managed at home and not transported by ambulance clinicians (within agreed time-frames); joint planning with GPs and other relevant system partners (e.g. acute trusts) to agree management plans for high-volume service users/frequent callers.
6. Workforce development	The development and up-skilling of the ambulance workforce (particularly paramedics) and the employment of a wider range of healthcare professionals (e.g. nurses, midwives and pharmacists) will increase the rates of both "see and treat" and "hear and treat" by enhancing the skills of the ambulance workforce.
7. Enhanced use of information and communication technologies	This includes (but is not limited to): sharing and access to electronic patient records to support clinical decision-making; implementation of electronic patient handovers; sharing predicted activity levels with acute trusts on an hourly and daily basis to trigger effective escalation protocols.
8. Increased use of alternative vehicles to convey patients	Ambulance services should consider the use of alternative vehicles to transport patients, whenever it is safe and appropriate to do so, thereby freeing up and improving the availability of "front line" ambulance resources.
9. For patients who do need to be taken to hospital, ambulance services should seek to minimise handover delays	Handover delays to be minimised by • Reviewing patients' conditions and needs en-route and sending details ahead to the receiving emergency department in the case of any special requirements/circumstances. • Avoiding the use of ambulance trolleys for patients who are able to walk into the department. • Using alternative vehicles to convey patients to the emergency department (e.g. patient transport service vehicles to transport patients, thus keeping paramedic staffed ambulances available. • Implementing electronic patient handovers. • Sharing predicted activity levels with acute trusts on an hourly and daily basis to trigger effective escalation when demand rises.