To: NHS CCG Accountable Officers,

Trust and Foundation Trust Chief Executive Officers

CC: Local Government Chief Executive Officers

2 March 2015

NHS England Publications Gateway Reference 03153

Dear colleague,

Resilience planning for early 2015/16

We are writing to you as we reach the end of winter and look ahead to continuing operational resilience through the next holiday period and into 2015/16. Over recent months we have seen a decline in our delivery against the four hour A&E standard. This is measured to give assurance that patients are receiving their constitutional right to be treated or discharged within four hours of arrival at A&E. We expect every effort to be made to return to this standard in April.

Much of this will depend on the continuation of the full range of schemes initiated this year as part of resilience planning.

We therefore want to be clear that all schemes that have already been put in place as part of operational resilience plans for 2014/15 should continue to operate during April. CCGs will be expected to fund all these schemes in full during April pending the resolution of 15/16 plans in the planning round.

This will be especially critical as we go in to 2015/16, as the Easter weekend falls particularly early this April. For this public holiday in particular, the national tripartite organisations, working with the Association of Directors of Adult Social Services, would like to reinforce the importance of all organisations producing robust demand and capacity plans for the Easter period, with emphasis specifically on the following areas:

- Routine GP surgery capacity on the Saturday morning on the Bank Holiday weekend
- Sufficient capacity provided in GP OOH services
- NHS 111 staffing capacity increases to cope with potential surges in demand
- Sufficient capacity across primary care (including pharmacy and dentistry)

- Appropriate coverage for mental health services and patients with long term conditions
- Sufficient capacity to manage expected demand and flow within hospitals
- Ensuring continuation of discharge processes through local health and care economies working together to assess capacity across residential care, nursing care, domiciliary care and the voluntary sector and assuring themselves that the necessary provision is in place to meet the anticipated level of demand
- Local and national escalation arrangements

A detailed checklist to be used by SRGs is attached as annex A to this letter. Monitor and TDA will liaise with acute trusts to ensure that any gaps identified through use of this checklist are addressed, and will work with NHS England and ADASS in doing so.

As part of this planning process, systems should also review, and explicitly address, in plans any local issues and risks that were experienced during Christmas and New Year 2014/15. Plans should illustrate how those same risks will be mitigated at Easter, including those actions that have been taken to address any potential gaps.

Effective, evidence based demand management, including working with all local providers to ensure access to primary care, community services, social care and voluntary sector support, should continue to be central to developing resilience plans locally.

In support of delivery of services over Easter and throughout April, systems will be expected to join in 'National Breaking the Cycle' initiatives running from 1 April to 15 April. These initiatives will support delivery of urgent care services over the Easter period and into April, with the ambition of improving patient safety and experience and reducing the number of breaches of the A&E four-hour standard over that period.

At the heart of this initiative is the core structure of the 'National Breaking the Cycle' exercise and the SAFER patient flow bundle (Senior review, All patients to have an expected discharge date, Flow of patients to commence early, Early discharge, Review weekly in long length of stay cases – more detail in Annex B). This will be supported by ECIST with access to telephone and direct support and a range of guidance. It is especially important that this is not only seen as an acute hospital - focused initiative, but also engages primary, social and community care providers to ensure real impact for patients. Further information will be provided to systems in the near future via the NHS England website.

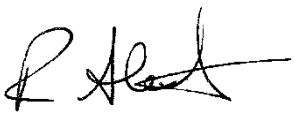
Some systems may already be planning 'Breaking the Cycle' type initiatives in the near future, or have recently undertaken one, and requiring them to bring forward or

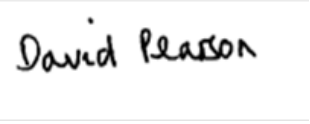
repeat the exercise may not be helpful. It may also not be appropriate to implement in areas that are currently performing well and achieving operational standards. All other trusts and the local partners should give full consideration to participating, and this should be discussed with your regional tripartite panel.

However, we do expect every Trust and their local partners in the wider system to ensure that they are taking the following actions over the fortnight:

- Ensure emergency departments are well staffed with extended senior medical and nursing presence and are well supported by social care, community and mental health services.
- Encourage acute hospitals to implement the SAFER patient flow bundle
- Focus on non-complex discharges from acute *and* community hospitals so that flow is maintained through effective local management of out of hospital capacity
- Ensure out-of-hours GPs and ambulance services have easy access to appropriate senior clinicians to advise on the appropriateness of admissions and proposed conveyance to hospital.

Yours sincerely,



Barbara Hakin	**Bob Alexander**	**Stephen Hay**	**David Pearson**
NHS England	NHS Trust Development Authority	Monitor	Association of Directors of Adult Social Services

Annex A – ECIST planning priorities for the Easter bank holiday period

SRGs and their local health systems should ensure that over the long bank holiday weekend, the following are in place:

1. Type 1 emergency departments should have extended consultant presence (of at least 12 hours) every day and a senior nurse coordinating the department 24-hours a day.

2. As part of escalation, additional staff should be provided to emergency departments when agreed occupancy triggers are met.

3. Mental health liaison and rapid response community teams should be present in all type 1 emergency departments 24/7 across the bank holiday weekend

4. Acute medical assessment units and short stay wards should have extended consultant presence every day (of at least 12 hours), with consultants working in blocks of more than one day.

5. Every patient in every bed should be reviewed by midday every day by a consultant and discharged as soon as their planned care is complete. Particular priority should be on patients with a NEWS score of >3 and potential discharges.

6. To expedite discharges and maintain flow, senior clinical decision makers must have excellent and timely support from diagnostics, pharmacy, therapists, community services and junior doctors.

7. Activities focused on discharging non-complex patients should be prioritised. This includes ensuring take-home medicines are written up and dispensed promptly; there is senior review of all patients, not just new and unstable patients; social care assessments and non-complex packages of care are available same-day; processes to enable ‘nurse-led’ discharge are in place.

8. Community hospitals should ensure that a senior doctor (a GP or a consultant) reviews every patient daily and that discharges are facilitated across the bank holiday weekend.

9. Out of hours general practitioner services should have clear and easy processes to enable them to discuss potential admissions with a consultant prior to transferring a patient to hospital.

10. Ambulance services should be able to discuss patients with a general practitioner where this might affect a conveyance decision. Where possible, a GP should be based in ambulance control rooms to take calls and provide an urgent visiting service.

11. Staff in care homes should have access to 24-hour telephone support and rapid response teams.

Annex B – SAFER patient flow bundle

The patient flow bundle is similar to a clinical care bundle. It is a combined set of simple rules for adult inpatient wards to improve patient flow and prevent unnecessary waiting for patients.

If we routinely undertake all the elements of the SAFER patient flow bundle we will improve the journey our patient's experience when they are admitted to our hospital:

S - **Senior Review**. All patients will have a Consultant Review before midday.

A - **All patients** will have an **Expected Discharge Date** (that patients are made aware of) based on the medically suitable for discharge status agreed by clinical teams.

F - **Flow of patients** will commence at the earlier opportunity (by 10am) from assessment units to inpatient wards. Wards (that routinely have patients transferred from assessment units) are expected to 'pull' the first (and correct) patient to their ward before 10am.

E – **Early discharge, 33%** of our patients will be discharged from base inpatient wards before midday. Medication to take home for planned discharges should be prescribed and with pharmacy by 3pm the day prior to discharge wherever possible to do so.

R – **Review**, a weekly systematic review of patients with extended lengths of stay (> 14 days) to identify the issues and actions required to facilitate discharge. This will be led by clinical leaders supported by operational managers who will help remove constraints that lead to unnecessary patient delays.

Senior Review

The Board Round introduces structure to the day to day running of the ward and helps the ward team to manage the patients safely and effectively

- Consider sick and unstable patients first – is the patient deteriorating? What actions are required
- Have new patients been given an n expected date of discharge that the MDT agree on?
- Are there any patients to be discharged today/tomorrow? What needs to be done to ensure they go before midday?
- Are there any delays that need to be expedited?

The ward round should promote a consistent organised and disciplined approach to ensure an efficient use of time and resources, ensuring care is coordinated appropriately

- The ward round should follow the board round in the morning each day
- Patients should be seen in a specific order:
    - Sick unstable patients
    - Potential discharges
    - The remaining patients
- A record of the round, with clear management plans, should be written in the patient's notes
- TTOs (medication) should be prescribed and diagnostics ordered in real time
- Identify patients for discharge early discharge tomorrow

ALL Patients have an expected date of discharge

Expected Date of Discharge (EDD) helps the Hospital to plan and understand its available capacity at all times – it must be up to date

- Has the patient's EDD been set within 24 hours of admission?
- Is the EDD realistic and does it reflect the actual date and time the patient is expected to go home?
- Has the EDD been reviewed and, if necessary, updated each day?
- Is the patient aware of the **date and time** they are expected to go home? Have they been given a welcome card or letter?

Flow early from assessment units

Wards that routinely have patients transferred to them from assessment units on a daily basis will 'pull' the first (and correct) patient before 10am every day to create the required capacity for incoming patients

- Inpatient wards that routinely have patients transferred to them from the assessment units need to 'pull 'the first patient to their wards before 10am everyday
- Ward and assessment unit teams will communicate effectively to ensure wards know the details of the next patient they need to 'pull' from the assessment unit ensuring there are no delays for patients
- By creating assessment unit capacity earlier in the day, unnecessary waiting for patients awaiting admission will be significantly reduced

Earlier discharge

- A third of discharges from inpatient wards should be before midday
- Patients pre-prepared on admission for early discharge and use of Discharge Lounge (if there is a discharge lounge)
- Non-use of Discharge lounge by exception
- Potential to write up and issue TTOs even though patient has already gone to Discharge Lounge

Review long length of stay patients

We need to proactively respond to the identified delays through appropriate action planning

- Do all patients have clear management plans for their medical care within the medical record?
- Is the patient waiting for any procedures or tests? Do these need chasing?
- Have you considered whether the care of the patient can be provided in an alternative setting rather than an acute hospital

Benefits

- **Patients** will benefit from improved care co-ordination and standardisation of approach (the same as with a clinical care bundle)
- **Patients** will benefit from a well-planned, informed and timely discharge
- **Patients** will be less likely to be outliers (i.e. cared for on the wrong ward)
- **Patients** will be less likely to be cared for in crowded wards and departments

Key Points

- **Implementing** the **SAFER** patient flow bundle should be clinically led with operational managers removing constraints
- **Implementing** all elements of the bundle consistently will deliver the greatest benefits for patients and staff
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