UEC Recovery 10 Point Action Plan – Implementation guide

Working together to ensure urgent and emergency care recovery

NHS England and NHS Improvement

Introduction

This year has seen significant pressure put on urgent and emergency care (UEC) services. As demand has returned to pre-pandemic levels, managing this activity whilst impacted by, for instance, staff isolation and Infection prevention and control measures has constrained the capacity within the system to manage this demand.

There are further, complex, reasons for the current challenges within UEC which mean that it will take all parts of the system working together to ensure a strong recovery across urgent and emergency care services.

The NHS has a plan on how the whole system will work together to ensure UEC services have resilience, by:

1. Supporting 999 and 111 services
2. Supporting primary care and community health services to help manage the demand for UEC services.
3. Supporting greater use of Urgent Treatment Centres (UTCs)
4. Increasing support for Children and Young People
5. Using communications to support the public to choose services wisely
6. Improving in-hospital flow and discharge (system wide)
7. Supporting adult and children's mental health needs
8. Reviewing Infection Prevention and Control (IPC) measures to ensure a proportionate response
9. Reviewing staff COVID isolation rules
10. Ensuring a sustainable workforce

Purpose

Our plan builds on many conversations that have taken place with leaders across UEC at both national and local level to agree consensus on how we, as a system, can recover services and ensure patients receive a clinically appropriate response in the necessary timeframe.

The purpose of this document is to share the immediate and medium term actions we can collectively take. It highlights what you can expect from the NHS England and Improvement national team – as well as setting out actions for regional NHS England and Improvement teams and at ICS and provider level. Full recovery of UEC will take time and require actions beyond this plan; this recovery plan is by necessity focused on the actions intended to be taken with immediate effect to mitigate against the current pressures felt across systems and improve performance in all settings. A key enabler to support implementation of the plan, and associated benefits, will be the collaboration with social care colleagues at every level of our organisation.

With support from both regional and national teams, ICSs will co-ordinate and lead the implementation of these actions, working with providers and system partners across the health and social care sector. There is a critical role for ICSs in leading local assessment of demand in all settings, and ensuring that plans are in place to match demand with capacity.

We recognise that as ICSs develop towards full capability by April 2022 there may be some fluidity between the actions of the region, the ICS and other system partners. It is imperative that the following actions are translated effectively across individual ICS footprints in a collaborative and comprehensive manner.

Addressing Health Inequalities

COVID-19 has highlighted the urgent need to prevent and manage ill health in groups that experience health inequalities, as outlined in the NHS Long Term Plan. It is important that as systems take both short and longer term actions to restore UEC services that they do so inclusively, with a particular focus on deprivation and ethnicity. Guidance is set out at NHS England » 2021/22 priorities and operational planning guidance: Implementation guidance, and systems should be mindful of the five key priorities for tackling health inequalities:

- Restoring NHS Services Inclusively;
- Mitigating against digital exclusion;
- Ensuring datasets are timely and complete (e.g. ethnicity coding);
- Accelerate preventative programmes (annual health checks for LD, SMI, Continuity of Maternity Carer); and
- Ensure Leadership and Accountability.

We would advise systems to cut UEC data by indices of multiple deprivation and ethnicity. This presents a powerful lens to understand e.g. acuity of attendances at A&E and subsequent outcomes by deprivation. Systems can use this information to understand local barriers, or perceived barriers, to access and consider whether targeted communication, or specific services, in the community are required to better meet patient need and avoid attendance and / or emergency admissions.

We will offer further advice on UEC and tackling Health Inequalities in the future; an early priority is to explore UEC pathways for people experiencing homelessness.

1. Supporting 999 and 111 services.

National commitments: what you can expect from us

111 funding and CAS capacity – addressing operational pressures

To support both 999 and 111 services it is critical that local systems understand demand and have commissioned suitable alternatives to referral and / or conveyance for appropriate patients.
111:

- We will work, through regions, to support ICSs and commissioners to ensure baseline funding is increased to support 111 and ensure there is sufficient capacity.
- We offer guidance and support on the uptake of recent NHS Pathways licence easements to facilitate remote clinical supervision, call handlers homeworking and increased training throughput.
- We will offer technical support around the deployment of homeworking technology to mitigate against high levels of staff abstraction resulting from positive testing and isolation requests.
- We will roll out the use of Video Consultation offering “eyes on” for clinicians to improve outcomes reduce referrals, and IUC providers should be maximising utility of this offer.
- We propose further automation of elements of the call flow such as demographics capture to reduce the reliance on human resources.
- We ask systems to support greater pooling of resources at regional level increasing economies of scale and more cross regional buddying arrangement.

Supporting NHS 111.

System commitments: what we expect from you

Actions at regional level

111:

Participate in bi-lateral discussions with National colleagues to discuss:

- Service funding;
- Service demand and required resource;
- Performance; and
- Implementation of strategic developments.

Ensure continued implementation of NHS 111 First.

Implement Further, Faster (where applicable).

Consider regional networked call handling.

Actions at system/ICS level

111:

Demonstrate system leadership across UEC.

Ensure appropriate commissioning of UEC services and oversight of CAS services.

Facilitate discussions with local primary care, urgent care and secondary care services.

Continue to embed the principles set out through the NHS 111 First Programme.

Actions at provider level

111:

Ensure performance and quality of service.

Spend funding appropriately to maximise resource.

Plan for forthcoming winter.

Supporting 999 and 111 services.

National commitments: what you can expect from us

999 funding and CAS capacity – addressing operational pressures

To support both 999 and 111 services it is critical that local systems understand demand and have commissioned suitable alternatives to referral and / or conveyance for appropriate patients
999:

- We will support the ongoing roll out of the £55m winter funding made available to all ambulance services to stabilise and improve performance by delivering increased call handling and operational response capacity, clinical support, and e.g. HALO support for acute trusts with continued challenges in handover of patients.
- We have set out national guidance and support ambulance trusts on clinical validation to support the implementation of C3/4 999 clinical validation changes for lower acuity ambulance calls, safely fast tracking key learning from the ongoing pilot sites.
- We will support cross-system work on reducing hospital handovers i.e. minimise patient safety risks and enable crews to turnaround vehicles more rapidly.
- We will provide a national escalation point as required to increase ambulance service capacity according to local requirements e.g. through identifying and deploying or coordinating national levers and organisations e.g. St John's; and, issuing revised self isolation advice
- NHSE/I People Directorate will lead work with HRDs, AACE and Unions to optimise the health and wellbeing of the existing workforce
- We will nationally review options to manage demand for lower acuity ambulance dispositions from NHS 111.

Supporting 999 services.

System commitments: what we expect from you

Actions at regional level

999

Ensure the £55m allocations are spent through ICSs.

Ensure that tackling ambulance handover delays is a system priority in order to reduce risk of harm to patients both in the community and delayed at hospital.

Actions at system/ICS level

999

Make sure there are robust steps in place to avoid handover delays and swift escalation and resolution of delays

Ensure alternative pathways (such as urgent community response, falls service, mental health crisis) are available to ambulance services to limit avoidable ED conveyance.

Ensure PTS is being most effectively deployed to support UEC and elective recovery.

Actions at provider level

999

Use the £55m allocations to drive improvement against trajectories.

Ensure C3/4 validation amends are implemented as needed.

Make sure capacity issues are escalated rapidly.

Acute providers to accept ambulance transfers rapidly (including to SDEC and specialities).

2. Supporting primary care and community health services to help manage the demand for UEC services.

National commitments: what you can expect from us

Improving primary and community care access and moderating downstream demand – Part 1

We know that primary care is key to supporting UEC recovery through demand management; this should reflect a balance between making best use of technology and offering face to face appointments.

- We will maximise workforce capacity through:
  - additional staff resource for vaccination (£20m support over June and July).
  - General capacity funding at £120m during the first half of 2021-22 (TBC for H2).
  - Driving ongoing PCN recruitment through the ARRS and improving GP recruitment and retention.
- We will maximise the use of community pharmacies as part of integrated care pathways by:
  - Optimising referrals from NHS 111, 999, IUC CAS, UTC and ED to manage low-acuity activity and support access to urgent medicines supply as part of the NHS Community Pharmacist Consultation Service (CPCS).
  - Optimising referral from General Practice to CPCS for low acuity conditions to manage demand in primary care.
  - Comms push planned for CCGs and practices to drive up referral rates to the GP CPCS, aligned with IIF indicator going live on Oct 1st. Inclusion of requirements in winter planning and planning guidance.
  - Optimising referral from acute services into the Discharge Medicines Service (DMS) to reduce re-admission for patients discharged on multiple medicines.

Continued . . .

2. Supporting primary care and community health services to help manage the demand for UEC services.

National commitments: what you can expect from us

Improving primary and community care access and moderating downstream demand - Part 2

- We will prioritise urgent dental care delivery through maintaining a system for UDCs.
- We will support practices and PCNs through the Access Improvement Programme.
- Improvements will be made to remote triage/online consultation access.
- We will Improve direct booking functionality from 111 into practices and extended/enhanced access services .
- We will optimise access models through extended access including new arrangements via the network contract DES from April 22.
- Cancer – PCNs should use data provided to them on the 36k people who have not come into cancer services to support GP practices to identify patients who may have cancer.
- We will continue to support systems and providers with the roll out of two-hour crisis response (UCR) services at scale, ensuring provision is 7 days a week and a minimum of 8am until 8pm, along with enabling and diversifying referral routes into two-hour services from 111, 999 and other services to support admission avoidance and care in the right place. This includes the investment of £273.4 m in 21/22 to support community transformation.

Supporting primary care to help manage the demand for UEC services.

System commitments: what we expect from you

Actions at regional level

Workforce

Work *with systems and Primary Care Networks (PCNs) to* achieve full use of the Additional Roles Reimbursement Scheme funding in 2021/22 to recruit 15,500 FTE by end of 2021/22. 14 roles are included in the scheme, with paramedics and mental health practitioners added to the scheme in April 2021. Continue to work with the ambulance trusts to introduce rotational models for trainee First Contact Practitioner paramedics in PCNs.

Access

Work with ICSs to effectively plan and deliver support to PCNs and practices to develop effective PCN extended/enhanced access approaches which enable use of digital tools in general practice and PCNs.
Continue to support local implementation and uptake of community pharmacist consultation services, from all referral points, working with 111 and GPs.

Dental

Maintaining urgent dental care systems and current contracted activity. Utilising flexible commissioning and local schemes to target highest need with their populations.

Actions at system/ICS level

Workforce

Work with Primary Care Networks (PCNs) to achieve full use of the Additional Roles Reimbursement Scheme. Utilise the PCN Development funding and funding for training hubs to provide PCNs with the support required to recruit, train and retain the additional staff. Continue to work with PCNs to develop system-wide workforce plans.

Access

Use national DFPC funding to provide support to PCNs and practices to enable effective use of digital tools in general practice.
Ensure PCN plans FOR extended/enhanced access form part of a cohesive ICS approach.
Make plans to roll out PCN wide implementation and uptake of community pharmacist consultation services, from all referral points, working with 111 and GPs.

Actions at provider level

At Trust Level

Workforce

Continue to work with PCNs to developed rotational working models where it is appropriate to do so.

At PCN level:

Access

Use new network DES to develop additional capacity to support practices and PCNs across core and extended hours and make better links with IUC system.

At Practice level:

Access

Access support to enable effective use of digital tools in general practice to support improved access and improved practice workflows.
Implement referrals to community pharmacist consultation service for low acuity patients.

Workforce:

Primary Care Networks to use their full entitlement of Additional Roles Reimbursement Scheme (ARRS) funding to recruit additional staff into PCNs.
Continue to support GPs and additional staff through accessing support offers like #LookingAfterYouToo.

Supporting community health services to help manage the demand for UEC services.

System commitments: what we expect from you

Actions at regional level

Continue to support systems with the rollout of two-hour crisis response services.

Support systems and providers in working collaboratively with providers of NHS111 integrated urgent care services.

Where needed, support coordination and linking of 999 ambulance services with community health services.

Ensure systems and providers are working with directory of service (DoS) leads to add services to the DoS to ensure visibility and coverage of two-hour crisis response (UCR) services across the system.

Ensure any local communications campaigns align with national messaging and requirements around two-hour crisis response (UCR) and support the dissemination of national communications.

Actions at system/ICS level

Continue to support the rollout of two-hour crisis response services across the ICS in line with the NHSE/I Operational Planning and Contracting Guidance 2020/21.

Work with providers and DoS leads to profile (add) two-hour crisis response (UCR) services onto the DoS.

Work to understand potential demand for two-hour crisis response (UCR) services from key referral sources including NHS111 and 999 and link with wider UEC work around admission avoidance and care in the right place.

Along with 999 ambulance Trusts and community health service providers develop streamlined referral pathways to support ambulance hear and treat and see and treat.

Actions at provider level

Ensure delivery of two-hour crisis response (UCR) services in line with the NHSE/I Operational Planning and Contracting Guidance 2020/21.

Work with local DoS leads to profile (add) two-hour crisis response (UCR) services onto the DoS.

Work collaboratively with local NHS111, clinical assessment services (CAS) and 999 ambulance Trusts to agree streamlined and well governed referral pathways for clinicians (non-clinician referrals can be agreed locally). This may include validated cat3/4 999 calls.

Work collaboratively with local NHS111, CAS and 999 Ambulance Trusts to engage and support referring clinicians' knowledge and understanding of two-hour services to maximise referrals from these sources, through sharing of comms, CPD events and local feedback mechanisms to share learning.

Continue to monitor numbers of referrals from key sources and identify and address any gaps.

3. Supporting greater use of Urgent Treatment Centres (UTCs).

National commitments: what you can expect from us

Urgent Treatment Centres (Type 3 & 4 services)

- We will, where asked, work with regions and systems to explore the suitability of the UTC model locally, including co-located UTCs alongside ED to manage demand.
    - Alternatives may be other forms of primary care provision in the community, or forms of enhanced streaming and / or triage at the front door of ED.
- We have set clear expectations on what a UTC should offer through the published UTC standards.
- We will work with NHS Digital and NHS X to support and implement direct booking of appointments in all UTCs
- We will support the adoption of the national information booking standard, Care Connect, which aims to standardise appointment booking in urgent care.
- We will promote the adoption of referral pathways into UTCs from NHS 111 and 999.

Supporting greater use of Urgent Treatment Centres (UTCs).

System commitments: what we expect from you

Actions at regional level

Ensure that systems are reviewing demand and capacity for lower acuity urgent and emergency care, and that the status of temporarily closed Type 3 and 4 services is reviewed to ensure capacity is aligned to local demand.

Work with their systems to explore UTCs or other enhanced triage services for lower acuity patients at the front door of ED, where this would address demand and capacity issues.

Actions at system/ICS level

Review capacity and demand across their portfolio of type 3 & 4 services, including those temporarily closed during Covid.

Ensure available capacity and capability of Urgent Treatment Centres is matched to demand, and that UTCs are commissioned and delivering against the agreed UTC standards.

Agree and develop new pathways for lower acuity patients as an alternative to ED, including booking from NHS 111.

Where outstanding, agree long term reconfigurations to adopt the UTC model.

Actions at provider level

Deliver the UTC model and support implementation of new pathways.

Where necessary, enhance current UTC capability and/or capacity to meet demands (e.g. extended hours, enhanced case mix.)

Where this would manage ED demand more effectively, review the need for enhanced triage and/or redirection at ED front door, with an emphasis on primary and community led-provision.

4. Increasing support for Children and Young People.

National commitments: what you can expect from us

Children and Young People

- We will work with our key partners, including PHE/DHSC on national and targeted messages, alerting parents to symptoms and appropriate management for common seasonal illnesses.
- With DHSC, provide a 1.8m fund for Voluntary, Community and Social Enterprise (V.C.S.E) organisations to support self management and provide tailored information to targeted groups of children, young people, families and carers (including the most vulnerable) and carers with seasonal illness in 21/22. The bidding process for this funding will begin in August.
- Issue guidance and case studies to support CCGs / ICSs who wish to establish an Adult and Paediatric (all ages) out of hospital Respiratory Clinical Assessment Services (RCAS) to manage the likely increase in respiratory infections.
- HEE have produced a 'Respiratory Surge in Children programme – e – learning programmes. This includes modules for recognition, management and escalation for CYP across settings.
- We have worked with the Joint Committee on Vaccination and Immunisation (JCVI), partners and the palivizumab manufacturer to mobilise an early programme to identify and protect those at risk of severe complications from RSV.
- We will develop the role of the paediatric workforce to reduce pressure on UEC by **piloting** a national paediatric CAS in 111. This builds on previous work undertaken to place paediatricians into local CAS services. Learning will be shared with local systems.
- We will establish a National Cell specifically to manage actions for Children and Young People.

Increasing support for Children and Young People.

System commitments: what we expect from you

Actions at regional level

To oversee Regional surge planning/mitigations for RSV/seasonal demand in CYP services.

Actions at system/ICS level

To implement agreed surge planning and mitigations for RSV/seasonal demand in CYP services as appropriate.

Actions at provider level

To implement agreed surge planning and mitigations for RSV/seasonal demand in CYP services as appropriate.

5. Using communications to support the public to choose services wisely.

National commitments: what you can expect from us

National communication activity and campaigns

- **Immediate action:** we will undertake a number of activity strands to:
  - Push lower acuity cases to NHS 111 online through a campaign via social media and digital channels (incl. video on demand)
  - Ensure good signposting on nhs.uk.
  - Create a template press release for ambulance services re: pressures.
- **Immediate action:** we will create a suite of materials aimed at people holidaying in England as well as covering when to use NHS 111, GP practices and pharmacy as well as encouraging people to stock up on prescriptions before they go away.

- We will plan and develop a schedule of national communications campaigns and activity to guide patients to access UEC services appropriately (whether online, telephone, face to face).

- We will roll out a campaign to support reducing long hospital stays:
  - With the aim of empowering the patient to being confident to ask questions about their care;
  - as well as push the previous staff engagement campaign to enable better flow within hospitals and understanding system pressures.

- We will develop materials to promote understanding among clinicians of what Same Day Emergency Care (SDEC) services can offer and encourage peer-to-peer conversations/referrals.

Using communications to support the public to choose services wisely.

System commitments: what we expect from you

Actions at regional level

Ensure signposting messaging is accurate and consistent across ICSs and providers in your region.

Amplify national campaigns and cascade regionally.

Ensure take-up of campaigns at provider level i.e. length of stay or flu campaigns.

Ensure local campaigns are consistent with national messaging.

Actions at system/ICS level

Work in partnership to co-ordinate consistent messaging across your ICS area.

Ensure messages/campaigns are shared, where appropriate, to your strategic partners such as local councils and voluntary sector.

Actions at provider level

Ensure promotion of length of stay campaign within your trust.

Work with ICS and regional colleagues to ensure understanding of other system pressures (i.e. NHS 111) before signposting patients to alternative services at busy times.

6. Improving in-hospital flow and discharge.

National commitments: what you can expect from us

Improving in-hospital flow and discharge

Same Day Emergency Care:

- We will support systems to maximise SDEC provision through restoration of workforce and estate to pre-pandemic levels as a minimum, develop further guidance and promote direct access for all appropriate patients (e.g. paramedic referral).
- Working with systems to support acute providers develop short -long term plans for staffing models, estate and facilities to embed this model of care and avoid usage of SDEC areas as a bedded ward.

To support flow in Emergency Departments (CRS):

- We will work through regions to support providers and ICSs to improve patient flow through hospitals; from arrival to discharge.
- We will offer technical and operational support for all providers to adopt the Clinical Review of Standards and the principles of Clinically Ready to Proceed (CRTP), requiring trust wide adoption of and engagement to 'own' ED flow issues.
- We ask systems to support every aspect of seven day working to ensure all patients are seen promptly by a senior clinical decision maker.
- We will work through regions to reduce 12 hour stays in ED, linking ambulance offload difficulties, clinically ready to proceed delays and 12-hour delays.
- We will provide guidance to support for frequent attenders and rough sleepers and people experiencing homelessness to ensure continuity of care and reduced attendances.

Improving in-hospital flow and discharge.

National commitments: what you can expect from us

Improving in-hospital flow and discharge

To support early discharge and reduce in hospital length of stay:

- We will continue working with systems to reduce in-hospital length of stay to levels which remain clinically appropriate and make more efficient use of NHS resources eg utilise data to focus on trusts that are above the mean average for LoS on 21 and 14 days and have greatest potential release of capacity.
- We will continue to drive clinical leadership and engagement to support Discharges and reduce LOS.
- We will support systems to implement the National Operational Hospital Discharge policy.
- We will continue working with systems to maximise flow over seven days, including increasing weekend discharges.
- We will continue working with systems to embed the Discharge to Assess model and ensure that people are efficiently discharged on the correct pathway when they no longer meet the Clinical Criteria to Reside, with a view that the average length of stay in acute care will continue to reduce.
- Nationally we will continue to monitor availability of critical care and specialist beds and support regions and providers in the availability and management of these beds, using the Critical Care Capacity Panel as required to provide strategic oversight and support.
- We will provide guidance to systems on non-emergency patient transport services, this will support rapid discharge and assist in embedding other good practice (rapid access to pharmacy and deployment of cleaning teams).
- We will support systems to increase appropriate referrals to the community pharmacy discharge medicines service (DMS), which is now available in all community pharmacies in England. All NHS Acute, community and Mental Health Trusts can refer into the NHS DMS. Based on the evidence, for every 30 completed NHS DMS referrals, one 30-day re-admission can, on average, be avoided.

Improving in-hospital flow and discharge (SDEC).

System commitments: what we expect from you

Actions at regional level

Assure plans to implement direct referral from GP/111/999 to SDEC / secondary care.
Dedicated regional leadership to support SDEC/ Acute Frailty.
Assure provider plans to restore SDEC provision.
Escalate provider constraints to restoring SDEC minimum requirements to national team.
Assure capital spend for additional SDEC capacity, identifying gaps in estate provision against capital funding.
Identify providers requiring additional support with SDEC modelling.
Communicate new guidance and best practice to providers.

Actions at system/ICS level

Drive system culture and leadership plans to support Direct Referrals into secondary care/ SDEC.
Drive best practice sharing, peer reviews.
Own and monitor improvement programmes.
Drive conversations on capital spend for SDEC activity.
Drive provider plans to deliver SDEC/ AF to minimum standards.
Undertake system wide demand and capacity reviews for SDEC services ensuring these are aligned to ED demand.
Develop/strengthen governance arrangements to support collaboration.

Actions at provider level

Have plans in place to restore SDEC provision 12hrs, 7 days as a minimum.
Promote direct referral provision from GP/111/999 and virtual ward.

Ensure Rapid Demand and Capacity Reviews match ED Demand, supporting patient flow.

Ensure sufficient estate to meet the increase in demand and constraints around IPC.

Avoid usage of SDEC as a bedded ward overnight.

Ensure acute Frailty SDEC Provision 70hrs + per week.

Improving in-hospital flow and discharge (CRS).

System commitments: what we expect from you

Actions at regional level

Assure system plans to measure:

- time to initial assessment for all patients presenting to A&E.
- the proportion of patients spending more than 12 hours in A&E from time of arrival.
- the proportion of patients spending more than one hour in A&E after they have been declared Clinically Ready to Proceed.

Assure system plans to incorporate daily reviews against the metrics, that meaningful conversations are taking place with referring specialties and that long waits are improving.

Actions at system/ICS level

Drive system culture and leadership plans to support CRS.

Drive best practice sharing, peer reviews and case studies.

Own improvement programmes with ongoing monitoring.

Drive provider plans to operationalise CRS metrics with specific focus on mobilisation and implementation plans.

Develop/strengthen governance arrangements to support collaboration.

Actions at provider level

Develop processes to implement time to initial assessment within 15 minutes of arrival.
Early senior review to support early discharge/ admission.
Review proportion of patients residing in ED for more than 12-hours.
All patients presenting to ED will have CRtP recorded.
Timely onward care once a decision has been made that the patient no longer requires treatment in ED and is ready to proceed to their next point of care, or discharged home – within 60-minutes.
Processes in place to review patients in ED longer than 60-minutes when declared CRtP with referring specialities.
Review 12+ hours waits - patients should not spend longer than 12 hours in ED from time of arrival.
Processes in place to treat the sickest patients quickly and departments do not become crowded by those patients who do not require admission into hospital.

Improving in-hospital flow and discharge (reducing length of stay).

System commitments: what we expect from you

Actions at regional level

Undertake data driven conversations, paying particular attention to key metrics to monitor progress.
Drive implementation of the National Operational Hospital Discharge policy
Maximise flow over seven days including increasing weekend discharges.
Drive clinical leadership and engagement to support discharges and reduce LoS .
Promote implementation of the RCP Ward Round/Board Round best practice.
Promote use of Criteria to admit improvement tools.
Continue to identify and work with Trusts of Focus.
Work with ECIST/Improvement colleagues where needed and promote Trust participation in the forthcoming Winter Alliance.

Actions at system/ICS level

Provide robust system leadership and undertake data driven conversations, paying particular attention to key metrics to monitor progress.
Drive implementation of the National Operational Discharge policy
Maximise flow over seven days including increasing weekend discharges
Promote clinical leadership and engagement to increase discharges and reduce LoS
Undertake system wide capacity/service provision gap analysis and apply integrated commissioning approach

Develop/strengthen governance arrangements to support collaboration.

Actions at provider level

Undertake data driven conversations, paying particular attention to key metrics to monitor progress
Drive implementation of the National Operational Hospital Discharge policy
Maximise flow over seven days including increasing weekend discharges
Utilise clinical leadership and engagement to increase discharges and reduce LoS
Promote implementation of the RCP Ward Round/Board Round best practice
Promote use of Criteria to admit improvement tools.
Work with ECIST/Improvement colleagues where needed and actively participate in the forthcoming Winter Alliance.
Building on Transfers of Care around Medicines (TCAM) work with AHSNs, providers should increase referrals into the community pharmacy discharge medicines service, to support safe and timely discharge of patients with complex medicines usage and to reduce emergency readmissions due to medication issues.

7. Supporting adult and children's mental health needs.

National commitments: what you can expect from us

Addressing Mental Health Pressures

• We will continue to increase investment in mental health, with clear published expected investment profiles for each ICS, to:
- improve access and capacity in community based mental health crisis services and alternatives to A&E for children and adults;
- improve access and capacity in adult mental health liaison and CYP equivalent services in ED and general hospital wards; and
- increase dedicated MH capacity in ambulance services to reduce avoidable conveyance to ED.
• Data and analysis: We will develop and share specific mental health data reports from ECDS, split by age at region, ICS and provider level on total attendances, and 12h waits in ED for mental health patients. Intended to bring transparency benchmarking and identify systems with highest mental health pressures for the first time at national.
• We will ensure that all CCGs/providers in England have s.140 compliant MH bed management protocols in place, and all regions have clear MH escalation process.
• We will develop and issue national guidance on open access community MH crisis services, including expectations for access to urgent mental health care via NHS 111 and delivery against proposed new standards.
• We will develop and issue national guidance on adult acute mental health inpatient care (including flow and discharge).
• We will explore strengthening national mechanisms to support integration of NHS/LA mental health services (eg BCF, DHSC social care plan).
• We will work with CQC in relation to closures of CAMHS beds to better align bed capacity and bed demand at system level.
• We will improve integration between CYPMH and acute trusts (with particular focus on supporting the paediatric workforce) through ensuring there are clear pathways and guidance to support joint working, and integration, across physical and mental health.
• We will continue the roll out of CYPMH provider collaboratives.

Supporting adult and children's mental health needs.

System commitments: what we expect from you

Actions at regional level

UEC and MH regional leads to ensure MH integral to winter planning.

Use ECDS dashboards to identify ICS with high/worsening mental health ED pressures, as well as where improvements have occurred.

Bring systems together to share learning.

Ensure all local areas have s.140 compliant MH service escalation in place as well as clear regional process.

Ensure MH funding allocated in line with MHIS; provide system support/challenge where spend not in line with expectations or LTP delivery off track (based on regular assurance returns).

Support use of discharge/LTP MH funding to enable multi-agency discharge planning / admission avoidance across providers CCGs and LAs and VCS, including through MADE events.

Promote and encourage access to staff wellbeing hubs and other initiatives.

Actions at system/ICS level

Promote 24/7 urgent MH helplines locally. Ensure all are profiled onto NHS 111 DoS as a minimum in short term (ahead of formal access to urgent MH care via 111 as per LTP).

Expand capacity and range of alternative spaces to A&E to meet urgent MH needs in the community.

Explore liaison at ED front door to support diversion where possible.

Allocate share of local capital funding for MH capacity pressures.

Ensure MH integration with ambulance response for see and treat to minimise conveyance toE.

Ensure NHS working alongside LA mental health services, including through place-based funding, s.75 arrangements, regular MADE events and use of discharge funding.

In particular, work with LAs on adult bed pressures – by commissioning and developing market of short/long term supported housing and AMHP provision as priorities.

Work with CYP LA services to avoid lengthy delays in ED or paeds wards for CYP with MH needs while awaiting LA input.

Put in place s.140 compliant bed escalation protocols.

Afford funding/operational freedom to provider collabs, embed light touch approach to contracting avoiding lengthy processes.

Actions at provider level

Invest in staff wellbeing initiatives.

Recover face to face care in CMHTs, particularly to prevent relapse for people with SMI to prevent relapse and high acuity presentations to crisis services.

Focus on reducing excessively long LoS in inpatient MH services using approaches such as setting estimated discharge dates, recording purpose of admission, red to green, D2A, 'perfect week'.

Ensure exec clinical/operational oversight of bed escalation and MH inpatient flow, with daily flow meetings, senior alerts for ED waits above 4/6hrs, long stayers in wards.

MH providers should work with the police to reduce avoidable use of s.136.

Acute providers should work with MH services to ensure dedicated MH assessment space available in or near acute hospital sites.

Provider Collaboratives to develop capability to directly sub-commission at place flexibly, including VCS and LA providers, with reduction in l contracting and procurement processes.

8. Reviewing Infection Prevention and Control (IPC) measures to ensure a proportionate response.

National commitments: what you can expect from us

Changes to IPC guidance

Social/physical distancing measures have impacted capacity and operational flow. A review of the IPC guidance is in progress, this should provide an evidence based, proportionate approach to service restoration that protects patients and staff whilst releasing capacity within established estate requirements.

Whilst we await outcomes of this review, we must reiterate the following principles:

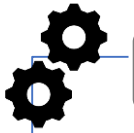
- There should be an expectation of no corridor care.
- Patients should not be left waiting in ambulances for handover to emergency departments.
- Patients and staff in the UEC pathway experience parity of safety with other parts of the health system.

Reviewing Infection Prevention and Control (IPC) measures to ensure an proportionate response.

System commitments: what we expect from you

Actions at regional level

Actions will be formulated following the review of the IPC guidance.



Actions at system/ICS level

Actions will be formulated following the review of the IPC guidance.

Actions at provider level

Actions will be formulated following the review of the IPC guidance.

9. Reviewing staff COVID self isolation rules.

National commitments: what you can expect from us

Staff isolation policy

- COVID-19 absences due to Test & Trace and Self-Isolation in England had been steadily rising from the beginning of June 2021. Guidance for NHS and social care staff was issued 19 July 2021 to address this and has been further updated in August 2021.

Reviewing staff COVID self isolation rules.

System commitments: what we expect from you

Actions at regional level

Monitor the impact of staff absence due to isolation across Regional footprint supporting challenged organisations to take mitigating actions where appropriate.

Actions at system/ICS level

Monitor the impact of staff absence due to isolation across ICS footprint supporting challenged organisations to take mitigating actions where appropriate.

Actions at provider level

Ensure Compliance with updated Staff Isolation guidance.

10. Ensuring a sustainable UEC workforce.

National commitments: what you can expect from us

Workforce

- We will work with the Royal Colleges and other stakeholders to ensure we improve the pipeline for the future by having a long-term plan for workforce across the UEC pathway.
- We will develop new models of acute medicine - such as the increasing utility of SDEC and acute frailty services, as well as the need for increasing consultant presence at the front door to support admission decisions.
- We will address short term staff capacity pressures felt in all patient facing workforce groups, exacerbated by additional time donning and doffing PPE.

Ensuring a sustainable UEC workforce.

System commitments: what we expect from you

Actions at regional level

Ensure sufficient Pillar 1 testing is available to support self-isolation.

Actions at system/ICS level

Work with the local Domiciliary and Care Home market to develop ICS led response to workforce shortages

Actions at provider level

Fully support and engage with staff on local and national HWB offers.

Plan recruitment across 111 services.

Repatriate workforce back to SDEC – looking at new way staffing models/ skill mix.