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PART 2 BOARD PAPER - NHS ENGLAND

Title: Update on Resilience Planning and Preparation for Winter 2015/16.
Lead Director: Dame Barbara Hakin, National Director: Commissioning Operations.
Rationale for this Paper Being Discussed in the Closed Session: There will be a public announcement about arrangements for winter in October 2015 and therefore at present this information is not in the public domain.
Purpose of Paper: • To provide the Board with an update on winter planning arrangements for 2015/16.
The Board is invited to: • The Board is invited to receive assurance that adequate preparations for winter are being put in place.

1.0 INTRODUCTION

1.1 This paper provides an update for the Board on the work taking place across the NHS in terms of resilience planning, and wider preparations for winter 2015/16.

1.2 2014/15 saw a particularly challenging winter for the NHS. We have analysed the reasons for the additional pressures, looked at what worked well and used this as a basis for our preparations for 2015/16. Our actions are part of, and the precursor to, the medium term implementation of the recommendations of the Urgent and Emergency Care Review.

1.3 Last year we saw the highest levels of emergency admissions since monitoring began. In addition, the service struggled with recruitment problems for some clinical groups and pressures in social care and out of hospital NHS care resulted in a higher number of Delayed Transfers of Care than in previous years. Whilst services were stretched, staff in the NHS worked hard to deliver high quality care and most patients were treated within the time standards set out in the NHS Constitution.

1.4 The most challenging weeks were in the period immediately following the Christmas and New Year break. Data from Public Health England shows that in the two week period covering Christmas and New Year's Eve (22 December to 4 January) syndromic surveillance indicators for respiratory infections, including influenza-like illness, increased across all systems. In the Christmas week (22-28 December), there were 14 new acute respiratory outbreaks recorded. This rose to 74 new acute respiratory outbreaks over the New Year's Eve period (29 December to 4 January). This is a significantly higher number of outbreaks than in Christmas 2013/14, when there were three outbreaks reported during the Christmas week, which then rose to five outbreaks over the New Year's Eve period (30 December to 5 January). Weekly ICU/HDU influenza admissions rates were considerably higher in 2014/15 than in 2013/14, which added significant operational pressure. This demonstrates a very significant episode with which the NHS, for the most part, coped well but demonstrated that resilience needs to be strengthened to cope with any such surge in the future.

2.0 PREPARING FOR WINTER 2015/16

2.1 Preparations detailed here include a number of national initiatives, including strengthened national coordination and oversight, but the essential work is done locally, with system resilience groups (SRGs) and their constituent organisations defining their own solutions to fit their local circumstances.

Earlier Funding Release

2.2 For 2015/16, resilience funding has been included in clinical commissioning group (CCG) baselines, meaning that local health economies can plan and implement initiatives earlier this year. In addition, there will be more security of funding for urgent and emergency care providers as a result of the marginal tariff for emergency admissions above baselines rising from 30% to 70%.

2.3 £18m has been made available to support ambulance services, £11m for specialised commissioning, and £6.6m to support a winter communications campaign.

Securing Adequate Activity and Capacity

2.4 During the 2015/16 operational planning round, there was extensive work to ensure that CCGs commissioned sufficient activity to meet projected activity growth. This resulted in CCGs commissioning a 2.3% increase in non-elective activity in 2015/16, compared with a 1.8% decrease commissioned in 2014/15. In addition, we have asked all trusts and CCGs to work closely together to identify and secure the appropriate capacity, in both the acute and out of hospital sectors.

System Resilience Group (SRG) Assurance

2.5 Regions have been assuring SRGs since the submission of operational plans in May, with a particular focus on implementation of the eight high impact resilience interventions (Annex A) in high risk systems. High risk SRGs are also being assessed for improvements in their resilience plans compared with 2014/15. Commissioning plans for ambulance services are also being assessed and assured, including a review against the nine high impact interventions for ambulance services (Annex B).

2.6 Building on the approach taken in previous years, there will be greater levels of escalation by NHS Improvement, in partnership with NHS England, in response to systems with significant ongoing problems.

Urgent and Emergency Care Networks

2.7 Establishment of Urgent and Emergency Care (UEC) networks is key to the coordination of delivery of the Urgent and Emergency Care Review objectives. It is our intention that SRGs will evolve to fulfil their role as the operational arm of the emerging Urgent and Emergency Care Networks. Objectives and early actions for networks have been nationally defined, with 23 networks preparing to be fully live by 1 October 2015. Membership and Terms of Reference will be agreed across all networks by September 2015, and we anticipate a stocktake of UEC services within each network to be undertaken by November 2015.

Mental Health Resilience

2.8 In line with the Parity of Esteem agenda, expectations around mental health resilience have been communicated alongside wider system resilience for the first time. Recognising the interplay between urgent and emergency care and mental health, this will be a continued area of focus for SRG assurance. In addition, all SRGs are producing plans for implementation of 24/7 mental health liaison services in A&E departments.

Supporting Challenged Economies

2.9 NHS Improvement is developing a programme of support to assist the most challenged urgent and emergency care systems:

i. Expanding the Emergency Care Intensive Support Team (ECIST) and supplementing it with experts from other parts of the urgent care pathway, including social care, building on the work of the Helping People Home team in 2014/15;
ii. Creating four learning collaboratives to support trusts to share improvement knowledge with their peers and provide mutual support;
iii. Matching challenged systems with higher performing ones in buddy arrangements, similar to those already developed for local government;
iv. Providing additional clinical, operational and analytical expertise where necessary, to help systems embed and sustain performance improvements;
v. Sharing the resources developed as part of ECIST's work to help all systems identify and implement improvements to the way they deliver urgent care.

Updating Delayed Transfers of Care (DToC) Guidance

2.10 NHS England, with support from the Department of Health, will be publishing updated technical definitions and guidance on Delayed Transfers of Care (DToC) during September 2015 to ensure clarity and consistency.

NHS 111 and Out of Hours (OOH) Services

2.11 We will be publishing strengthened Commissioning Standards by the end of September which will improve resilience over the winter. These standards include: enhanced clinical assessment including clinical advice hubs, improvements to Directories of Services, and improved access to Summary Care Records. There is also considerable work to ensure adequate capacity to meet call volumes, especially at times of high demand, including contingency arrangements for any technical issues or staff shortages. SRGs review plans for out of hospital capacity, including GP capacity in and out of hours. These plans are assured by the tripartite of NHS England, the TDA and Monitor.

Preparation for Christmas and New Year's Eve

2.12 Preparation for the Christmas and New Year's Eve period has begun earlier than in previous years. This will focus on ensuring local health economies have sufficient plans for extended primary care opening hours, robust out of hours arrangements, and additional NHS 111 call handling capacity. Systems will prioritise improvements to the local Directory of Services to ensure all local capacity is utilised effectively. Assurance of these arrangements will be undertaken during the autumn.

Seasonal Flu Programme

2.13 The action plan for the seasonal flu programme, developed by NHS England and with Public Health England (PHE), will be launched on 05.10.15. For the first time it includes a national contract with community pharmacy for eligible over 18 year olds to reduce the variation in access across England and support 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:

i. Targeting two to four year olds and a national roll out of delivery to all children in school years 1 and 2. Vaccination rates for older people and clinical risk groups have reached a steady state.
ii. Asking CCGs to ensure that messages and resources are shared within their practice nurse and GP forums.
iii. Continuing the expectation that all NHS organisations will improve the uptake of flu vaccinations amongst their workforce, with the aim of achieving a minimum coverage rate of 75% for staff vaccinations. Improvement support will be focused on organisations with low rates from previous years.

2.14 NHS Employers is also developing a digital pack of 'flu fighters' materials for employers. NHS Employers will also lead on engagement with employers and representatives of care homes to establish further information on the issues with delivering the flu vaccine in this sector.

Communications

2.15 For 2015/16, NHS England, TDA, Monitor, PHE, and the Department of Health are joining up our winter communications campaigns. This joint approach is being taken to:

i. 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.
ii. Align messages about behaviour changes. The programme will be developed by a single creative agency, covering a variety of media including television, radio, outdoor and social media, as well as materials for local teams to use.
iii. Support the use of nationally consistent messaging to guide patients and the public.
iv. Align local activity of SRGs and CCGs with the national campaign to avoid duplication and use resources effectively.

2.16 A single, aligned winter readiness communication was sent to the system on 11.08.15 which included SRG assurance, ambulance service high impact interventions, capacity and demand, 24/7 liaison mental health services in A&E (and accompanying non-recurrent funds), the enhanced support team, delayed transfers of care, communications and marketing, surge management, and the flu campaign.

3.0 RECOMMENDATION

3.1 The Board is invited to receive assurance that adequate preparations for winter are being put in place.

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Date: **September 2015**

ANNEX A

Resilience High Impact Actions published in April 2015

- No patient should have to attend A&E as a walk in because they have been unable to secure an urgent appointment with a GP. This means having robust services from GP surgeries in hours, in conjunction with comprehensive out of hours services.

- Calls to the ambulance 999 service and NHS 111 should undergo clinical triage before an ambulance or A&E disposition is made. A common clinical advice hub between NHS111, ambulance services and out-of-hours GPs should be considered.

- The local Directory of Services supporting NHS 111 and ambulance services should be complete, accurate and continuously updated so that a wider range of agreed dispositions can be made.

- System Resilience Groups (SRGs) should ensure that the use of See and Treat in local ambulance services is maximised. This will require better access to clinical decision support and responsive community services.

- Around 20-30% of ambulance calls are due to falls in the elderly, many of which occur in care homes. Each care home should have arrangements with primary care, pharmacy and falls services for prevention and response training, to support management falls without conveyance to hospital where appropriate

- Rapid Assessment and Treat should be in place, to support patients in A&E and Assessment Units to receive safer and more appropriate care as they are reviewed by senior doctors early on.

- Consultant led morning ward rounds should take place 7 days a week so that discharges at the weekend are at least 80% of the weekday rate and at least 35% of discharges are achieved by midday throughout the week. This will support patient flow throughout the week and prevent A&E performance deteriorating on Monday as a result of insufficient discharges over the weekend.

- Many hospital beds are occupied by patients who could be safely cared for in other settings or could be discharged. SRGs will need to ensure that sufficient discharge management and alternative capacity such as discharge-to-assess models are in place to reduce the DTOC rate to 2.5%. This will form a stretch target beyond the 3.5% standard set in the planning guidance.

ANNEX B

Ambulance High Impact Actions published in August 2015

A set of nine high impact interventions to improve ambulance services have been developed based on best practice from *Safer, Faster, Better*. These were communicated to the system in the winter readiness letter of 11.08.15.

Action	Description
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.
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.
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.
Enhanced working with community mental health teams	Ambulance services should work with SRGs, commissioners, community mental health teams and other system partners to 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.
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.
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.
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.

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.
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.