Wellington House
133-155 Waterloo Road
London SE1 8UG
martin.wilson1@nhs.net

Friday 7 September 2018

To: Chairs of A&E delivery boards
Chief Executives of acute trusts
CCG Accountable Officers
Directors of Adult Social Services
Chief Executives of community, ambulance and mental health trusts
Regional Directors of NHS England & NHS Improvement
STP chairs

Dear Colleague

Supporting the delivery of elective and emergency care

Last winter was challenging and it is thanks to the efforts and dedication of hard working frontline staff, more people were seen in A&E and admitted or discharged within four hours every day than last year. We know there are ongoing demand challenges and we need to continue working towards achieving clinical standards over this coming winter.

Following the publication of the national planning guidance on 2 February 2018 and the letter from Ian Dalton to trust chief executives on 18 April 2018, the focus has been on the development and delivery of annual demand and capacity plans. You are continuing to work with your system partners and regional directors to ensure ongoing refinement of your plans.

As a reminder, operating guidance asks you to deliver 90% performance against the four-hour operational target over winter with the majority of trusts expected to achieve 95% performance in March. Your plans also commit you to ensuring that the number of patients on an incomplete elective pathway will be no higher in March 2019 than in March 2018. As part of the long-term plan, we are looking at whether there are any ways to improve the standards, but throughout this year the NHS will continue to focus on the current standards for emergency and elective care.

To deliver, we understand that trusts will need to maximise the flexibility of the clinical workforce, enabling staff to respond to times of increased workload. Trusts should consider annualised clinical job plans, with capacity for amendment/ redeployment and effective, electronic systems of e-rostering and leave planning.

Reducing the number of long-stay patients in hospital

In June I wrote to you about reducing long stays in hospital. Our ambition is to reduce the number of beds occupied by long stay patients by 25%, freeing up at least 4,000 beds compared to 2017/18. This capacity is required by December 2018. Since then, many of you have made significant progress to achieve this ambition. However, as

you know, we need to make faster progress, including enhanced winter support from local social services, and this needs continued attention.

This includes helping to move patients out of the acute setting and to help prevent patients arriving there. To close the capacity gap, community providers also need to free up bed capacity, reduce length of stay and ensure that a greater proportion of patients receive the appropriate level of care, including in patients' own homes. We need each local system to identify and implement a set of interventions designed to do this over the coming months. This needs to include the winter contribution that local authorities will make in commissioning appropriate care packages.

To support your work, we have provided some materials including: an improvement guide; repurposing the Emergency Care Intensive Support Team (ECIST); and a dashboard for operational use and for board reporting. Follow links to the dashboard and guidance:

https://analytics.improvement.nhs.uk/#/workbooks/250/views

https://improvement.nhs.uk/resources/guide-reducing-long-hospital-stays/

A small number of you have been in ongoing dialogue with regional directors about specific capital asks to increase capacity and patient flow in the areas of greatest need ahead of winter. Where we have been able to support these through budgeted capital, trusts have been notified separately. These recipient trusts are required to ensure that these schemes are operational by Christmas, and if not delivered on time, the capital funding will be reclaimed.

Triaging patients away from A&E departments and admitted pathways

The best performing A&E departments and hospitals owe their success partly to triaging patients into other pathways. These include:

- using primary care streaming for minor illnesses and injuries;
- consistently treating and discharging over 99% of non-admitted patients in less than four hours. This helps reduce risks of overcrowding that can otherwise be a safety concern, to support this work, we have set up a small intensive support team.
- managing up to 50% of acute medical referrals via non-admitted care pathways. This is often preferable for patients and reduces the pressures on in-patient beds.

We ask trusts to review their existing A&E patient pathways against these best practices, taking into account the needs of their local populations.

For more information follow this link:

https://improvement.nhs.uk/documents/2982/AEC_Managing_increased_demand_winter_illness_June2018.pdf

It is a significant concern that during last winter, due to high levels of bed and emergency department occupancy arising from poor flow, patients were receiving care in corridors. Your work to close your local capacity gap should help eliminate corridor care which is inappropriate and avoidable, but it is important that we make rapid progress. Corridor care also affects patients waiting in ambulances, who may be very sick. Ambulances that are waiting in hospital car parks are not able to respond to emergency calls.

In support of this we are continuing to work with the 40 most challenged trusts on ambulance handover delays; we have established an intensive support team to work with trusts, focused on eliminating corridor care; we are continuing to work with CQC, which considers when assessing trusts whether corridor care has occurred; and we continue to advocate the use of the ED patient safety checklist.

Healthcare worker flu vaccination

Alongside this letter, Trusts will have also received a letter regarding flu vaccination for healthcare workers. Your ambition should be to achieve near universal flu vaccine uptake by healthcare workers. This has the backing of the professional and clinical bodies and trade unions. In higher risk areas, trusts should also take robust steps to move quickly to 100% staff vaccination uptake, including ensuring easy access to the vaccine, and notification from staff as to whether they have been vaccinated. We expect trusts to take steps to protect patients in higher-risk clinical areas, including consideration of changing deployment of staffing in these areas if compatible with maintaining safe operation of the service to limit the exposure of the most vulnerable patients to unvaccinated staff. Trust boards should publicly assure uptake of the flu vaccine and opt-out of healthcare workers.

This year, we are continuing the social workers flu vaccine scheme and encourage staff in care homes, nursing homes and hospices to go to their GP or pharmacy for vaccination.

Primary care

Primary care plays a fundamental role in managing increasing demands over winter. By October 2018, everyone across the country will have more convenient access to GP services, including access to appointments during evenings and weekends, which will provide more than 9 million additional appointments. This should reduce the impact on other parts of the system and reduce attendances at emergency departments.

As part of the work on extended access, this autumn, NHS England will have made available a tool for every general practice to measure appointment capacity and utilisation. This tool is designed to help practices better understand their demand and capacity, including over the bank holiday, Christmas and New Year periods.

Commissioning teams are reminded to ensure the NHS website Directory of Services (DOS) is up to date and accurate for urgent treatment centres (UTCs), general practice and dental services opening times, including the new evening and weekend services. CCGs will not only need to ensure there is adequate capacity in primary care

and UTCs but also that there is good public awareness of what is available over the peak periods, particularly at the weekend and during holidays.

Mental health

Urgent and emergency mental health services should be included in local planning. Please work with your local system to ensure that you identify gaps in capacity, specifically at the interface between mental health services and A&E pressures by:

- increasing capacity in community mental health crisis services, as well as alternatives to A&E that can provide a more suitable service for many people who would otherwise attend A&E,
- moving towards provision of 24/7 liaison psychiatry to provide safe care in A&E and general hospital wards, as well as preventing avoidable emergency admissions via A&E and facilitating earlier discharge,
- ensuring sufficient capacity in core community and acute mental health services so that people are able to access local beds when needed, and can be transferred from A&E in a timely manner.

We ask mental health trusts to work closely with their local acute trusts to help deliver significant improvements to A&E care for these vulnerable patients, particularly in areas where patients have experienced unacceptably long waits.

Underpinning all the above, should be improved local data collection, and monitoring of key metrics across these parts of the mental health system to understand where improvements to local pathways are needed.

National Escalation Pressures Panel

Finally, I would like to inform you that after introducing NEPP to provide national expertise and advice last winter, we have decided to continue this arrangement this winter, as it has proved to be invaluable support for national policy-setting.

Success this winter is dependent on continuing transformation work and having real operational grip led by all of you as system leaders.

Yours sincerely

Pauline Philip
National Director of Urgent and Emergency Care
NHS England and NHS Improvement