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Operational resilience and capacity planning for 2014/15

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Operational resilience and capacity planning for 2014/15

First published: 13 June 2014

Prepared by NHS England, the NHS Trust Development Authority, Monitor, and the Association of Directors of Adult Social Services

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Introduction

Following the pressure experienced during the winter of 2012/13, NHS England published the A&E Recovery Plan[1] in May 2013. The plan brought together the national and regional 'A&E tripartite' panels, comprised of representatives from NHS England, the NHS Trust Development Authority (NHS TDA), Monitor, and the Association of Directors of Adult Social Services (ADASS). The plan also called for the creation of Urgent Care Working Groups (UCWGs).

After the success that UCWGs have achieved in the past year, there is now a need for these groups to build upon their existing roles, and expand their remit to include elective as well as urgent care. They will now become the forum where capacity planning and operational delivery across the health and social care system is coordinated.

Bringing together both elements within one planning process underlines the importance of whole-system resilience and that both parts need to be addressed simultaneously in order for local health and care systems to operate as effectively as possible in delivering year-round services for patients. It is imperative that resilience is delivered while maintaining financial balance. There can be no trade-off between finance and performance.

Whilst winter is clearly a period of increased pressure, establishing sustainable year-round delivery requires capacity planning to be ongoing and robust. This will put the NHS, working with its partners in local authorities, in a position to move away from a reactive approach to managing operational problems, and towards a proactive system of year round operational resilience.

The introduction of the Better Care Fund brings additional opportunities for working across health and social care. The presence of all health providers and commissioners, as well as local authorities and social care partners, on these groups will be crucial to delivering an integrated approach.

This document sets out in detail the planning arrangements and requirements for the coming year. It describes the mechanisms for monitoring delivery and allocating non-recurrent funding.

More broadly, the work undertaken by local systems this year will set the ground work for the longer term changes to strategic and operational delivery that will be brought about by outputs from the Urgent and Emergency Care Review. The review and its proposals will have a clear impact on the operation of UCWGs within local systems[2].

The key elements of a ‘System Resilience Group’

Role and remit

The creation of UCWGs presented a unique and valuable opportunity for all parts of local health and social care systems to co-develop strategies and collaboratively plan safe, efficient services for patients. Following on from the successful work UCWGs have undertaken since their creation, their next evolution is to expand their role to cover elective, as well as non-elective care. This shift is reflected in the change in name of UCWGs to System Resilience Groups (SRGs).

SRGs are the forum where all the partners across the health and social care system come together to undertake the regular planning of service delivery. The group should plan for the capacity required to ensure delivery, and oversee the coordination and integration of services to support the delivery of effective, high quality accessible services which are good value for taxpayers.

Membership

Each SRG should normally be chaired by a senior leader from the CCG(s) represented on the group. All local provider, commissioner, and social care organisations should have membership in the group, in order for plans to be developed and agreed by representatives from across the health and social care system. SRGs may also wish to consider independent or voluntary sector representation.

There should be a particular emphasis on a broad range of clinical representation in the groups’ membership, to ensure elective and non-elective pathways can be regularly reviewed and revised.

It is particularly important that all care providers are represented – especially ambulance services, mental health care and primary and community care providers, and play a key role in delivery

Responsibilities

Across the group, there should be rigorous and ongoing analytical review of the drivers of system pressures, so that solutions to these pressures may be developed with a collaborative approach.

Whilst decisions on any aspect of funding will inevitably need to be made by the relevant statutory body or through shared governance arrangements where pooling is in place, the SRG has a key role in building consensus across members and stakeholders and advising especially on the use of non-recurrent funds and marginal tariff.

Members of SRGs should seek to hold each other to account for actions resulting from internal review, with member organisations sharing intelligence and pooling resources where possible, to improve system delivery against agreed key performance indicators. These arrangements do not supersede accountabilities between organisations and their respective regulators.

The plan

It is crucial that SRGs develop operational resilience and capacity plans by involving all key local organisations, in order to fulfil both planning requirements and ensure good system working in the future. These plans, collaboratively developed and signed-off by all SRG member organisations, have a number of mandatory elements that need to be included.

Good practice

Inclusion of these principles is an essential planning requirement that all plans must comprehensively cover. It is vital that plans demonstrate how organisations will implement all non-elective and elective care good practice requirements (pages 8 and 9). Where good practice requirements are already in place, plans must demonstrate this, and illustrate how these will continue to be sustained during times of significant pressure. Plans must be clear about how they will contribute to maintaining or improving financial performance.

Wider considerations

Plans need to comprehensively cover all wider planning elements (pages 10 to 13). In addition to good practice, plans must demonstrate that organisations are taking into account the wider context in which each SRG operates.

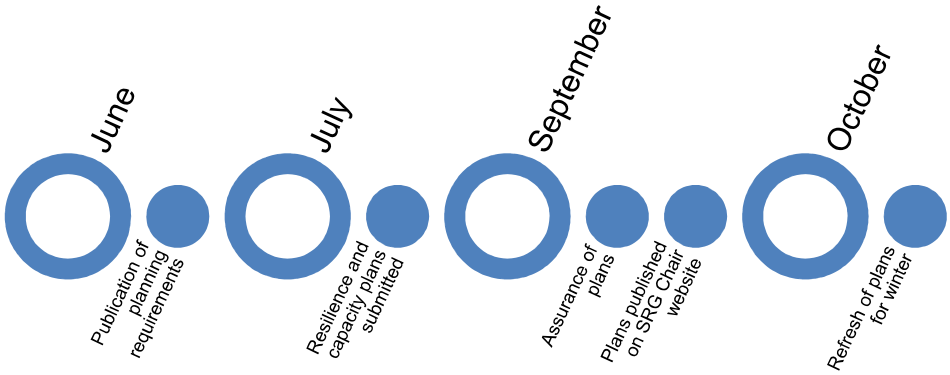
Governance

Whilst SRGs are not statutory bodies and hence have no formal binding decision making role, governance is especially important in describing the underpinning arrangements and any links with delegated authority arrangements from statutory bodies (pages 14 to 16).

Building on existing work

Operational resilience and capacity plans must align with and build upon capacity planning already being done throughout the system, including flu planning, to ensure elective plans in particular, contain all necessary quantitative and qualitative information for assurance and triangulation. Any mapping already being done should form an annex of operational resilience and capacity plans.

Key dates for organisations involved in submitting plans are given below:



Final SRG plans should be submitted to the relevant area team by 30 July.

Details regarding specific non-recurrent monies allocated to each CCG will be provided separately to this document.

Principles of good practice

These are the core aspects of good practice that local systems must include in their planning for 2014/15, using the templates in Annex A. Case studies will be made available online providing examples of successful schemes from 2013/14.

For non-elective care pathways

Planning

- **Enabling better and more accurate capacity modelling and scenario planning across the system** to successfully accommodate normal variation in non-elective demand, as well as modelling to consider how to plan for capacity for the following day. Examples of this, as well as details of where organisations can find support ,are located in the annexes.
- **Working with NHS 111 providers to identify the service that is best able to meet patients' urgent care needs**. For NHS 111, the Directory of Services (DoS) provides a vehicle for commissioners to map locally available urgent care services. It is important that the DoS is accurate, up-to-date and clinically valid, with commissioners and clinical leads fully engaged in reviewing disposition data, using it as a tool to help re-design local services so that they are more efficient and responsive.

Primary care

- **Additional capacity for primary care**, as part of local integrated strategies for supporting out-of-hospital care and wider community services[3]. This should include seven day working across the whole system, adoption of ambulatory care, and ensuring that where possible, the system is not running at or near 100 per cent. This should also extend to schemes relating to proactive care and avoiding unplanned admissions[4]. Plans sholud demonstrate comprehensive flu planning in line with guidance published by Public Health England in April 2014[5].

Seven day working

- **Improve services to provide more responsive and patient-centred delivery seven days a week**. This is in line with the fundamental elements required of commissioner plans in *Everyone Counts: planning for patients 2014/15 to 2018/19[6].*
- **SRGs should serve to link Better Care Fund (BCF) principles[7] in with the wider planning agenda.** This will support integrated seven day working across health and social care organisations.
- **Seven day working arrangements** in place for social care workers to facilitate hospital discharge, brokerage of packages of care, and senior social care management sign off of delayed transfers of care.

Patient experience

- **Expand, adapt and improve established pathways for highest intensity users within emergency departments**. To ensure these groups of patients get timely, consistent care in line with established best practice, pathways should be reviewed to maximise effectiveness. Highest intensity user groups will vary from one emergency department to another. Organisations will want to review the pathways for the group(s) most relevant to them (e.g. frail/elderly pathways[8], minors pathways[9], and mental health crisis presentations[10]) and there must be evidence of sign-up to local Mental Health Crisis Care Concordat arrangements[11].
- **Have consultant-led rapid assessment and treatment systems (or similar models) within emergency departments and acute medical units during hours of peak demand** to ensure swift, sound clinical decision-making and effective use of staffing and other resources. A large body of work has been produced to support this by the College of Emergency Medicine[12].
- **All parts of the system should work towards ensuring patients' medicines are optimised prior to discharge**. This is in line with British Geriatric Society (BGS) guidance[13] to help prevent avoidable readmissions.
- **Processes to minimise delayed discharge and good practice on discharge**, for example use of 'Trusted Assessors' [14] or 'Discharge to Assess'[15] process, which have both met with success in pilot areas. This is in conjunction with early notification to social care.
- **Plans should aim to deliver a considerable reduction in permanent admissions of older people to residential and nursing care homes**, whilst at the same time striving for a considerable increase in the proportion of older people who are still at home 91 days after discharge from hospital into reablement/rehabilitation services[16].
- SRG plans should utilise patient risk stratification tools, with an aim to gaining a **better understanding of the needs of the 2-5 per cent of highest risk patients** within their local population, and in order to commission appropriate alternatives to hospital care. This should then inform appropriate data sharing between local partners to support delivery.

Measurement

- **The use of real time system-wide data**, including the development of performance measures for non-acute providers, directories of services, and principles of intelligent data use that extend beyond emergency departments. This should link in with and build upon work already being done on community service indicators.

For elective care pathways

The NHS Elective Care Intensive Support Team (part of NHS IMAS) have helped in developing the following principles and guidelines for delivering efficient elective care pathways, as part of more detailed recommendations on elective care[17]. More information about NHS IMAS can be found in Annex D.

Planning	• Review and revise patient access policy, and supporting operating procedures. The policy should include reference to cancer and other urgent patients, and should be made accessible to patients and the public. A revised policy should be publicly available by September 2014. • Develop and implement an referral to treatment (RTT) training programme for all appropriate staff, focussing on rules application, and local procedures, ensuring all staff have been trained during 2014/15. • Carry out an annual analysis of capacity and demand for elective services at sub specialty level, keeping under regular review and updating when necessary. This should be done as part of resilience and capacity plans and then updated in operating plans for 2015/16.
Building on existing work	• Build upon any capacity mapping that is currently underway, and use the outputs from mapping exercises as an annex to operational resilience and capacity plans. This will avoid duplication and integrate capacity mapping into 'business as usual' arrangements.
Pathway design	• Ensure that all specialties understand the elective pathways for common referral reason/treatment plans, and have an expected RTT 'timeline' for each (e.g. decision to admin by week x). This should be in place by September 2014 in order to ensure that activity is maintained at a level where waiting lists remain stable. • Ensure that 'patient choice' and patient rights under the NHS Constitution are well communicated across elective care. • 'Right size' outpatient, diagnostic and admitted waiting lists, in line with demand profile, and pathway timelines (see IMAS capacity and demand tools - a link to the IMAS website is available in Annex D).
Measurement	• With immediate effect, review local application of RTT rules against the national guidance, paying particular attention to new clock starts and patient pauses. • Pay attention to RTT data quality. Carry out an urgent 'one off' validation if necessary (or if not done in the last 12 months), and instigate a programme of regular data audits. • Put in place clear and robust performance management arrangements, founded on use of an accurate RTT patient tracker list (PTL), and use this in discussion across the local system. • Ensure that supporting KPIs are well established (size of waiting list, clearance time, weekly activity to meet demand, RoTT rate, etc) and are actively monitored.
Governance	• Provide assurance during quarter two 2014/15 at Board level on implementation of the above.

Wider planning considerations for SRGs

Planning

- **Discharge planning.** SRGs can support improved discharge by ensuring that there are systems in place which allow multi-professional teams to standardise the approach to discharge planning across existing organisational boundaries, enabling active case management of patients with complex needs as they move across organisational boundaries. This will enable organisations to see and understand the flow of patients through beds and emergency care services in all organisations within the SRG.
- Member organisations of SRGs should work to **avoid inappropriate delays** in see and treat and subsequent discharge in A&E, thereby avoiding unnecessary overcrowding and promoting efficient clinical care.
- **Working with ambulance services.** About 31 per cent of attendances at emergency departments arrive by ambulance. SRGs should look to make sure ambulance services have access to live information from emergency departments to help distribute workloads between departments, develop area-wide capacity management systems that dynamically regulate flows between hospitals, and agree protocols for referrals between ambulance trusts and other providers.
- **Unscheduled care.** Demand for unscheduled care has risen steadily, meaning commissioners need to focus on the causes of that rise and act to avoid unnecessary episodes. SRGs should make sure expertise and resources inform and prioritise commissioning decisions.
- **Flu planning**. SRGs should submit plans that include robust and flexible preparations for the unpredictability of flu, and should meet all vaccination requirements, extending to voluntary and independent sector organisations where appropriate.
- Plans must be clear about how they will contribute to **maintaining or improving financial performance.**
- Plans should also demonstrate that organisations are considering how to **manage referrals effectively** and to ensure that all referrals are appropriate and reflect best practice.

Patient experience

- **Right care, right time, right place.** SRGs should facilitate open access with guidelines, and eliminate unnecessary gate-keeping, improve guidance and information for patients, and work to enable ambulances to take patients to urgent care centres (e.g. primary care centres, minor injury units or walk-in centres), and to access social care and mental health teams. SRGs may wish to explore opportunities to create for peak time, out of hours and bank holidays co-located urgent care centres with emergency departments where this is feasible, to provide effective alternatives to those patients who present at A&E and who could be seen by a GP.
- **Children's services.** Children and their parents or guardians should be able to access appropriate emergency care as close to home as possible. SRGs should communicate with local children's networks and specialist clinical networks to understand local needs, develop opportunities for care at home, and ensure children and families are consulted wherever possible on aspects of service redesign.
- **Mental health services.** In up to five per cent of visits to emergency departments, the patient has a primary diagnosis of mental ill health. SRGs need to ensure that mental health trusts are represented on networks and that emergency care is considered by local mental health implementation teams, and must identify individuals in mental health trusts and emergency departments who are responsible for liaison between the organisations.

Chronic conditions and home care

- **Caring for patients with chronic conditions.** In light of a high proportion of emergency admissions arising from an exacerbation of a chronic disease, SRGs should promote better self-care support for patients and case management techniques for those with more complex conditions, and consider auditing common re-admissions – patients who have more than three admissions per year.
- **Planning for care home residents.** SRGs should recognise that many care home residents have chronic health problems. Regular health surveillance decreases the risk of hospital admission, so should consider joint mapping requirements and calculating the appropriate occupancy to make sure beds are available at short notice, and should ensure regular primary care visits for residents with chronic conditions. SRGs should work towards whole system escalation plans which are predictive, not reactive. There should be planned distribution of services across a locality to avoid duplication.

It is important that operational resilience and capacity plans take account of the contribution which can be made by all NHS and social care funded providers, which includes the independent and voluntary sectors.

Engagement with the independent and voluntary sectors

Early engagement with the independent and voluntary sectors will enable local systems to understand the full picture of available capacity to deliver resilience in urgent and elective care.

It also enables the independent and voluntary sectors to better understand the needs of commissioners, including any aspects of current models of care which may need to flex to meet changing needs.

An example capacity template to aid planning and engagement with these sectors is provided in Annex C (p25).

Capacity planning

All resilience plans should describe how systems have identified and engaged with each of the following in their local areas:

- Independent and voluntary sector providers of elective care
- Independent and voluntary sector providers of step-up/step-down care (including homecare provision)
- Other voluntary sector providers

A model template for describing a snapshot of local independent and voluntary sector capacity is included at Annex C. In the absence of any other template which has been agreed with local independent and voluntary sector providers, systems should complete this template as part of their capacity plans.

The majority of the information set out on the template can be populated from information found on the Care Quality Commission website[18]. Providers adding locality specific information such as contact details and any comments to be included in the 'notes' column. This model template has been agreed with national representatives of the independent and voluntary sectors, and is not thought to include any commercially sensitive information.

Systems should also describe local agreements reached on the approach to updating this capacity map to inform operational working. Approaches will depend on local circumstances and may differ between providers of elective and non-elective care. Examples of good practice will be made available online.

Local approaches should take into account the principles of choice, and wherever possible ensure that choice can be exercised effectively at the start of a patient pathway rather than expecting or requiring patients to be redirected during their care. Notwithstanding that principle, there will need to be a balance between the primacy of choice and the best use of scarce resources, for example in the case of patients ready for discharge from an acute hospital bed but whose first choice of care home is not available.

Pricing

In the absence of a national tariff for step-up/step-down care or for other services provided by the voluntary secto, it will be necessary for price negotiations to be undertaken locally. Work is being undertaken between ADASS and the Local Government Association to develop a set of commissioning standards from which local authorities (and partners) will be able to self-assess their position in respect of best practice, and is expected to be available later in the year.

In the absence of any other local agreements, systems should also follow the principles of this guidance for NHS-funded care. For elective care, clearly the national tariff provides a steer, but, consistent with the National Tariff Document[19], local variations may be agreed.

Governance

Plans should set out how systems will involve local independent and voluntary sector providers in their governance arrangements. Depending on local circumstances, this may include formal representation on local governance groups, or may be delivered through clear stakeholder engagement arrangements linked to those groups.

The Social Action Fund	This is a joint fund between the tripartite and the Cabinet Office. This is to be used to develop the potential of services that use social action to help older people stay well, manage their conditions or recover from illness or injury, and thereby reduce growing pressure on hospitals. Currently such services are small in scale and piecemeal – often they are not robustly evaluated.
The tripartite is working with Cabinet Office on a £2 million fund to scale up and robustly test interventions that use social action to reduce demand on hospital services by the elderly, with funded projects making their impact over the course of winter 2014/15.	The Cabinet Office's Centre for Social Action[20] and the tripartite have therefore launched this fund with the objective of scaling up and robustly testing a small number of social action services over winter 2014/15, with a view to mainstreaming successful interventions further down the line.
	By March 2015, the aim for each project that is funded will be to have: - made a significant impact in its local area over winter 2014/15 - developed a robust evidence base on its effectiveness - laid the foundations for the service to continue and grow on a long-term, mainstream basis.

As part of planning for both elective and non-elective care, SRGs should ensure that there is a link-up between principles incorporated within the wider planning agenda, such as the Care Act 2014 and the Better Care Fund.

The Care Act 2014	**The introduction of a new national minimum eligibility threshold to access adult care and support**. This maintains and in some places widens eligibility and provides clear assurance on the minimum level of access to care and support that local authorities will meet.
SRGs will be need to ensure they are aware of the main components of the Care Act 2014. This is essential as the Act fundamentally changes the way social care providers and their partners support vulnerable people and their carers in the community.	**Introduction of preventative regulations**. This will require all Councils and their partners to consider preventative approaches to avoid a deterioration in their circumstances.
	The introduction of a cap on care costs and an extension to means tested support. This will mean that councils provide more people with financial help with their care costs so that people no longer only receive support if they have less than £23,250 in assets
	New criteria to assess carers. This will ensure that there is a statutory requirement to assess the needs of carers and consider a range of services to support their eligible needs.
	The need for SRGs to be aware of the **new statutory responsibilities for safeguarding**.
The Act was passed on 14 May 2014, and the key elements include:	The Care Act also consolidates the 2003 Delayed Discharges Act and is a re-working of relevant statutory guidance. It is therefore timely for SRGs to ensure they are aware of current guidance, for example the "Monthly Delayed Transfer of Care SitReps: Definitions and guidance. Version 1.07 says : "Figures on delayed transfers of care must be agreed with the Directors of Social Services, in particular those whose residents are regular users of hospital services. Trusts will need to have a secure and responsive system with local social care partners, which will enable these figures to be agreed by an appropriate person acting in the authority of the Director of Social Services within the necessary timescale for returning data."
	It is essential that SRGs are aware of the new regulations and take steps to ensure they are considered within the overall strategic approach to avoid hospital admissions and to ensure a speedy discharge from hospital.

The Better Care Fund The £3.8bn Better Care Fund (BCF - formerly the Integration Transformation Fund) was announced by the Government in the June 2013 spending round, to ensure a transformation in integrated health and social care.	The BCF provides an opportunity to transform local services so that people are provided with better integrated care and support. It encompasses a substantial level of funding to help local areas manage pressures and improve long term sustainability. The Fund will be an important enabler to take the integration agenda forward at scale and pace, acting as a significant catalyst for change.
	The Fund provides an opportunity to improve the lives of some of the most vulnerable people in society, giving them control, placing them at the centre of their own care and support, and, in doing so, providing them with a better service and better quality of life. It will support the aim of providing people with the right care, in the right place, at the right time, including through a significant expansion of care in community settings. This will build on the work CCGs and councils are already doing, for example, as part of the integrated care 'pioneers' initiative, through Community Budgets, through work with the Public Service Transformation Network, and on understanding the patient experience.
	The BCF is a critical part of, and aligned to, the NHS two year operational plans and the five year strategic plans as well as local government planning that have been developed. As part of operational resilience and capacity planning for non-elective care, SRGs should serve to link (BCF) principles in with the wider planning agenda - this will support integrated seven day working across health and social care organisations.

Governance process for preparing and monitoring local plans

Operational resilience and capacity plans should be prepared and signed-off by the representatives of the SRG, utilising the staffing resource of member organisations as appropriate in their production. SRGs should use the following guidance when planning governance arrangements for the coming year and beyond. The information presented in this section should also be used to inform how SRGs operate in-year, when planning and delivering both elective and non-elective care.

A range of support organisations and resources to aid planning and delivery are given in detail in Annex D (page 26), and for provider organisations, an example care flow model is provided in Annex B (page 23). The incorporation of elective care resilience planning into the responsibilities of SRGs is additional to the tasks required of them last year.

However, bringing together both elements within one planning process underlines the importance of whole-system resilience and that both parts need to be addressed simultaneously in order for local health and care systems to operate as effectively as possible in delivering year-round services for patients. Although many of the member organisations of the SRG involved in planning for urgent and emergency care may be the same as those involved for elective care, SRGs may still wish to review and expand membership if needed, when developing plans for elective care.

SRG overview

The broad focus of an SRG should be to:

- Determine service needs on a geographical footprint;
- Initiate the local changes needed; and
- Address the issues that have previously hindered whole system improvements

SRGs offer a powerful opportunity to improve care for patients by, for example, fully integrating emergency healthcare development with primary care (where most unscheduled care takes place). In some areas SRGs have already helped to establish more patient-centred care and are encouraging shared learning across health and social care communities by working in partnership.

The overarching goals for SRGs are two-fold: to bring together both urgent and planned care and to enable systems to determine appropriate arrangements for delivering high quality services.

Successful SRGs should work across boundaries to improve patient experience and clinical outcomes, by establishing partnerships and better working relationships between all health and social care organisations in a geographical area and health community. SRGs can work towards these goals by agreeing and developing local standards and protocols to underpin audit and training; developing and sharing infrastructure, for example data metrics and policy documentation; and by developing a mechanism in order to improve and spread knowledge and skills throughout the whole system.

An SRG's terms of reference set out its parameters and guides its output. The terms of reference should specify the areas of care that the SRG will focus on and how its performance will be measured.

The membership of SRGs will vary from area to area, depending on the aims of the groups and local circumstances. However, core membership will likely include representatives from: CCGs, acute trusts, ambulance trusts, local authorities (especially public health and social services), mental health trusts, area teams, crisis and rapid response teams, community providers, children's services, and patient/public voice representatives or a patient/carer forum so that genuine challenge from a patient experience perspective can be made.

SRGs may benefit from seeking support from representatives of dental services, pharmacy, local education authorities, minor injuries units and walk-in centres, out-of-hours providers, and other networks/collaborative leads.

In developing terms of reference each SRG needs to consider the targets, standards, plans and progress of other relevant work streams in the local health economy. CCGs are responsible for the performance of the SRGs and are expected to make the appropriate arrangements for delivery and assurance.

There is a definite need for SRGs to have strong clinician representation and leadership. This is to provide expert advice focussing on improving outcomes across the whole urgent care system, and encourage senior clinician in the implementation plans that will deliver better outcomes for patients.

Reporting arrangements The use of funds to strengthen resilience and transform urgent and elective care should be transparent within each system	This would include a clear presentation on the agreed use of the 70 per cent marginal tariff funding to full SRG representation and a discussion involving the full group on the use of any other non-recurrent funds to support system resilience. A final plan for the use of resilience funding should be agreed at an SRG meeting including agreement of relevant and specific KPIs for each scheme. All members of the SRG must be signed up to the plan in order for it to be assured. Area teams and regional panels can offer advice if support is required by the membership ahead of sign-off .
	The SRG should receive on a monthly basis an update on the use and impact of non-recurrent resilience funding. Many (but not all) systems have operated this form of transparent approach to date.
	All members should sign-off proposals for the use of non-recurrent resilience funds. The SRG Chair will be held to account for the use of non-recurrent funding in the local system. The Chair will be responsible for proposing any change of use of non-recurrent funding to the regional tripartite panel. This increases both the accountability and responsibility of the Chair of the SRG, but does not however remove individual accountability from all members of the SRG in signing up to and ensuring delivery of plans.
Role of the Chair The strongest SRGs will have members that hold each other to account for the delivery of agreed actions to improve resilience across local systems, and thus the role of the Chair is crucial in developing such an approach.	The Chair of the SRG has responsibility for smooth running, and including and supporting all members to hold each other to account for improving system delivery using a clear set of agreed KPIs and a dashboard. In holding a system to account the regional tri-partite group will do this through the Chair of the SRG, as well as through the provider CEOs.
	The Chair of an SRG would normally be a senior leader from a CCG, such as the Chair or nominated Clinical Lead. The relevant area team should work with SRG Chairs who need support and development to help them to succeed in their role.
Independent analytical review of 2013/14 Each local system is expected to have undertaken a rigorous independent analytical review of the drivers of pressure in 2013/14 to inform their planning for 2014/15. Many systems have completed this form of review and are well placed to develop demand, capacity and resilience plans based on evidence that identifies the real drivers of pressure.	Systems that have not undertaken such a review are expected to do so and complete this work including presentation of the findings and sharing of a written report to the full SRG by the end of July. Commissioners and providers are expected to make available the data necessary to complete such a review.
	This form of review should cover: • The level and drivers of increased demand • Whether acuity and complexity has actually increased • Whether there is any redistribution of demand • Changes to the volatility of demand • Reduced capacity in trusts to meet demand • Increased resource use in response to demand

Identifying local needs

A crucial step in maximising the effectiveness of a local SRG is to identify problems by asking:

• What is working well?

• What areas can be improved?

• Where are delays occurring?

To answer those questions, SRGs should consider process-mapping several common conditions and conducting local workshops within their local health community (ensuring that patients are represented)

Other questions to consider include:

• What are the weak points in access to emergency care and in the rest of the patient pathway?

• Is there any duplication in the local health and social care system?

• Are all the services that patients and providers need fully available?

• What quality measures can be applied across the whole patient pathway? And how can these measures have a national basis with local flexibility?

• Are arrangements in place to provide assurance that demand for clinically unnecessary or ineffective treatments is robustly managed?

Assurance and sign-off, publication, and accountability

As part of resilience and capacity planning, systems will be categorised differently in terms of assurance, depending on the level of risk they face in delivering standards. This will have implications for what each SRG will have to submit.

However, all SRGs will be expected to follow the governance structures laid out above, to be chaired by a CCG (in most cases), and to publish their plan once finalised.

All SRGs producing resilience and capacity plans will be risk assessed in relation to the likelihood of the acute provider at the centre of the system being able to maintain high quality services for patients, and delivering key performance standards. Perceived risk will be assessed on the basis of past performance, financial position, previous ability to successfully implement plans, as well as on local intelligence.

'High risk' systems are those whose acute provider(s) have historically struggled to meet and maintain the A&E and RTT waiting time performance standards, and who may have also experienced regular organisational and financial difficulties. Similarly, 'earned autonomy" systems will be the opposite - strong A&E and waiting time performance, and on a sound organisational and financial footing. All systems that fall in between these two categories will still need to have plans signed-off in order to have non-recurrent funding released to them, but the sign off process will be more light touch than that of 'high risk' systems.

Where an SRG is deemed to have 'earned autonomy', allocated non-recurrent monies will be released without formal sign-off of plans being required. All other SRGs will need to have plans formally signed-off following review in order for monies to be released. Where an SRG is deemed to be 'high risk', release of non-recurrent monies will only occur once a plan has been signed-off, and the tripartite are assured that actions are in place to implement improvement recommendations resulting from an independently conducted diagnostic of the provider. All systems will need to submit capacity plans, to build upon RTT mapping exercises already underway throughout the system.

SRGs deemed to have 'earned autonomy' will be given considerably more freedom in terms of planning, and will be expected to conduct self-assurance on plans. The only requirement that the tripartite has of these SRGs is that they develop a plan addressing the best practice lists and wider considerations detailed in this document, and publish that plan once finalised. All other SRGs are also required to publish their plans following sign-off. Plans should be published on the website of the SRG chairs' organisation - in the vast majority of cases this will be a CCG website.

Published plans will be used to hold SRGs to account for delivering safe, sustainable, high quality servies for patients, and to assess the impact that non-recurrent monies are having on local health systems. In line with the principles of transparency and openess, published plans will also allow patients to see how organisations in their local health system are preparing for episodes of increased pressure.

Allocation of funding

Mainstream allocations

• The majority of monies will be allocated on fair shares basis to local systems to support implementation of operational resilience and capacity plans. The amount allocated will be based on the population within each CCG's geographical footprint.

• Release of funding will be dependent on the inclusion of the principles of good practice in plans. The majority of systems will have the autonomy to allocate funds as determined most appropriate to ensure adequate provision of high-quality emergency services and elective care for local populations. Money will be distributed to systems through CCGs but plans and spending will need to be agreed by local partners through SRG arrangements, and will be closely monitored.

Centrally retained funding

A core part of the funding will be top-sliced and used to support various central initiatives, including:

• supporting ambulance services, in particular to increase 'see and treat' and 'hear and treat' rates and reduce conveyance.

• increasing NHS 111 call capacity over winter.

• increasing IST capacity to support the diagnostic work in the identified local systems.

• supporting commissioning of specialised beds e.g. intensive care and paediatric intensive care.

• supporting flu vaccinations for clinical staff in the independent sector.

• supporting the 'reduce pressure in hospital' joint social action fund with the Cabinet Office.

Publication

All SRGs are expected to publish their resilience and capacity plans (more detail on page 16), and in the interest of transparency, this should include a summary breakdown of how allocated monies will be spent

Marginal tariff usage

This year, local plans will also be expected to describe the use of the 70% marginal tariff in the local health economy and systems will be held accountable as to how this money has been reinvested to improve performance

Targeted funding and 'earned autonomy'

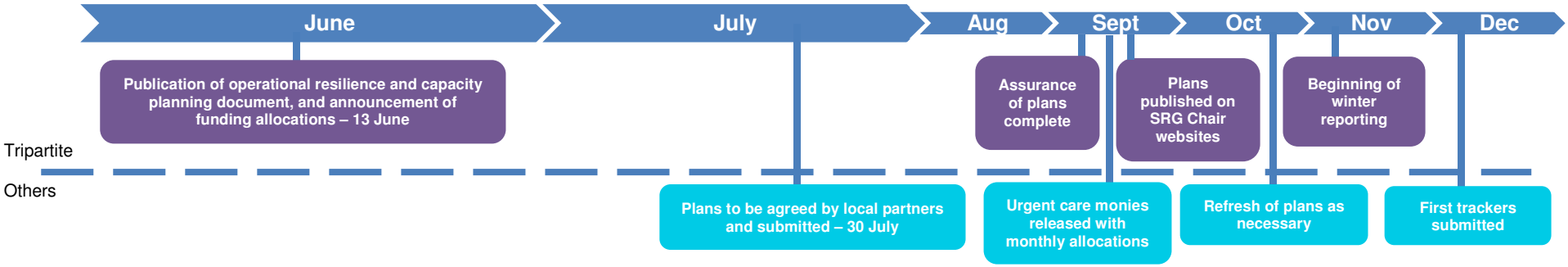
Plans will be created by SRGs over the summer, and submitted via NHS England area teams. There will be three cohorts of systems with differing levels of scrutiny:

• High: The systems most at risk of delivery of A&E and/or RTT will be subject to a diagnostic from a specialist support team and required to implement the resulting action plan, as well ensuring that all elements of the best practice guidance are incorporated within plans. Disbursement of funding will be conditional on this.

• Low: In very high-performing areas (defined as systems where RTT and A&E standards have been met consistently) there will be a policy of 'earned autonomy', whereby systems will self assure their plans prior to local publication.

• All others: All other systems, not defined as 'high' or 'low' as described above, will be expected to produce plans that contain all actions from the best practice guidance, which will be assured.

When the plan should be submitted and to whom



Assurance and sign-off of plans

- Following the above timetable, SRGs will need to submit their plans to NHS England Area Teams to review in conjunction with regional and national tripartite panels. Plans must include best practice principles, capacity and bed modelling, and all other aspects covered in the planning templates (see Annexes A, B and C). Additionally, SRGs must also submit a letter co-signed by all constituent member organisations of the SRG.
- Plans will be assured on the basis of perceived risk. There will be time allocated in the planning process for confirm and challenge sessions at regional level where appropriate, for any questions to be addressed before plans are finalised.
- Following review, including time allotted for any potential changes in light of feedback, plans will be formally signed off by the national tripartite panel.

Plan requirements, reporting and tracking

- The tripartite panels will assess the impact schemes are having throughout the system and if support is being used appropriately and effectively. To enable this, each SRG will be required to complete and submit trackers to their regional tripartite panel on a regular basis.
- These trackers will capture the impact resilience and capacity schemes are having. Tracker returns will be used to inform local discussions to ensure SRGs are working as effectively as possible to improve services for patients, and to aggregate information to give a regional and national picture of progress.

Accountability

- Systems deemed to have 'earned autonomy' will be given more freedom and local discretion regarding planning. To reflect this, these SRGs will be expected to conduct self-assurance of their own plans, and will receive minimal intervention and oversight. These SRGs will however need to submit capacity plans as part of national mapping, and will need to publish plans once completed.
- For systems facing significant operational pressures, there will be greater scrutiny of plans, and increased oversight to monitor delivery against plans developed following diagnostic review. SRGs will be held to account for overall system delivery through regional tripartite panels, with each individual part of the system remaining accountable to the relevant regulator.
- Systems that are in neither the 'earned autonomy' or 'high risk' categories will need to submit plans to be signed off, but will undergo a more light touch assurance process than the 'high risk' systems.

Annex A – Planning summary templates

The following templates are also available online in Excel format, which SRGs are expected to use when returning completed plans.

Operational resilience planning template for non-elective care 2014/15

Lead CCG:	
Lead acute trust:	

Central Resilience Funding	
Marginal Tariff savings to reinvest	
Other funding available locally	
Total non-elective care support funding for 2014/15	

Section 1: Narrative on local system configuration, key strengths and key challenges

Section 2: Minimum plan requirements. Please note that development of a sufficient plan to deliver all of these elements is a pre-requisite to qualify for any central resilience funding

Text in blue italics is provided as examples only and should be overtyped

Ref	Minimum Plan Requirements	Summary of plan to achieve requirement	KPIs	Target Outcomes	Timeframe for Completion	Lead Accountable Officer	Estimated Costs in 2014/15
1	Enabling better and more accurate capacity modelling and scenario planning across the system					Name: Email: Job Title: Organisation:	
2	Working with NHS 111 providers to identify the service that is best able to meet patients' urgent care needs					Name: Email: Job Title: Organisation:	
3	Additional capacity for primary care					Name: Email: Job Title: Organisation:	
4	Improve services to provide more responsive and patient-centred delivery seven days a week					Name: Email: Job Title: Organisation:	
5	SRGs should serve to link Better Care Fund (BCF) principles in with the wider planning agenda					Name: Email: Job Title: Organisation:	
6	Seven day working arrangements					Name: Email: Job Title: Organisation:	
7	Expand, adapt and improve established pathways for highest intensity users within emergency departments. Organisations will want to review the pathways for the group(s) most relevant to them (e.g. frail/elderly pathways, minors pathways, and mental health crisis presentations) and there must be evidence of sign-up to local Mental Health Crisis Care Concordat arrangements.					Name: Email: Job Title: Organisation:	
8	Have consultant-led rapid assessment and treatment systems (or similar models) within emergency departments and acute medical units during hours of peak demand					Name: Email: Job Title: Organisation:	
9	All parts of the system should work towards ensuring patients' medicines are optimised prior to discharge					Name: Email: Job Title: Organisation:	
10	Processes to minimise delayed discharge and good practice on discharge					Name: Email: Job Title: Organisation:	
11	Plans should aim to deliver a considerable reduction in permanent admissions of older people to residential and nursing care homes					Name: Email: Job Title: Organisation:	
12	Cross system patient risk stratification systems are in place, and being used effectively					Name: Email: Job Title: Organisation:	
13	The use of real time system-wide data					Name: Email: Job Title: Organisation:	
				Total costs of all minimum requirement schemes:		*Sum of cells above*	

Section 3: Local Plans for Innovation. Plans over and above the minimum requirements to meet local patient needs. If there is any funding gap between the total emergency care

Ref	Local Requirements	Summary of plan to achieve requirement	KPIs	Target Outcomes	Lead Accountable Officer	Estimated Costs in 2014/15
13	*Implementation of community outreach team for COPD*	*Recruitment of 1 x band 7 nurse and 2 x band 6 nurses to provide community outreach to known COPD patients (about 250 patients currently). The aim is to improve prevention of exacerbations and increase patients' self-management of COPD.*	*Reduce emergency admissions of known COPD patients.*	*Reduction of 20% by March 2014 (on March 2013 baseline)*	Name: *Jane Doe* Email: *jane.doe@nhs.net* Job Title: *COO* Organisation: Sunnytown Hospitals Trust	*£75,000*

*please add rows as appropriate

Section 4: Local Stakeholder Engagement. Please describe how you have considered each of the elements listed below and how you have included them in your resilience plans (as appropriate)

A	Independent Sector non-acute bed capacity (intermediate care, nursing homes, etc.)	
B	Other Independent Sector capacity (e.g. healthcare at home etc.)	
C	Voluntary Sector capacity and expertise	
D	Flu vaccination of healthcare workers	
E	7-day a week commencement of new care packages (including over holiday periods)	
F	Improvement in access to psychiatric liaison service teams in A&E	
G	Collaboration with and development of Children's services	
H	Engagement with patient representative groups	

Section 5: Key Partner Organisation Sign-Off. By signing this document you are stating both that you have been fully involved in developing this plan and that you will commit to attending all SRG meetings (or sending an appropriate deputy when unavailable).

Representative of:*	Name	Email	Job Title	Electronic Signature
SRG (Chair)				
Lead Acute Trust				
Lead Community Care Provider				
Local Authority				
Lead Mental Health Provider				
Ambulance Service				

*please add rows as appropriate

Section 6: CCGs and Trust Finance Directors sign off that the plans are affordable, and will delivered whilst maintaining or improving their financial position

Representative of:*	Name	Email	Job Title	Electronic Signature
CCG representative				
Acute Trust Representative				
Lead Community Care Provider				
Local Authority				
Lead Mental Health Provider				
Ambulance Service				

*please add rows as appropriate

Non-elective care costings template 2014/15

Section 1: Minimum Plan Requirements

Minimum Plan Requirements	Itemised Net Costings	WTE Nurse increases	WTE Doctor increases	WTE other staff increases	Increases in bed capacity	(Please add additional columns as necessary)
Enabling better and more accurate capacity modelling and scenario planning across the system						
Working with NHS 111 providers to identify the service that is best able to meet patients' urgent care needs						
Additional capacity for primary care						
Improve services to provide more responsive and patient-centred delivery seven days a week						
SRGs should serve to link Better Care Fund (BCF) principles in with the wider planning agenda						
Seven day working arrangements						
Expand, adapt and improve established pathways for highest intensity users within emergency departments. Organisations will want to review the pathways for the group(s) most relevant to them (e.g. frail/elderly pathways, minors pathways, and mental health crisis presentations) and there must be evidence of sign-up to local Mental Health Crisis Care Concordat arrangements.						
Have consultant-led rapid assessment and treatment systems (or similar models) within emergency departments and acute medical units during hours of peak demand						
All parts of the system should work towards ensuring patients' medicines are optimised prior to discharge						
Processes to minimise delayed discharge and good practice on discharge						
Plans should aim to deliver a considerable reduction in permanent admissions of older people to residential and nursing care homes						
Cross system patient risk stratification systems are in place, and being used effectively						
The use of real time system-wide data						
Sub Totals						

Section 2: Local Plans for Innovation

Minimum Plan Requirements	Itemised Net Costings	WTE Nurse increases	WTE Doctor increases	WTE other staff increases	Increases in bed capacity	(Please add additional columns as necessary)
Implementation of community outreach team for COPD	1 x band 7 nurse - £55,000 2 x band 6 nurses - £80,000 Non-recurrent set up costs - £15,000 Less expected in-year savings (£70k) Total - £80k	3	0	0	-4	
* add more rows as required						
Sub Totals						

Total Capacity Increases*						

* needs to link to capacity plan

Operational resilience planning template for elective care 2014/15

Lead CCG:	
Lead acute trust:	

Central Resilience Funding	
Other funding available locally	
Total elective care support funding for 2014/15	

Section 1: Narrative on local system configuration, key strengths and key challenges

Section 2: Minimum plan requirements. Please note that development of a sufficient plan to deliver all of these elements is a pre-requisite to qualify for any central resilience funding in 2014/15. More detail on these plan requirements can be found on page 10 of the operational resilience and capacity planning document.

Text in blue italics is provided as examples only and should be overtyped

Ref	Minimum Plan Requirements	Summary of plan to achieve requirement	Timeframes for completion	Assurance Mechanisms	Lead Accountable Officer	Estimated Costs in 2014/15
1	Review and revise the Trusts' patient access policy, and supporting operating procedures. The policy should include reference to cancer and other urgent patients, and should be made accessible to patients and the public. A revised policy should be publicly available by September 2014	*Trust elective care lead to spend 2 months full time revising Access Policy and supporting standard operating procedures. Trust to source interim resource to back fill.*	*By 31 August 2014*	*SRG to review Access Policy against national rules and guidance in September*	Name: *Joe Bloggs* Email: *joe.bloggs@nhs.net* Job Title: *COO* Organisation: *Sunnytown FT*	*Backfill for Trust Elective Care lead full-time (2 months): £10,000*
2	Develop and implement a RTT training programme for all appropriate staff, focussing on rules application, and local procedures, ensuring all staff have been trained during 2014/15	*Use the IMAS IST elective capacity and demand tool to build up a specialty-level capacity and demand model.*			Name: Email: Job Title: Organisation:	
3	Carry out an annual analysis of capacity and demand for elective services at sub specialty level, and keep under regular review and update when necessary. This should be done as part of resilience and capacity plans and then updated in operating plans for 2015/16				Name: Email: Job Title: Organisation:	
4	Build upon any capacity mapping that is currently already underway, and use the outputs from mapping exercises as an annex to resilience and capacity plans. This will avoid duplication and integrate capacity mapping into 'business as usual' arrangements				Name: Email: Job Title: Organisation:	
5	Ensure that all specialties understand the elective pathways for common referral reason/treatment plans, and have an expected RTT 'timeline' for each (e.g. DTA by week x). This should be in place by September in order to ensure that activity is maintained at a level where waiting lists are stable				Name: Email: Job Title: Organisation:	
6	'Right size' outpatient, diagnostic and admitted waiting lists, in line with demand profile, and pathway timelines (see IMAS Capacity and demand tools)				Name: Email: Job Title: Organisation:	
7	With immediate effect, eview local application of RTT rules against the national guidance, paying particular attention to new clock starts and patient pauses				Name: Email: Job Title: Organisation:	
8	Pay attention to RTT data quality. Carry out an urgent 'one off' validation if necessary if not done in that last 12 months, and instigate a programme of regular data audits				Name: Email: Job Title: Organisation:	
9	Put in place clear and robust performance management arrangements, founded on use of an accurate RTT PTL, and use this in discussion across the local system				Name: Email: Job Title: Organisation:	
10	Ensure that supporting KPIs are well established (size of waiting list, clearance time, weekly activity to meet demand, RoTT rate, etc) and are actively monitored				Name: Email: Job Title: Organisation:	
11	Demonstrate how good practice in referral management is being followed				Name: Email: Job Title: Organisation:	
12	Demonstrate that patients receiving NHS funded elective care are made aware of and are supported to exercise choice of provider				Name: Email: Job Title: Organisation:	
13	Provide assurance during Q2 2014/15 at Board level on implementation of the above				Name: Email: Job Title: Organisation:	
				Total costs of all minimum requirement schemes:		*Sum of cells above*

Section 3: Local Plans for Innovation. Plans over and above the minimum requirements to meet local patient needs. If there is any funding gap between the total elective care support funding and the total costs of the minimum plan requirements, SRGs must present plans to close such gaps such that the minimum requirements are deliverable

Ref	Local Requirements	Summary of plan to achieve requirement	KPIs	Target Outcomes	Lead Accountable Officer	Estimated Costs in 2014/15
13	*Reduce routine referrals to consultant-led orthopaedic services*	*Develop a referral management centre for all non-urgent orthopaedics referrals*	*Routine referrals to consultant-led orthopaedic services*	*Reduce by 5% by 31/12/14*	Name: Email: Job Title: Organisation:	*£35,000*

*please add rows as appropriate

Section 4: Local Stakeholder Engagement. Please describe how you have considered each of the elements listed below and how you have included them in your resilience plans (as appropriate)

A	Independent Sector non-acute bed capacity (intermediate care, nursing homes, etc.)	
B	Other Independent Sector capacity (e.g. healthcare at home etc.)	
C	Voluntary Sector capacity and expertise	
D	Flu vaccination of healthcare workers	
E	7-day a week commencement of new care packages (including over holiday periods)	
F	Collaboration with and development of Children's services	
G	Engagement with patient representative groups	

Section 5: Key Partner Organisation Sign-Off. By signing this document you are stating both that you have been fully involved in developing this plan and are committed to its delivery

Representative of:*	Name	Email	Job Title	Electronic Signature
CCG representative				
Acute Trust Representative				
Lead Community Care Provider				
Local Authority				
Lead Mental Health Provider				
Ambulance Service				

*please add/delete rows as appropriate

Section 6: CCGs and Trust Finance Directors sign off that the plans are affordable, and will delivered whilst maintaining or improving their financial position

Representative of:*	Name	Email	Job Title	Electronic Signature
CCG representative				
Acute Trust Representative				
Lead Community Care Provider				
Local Authority				
Lead Mental Health Provider				
Ambulance Service				

*please add rows as appropriate

Elective care costings template 2014/15

Section 1: Minimum Plan Requirements

Ref	Minimum Plan Requirements	Itemised Net Costings	WTE Nurse increases	WTE Doctor increases	WTE other staff increases	Additional Outpatient Appointments	Additional Inpatient/Daycase procedures	Add more columns as required
1	Review and revise the Trusts' patient access policy, and supporting operating procedures. The policy should include reference to cancer and other urgent patients, and should be made accessible to patients and the public. A revised policy should be publicly available by September 2014	*1 x band 7 manager - £10,000*	*N/A*	*N/A*	*1 wte manager (2 months)*	*N/A*	*N/A*	
2	Develop and implement a RTT training programme for all appropriate staff, focussing on rules application, and local procedures, ensuring all staff have been trained during 2014/15							
3	Carry out an annual analysis of capacity and demand for elective services at sub specialty level, and keep under regular review and update when necessary. This should be done as part of resilience and capacity plans and then updated in operating plans for 2015/16							
4	Build upon any capacity mapping that is currently already underway, and use the outputs from mapping exercises as an annex to resilience and capacity plans. This will avoid duplication and integrate capacity mapping into 'business as usual' arrangements							
5	Ensure that all specialties understand the elective pathways for common referral reason/treatment plans, and have an expected RTT 'timeline' for each (e.g. DTA by week x). This should be in place by September in order to ensure that activity is maintained at a level where waiting lists are stable							
6	'Right size' outpatient, diagnostic and admitted waiting lists, in line with demand profile, and pathway timelines (see IMAS Capacity and demand tools)							
7	With immediate effect, eview local application of RTT rules against the national guidance, paying particular attention to new clock starts and patient pauses							
8	Pay attention to RTT data quality. Carry out an urgent 'one off' validation if necessary if not done in that last 12 months, and instigate a programme of regular data audits							
9	Put in place clear and robust performance management arrangements, founded on use of an accurate RTT PTL, and use this in discussion across the local system							
10	Ensure that supporting KPIs are well established (size of waiting list, clearance time, weekly activity to meet demand, RoTT rate, etc) and are actively monitored							
11	Demonstrate how good practice in referral management is being followed							
12	Demonstrate that patients receiving NHS funded elective care are made aware of and are supported to exercise choice of provider							
13	Provide assurance during Q2 2014/15 at Board level on implementation of the above							
	Sub Totals							

Section 2: Local Plans for Innovation

	Local plans for innovation	Itemised Net Costings	WTE Nurse increases	WTE Doctor increases	WTE other staff increases	Additional Outpatient Appointments	Additional Inpatient/Daycase procedures	Add more columns as required
12	*Reduce routine referrals to consultant-led orthopaedic services*	*2 GP sessions per week to review all routine orthopaedic referrals £25,000.* *0.2 Admin support £5,000* *IT and stationery £1,000*	*N/A*	*0.2*	*0.2 (admin support)*	*-200*	*N/A*	

* Add more rows as required

	Sub Totals						
	Total Capacity Increases*						

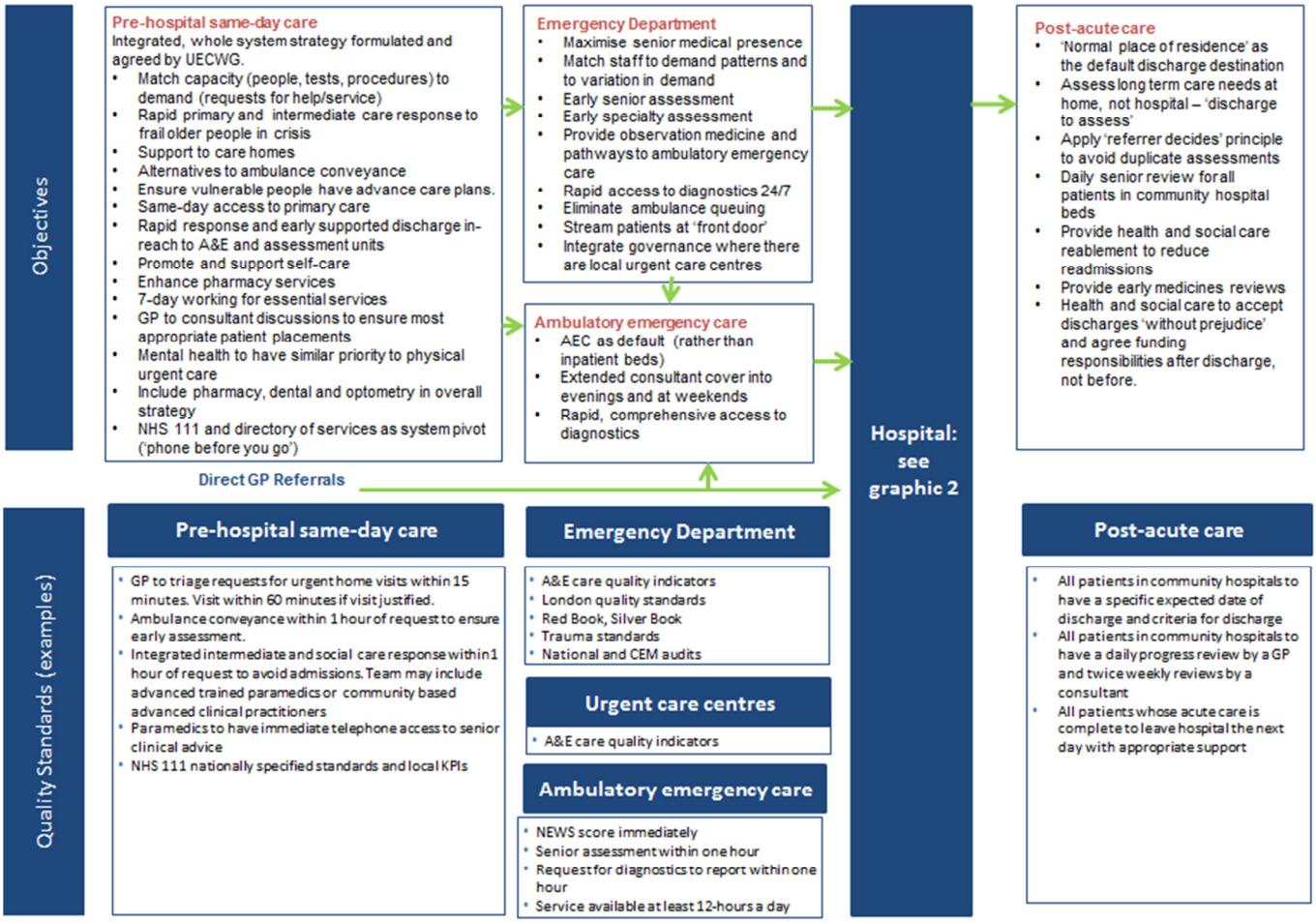
* needs to link to capacity plan

Annex B: Whole system urgent and emergency care flow model

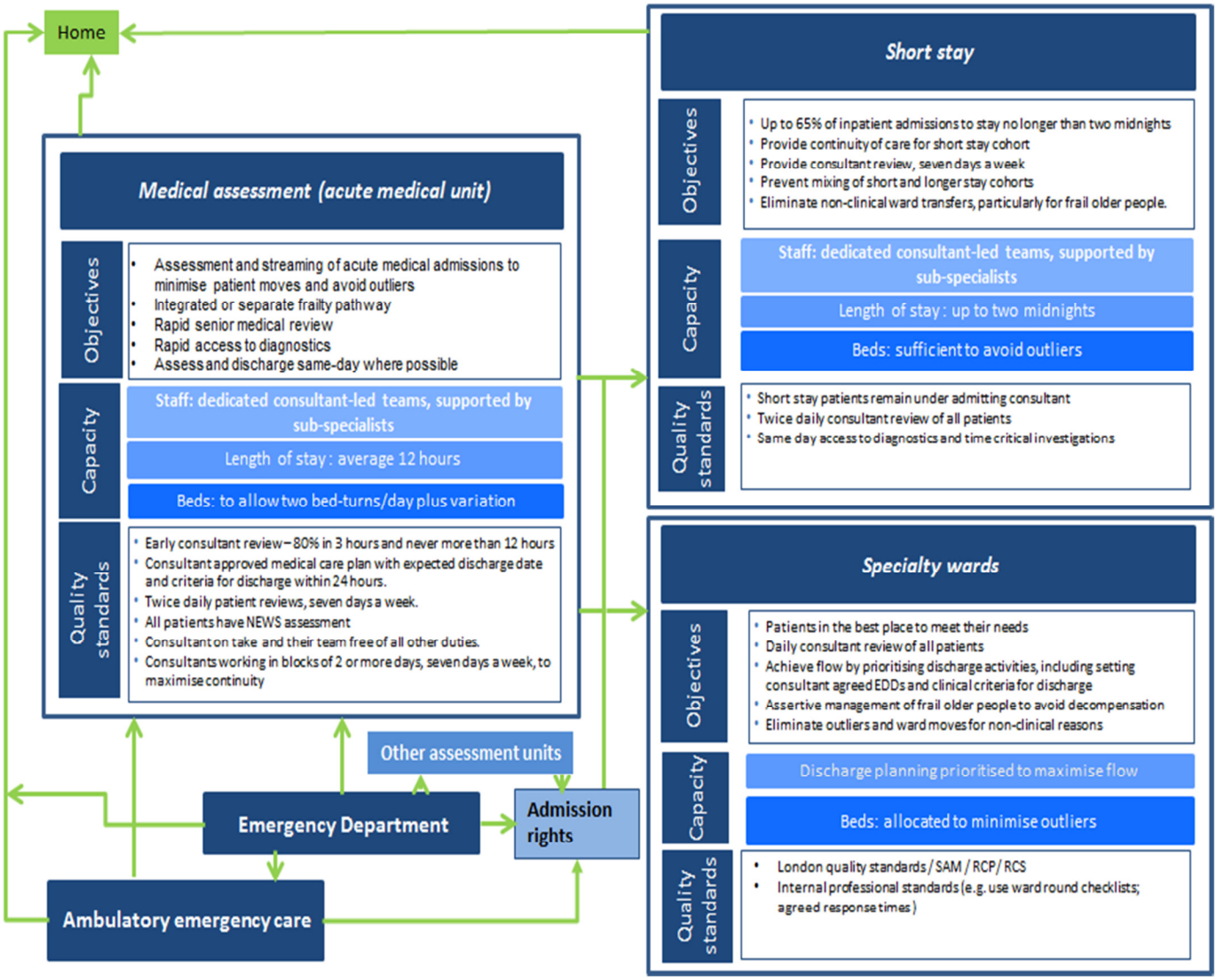
This is an illustrative example of a whole system urgent and emergency care flow model, showing 'what good looks like', with example standards.

- SRGs should have a clear vision of 'what good looks like' in each of the major component parts of its urgent and emergency care system
- All systems will aim to provide safe, effective, prompt care to their local populations while minimising emergency department attendances, hospital admissions and inpatient bed days
- The following two graphics provide an illustrative example of a model that outlines objectives for system partners, shows broad patient flows and provides some illustrative delivery standards
- SRGs may want to consider populating this model with local objectives and standards
- The model may also be used to consider how the system will develop the capacity to deliver its agreed objectives to meet patient demand within a framework of agreed standards
- In addition to wider patient experience plans, SRGs need specific plans to deal with emergency department exit block, when it occurs, so that the flow of patients is maintained from the emergency department into the hospital including developing local 'Full Capacity Protocols' and 'Boarding Protocols. The College of Emergency Medicine have published best practice guidelines regarding crowding in emergency departments[21].

An illustrative example of a whole system urgent and emergency care flow model, showing, '*what good looks like*', with example standards: Graphic 1. Pre and post acute admission



Graphic 2. Acute admission (with examples of objectives and standards).



Annex C: Local independent and voluntary sector capacity template

Organisation details			
Organisation name:		Organisation code:	
Healthcare provider (owner):			
CQC listed specialisms/services:			
Key contact (and their contact details):			
Total capacity - by unit, or by care type (please specify):			
Notes:			
National grouping code:		High level Local Authority code:	
CCG:		LSOA:	
Local Authority:			
How are NHS-funded elective care patients being made aware of their constitutional rights to choose where they receive treatment?			

Annex D: Resources, guidance and tools for capacity and demand management

NHS Interim Management and Support	NHS IMAS offers NHS organisations that need short or medium term support, the means to access the management expertise that exists throughout the NHS. It was established in 2008 to encourage and facilitate the NHS to use the wealth of skills already available to it. The aim is to improve and sustain the quality of health care services in the local community they serve. It is committed to providing assistance to the NHS in a way that builds a sustainable legacy.

http://www.nhsimas.nhs.uk/

Emergency and elective care intensive support teams	Since April 2009, NHS IMAS has incorporated the intensive support teams (ISTs) who specialise in urgent and emergency care, elective care and cancer, focusing on improving performance, quality assurance and programme enhancement. Assignments typically include working with local health communities jointly to diagnose areas for performance improvement; supporting implementation planning and delivery; and transferring knowledge to produce sustainable and resilient solutions.

http://www.nhsimas.nhs.uk/what-we-can-offer/intensive-support-team/

NHS Elect	NHS Elect is an NHS members' network that provides NHS organisations with high quality support to supplement in-house management teams and support these teams to develop new skills. Subscription to NHS Elect provides member organisations with tools and support to drive sustainable innovation and implement best practice locally. NHS Elect offer support on a range of areas from ambulatory emergency care to capacity and demand management.

http://www.nhselect.nhs.uk/Service-Transformation/Capacity-and-Demand

Ambulatory Emergency Care Network	In 2011/12 the NHS Institute worked with trusts, commissioners and primary care teams in a network designed to support and accelerate the local development of ambulatory care through the spread and adoption of good practice and utilisation of improvement methodologies. Following on from the Institute's work, NHS Elect agreed to host the programme. Subsequent cohorts have been very successful, with teams reporting significant progress in converting emergency admissions into 'same day' emergency episodes, reducing avoidable admissions. The Network delivers two cohorts per year, once starting in the spring and one in the autumn.

http://www.ambulatoryemergencycare.org.uk/

The ambulance commissioners network	Hosted by NHS Clinical Commissioners (NHS CC), from its early roots as an informal forum for the lead ambulance commissioners in England it has developed to encompass a wider network of commissioning managers and clinical leads from CCGs across the country, each with a key interest in ambulance commissioning. The NHSCCA ambulance commissioners network (ACN) provides a network for any CCG member with an interest in ambulance commissioning. ACN offers a national voice, influencing upwards (to policy makers) and laterally (to other urgent and emergency care stakeholders); peer-to-peer support for those working in what can be seen as a rather niche area of commissioning; a safe space for CCG ambulance commissioners to talk openly about issues and concerns; and the opportunity to share good practice (and safely share less successful initiatives) to develop consistently better outcomes for patients.

http://www.nhscc.org/networks/ambulance-commissioners/

The mental health commissioners network	Hosted by NHS clinical commissioners and similar to the ambulance commissioners network, its purpose is to enable members to become more effective mental health commissioners – achieving better mental health and wellbeing outcomes for the populations they serve. The network is member led and aims to provide • A strong collective voice for mental health commissioners • A place to share best practice with peers • Provide development opportunities and peer support to mental health commissioners

http://www.nhscc.org/networks/mental-health-commissioners/

Triprartite online resources	On behalf of tripartite member organisations, NHS England will make available a wide range of tools and resources applicable to both emergency and elective care. These resources will support providers and commissioners in the planning and delivery of safe and sustainable services. Content generated by the planning work streams will be shared online, as and when it becomes available.
The Health Foundation	The Health Foundation is an independent charity working to improve the quality of healthcare in the UK. Their aim is to support people working in healthcare practice and policy to make lasting improvements to health services. The Health Foundation conducts research and runs programs of work testing out new ideas for improving the quality of healthcare across range of topics including acute care, and have published substantial research findings and guidance documents

http://www.health.org.uk/

The King's Fund	The King's Fund is an independent charity working to improve health and health care in England, producing research and analysis on both policy and practical solutions for improving healthcare quality. The King's Fund has published a multitude of analysis and guidance on urgent and emergency care amongst other areas, both from a trust and commissioner perspective

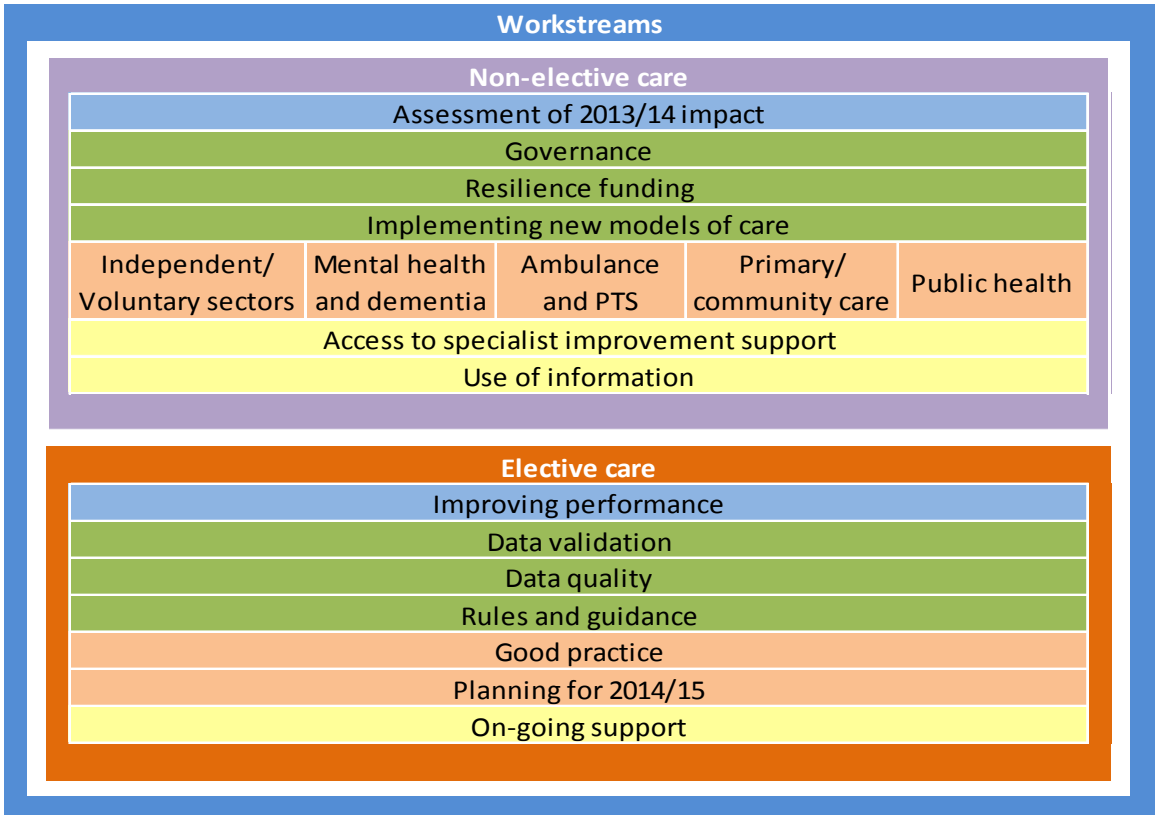
http://www.kingsfund.org.uk/

Annex E – National workstreams for 2014/15

The following workstreams have been developed following considerable input from key stakeholders from across the service, as well as being progressed in line with Department of Health and Secretary of State ambitions.

Each workstream is being chaired by a recognised leader in the relevant field. Membership is comprised of a number of subject matter experts from a range of provider, commissioner, and regulator organisations, as well as clinical networks and professional bodies.

These workstreams are detailed below:



The access to specialist improvement support and use of information workstreams will act in an advisory capacity, but will run for a longer period to reflect the evolving nature of the work involved. The workstreams in the green boxes will involve larger membership and will have a more substantial programme of work, which will continue to evolve throughout the year.

A number of workstreams (assessment of 13/14 impact, allocation of funding) have been on-going for some time, as these work streams were required to be started in advance of others to inform the planning process for the coming year.

The outputs of these workstreams will take various forms, from sharing examples of best practice, to innovative methods for introducing new models of care, to new ways of capturing data to improve services for patients. All relevant outputs will be made available online as they are produced.

References

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