14 July 2017

on the day BRIEFING

NHS Providers

ON THE DAY BRIEIFING: A REVIEW OF WINTER 2016/17 – NHS IMPROVEMENT AND NHS ENGLAND

Today NHS Improvement (NHSI) and NHS England (NHSE) have published a report which reviews the impact of winter on secondary care in 2016/17. It notes some of the key statistics in this period as well as assessing actions taken by both national bodies and local organisations. Based on the review of winter 2016/17, it also makes 10 recommendations to help improve system performance this coming winter. This briefing summarises the publication for our members and also provides our press statement on the publication. If you have any questions about this briefing, please email Edward.Cornick@nhsproviders.org.

In addition to this, NHSI has published a good practice guide on improving patient flow. Designed to improve emergency departments and non-elective pathways, the guide contains actions focused on better patient flow and performance against the four-hour standard. A separate summary of this is in Annex A to this briefing.

SUMMARY

Both the key findings and the recommendations of the winter 2016/17 report can be broken down into 5 key areas.

1. System capacity
2. Planning for peaks in demand
3. Variation in practice
4. Work of the national bodies
5. Services outside of hospital

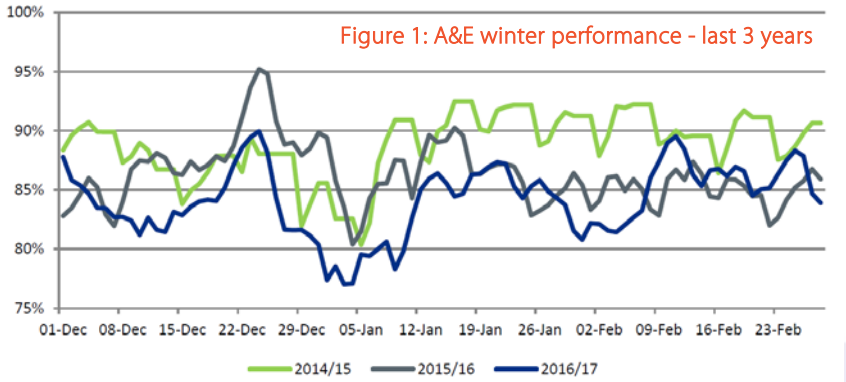
This briefing summarises the findings and recommendations from each area, but the following section pulls out some of the key headlines that cut across these areas.

Headlines

- Demand growth, from December to March, was lower than the 5 year average growth on all measures (see table right)
- From late December 2016 to early March 2017, performance dipped sharply. On some days national performance was as low as 76%. From 27 December to 14 January 2017, national performance was below 80% on 11 of these days.
- By 14 January performance had recovered to 85%, and performance did not drop below 80% again. Performance for March 2017 was 90%.

	Year on year growth 16 vs 15	5 year average growth
Non-elective admissions	1.4%	2.9%
A&E attendances	-1.7%	1.4%
Ambulance calls	1.1%	3.2%
NHS 111	-4.2%	5.3%

Figure 1: A&E winter performance - last 3 years



1. System capacity

Review and findings based on winter 2016/17

- Over winter dips in national performance corresponded with spikes in bed occupancy levels:

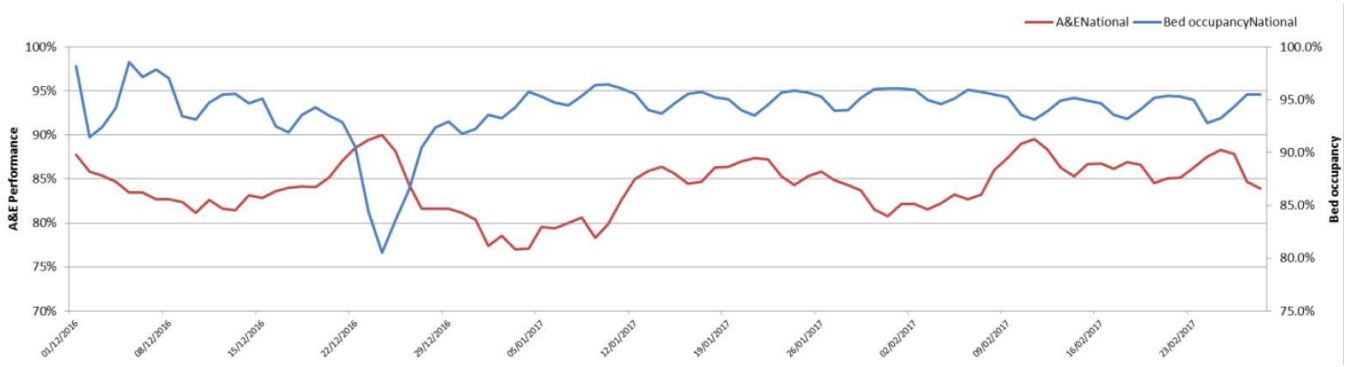


Figure 2: Winter 16/17 - performance and occupancy

- In aggregate across England, acute providers had more acute hospital beds open in winter 16/17 than the previous winter, with bed capacity increasing in October 2016 to March 2017 compared to 15/16. There were on average 600 (0.8%) more acute hospital beds in Quarter Three 2016/17 compared to the same period the previous year. However, bed occupancy was on average 1.5% higher.
- Delayed transfer of care (DTOC) levels reached their highest recorded level in January, with DTOC levels over winter on average 22% higher than the year before, occupying on average about 6,400 beds everyday. Between April and November there was an increase in DTOC of 25% compared to the same period in the previous year. In November nearly 7000, or 5.2%, of available beds in the system were occupied by DTOC patients..
- DTOC represents only a subset of patients fit to discharge. The medically fit (MFFD) number was estimated to be approximately double that of DTOCs.
- Decline in A&E performance over the course of the past three years has largely arisen because the usual balance between demand and capacity has been altered which has further caused patient flow to slow. In the past three years increasing difficulties with discharging patients have led to a significant rise in emergency bed days (1.8m). This has in turn pushed up occupancy.

Recommendations ahead of winter 2017/18

- Recommendation one – occupancy levels should be more actively monitored and actions taken to ensure that they remain below 92%, to allow patient flow to be maintained to deliver A&E performance.
- Recommendation two – to ensure delivery of safe, effective care this winter the NHS needs to free up 2,000-3,000 acute beds. This freeing up beds should come from a reduction in DTOCs.
- Recommendation three – building on the forthcoming additional collection of data on primary care capacity, the NHS needs to routinely have a more complete picture of capacity available across the system, particularly in community care.

2. Planning for peaks in demand

Review and findings based on winter 2016/17

- Prior to winter, trusts were advised through local A&E deliver boards to ensure bed occupancy was 85% ahead of bank holiday periods to deliver headroom for early January. The aggregate achieved was 87% occupancy

- The peaks in demand that the NHS faces over the winter period is generally predictable and does not vary significantly from previous winter periods and other bank holidays. Systems are in a constant cycle of improvement and decline week on week and from holiday period to holiday period.
- During winter 16/17 the average number of attendances on a Monday was above 56,000. Throughout the week this declined, down to around 50,000 by Friday. Average performance tended be lower at the start of the week and improve by Thursday.
- Whilst there was little winter demand growth compared to the previous year last year (which had seen very significant growth from years previous to that) there were significant peaks in that demand. For example, attendances peaked at record levels on 27 December, when the NHS saw over 60,000 people. It then peaked significantly again on 3 January. These peaks reflect a broader trend that is seen throughout the year, but is particularly acute after bank holidays, of attendances at A&E peaking at the start of the week.
- There were also large peaks in demand on 27 December and during the two weekends following Christmas for NHS 111 calls. The 16/17 Christmas period (23rd December to 5th January) had a 9.5% (72,000) increase in calls offered in comparison to 15/16. 26 December 2016 to 1 January 2017 was the busiest week ever for NHS111 services with over 455,000 calls.

Recommendations ahead of winter 2017/18

- Recommendation four – all parts of the NHS need to work with local government partners to ensure that there are enough resources available to maintain patient flow seven days a week and plan effectively for the predictable peaks in demand at weekends and bank holidays.

3. Variation in practice

Review and findings based on winter 2016/17

- Whilst four-hour waits were distributed relatively widely across the system, 12-hour waits were markedly concentrated in a small number of systems -two-thirds of the 12-hour trolley waits over this period were in only six organisations.
- There was significant variation in performance between different parts of the country. Some acute trusts continually performed above 98% whilst others performed below 70% over the 16/17 winter period. The report states "this variation cannot be attributed entirely to external factors" and "the implementation of best practice is still not consistent across the country."
- There is also substantial variation in the levels of A&E workforce in different parts of the country. Some systems struggle to recruit even half of their workforce substantively, whereas other systems are far more resilient. Trusts continually raised over winter that workforce issues held back performance improvements and caused challenges in delivering quality care

Recommendations ahead of winter 2017/18

- Recommendation five – there needs to be a renewed drive and focus to implement best practice across all systems. Much of this is down to local focus, attitudes, behaviours and cultures of clinicians and managers which need to be tackled as part of the work of NHS England and NHS Improvement regional and improvement teams.
- Recommendation six – specific action needs to be taken to address workforce shortages in key areas in Urgent and Emergency Care, most notably in primary care and emergency medicine, both for this winter and for the medium-term.

4. Work of the national bodies

Review and findings based on winter 2016/17

- In response to the continued decline in A&E waiting time performance and increases in demand, a five point improvement plan was developed by senior operational and clinical leads from across NHSE and NHSI during 2016. Assurance against the five key points of the plan was conducted in September and repeated in December to determine progress.
- Locally, Systems Resilience Groups became Local A&E Delivery Boards, charged with focusing solely on delivering UEC services. A&E Delivery Boards were asked to appoint an acute trust chief executive as chair or appropriate alternative where this was agreed by the board. Board membership now consists of senior representatives from across each local health system to facilitate collaborative system-wide change.
- The national A&E Improvement Plan was launched in mid-July 2016. Assurance was conducted through a rolling programme with regional teams, which focused on general progress with the improvement plan, what the best performing systems were doing, and specific actions being taken with the poorest performers. There were also detailed quarterly assurance checkpoint reports submitted by all systems.
- Winter communication was sent to all local A&E delivery boards in October setting out the mandated planning actions that all local systems were expected to address in their winter plans. Plans were submitted for assurance to regional A&E delivery boards, who oversaw sign-off and further work where gaps were identified. Widespread feedback was that this was too late in the year and did not allow for the decisions to be made that could change course in some systems and deliver the resilience needed to get through the pressurised period.
- The Operational Pressures Escalations Levels (OPEL)[7] framework was introduced as the winter process began, to eliminate the discrepancy between serious operational issues being reported on the daily sitrep and escalation of systems under pressure based on the EPRR framework

Recommendations ahead of winter 2017/18

- **Recommendation seven** – The NHS should plan for winter earlier than in previous years with decisions made on the 'winter plan' including what additional support is needed in the summer.
- **Recommendation eight** – NHS England and NHS Improvement need to be more aligned and present joint messages to the system, combining improvement resources to best support the system in the coming months.
- **Recommendation nine** – NHS England and NHS Improvement should work with national system partners, including central government departments, to reduce the burden of assurance and reporting to allow space for local delivery

5. Services outside of hospital

Review and findings based on winter 2016/17

- Prior to winter, local systems were advised through local A&E deliver boards to ensure availability of primary care and other out of hospital services, according to locally forecast demand, and that NHS 111 providers were sufficiently staffed to meet forecast demand.
- Throughout the winter period (December to March) 5,230,25612 calls were made to NHS 111, a decrease of 231,395 calls (4.2%) compared to the previous year. Of the calls answered, 88.5% were answered within 60 seconds this winter, compared to 79.6% last winter. The ambition set out to A&E delivery boards that 30% of calls should be handled by clinicians was achieved in the last week of March.

- For ambulance providers, performance against the Red 1 standard was better this winter (68.2%) compared to 15/16 (67.6%).
- In community services, non-acute DTOCs were 20% higher this year compared to last.
- DTOCs attributed to social care rose by over a third in winter 16/17.
- There is limited national data collated on activity in primary care over the winter period - a more sophisticated real time measure of primary care capacity is in development.

Recommendations ahead of winter 2017/18

- **Recommendation ten** – NHS England and NHS Improvement should ensure the local NHS make rapid progress over the course of 2017/18 in implementing the wider changes to the Urgent and Emergency Care system that will improve patient care and reduce pressure on Emergency Departments as set out in the Next Steps on the NHS Five Year Forward View document (these can be found in Annex B)

NHS PROVIDERS: PRESS STATEMENT

NHS Winter review: we must act now to deal with the pressures ahead

Responding to the review of winter 2016/17 published by NHS England and NHS Improvement, the director of policy and strategy at NHS Providers, Saffron Cordery, said:

"Last winter was very tough for the NHS. For short periods of time some local services were overwhelmed. Front line staff showed fantastic commitment and professionalism in response to growing pressures, but the situation was unsustainable. We led the calls for a winter review to ensure lessons were learned, and to help preparations for next time. We are pleased that NHS Improvement and NHS England have acted on those concerns.

"We support the broad conclusions of the report which emphasise the need to ensure there is sufficient capacity to cope with increased demand. They rightly focus on concerns about high bed occupancy rates, and delayed transfers of care (DTOCs) for patients who are ready to be discharged, often because of difficulties in lining up suitable social care. It is also right to identify and prepare for particular days – especially Mondays and holidays - when the pressures are likely to be at their greatest.

"Our recent *Winter Warning* report highlighted the importance of avoiding a narrow focus on hospital capacity, and ensuring we also invest in mental health, community and ambulance services as part of a wider programme to manage the extra pressures. Drawing on a survey and detailed discussions with trust leaders it found those from mental health and community trusts were particularly worried about their ability to meet winter demand. Those concerns are not sufficiently reflected in these recommendations.

"In *Winter Warning* we called for an additional £350 million for targeted support to allow the NHS to put in place extra beds in community and mental health services as well as hospitals whilst also enabling the ambulance service to deal with more patients.

"Trusts urgently need to know where they stand so they can plan properly and secure the extra staff cost effectively. Time for action, including appropriate investment, is running short."

ANNEX A – GOOD PRACTICE GUIDE: IMPROVING PATIENT FLOW

In light of last year's winter pressures, NHSI has published a guide on good practice for patient flow, based primarily on the recommendations in Bruce Keogh's report on transforming urgent and emergency care, as well as guidance from the Royal Colleges, the National Institute for Health and Care Excellence, specialist societies and publications from the health think tanks.

The guide contains 10 'modules' detailing good practice and provide checklists in order to assist in the identification of improvements in patient flow. The modules are summarised below and have been published alongside a set of case studies.

Ambulance handovers

The focus is on a seamless handover to ED without delay, with ambulance managers or hospital ambulance liaison officers (HALOs) playing a pivotal role. Escalation plans should be triggered when the system is under pressure and the use of cohorting should only be used as a temporary measure, with a clear plan for escalation. A full capacity protocol (FCP) can also be used to balance the risk to patients when emergency departments are crowded, although this should be deescalated as soon as is practically possible and the appropriate protocols need to be put in place.

Primary care streaming

Clinical streaming should always be performed by a trained ED clinician and should be performed as soon as possible and always within 15 minutes. Any co-located GP setting should be a self-contained service and although separate from the ED, the 4 hour target still applies. Clinical liaison and governance between the ED and the co-located primary care setting should be regular and robust; monthly governance meetings between the ED and co-located primary care organisations are recommended. There should also be an explicit agreement that the co-located primary care setting has the right to send back to ED any patient.

Emergency department

All patients attending an ED are streamed at the front door to the most appropriate area and clinicians and the department should prioritise the assessment and treatment of the sickest patients. The use of well-evidenced frailty assessment tools is encouraged for older patients (such as the Rockwood Clinical Frailty Scale). A senior doctor (minimum ST4 grade) should be present 24/7 and the deployment of advanced clinical practitioners is encouraged. Streaming involves taking a brief history and performing basic observations if appropriate; it should produce a calculation of an early warning score (for example the national early warning scores (NEWS)). Staffing should be based on analysis of patient demand on the system across the day and week. Patients are admitted if their needs cannot be met by ambulatory emergency care or other pathways.

Mental health

Appropriate risk assessment practices should be followed for people experiencing a mental health crisis. All ED staff should understand and comply with the Mental Health Act, with access available for the right support. The environment should be safe and at the point of discharge appropriate assessments should be carried out, with an urgent and emergency mental health (UEMH) care plan in place. Mental health activity needs to be specifically coded and recoded by the ED and acute staff should have access to an up to date NHS 111 Directory of Services (DoS) and primary care social prescribing directory. People thought to have a mental health condition should be triaged by compassionate staff trained in line with the National Confidential Enquiries into Patient Outcome and Death (NCEPOD) 2017 recommendations.

Clinical decision units

All hospitals require a facility that enables same-day emergency care in a non-inpatient setting (for example clinical decision units (CDUs) and ambulatory emergency care (AEC) services).Units must be open 24/7 and should be supervised and led by a consultant, and staffed by multidisciplinary teams that are competent in medical specialist assessment. They should be co-located with or in close proximity to the ED and governance should include all medical, nursing and allied health disciplines.

Decisions need to be made as soon as patient results become available and are not contingent on a ward round process. Capacity is protected and not released as escalation capacity when the hospital is under pressure.

Ambulatory emergency care

Patients whose condition may require admission are rapidly assessed and streamed to AEC, where they can be diagnosed and treated on the same day, avoiding admission where possible. Minimum AEC availability is seven days a week 14 hours a day. Hospitals introducing an AEC should aim to convert a third of their adult acute medical admissions to ambulatory care episodes. Again where possible the AEC should be in close proximity to the ED, with immediate access to a senior doctor when needed. Time standards in AEC should match the clinical quality indicators for ED. Consideration should also be given to *who* can refer patients to AEC. The timeframes for initial assessment and medical review in AEC should be similar to those in the main ED.

Acute assessment

Acute surgical and specialty assessment

As a minimum a speciality trained (ST3 or above) or a trust doctor with equivalent ability should be available to treat acutely unwell patients at all times within 30 minutes. An initial assessment should start within 15 minutes of arrival. Acute assessment services should also have a dedicated multidisciplinary team and have ready access to diagnostics and in-reach services to support patient care and early discharge.

Acute medical units (AMUs)

This is a consultant managed service that is open 24/7, with a dedicated multidisciplinary team that includes a range of staff. Ready access is required to in-reach services to support patient care and early discharge. Services are led by acute doctors with direct access to the hospital executive team, to foster collaborative working. Communication and handover rotas promote continuity of care and regular "board rounds" and core AMU team huddles should take place. Process to discharge should start as soon as the patient arrives in the AMU. As a quality marker of the unit, specific pathways should have standardised processes – for example, sepsis pathway, acute kidney injury pathway etc. To efficiently admit patients from ED to AMU, the AMU should run at between 85% to 90% bed occupancy.

Frailty

Frail patients are identified using an evidence-based assessment tool (for example the Rockwood clinical frailty scale (CFS))as soon as they present to the ED Hub and receive specialist, high quality care on the non-elective pathway focused on early discharge. The frailty pathway is embedded in processes in ED, AEC, CDU, AMU and on wards, with patients actively involved in their care.

Admission, transfer, discharge

Patients are discharged as soon as they no longer receive benefit from acute hospitals, in the majority of cases to their usual place of residence. Therapy and social work teams should work at the front of the acute care pathway, routinely collecting information on how patients have been managing at home before becoming acutely unwell. Discharges ensuring that the SAFER flow bundle and Red2Green days is implemented. Duplication of assessment should be minimised and discharge to assess should be via a single point of access for health and social care. Board rounds should take place on each ward every morning and there should be a single point of access for health and social care to support "discharge to access".

Specialties

Patients on hospital inpatient wards should receive person-centred, compassionate and skilled care. Specialties should use simple rules to standardise ward processes and minimise variation between individual clinicians and between clinical teams. This may include SAFER patient flow bundle and Red2Green days. Daily medical reviews should be normal practice seven days a week and a senior doctor should assess the progress of every patient, in every bed, every day on a board or ward round. Actions should be taken whenever possible, not at the end of ward rounds. High risk patients must be discussed with the consultant and be reviewed by a consultant within four hours if the management plan remains undefined. Morning discharges should be maximised and hospitals need to ensure that patients are admitted to the right ward to meet their needs. Requests for diagnostic tests and specialty review should routinely be completed on the same day and always within 24 hours.

ANNEX B: URGENT AND EMERGENCY CARE SYSTEM

Summary of the out of hospital care deliverables taken from the Next Steps on the NHS Five Year Forward View document and progress made to date:

Deliverable	Progress made
By October 2017 every local health and social care system must have adopted good practice to enable appropriate patient flow.	The improved Better Care Fund(iBCF) as well as the £1bn grant with its conditions looks to ensure local authorities work with relevant CCGs and providers to support system-wide improvement. This work includes the High Impact Change Model for reducing DToC.
Hospitals, primary and community care and local councils should work together to ensure people are not stuck in hospital beds waiting for community health and social care. This involves utilising the £1bn provided in the budget, helping free up 2000-3000 acute beds, as well as regularly publishing progress. This work will also involve ensuring that 85% of all assessments for continuing health care funding takes place out of hospital by March 2018. The High Impact Change Model must also be implemented.	Work is underway to support improvement and individuals who have responsibility for CHCH assurance are supporting CCGs to develop improvement plans to reduce the number of assessments taking place in an acute setting. The Better Care Fund Policy Framework, supported by the grant, includes a national condition to work on the High Impact Change Model. The arms length bodies are also working together to deliver support offers.
Enhance NHS 111 by increasing proportion of 111 calls eventually receiving clinical assessments, so that only patients who genuinely need to attend A&E are advised to do this. GP out of hour serves will increasingly be combined and by 2019 NHS 111 will be able to book people into urgent face to face appointments.	The proportion of NHS 111 calls receiving clinical assessment increased to 30% in March 2017 (up from 22% with a 30%+ target)
NHS 111 online to start during 2017, allowing people to enter specific symptoms and receive tailored advice on management.	Pilot trials are underway in West Midlands and Cambridge and Peterborough.
Roll out evening and weekend GP appointments, to 50% of the public by March 2018 and 100% by March 2019.	In March 2017 22.9% of registered patients had access to full extended access to GP care. On track to meet 50% target by March 2018.
Strengthen support to care homes to ensure they have direct access to clinical advice, including appropriate on-site assessment.	Work is progressing towards NHS 111 Care Home Line providing dedicated access for healthcare professionals to get urgent advice from a GP out of hours.
Roll out of standardised new "Urgent Treatment Centres" which will open 12 hours a day, seven days a week, integrated with local urgent care services. Anticipation is that around 150 designated UTCs will be treating patients by Spring 2018.	Standards for UTC's have been developed in collaboration with colleagues from across the NHS. Locally work is progressing on assessing readiness.
Working closely with Association of Ambulance Chief Executives and the College of Paramedics, implement the recommendations of the Ambulance Response Programme by October 2017, putting an end to long waits not covered by response targets.	Recommendations to be taken to Ministers for approval following general election.

Contact: Edward Cornick, Policy Advisor Edward.Cornick@nhsproviders.org