Dear all

Winter readiness in the NHS and care sectors – next steps

I am writing to set out more detail on plans to manage winter pressures. As you know, we go into this winter under real operational pressure, but also having put in place concrete action to seek to improve overall resilience. Since last winter the NHS has now:

- Substantially upgraded the NHS 111 advice and treatment service so that more than a third (36%) of calls are now dealt with by nurses, paramedics and doctors, compared with 22% last winter.
- Extended GP access, with over half of the population covered by evening and weekend GP appointments by Q4 this year, including everyone in major conurbations such as Greater London and Greater Manchester.
- Overhauled ambulance response protocols so that the whole of England (bar the Isle of Wight) will be operating to more clinically precise 999 response standards, freeing up an estimated 750,000 ambulance responses.
- Deployed £100 million of capital upgrades in A&Es across England.
- Brought on line front-door clinical streaming in every major A&E by October 2017, to ensure that patients with more minor illness are appropriately cared for by GPs.

Today we are setting out four further actions together we are taking to provide the best possible care for patients during the winter months.

1) Expanding the flu vaccination programme to additional patient groups, NHS staff, and care home staff

As you will be aware, Australia and New Zealand have had a challenging flu season. Were we to face similar flu levels we would clearly come under substantial additional pressure. Going full speed at flu vaccination is therefore an obvious ‘no
regrets’ move. This year 21 million people are eligible and being offered the vaccination across England. For at risk patients and the public, new for this year, for the first time we are:

- Vaccinating 8-9 year old children in school year 4 (as well as those in school years reception to year 3)
- Vaccinating children at their school (as well as through their GP)
- Expanding access to vaccinations for pregnant women and the morbidly obese.

In addition, we are asking you to intensify staff vaccination across the NHS and care system as follows:

- The NHS will for the first time nationally fund the vaccination of care home staff

We are announcing today our intention to commit £10m to expand the GP and national pharmacy service so that care home workers are able to access the flu vaccine via local GPs and pharmacies free of charge. This will supplement the existing responsibility of employers of these staff to ensure that they are vaccinated. This considerable investment is to recognise the vital role all staff play in helping our most vulnerable patients and how important it is they do not carry and pass on flu.

- Further improvements in frontline NHS staff vaccination.

Last year saw the highest level of NHS employee flu vaccination – reaching nearly two thirds of staff – since the programme began fifteen years ago. But that rate varies far too much - from over 90% in some trusts to under 20% in others. Today the NHS National Medical Director Sir Bruce Keogh, the Chief Nursing Officer Jane Cummings, and the Chief Allied Health Professions Officer are writing to every member of staff pointing out the patient safety case for staff flu vaccination given that a third of flu can be transmitted by asymptomatic individuals. Their letter is attached. We are therefore this year expecting all NHS organisations to ensure that it is easy for your staff to be vaccinated, so that having your vaccination is the default position, and that not being vaccinated is a conscious, considered and explicit decision by the individual. As part of this, we therefore require each NHS organisation to ensure that each and every eligible member of staff is personally offered the flu vaccine, and then either signs the consent form to do so, or states if they decline to do so this not because they have not been offered the opportunity to do so. Payment of this year’s flu CQUIN will require this record collection.

2) **Extra hospital bed capacity by reducing delayed transfers of care**

The NHS is planning to go into this winter with more acute hospital beds available than last winter. Hospitals report they will be opening significant extra beds over the December-February period. But we have been clear from the start of the year that additional capacity over and above this has to come from freeing-up 2500 of the
beds occupied by delayed transfer of care (DTOC) patients, not only because this is the right thing to do for those patients, but because hospitals rightly tell us there simply are not ‘surplus’ non-employed nurses available to open yet further hospital beds to compensate for the failure to sort DTOCs.

The Secretary of State for Health and the Secretary of State for Communities and Local Government have set clear DTOC reduction targets for each local area of the NHS and for every local authority, summing to 2500 beds freed up across England, split half and half between the NHS and social care. These targets are evidence based reflecting each area’s performance and opportunity.

Figures published at 9.30am this morning show some progress – with 180,065 delayed days in August 2017, compared to 187,851 in August 2016 – a decrease of 4.1%. But that means there are still over 5,000 beds in our system occupied by patients whose discharge is held up by delays.

The secretaries of state have therefore this week written to local authorities reminding them of the formal requirement they have set for 2017/18 BCF plan approval - and resultant funds transfer from the NHS to councils. This year they include a requirement that each council commits to meeting its DTOC reduction target. More than four fifths of councils have now agreed to do so. The Government has further stated that it will consider linking an individual council’s share of next year’s extra £1 billion for social care to actual delivery of these DTOC targets this year.

For the small minority of councils that have not yet committed to ensuring that appropriate BCF resources are directed to the unmet social care needs of their frail older residents in hospital, they have an opportunity to do so through the BCF escalation process that will run over the next 10 days. Either way, we are determined to ensure that NHS-sourced BCF funds in these parts of the country are indeed deployed on social care for these vulnerable patients, and would exceptionally consider authorising hospitals in areas without an approved BCF plan next month to use NHS-derived BCF funds to source additional home care and care home places over the winter period.

3) Increasing our emergency care workforce

We recognise there are significant workforce challenges in urgent and emergency care. Today NHS England, NHS Improvement and Health Education England in partnership with the Royal College of Emergency Medicine are announcing the biggest expansion in the ED consultant trainee workforce ever. This comprehensive plan backed by new investment (attached) includes:

- Increasing the number of people starting Emergency Medicine training to 400 a year for four years compared to 300 this year and 225 previously;
- Investing in the growth of the Advanced Clinical Practitioner (ACP) workforce in Emergency Care and expanding the Physician Associate training pipeline
• Investing in a leadership/personal development training programme for every emergency medicine trainee in England to help reduce attrition and improve the support for trainees in this intense and pressurised specialty
• Developing and implementing Clinical Educator Programme (CEP) strategies in trusts where the GMC training survey highlighted the greatest training needs.

4) Clinical oversight and risk management

We know that we will face increased clinical risk as a result of the pressure in winter. Local systems are developing clinically-led escalation plans, which should be agreed at Board level, setting out the actions that will be taken to manage clinical risk. Regional teams will provide support where needed in the development of these plans.

This year we are introducing a new element into the national winter patient safety oversight, with a new system of escalation levels, based on learning from previous years. A new National Emergency Pressures Panel – to be chaired by Sir Bruce Keogh, with Kathy McLean as deputy chair - and comprised of senior medical, nursing and other clinicians from the NHS, Public Health England, CQC and royal colleges, will identify levels of system risk and recommended contingency responses, graded to reflect levels of pressure regionally and/or nationally. Details of the Panel's operation will be released following the panel's formation this month.

Thank you again for your continued effort and dedication to providing high-quality care for patients.

Pauline Philip
National Urgent and Emergency Care Director
01/11/2017

Chief executives of trusts providing community health services

Dear colleague,

**Expectations for managing patient flow in community services over winter**

I am very grateful for your continued leadership in preparing the NHS for another challenging winter. I know you are working hard to ensure good patient flow through your services supporting the timely discharge of patients from acute hospitals to community services and community services to other settings. We need to significantly reduce the number of patients experiencing delays to discharge to improve their care and free up much-needed capacity in the acute and non-acute sector over winter.

Over the last two years, non-acute delays have risen by 24%. The interface between acute, social care and community services contributed significantly to this increase, with a 49% rise in patients awaiting care packages at home (with around two-fifths wholly or partly attributable to the NHS). It is vital for the patients under our care and for the efficient running of our services that you, together with your boards, prioritise reducing delays in discharge over the coming months. This will require both action within your organisation and working across your local system to improve flow throughout the entire patient journey.

We know that there are a number of barriers to ensuring good flow in the community. Many of these are structural and/or have medium-term solutions. However, there is a lot that can be done in the short term on areas such as cross-system working, patient choice and sharing of data. To address these, we have enclosed guidance\(^1\), based on current good practice in the system, which sets out six expectations of your organisations to improve patient flow over the coming months (**these are summarised in the annex**). We are also committed to supporting trusts to deal with the longer-term issues. We will maintain our focus on these longer-term issues as part of our work on performance improvement, flow across the system, and productivity and efficiency through the extension of the Operational Productivity programme to community services.

There are clearly actions we can take to support you in this work, and there is much good practice to share. I would therefore like to bring together all chief executives of

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\(^1\) Full guidance is available from [https://improvement.nhs.uk/resources/flow-in-providers-of-community-health-services-good-practice-guidance/](https://improvement.nhs.uk/resources/flow-in-providers-of-community-health-services-good-practice-guidance/)

NHS Improvement is the operational name for the organisation that brings together Monitor, NHS Trust Development Authority, Patient Safety, the National Reporting and Learning System, the Advancing Change team and the Intensive Support Teams.
trusts providing community health services, for a half-day event on 27 November to discuss how together we prepare for and manage this winter and successfully implement measures set out in the guidance (you can register for this event [here](#)). If there is something additional you feel we need to be dealing with to help you, please let me or Pauline Philip know directly, or provide feedback via your regional director.

Thanks again for your continued effort and support. Keep going...

Yours sincerely,

Jim Mackey
Annex. Expectations for managing flow in providers of community health services

In our good practice guidance, we have identified nine short-term solutions that will begin to address barriers to flow for providers of community health services. These include

- six measures we expect providers of community health services to implement over the next six months
- three wider areas of good practice.

Underpinning all of this is a need to ensure the whole organisation has an operational focus to reduce delays faced by patients, thereby improving the care they experience. This is especially the case as we face the challenges of winter. We know that many providers have a very strong focus on operations but we have also seen significant variation across the sector in the priority afforded to this issue. We would therefore encourage you to consider how to ensure that staff at all levels and care settings in your trust have delegated operational responsibilities, including monitoring and altering processes that do not facilitate good flow. For instance, ensuring that continuing healthcare (CHC) assessments occur where possible outside hospital and ensuring flexibility in staffing to enable organisations to manage planned services as well as urgent cases requiring a rapid response.

To achieve operational grip, providers of community services should run active conversations on flow and performance between staff, including updates between senior staff and each ward, and between different organisations in the local health and social care system. Conversations should reflect on currently available operating data, and identify where there is a need for data to monitor flow. These discussions can also allow staff from across care settings to check they are delivering care in a consistent way. Discussions should also happen with operational leads in local acute and social care partners and focus on shared high risk areas (eg joint workforce arrangements between acute and community services for domiciliary care, night care and assessments at home).

The six measures we expect providers of community health services to implement (where not already in place) within the next six months to improve patient flow are below. We expect providers to:

1. Engage with acute and social care partners to facilitate the sharing of relevant patient data, while ensuring information governance standards are met, to enable better, more rounded care decisions over the entire patient pathway. From 7 November 2017, providers of community services should also ensure they complete and return daily situation reports (SitReps), to enable a better understanding of community services at a national level. NHS Improvement has been working with providers of community services to make sure they are ready

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to start submitting this data, which will enable a better understanding of community services at a national level.

2. Participate in the operational management of discharge with all local partners, to jointly assess the discharge pathway of each patient across the whole local health and social care system. This will involve being an active participant in the local acute provider’s discharge discussions and hosting operational discussions daily where necessary to discharge patients in community settings.

3. **Over the next six months and beyond**, start to develop a ‘discharge hub’ with all local partners. This service will act as a single point of access for patients moving to and from both acute and community services. It will make facilitating admission avoidance and early supported discharge more straightforward, in addition to co-ordinating the most appropriate care pathway for each patient.

4. Ensure effective implementation of a robust patient choice policy, with clear legal contribution and endorsement from the executive teams of local partners. Truly successful implementation will require providers to support staff in effectively using and escalating this policy and leading impactful conversations with patients that highlight the benefits of moving a patient’s care towards their home.

5. Make clear to partner organisations, both at a senior and clinical level, what services they offer patients, to enable colleagues to refer the right patients into community services and set appropriate expectations for patients receiving community healthcare.

6. Ensure a clear collection of flow data, and data on initiatives to improve flow, such as the Red2Green system, in a format that shares progress, motivates clinical staff and drives measurable improvement. Providers should also make use of dashboards and similar tools to communicate operations.

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3 To support this we have developed a digital tool that uses provider data to auto-populate a Red2Green dashboard. This is available at [https://improvement.nhs.uk/resources/red2green-improvement-tool/](https://improvement.nhs.uk/resources/red2green-improvement-tool/)
Meg Hillier MP  
Chair of the Committee of Public Accounts  
House of Commons  
London  

Dear Chair

6 December 2017

Thank you for your letter dated 31 October 2017. Within your letter you requested definitive examples of where local NHS organisations had been working successfully on tackling delayed transfers of care and to provide more information and examples about how we envisage productivity increasing in the NHS.

Delayed Transfers of Care

The NHS and their local authority partners started planning for winter this year earlier than ever before. Work includes an ambitious package of measures alongside £100m of additional funding for A&Es as well as the additional £337m revenue funding announced last week in the Budget for winter pressures. There is an unprecedented, system-wide push for all NHS and care sector workers to have the influenza vaccine, aimed at helping protect patients in hospitals and in the community. I attach in an annex the NHS letter setting up winter for your information.

Delayed transfers of care (DTOC) is a particular issue in the plan for winter. Collectively, the NHS and social care are expected to free up 2,500 beds through more effective transfers of care. Our expectations for reducing delayed discharges are rightly stretching; they are vital for patient welfare as well as for improving efficiency, and are a shared endeavour.

Since February, nationally, more than 1000 extra beds have been freed up, following efforts by local authorities and the NHS to reduce delays. In particular, we recognise the significant progress being made in speeding up assessments, reducing waits for further non-acute NHS care and reducing waits for care packages in people’s homes.

But there is more to do. Ahead of winter we expect areas to continue to do everything they can and will be closely monitoring and supporting progress to make much faster and more significant progress to help free up hospital beds for the sickest patients and reduce pressures on the NHS. Local NHS organisations must work with local government to ensure that the flow of patients through the health and social care system is improved.
From the Permanent Secretary
Sir Chris Wormald

We have put in place clear support routes for local areas and provided guidance on best practice. This was pulled together in a national offer which is attached in an annex. NHSI has recently set out additional guidance to community providers about DTOCs.

One route for bringing this work together is the Better Care Fund which requires local areas to work together to implement the ‘high impact change model’ for managing transfers of care. The model identifies eight system changes which will have the greatest impact on reducing delayed discharge:

- Early discharge planning
- Systems to monitor patient flow
- Multi-disciplinary/multi-agency discharge teams, including the voluntary and community sector
- Home first/discharge to assess
- Seven-day services
- Trusted assessors
- Focus on choice
- Enhancing health in care homes.

Progress on implementing these changes will be reported via BCF quarterly returns. It is not possible to list everything that local areas are doing but a selection is attached in an annex.

Public Sector Pay and Productivity Gains

As you are aware the Chief Secretary to the Treasury made clear that there may be a case for greater pay flexibility for public sector workforces where there may be recruitment and retention problems in return for improved productivity.

During his budget speech the Chancellor made clear that in order to protect patient services, if ongoing discussions with NHS trades unions about reforming the Agenda for Change contract bears fruit additional funding above one percent will be made available in return for modernisation of the contract to improve productivity. The talks with Agenda for Change trades unions are without prejudice to the NHS Pay Review Body process.

The detail of 2018/2019 pay remits for specific Pay Review bodies is not yet finalised. They are being discussed and will be set out in due course. We plan to send our evidence Agenda for Change staff and Doctors and Dentists Pay Review Bodies by mid-December. We expect to receive the Review Bodies final reports in early summer next year.

The Carter Review, which includes a ‘model hospital’, has been developed to advise NHS trusts on the most efficient allocation of resources and allows hospitals to measure performance against other trusts. Identifying and quantifying the output contribution of individual NHS staff is complex, particularly in the healthcare setting and is influenced not just by pay, for example by how existing terms and conditions operate on the ground; opportunities for learning and development; the working
From the Permanent Secretary  
Sir Chris Wormald

environment; and opportunities for flexible working to support work life balance and for staff with caring responsibilities. A range of factors affect productivity and together contribute to how committed staff feel to their jobs, their organisations and how they are motivated to increase their output.

The potential scale of any productivity improvement in return for greater pay flexibility depends partly, but not solely on how existing national NHS terms and conditions, collectively agreed with NHS trades unions might be reformed through NHS organisations seeking to maximise output by making a stronger link between pay and performance supported by robust performance management systems.

For example, in the NHS the inbuilt cost of incremental pay is around £800m a year on top of annual pay awards. Removing virtually automatic annual increments, a long standing government policy, and strengthening the link between pay and performance could help improve productivity but would need to be part of a balanced package of reform that also addressed any recruitment, retention or motivation issues. We expect this to be part of the talks on reforming the Agenda for Change. contract.

We would not wish to undermine the PRB process by pre-empting final decisions government may make about the content of departmental remit letters or by disclosing now the detail of the evidence DH will submit, on behalf of the Government, in response to those remits.

I would be happy to write to you again following submission of our evidence this December setting out the detail of our approach for helping to improve productivity.

Department of Health’s Annual Report and Accounts

I wrote to you on 27 October with a list of the trusts in receipt of funding from the £100m capital for A&E announced in the Spring Budget 2017. NHS England has since confirmed that there was an error in the information provided to us in that a site had been incorrectly allocated to the wrong trust. In wave 1, East Surrey Hospital (site) was incorrectly attributed to East Sussex Healthcare NHS Trust. The correction is that East Surrey Hospital (site) is part of Surrey and Sussex Healthcare NHS Trust.

The correct figures are that 116 sites across 102 trusts that have been successful in bidding for this funding.

I apologise for any inconvenience caused.

Yours sincerely,

Sir Chris Wormald  
Permanent Secretary
ANNEX C

Multi-disciplinary or Integrated Discharge Teams (IDTs)

East Kent’s IDT was established in October 2014. It is made up of staff from; East Kent hospitals, Kent Community Health Foundation NHS trust, Kent County Council, Age UK and Carers Support. It has helped contribute towards:
- 30% reduction in DTOC in the first 12 months
- Inappropriate long term placements from hospital reduced by 67% in first 6 months
- Inappropriate short term placements reduced by 73% in first 6 months

Hounslow have implemented a jointly commissioned, 7 day integrated service. This whole system approach, from admission to discharge, involves an extended hospital social work service to facilitate timely discharge, along with a Community Recovery Service (CRS), who provide rehabilitation and reablement in the community post-discharge. This integrated way of working means there are no delays between a patient ready for discharge and packages of care being put in place. As of January 2017, there has been a 30% reduction in DTOC from the 2015-16 baseline. Residential home admissions (for 65+) reduced by 25.8% between 2014/15 and 2016/17, with nursing home admissions (for 65+) reduced by 42.6% in the same period.

Wigan’s IDT includes discharge coordinators from the hospital, district nurses from an integrated community services team, domiciliary care services, housing colleagues, a homeless service, reablement staff, social workers, social care officers and mental health workers. In 2016-17 the IDT helped discharge 81 patients directly home rather than into residential care.

Home first / Discharge to Assess (D2A)

Leicestershire NHS Trust identified challenges resulting from 56 different discharge pathways, meaning too often patients were put onto the wrong pathway and over-prescribed packages of care. Following a reduction to 5 discharge pathways, around 70% of patients are discharged through pathways 1 ‘Home with existing support’. A whole system change in how the hospital approaches health and social care has seen the Trust move from amongst the worst 10% of national DTOC performance to sustaining DTOC levels that place them amongst the top 2.5% of systems.

South Warwickshire’s D2A scheme has reported £500k net long-term costs averted per annum for patients moving from hospital to nursing care. D2A pathways have built-in links with primary care; two GP practices have been commissioned to provide clinical input for 30 nursing home beds. The trusted assessment between health and social care, in-house reablement and rehabilitation, and care co-ordinators supports patients and their families throughout the discharge process.

Sheffield’s D2A pathway operates across the whole hospital and has been running for 5 years. This has led to a 37% increase in patients who can be discharged on their day of admission or the following day, with no increase in the re-admission rate.
Medway's D2A pathway operates across the whole hospital and has been running since March 2016. The Trust reported a 25% DTOC reduction over a 3 month period following the implementation of the D2A pathway.

**Focus on choice**

Lancashire Teaching Hospitals NHS Foundation Trust commissions a personalised support service for people being discharged into care homes, supporting them to make choices. This has resulted in reducing delayed days from 16.2 to 5 days (over 5,200 patients supported in the first year of the scheme).

**Enhanced health in care homes**

Medicines optimisation can reduce in conveyances to A&E and hospital admissions. For example, 30 care homes have been visited in East and North Hertfordshire and potential hospital admission cost savings of £345,000 were identified. **Newcastle and Gateshead CCG** calculated potential savings from avoidable hospital admissions of £80,500 - £154,500 (from 494 reviews, from 19 care homes over 9 months).

**Newcastle and Gateshead CCG** has established front-of-house assessment teams for older people and have gone live with their 7-day 08.00 – 20.00 frailty nurse service. Early indications are that it will see a reduced number being admitted. Newcastle and Gateshead CCG have also experienced a 2 year low for care home admissions for UTI through a multifaceted approach i.e. improved education and training in relation to hydration, care home staff supported by community nurses for IV drug administration, 24/7 urgent care nursing team working at an advanced practice level making differential diagnosis and administering meds via PGDs, 24/7 nursing teams supporting care home teams with sub-cutaneous fluid administration and a growing number of patients having EHCPs and improved practice in developing them making them more meaningful.

Intermediate care and step up/step down beds can decrease the length of hospital stays and reduce the chance of readmission. There are considerable financial benefits to Acute Providers if patients are discharged quicker. This has been seen in Newcastle through the implementation of Trusted Assessors for intermediate care beds using discharge nursing team in Newcastle, and frailty nurses in Gateshead assessing for step down beds.