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| <p>Title:</p> <p>Corporate and NHS Performance Report</p> |
| <p>Lead Director:</p> <p>Karen Wheeler, National Director: Transformation and Corporate Operations Matthew Swindells, National Director: Operations and Information</p> |
| <p>Purpose of Paper:</p> <p>To inform the Board of progress against corporate programmes.</p> <p>To provide the Board with a summary of NHS performance and give assurance on the actions being taken by NHS England and partners to recover, sustain or improve standards.</p> |
| <p>The Board is invited to:</p> <p>Note the contents of this report and receive assurance on NHS England's actions to support corporate and NHS performance.</p> |

Corporate and NHS Performance Report

INTRODUCTION

1. This paper informs the Board of current performance and describes actions being taken by NHS England and our national partners to recover, sustain or improve standards.
2. It is in two parts. The first part considers NHS England's performance against current corporate objectives. The second part considers the performance of the NHS against the NHS Constitution standards and other commitments.

Part 1 – NHS ENGLAND'S PROGRAMMES

3. Mid-year stocktakes of NHS England's priority programmes have been undertaken, with the detailed findings presented to the December meeting of the Audit and Risk Assurance Committee. In summary the stocktakes determined that key progress was being made in delivering NHS England's priorities, with some cross cutting issues identified which require further work to address.
4. Priority programmes have submitted their business planning submissions for 2017/18 and 2018/19. The allocation of programme funding will be signed off at the December meeting of the Board. Alongside this is work to determine how NHS England will work with partners to support the delivery of locally developed sustainability and transformation plans (STPs). NHS England's executive management team are considering the implications of this change of focus in terms of building the capabilities and capacity required within NHS England in order to do this successfully.
5. Additional detail on a number of the corporate priorities is as follows:
 - **Learning disabilities** – Work is on-going on the creation of community provision and reduction of in-patient beds.. A twelve week public consultation on the approach relating to options to closing of Calderstones Hospital and moving in-patients off the Mersey Care Whalley site was launched on Thursday 1 December 2016.
 - **Science and innovation** – Within the 100,000 Genomes programme the DNA sample target was met for Q2 2015/16, and a number of interventions are being taken to improve performance. This include working closely with NHS GMC's Cancer Centres to identify blockages in the patient pathway that need 'unblocking' to expand patient recruitment .
 - **Self-care** – Following work on initial financial modelling the programme is looking at refocussing work based on identifying specific cohorts of patients who will benefit from self-care along with the specific interventions required.
 - **Information technology** – A new Digital Delivery Board (DDB) has been established to replace the previous Informatics Portfolio Management Board and to oversee the Paperless 2020 'Driving Digital Maturity' portfolio on behalf of the wider health and care system. This is chaired by Professor Keith McNeil (Chief Clinical Information Officer, Health and Care System) and attended by Matthew Swindells (National Director: Operations & Information) and Will Smart (Chief Information Officer) from NHS England. Work is underway to support the transition of portfolio management from the Department of Health to NHS England.

6. The following areas are also brought to the Board's attention with relation to the corporate risk register:
 - **Risk 28 Primary Care Services (PCS)** – An overall recovery plan, setting out how and when services will be stabilised and returned to acceptable performance, has been agreed and communicated. The majority of recovery actions for the major services will be completed by March 2017, with significant improvements happening during December and January.

PART 2 – NHS PERFORMANCE

7. In its commissioning oversight role, NHS England continues to work with clinical commissioning groups (CCGs) and NHS Improvement to improve the delivery of services and their associated access and performance standards. This report provides the Board with a summary of the most recent NHS performance data. The report also highlights the actions we have taken with our partners to ensure delivery of key standards and measures. The latest performance data for measures relating to NHS standards and commitments are shown in Appendix B of this report.

Urgent and emergency care

8. A&E performance
Data for October 2016 shows that 89.0% of the 2,001,000 patients attending A&E were either admitted, transferred or discharged within 4 hours. Attendances over the last twelve months have increased by 4.5% on the preceding twelve-month period.
9. There were 493,000 emergency admissions in October 2016. Emergency admissions over the last twelve months are up 2.7% on the preceding twelve-month period.

Delayed transfers of care

10. There were 200,000 total delayed days in October 2016, of which 134,200 were in acute care. This is an increase from October 2015, where there were 160,100 total delayed days, of which 104,100 were in acute care. The 200,000 delayed days this month is the highest figure since monthly data was first collected in August 2010.

Ambulance response times

11. Of Category A calls resulting in an emergency response in October 2016, the proportion arriving within 8 minutes was 67.3% for Red 1 calls and 62.9% for Red 2 calls. 90.4% of Category A calls received an ambulance response within 19 minutes. It should be noted that data on Category A calls are only available for 8 of the 11 Ambulance Trusts. South Western Ambulance Service (SWAS), Yorkshire Ambulance (YAS) service and West Midlands Ambulance Service (WMAS) are participating in the ARP Clinical Coding trial. This means that Category A performance, whilst still reported, is only available for 8 of 11 ambulance services and is no longer comparable with previous months.
12. There were 839,724 emergency phone calls handled in October 2016, an average of 27,000 calls per day. This is higher than the average 25,800 calls per day handled in October 2015, an increase of 4.8%.

NHS 111 performance

13. There were 1,235,035 calls offered to the NHS 111 service in England in October 2016, a 14% increase on the 1,083,628 in October 2015. The number of calls

answered by the service was 1,137,200 in October 2016, a 10.4% increase on answered calls in October 2015. 88.5% of the calls answered by NHS 111 services were answered within 60 seconds; a decrease on the 92% in September 2016 and 91.4% in October 2015. Of the calls triaged by NHS 111 in October 2016, 13.2% had ambulances dispatched and 8.7% were recommended to attend A&E.

14. All NHS 111 providers are submitting trajectories to demonstrate how they will get to the required 30% of calls transferred to clinicians by March 2017. This will be backed up by recruitment plans and the necessary contract variations required to deliver the planned improvements.

A&E improvement plan

15. All A&E Delivery Boards are progressing implementation of the plan, following best practice guidance detailed in the Rapid Implementation Guidance. A Baseline assessment of progress has been supplemented with a survey looking at services co-located with EDs. Both of these showed good progress made in a number of areas. The baseline will be refreshed to gauge progress.
16. An area of particular concern is delayed transfers of care (DToC), where numbers have been rising continuously. A cohort of high risk systems (33) have been identified to be targeted for increased intervention and support, to ensure their DToC reduction initiatives are accelerated. This includes (among other things) a new central support team which will be composed of acute trust CEOs, CCG Accountable Officers and senior ADASS personnel. Between December and March the team will visit the most high risk systems that display a combination of performance challenges including, high DTOC rates (above 8%), a high proportion of delays recorded as NHS related and also where 'Discharge to Assess' home based assessment models are not yet in place. The discussions will agree rapid improvement actions along with support to implement best practice.
17. The other area of urgent focus is streaming/co-located services. Following a similar approach as DToC, a shortlist of high risk systems have been identified who will prioritise and accelerate plans to stand up streaming services at the front door. The requirement is for every single acute provide to have streaming/co-located services during peak hours in the first instance, expanding to 12 hours per day minimum in the medium term.
18. Winter resilience preparations are covered in Appendix C.

Referral to treatment (RTT) waiting times

19. At the end of October 2016, 90.4% of RTT patients were waiting up to 18 weeks to start treatment. The number of patients waiting to start elective treatment at the end of the month was 3.8 million. Of these, 1,427 patients were waiting more than 52 weeks for treatment. During October 2016, 1,013,301 patients began consultant-led treatment.
20. NHS England and NHS Improvement joint regional teams are supporting commissioners and providers to help recover RTT performance in 2016/17 in line with the Sustainability and Transformation Fund improvement trajectories that organisations have committed to.

21. Demand for elective care services continues to increase more than the capacity to treat patients and it will not be easy to recover RTT performance in the short term. However, the joint national oversight and programme arrangements that are now in place continue to mobilise action through regional teams in a co-ordinated way. In particular, commissioners and providers are working to appropriately reduce demand as well as to ensure that there is alternative capacity in place to treat patients who might breach maximum waiting times.
22. We are also developing longer term elective care programmes of work that will identify and promote more innovative models of managing demand.

Cancer waiting times

23. In October 2016, the NHS delivered against the cancer waiting time operational standards, with the exception of the 62 day standard from urgent GP referral to first definitive treatment (performance of 81.1% against a standard of 85%).
24. Work is in progress at five pilot sites across the four regions to test and define the new cancer 28 day faster diagnosis standard. The cancer diagnostic capacity fund has also been allocated to selected providers to demonstrate measureable outcomes to improve diagnostic capacity.

Diagnostic waits

25. A total of 1,795,400 diagnostic tests were undertaken in October 2016, an increase of 7.1% from October 2015 (adjusted for working days). The number of tests conducted over the last twelve months is up 4.7% (adjusted for working days) on the preceding twelve month period. 98.9% of patients waiting at the end of October 2016 had been waiting less than six weeks from referral for one of the 15 key diagnostic tests. Data indicates continued improvement in endoscopy performance in the past 12 months.

Improving Access to Psychological Therapies

26. The NHS Mandate commits that at least 15% of adults with common mental health disorders will have timely access to psychological therapies. In August 2016, an annualised IAPT access rate of 15.2% was achieved, an increase when compared to performance in July 2016 (14.9%) and a slight decrease when compared to June 2016 (16.2%).
27. The rate of recovery has continued to show improvement towards the 50% ambition. In August 2016 the rate was 48.4%. NHS England continues to work on reducing variation, with intensive support focussed on the lowest-performing IAPT providers to improve their recovery rates. In August the recovery rate was met by 93 (43%) of CCGs.
28. IAPT waiting time standards have been met since January 2015. In August 2016, 87.0% of people completing a course of treatment entered such treatment within 6 weeks, against a standard of 75%. The percentage of people completing treatment that began this treatment within 18 weeks was 98.0%, against a standard of 95%.

Dementia

29. In October 2016, the ambition of two-thirds of people living with dementia receiving a formal diagnosis was achieved at 67.7%. This is 0.2% higher than the end-September rate of 67.5%. This ambition has been met and sustained nationally since July 2016.
30. The dementia diagnosis rate is calculated for people aged 65 and over, for whom the end-October 2016 estimate on dementia registers is at 432,492, an increase of 1,018 people compared to September 2016.
31. The number of people of all ages estimated to be on the dementia registers at end of October is 446,475, which is an increase of 1,016 from the end of September 2016.

Early Intervention in Psychosis

32. Performance against the referral to treatment (RTT) element of the standard from the UNIFY collection published on Unify shows 76.6% of people started treatment within 2 weeks in October 2016. Nationally the median waiting time was 1.28 weeks.
33. Delivery of the 2 week RTT requirement is intended to be measured through the NHS Digital's patient-level mental health services dataset (MHSDS) and we will review when this can commence in December.
34. The second component of the EIP standard is that people should receive care in line with NICE recommendations. These NICE recommended interventions have been acknowledged as the more complex component to measure and an approach is being developed, in parallel to workforce development.

Transforming Care for people with learning disabilities

The total number of learning disability inpatients continues to reduce month on month, according to the latest reported data, at the end of Q1 June 2016 there were 2,635 inpatients, and at the end of Q2 September 2016 the inpatient count was 2,590. Most recent data shows that in 2015/16 1,965 people were admitted or transferred 2,095 people were discharged or transferred.

35. Work is continuing as part of the wider operational planning round to assure the inpatient reduction trajectories from local Transforming Care Partnerships which aim to deliver the step-change in provision set out in Building the Right Support, supported by both transformational and capital funding to secure a significant change in the provision of care by 2018/19.

RECOMMENDATION

36. The Board is asked to note the contents of this report and receive assurance on NHS England's actions to support both corporate and NHS performance.

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Date: December 2016

APPENDIX A - NHS England Corporate Risk Register summary

| NHS England Corporate Risk Register Summary - Part One for November 2016 | | | | | | |
|--|--|--|--|--------------------------|---------------------------|--|
| Risk Ref | Risk <i>High-level potential risks that are unlikely to be fully resolved and require ongoing control</i> | Risk Owner | Change in Current RAG Status Since Last Report | Current Gross RAG Status | When Mitigated RAG Status | Date By Which Mitigated RAG To Be Achieved |
| NHS-wide (risk to NHS England) | | | | | | |
| 1 | Major quality problems - risk that there is a quality failure in services commissioned by NHS England. | National Medical Director / Chief Nursing Officer | ↔ | A | A | Apr-2017 |
| 3 | Finances - risk that NHS England is unable to secure high quality, comprehensive services within its financial envelope. | Chief Finance Officer | ↔ | AR | A | Dec-2016 |
| 5 | Relationship with patients and the public - risk that patient voice and public participation is not embedded in everyday work. | Chief Nursing Officer | ↔ | AR | A | Mar-2017 |
| 7 | Urgent care - risk that NHS England has not planned or acted effectively to support delivery of high quality urgent care services in line with patients' NHS constitutional standard. | National Director Operations & Information | ↔ | R | AR | Mar-2017 |
| 12 | Data sharing - risk that commissioners have inadequate access to the information they need for effective commissioning. | National Director Transformation and Corporate Operations/National Director Operations & Information | ↔ | AR | A | Mar-2017 |
| 21 | Transforming Care - risk that NHS England is unable to deliver and/or is unable to demonstrate delivery of all business plan commitments to transform care for people with learning disabilities. | Chief Nursing Officer | ↔ | AR | A | Mar-2017 |
| 22 | The state of general practice - risk that insufficient growth in capability and capacity of primary care to deliver quality of service. | National Medical Director | ↔ | R | AR | Apr-2017 |
| 23 | Devolution - risk to NHS England's operating model and workforce, general capability and capacity, assurance of functions and operational processes to support policy and local devolution initiatives. | Chief Finance Officer | ↔ | A | AG | Dec-2016 |
| 24 | Cyber threats - risk that some commissioners and providers do not have appropriate safeguards in place to protect information from cyber attack and other information security threats. | National Director Transformation and Corporate Operations | ↑ | A | A | Nov-2016 |
| 27 | FYFV implementation - risk that NHS England, working with the wider NHS coalition, does not fully implement commitments made in the Five Year Forward View in time by 2020. | National Director Commissioning Strategy | ↔ | R | A | Nov-2016 |
| NHS England | | | | | | |
| 9 | Specialised services - risk that we are unable to deliver the full range of specialised services in line with appropriate quality standards within the resources available. | Director Specialised Commissioning | ↔ | AR | A | Mar-2017 |
| 11 | Commissioning support services - risks of disruption to service and unfunded costs associated with transition caused by CCGs procuring and transitioning services through LPP | National Director Transformation and Corporate Operations | ↔ | AR | AR | Mar-2017 |
| 14 | Organisation ability to deliver commitments and priorities - risk of supporting so many initiatives and programmes to deliver sustainable system change. | National Director Transformation and Corporate Operations | ↔ | AR | A | Dec-2016 |
| 28 | Primary Care Services - Capita have failed to deliver key aspects of operational service in support of primary care users, putting primary care service and patients at risk. | National Director Transformation and Corporate Operations | ↔ | R | R | Mar-2017 |

Key

| | | | |
|---|---|---|---|
| ↔ | No change in RAG status compared to last report | ↓ | RAG status deteriorated compared to last report |
| | Risks recommended for removal | ↑ | RAG status improved compared to last report |

Summary of Measures Relating to NHS Standards and Commitments

| Indicator | Latest data period | Standard | Latest Performance | Change in performance from previous data period |
|---|--------------------|----------|--------------------|---|
| Patients on Care Programme Approach (CPA) who were followed up within 7 days after discharge from psychiatric inpatient care | Q2 2016/17 | 95% | 96.8% | ↑ |
| IAPT access rate | Aug-16 | 15% | 15.2% | ↑ |
| IAPT recovery rate | Aug-16 | 50% | 48.4% | ↓ |
| People referred to the IAPT will be treated within 6 weeks of referral | Aug-16 | 75% | 87.0% | ↑ |
| People referred to the IAPT will be treated within 18 weeks of referral | Aug-16 | 95% | 98.0% | ↑ |
| Dementia diagnosis rate | Oct-16 | 66.7% | 67.7% | ↑ |
| People experiencing a first episode of psychosis will be treated within two weeks of referral | Oct-16 | 50% | 76.6% | ↓ |
| Maximum two-week wait for first outpatient appointment for patients referred urgently with suspected cancer by a GP | Oct-16 | 93% | 94.8% | ↑ |
| Maximum two-week wait for first outpatient appointment for patients referred urgently with breast symptoms (where cancer was not initially suspected) | Oct-16 | 93% | 96.1% | ↑ |
| Maximum 31-day wait from diagnosis to first definitive treatment for all cancers | Oct-16 | 96% | 97.4% | - |
| Maximum 31-day wait for subsequent treatment where that treatment is surgery | Oct-16 | 94% | 95.8% | ↑ |
| Maximum 31-day wait for subsequent treatment where that treatment is an anti-cancer drug regimen | Oct-16 | 98% | 99.3% | ↑ |
| Maximum 31-day wait for subsequent treatment where the treatment is a course of radiotherapy | Oct-16 | 94% | 97.4% | ↑ |
| Maximum 62-day wait from referral from an NHS screening service to first definitive treatment for all cancers | Oct-16 | 90% | 91.3% | ↓ |
| Maximum 62-day wait from urgent GP referral to first definitive treatment for cancer | Oct-16 | 85% | 81.1% | ↓ |
| Maximum 62-day wait for first definitive treatment following a consultant's decision to upgrade the priority of the patient (all cancers) | Oct-16 | Not set | 88.7% | ↑ |
| Patients on incomplete non-emergency pathways (yet to start treatment) waiting no more than 18 weeks from referral | Oct-16 | 92% | 90.4% | ↓ |
| Number of patients waiting more than 52 weeks from referral to treatment | Oct-16 | 0 | 1,427 | ↑ |
| Patients waiting less than 6 weeks from referral for a diagnostic test | Oct-16 | 99% | 98.9% | ↑ |
| Patients admitted, transferred or discharged within 4 hours of their arrival at an A&E department | Oct-16 | 95% | 89.0% | ↓ |
| Category A calls resulting in an emergency response arriving within 8 minutes (Red 1) | Oct-16 | 75% | 67.3% | ↓ |
| Category A calls resulting in an emergency response arriving within 8 minutes (Red 2) | Oct-16 | 75% | 62.9% | ↑ |
| Category A calls resulting in an ambulance arriving at the scene within 19 minutes | Oct-16 | 95% | 90.4% | ↓ |

| | | | | |
|---|------------|----|------|---|
| Mixed sex accommodation breaches | Oct-16 | 0 | 770 | ↑ |
| Operations cancelled for non-clinical reasons on or after the day of admission not rescheduled within 28 days | Q2 2016/17 | 0% | 6.3% | ↓ |

APPENDIX C

Introduction

1. This paper provides an update to the Board on actions being made across the service to support the system through winter 2016/17. The paper will cover the latest progress, and will set out the next steps.
2. Since the last update to the Board in September 2016, all local A&E Delivery Boards have submitted combined winter and improvement plans, which have been assured by Directors of Commissioning Operations' (DCO) teams and regions. Early progress against the 5 mandated initiatives of the A&E improvement plan has been mapped (please see Annex 1 below), and where gaps have been identified urgent actions are being taken. Additionally, a detailed bank holiday capacity assurance exercise is underway to ensure all systems have services available every day, and the national and regional winter resilience monitoring process has been live since the beginning of November.

Winter Planning Letter and Governance

3. Building on the approach taken in previous years, a joint communication from NHS England and NHS Improvement in the form of a 'Winter Readiness Letter' was sent out to all local A&E Delivery Boards in early October.
4. This letter complemented the formal communications on the A&E Improvement Plan which has already set out the improvements all providers and commissioners are to put in place during 2016/17.
5. Preparations for winter are managed through the local and regional structures and through governance developed for the implementation of the A&E Improvement Plan, with oversight provided by the National A&E Delivery Board. The Regional A&E Delivery Boards comprising NHS England and NHS Improvement teams support delivery of winter resilience, manage high risk systems, report progress, and deploy improvement support. These boards are aligned with the work underway on the Urgent & Emergency Care (UEC) Review, and include regional primary care and NHS 111 leads to ensure all parts of the UEC pathway are represented.

A&E Improvement

6. Since the A&E Improvement Plan was launched in July, all systems have in place executive-led A&E Delivery Boards, and developed combined improvement and winter plans. These have been assured by DCO teams, and implementation has been underway on the five national 'must do's' for some time.
7. A baseline assessment of all systems was conducted in September to gauge early progress, which was supplemented by a survey in October. This showed good progress being made, but also significant gaps in a number of systems.

8. In response, two shortlists of trusts have been identified as high risk – one on streaming/co-located services, and one on delayed transfers of care (DToC). These systems are now required to prioritise getting streaming/co-located services up and running by Christmas, and agreeing ways to rapidly reduce DToC with partner organisations. These systems will also be subject to closer monitoring and intervention.
9. To support this, a central team has been assembled to support a number of systems to reduce their DToC. This team is comprised of senior leaders from trusts, CCGs and local authorities who have a proven track record of successfully reducing DToC. They will target approximately 8 systems to support improvement.
10. Trajectories are being agreed with NHS 111 providers to ensure the ambition of 30% of calls transferred to clinicians is achieved. This will include recruitment plans and contract variations.

Escalation, winter resilience rooms & reporting arrangements

11. The Operational Pressures Escalation Levels (OPEL) Framework¹ was published in late October, and provides new guidance on best practice protocols for system wide escalation.
12. National and regional winter resilience rooms are now up and running. Through these rooms, operational pressures are monitored closely and information fed up through national and regional structures as appropriate.
13. Winter resilience rooms began operating in early November, with full operations running from 1 December to 28 February, at which point they will be reviewed to determine if there is a need for them to continue.
14. The national winter resilience room is staffed by NHS England and NHS Improvement operational teams, as well as having comms and media team representatives, in order to collectively manage pressures as they arise. The national room is hosted in the new national EPRR suite recently constructed in Skipton House.

Investing in stronger primary care

15. All general practice and community pharmacy colleagues have been contacted to set out their formal contract requirements for services over the bank holiday period. Additional primary care actions are also being taken in preparation for winter, to assure patients can receive care as close to home as appropriate:
 - a. £10m support to 882 vulnerable practices
 - b. £16m support to strengthen resilience across a further 1062 practices
 - c. £94m issued to sustain extended access across c. 30% (previous GP access fund schemes)
 - d. £21m to improve access elsewhere – with priority on winter/Christmas/New Years' period
 - e. £5m to cover extra indemnity costs for GPs working out of hours over winter

¹ <https://www.england.nhs.uk/resources/resources-for-ccgs/#operational-pressures>

- f. Established new urgent medicines supply route to divert 200,000 calls to NHS 111 away from GP OOHs to pharmacy, to free up GP time to see more patients

Bank Holiday expectations for the wider system

16. All A&E Delivery Boards have submitted bank holiday capacity plans, covering the following areas:
 - a. Acute care
 - b. NHS 111 (including assurance of NHS 111 DoS – to ensure there are timely updates enabling quick access to appropriate services)
 - c. Out of hours care
 - d. Primary Care (specifically commissioned by CCGs in addition to care available as per normal contracts)
 - e. Community care capacity
 - f. Links with social care
17. NHS England and NHS Improvement teams are assuring these plans; where any gaps are identified, they will provide challenge back to A&E Delivery Boards to ensure there are no service gaps on any days. The expectation is that access to primary care services will be available in every A&E Delivery Board across each day of the bank holiday period.

On-call arrangements across NHS England and NHS Improvement

18. Given the levels of operational pressure normally encountered around or shortly after the bank holiday periods, robust plans must be in place for senior leaders with operational experience to be a part of the on-call system. This will provide crucial oversight to the system during out of hours periods, as well as provide assurance to ministers that the system is being supported to cope with surges in demand.
19. For NHS England, there will be on call rotas at national, regional and DCO level and we will be assuring the arrangements at local A&E Delivery Board level, to ensure that appropriate on call arrangements are in place, including for CCGs.
20. NHS Improvement is also in the process of reviewing and strengthening its own on-call arrangements, with a particular focus on how this will align with NHS England.

General and acute bed occupancy and elective pacing

21. In preparation for managing winter pressures it is recommended that providers 'pace' their elective work, by introducing elective breaks where trusts cease most elective activity and focus on treating emergency activity. By optimising elements of elective care in the lead up to Christmas, and continuing during the winter months a sustainable level of throughput can be maintained whilst accommodating increased hospital activity due to winter pressures. All providers were written to formally to advise them of this requirement, and NHS Improvement are currently assuring provider elective pacing plans.
22. As per the winter planning letter, all acute providers will be aiming to reduce their general and acute (G&A) bed occupancy to 85% from 19 December to 16 January. This will enable providers to accommodate anticipated increases in non-elective demand during this period.

Public Stay Well Campaign

23. The Stay Well This Winter campaign is run by NHS England and Public Health England, with additional support from local NHS trusts, local authorities, charities and commercial sector partners.
24. Following the strong performance of the Stay Well This Winter campaign in 2015/16, we have refined the campaign for winter 2016/17.
25. The campaign will continue to deliver simple advice on the evidence-based behaviours people should adopt to keep themselves out of hospital. The focus for winter 2016/17 will be on the two most important: flu vaccination, and getting advice from a pharmacist at the first signs of a cold or flu.
26. The campaign objectives are:
 - a. To prompt a minimum additional 1.2 million visits to pharmacies, to seek advice and/or treatment for seasonal illnesses, among people who are at-risk of hospital admission, between October 2016 and March 2017, measured by tracking study data.
 - b. To ensure that at least 70% of people in the target groups have either taken up their invitation for the seasonal flu vaccination or are very/definitely likely to do so by end of November 2016, as measured by the tracking study.
27. The campaign is being delivered in four phases, which focus on different 'stay well' actions during the campaign period:
 - a. Phase One: 10 October to 30 October 2016 - Get a flu vaccination.
 - b. Phase Two: 7 November to 11 December 2016 - Seek immediate advice and help from a pharmacist as soon as you start to feel unwell, before it gets more serious / get a flu vaccination.
 - c. Phase Three: 12 December to 25 December 2016 - Stock-up on medications ahead of the Christmas break / Seek immediate advice and help from a pharmacist as soon as you start to feel unwell.
 - d. Phase Four: 26 December 2016 to 4 March 2017 - Seek immediate advice and help from a pharmacist as soon as you start to feel unwell, before it gets more serious.
28. Phase one has been completed and the second phase of the campaign started on Monday 7th November.

Flu

29. The Annual Flu Plan and Flu Letter were published in May 2016. This set out information for service providers on the seasonal flu immunisation programme and the necessary information to help local areas prepare for vaccinating eligible groups with the seasonal flu vaccine.
30. Key areas of progress for 2016/17 include:
 - a. Extending the flu immunisation programme to all children of appropriate age for school year three.
 - b. Setting uptake ambitions for all groups who are eligible for the flu immunisation to help focus local action.

- c. Under the [CQUIN](#) scheme, NHS Trusts will be rewarded financially for improving the uptake of flu vaccine for front line staff.
- d. Using behavioural insights to modify the national invitation template letter that is available for schools and GP practices to use.
- e. GP best practice guidance for increasing influenza immunisation uptake among children, based on evidence and best practice examples, was published in June 2016.
- f. Developing resources for the nursery and preschool sector to signpost parents to GP practices for flu immunisation of preschool children.

31. Latest flu vaccine uptake data (for week 44 – ending 06/11/2016) shows that uptake rates are currently higher for all groups than the same week last year.

32. NHS Improvement are leading on the drive to ensure as many provider based staff as possible have had a flu vaccination.

Conclusion

33. To summarise, winter preparations are well underway, and are in a strong position building on the work from previous years. The Board are asked to note progress to date.

Accident and Emergency Improvement Plan Initiatives

- 1. Streaming at the front door – to ambulatory and primary care.**
This will reduce waits and improve flow through emergency departments by allowing staff in the main department to focus on patients with more complex conditions.
- 2. NHS 111 – increasing clinical call handler capacity in advance of winter.** This will decrease call transfers to ambulance services and reduce A&E attendances.
- 3. Ambulances – DoD and code review pilots; HEE increasing workforce.**
This will help the system move towards the best model to enhance patient outcomes by ensuring all those who contact the ambulance service receive an appropriate and timely clinician and transport response. The aim is for a decrease in conveyance and an increase in ‘hear and treat’ and ‘see and treat’ to divert patients away from the ED.
- 4. Improved flow – ‘must do’s that each Trust should implement to enhance patient flow.**
This will reduce inpatient bed occupancy, reduce length of stay, and implementation of the ‘SAFER’ bundle will facilitate clinicians working collaboratively in the best interests of patients.
- 5. Discharge – mandating ‘Discharge to Assess’ and ‘trusted assessor’ type models.**
All systems moving to a ‘Discharge to Assess’ model will greatly reduce delays in discharging and points to home as the first port of call if clinically appropriate. This will require close working with local authorities on social care to ensure successful implementation for the whole health and care system.