

# WINTER WARNING

**Managing risk  
in health and care  
this winter**



# SUMMARY

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- NHS performance last winter showed unacceptable levels of patient risk as growing demand outstripped NHS capacity.
- The government's plans to manage this escalating risk next winter assume that the extra £1bn for social care in 2017/18, announced in the March 2017 Budget, will be spent in a way that reduces NHS delayed transfers of care (DTOCs), freeing up 2,000-3,000 NHS beds.
- Our member survey shows that only 28% of trusts have been able to secure a commitment from their local authority that the extra social care funding will be spent in a way that directly reduces DTOCs and frees up NHS capacity.
- The survey also shows that only 18% of trusts believe they have a commitment that will enable them to deliver the NHS mandate requirement of reducing DTOCs to 3.5%.
- Trusts report a lack of capacity across all parts of the health and care system to deal with the expected demand: 64% of trusts report a lack of ambulance capacity; 71% a lack of acute capacity; 76% a lack of community capacity; 80% a lack of mental health capacity; 91% a lack of social care capacity and 92% a lack of primary care capacity.
- To manage next winter's risk safely, the NHS needs the added capacity that the extra social care investment was intended, but is failing, to secure. This requires an extra winter pressures funding injection of £350m.
- Any extra funding must be committed by the end of July at the latest. It should be funded by a repayable advance on or early draw down of the extra £8bn committed to the NHS in the Conservative manifesto.
- Trusts also need flexibility on agency spending over the winter period; more support for better cross health and care sector resilience planning; simplified SITREP reporting; and a shift of NHS England and NHS Improvement activity from assurance to support.
- We need a longer-term, sustainable approach to urgent and emergency care that avoids the annual cycle of winter crisis. This includes funding growth that matches demand growth; capital investment to grow infrastructure to meet growing demand; a comprehensive workforce strategy to tackle workforce shortages; and better planning, focusing on prevention rather than crisis management.
- In looking at all these short and long term solutions, we must adopt a whole system approach. Too often winter pressures has just been about acute hospital capacity. Last winter showed that ambulance, community and mental health capacity are just as important, as is primary and social care capacity.

## OVERVIEW

### The escalating risk shown last winter

Earlier this year the NHS experienced what many consider to be one of the toughest winters on record. Twelve-hour trolley waits in A&E departments and ambulance diversions increased. Performance against the 95% four-hour A&E wait target deteriorated. Many parts of the NHS operated for a number of weeks with unsafe levels of bed occupancy.

Critically, this translated into increased risk for patients as the whole health and care system struggled to cope under sustained pressure. A few local systems were unable to cope with this pressure for short periods of time as demand overwhelmed the available capacity. The NHS as a whole coped, but only just. This was mainly due to the extraordinary but unsustainable levels of discretionary effort from staff who reported themselves as having to shoulder an increasingly unacceptable burden.

Underlying this increasing risk is a simple truth. Current NHS capacity, which is largely static, cannot keep up with the continued growth in demand for services from a population whose profile is ageing and where the growth in patients with multiple co-morbidities creates greater patient acuity.

The NHS experienced record demand last winter. It also treated a record number of patients. But, in too many places demand overwhelmed capacity. Although the media focus was on hospitals, there was insufficient capacity right the way across local systems – in acute hospital, mental health, community and ambulance trusts, but also in primary and social care. A particular problem last winter was the rapid growth in delayed transfers of care (DTOCs) due to inadequate capacity in social care.

As soon as last winter finished, there were immediate demands for the NHS to learn lessons and to manage this growing risk more effectively. Although there are early signs from a small number of new care model vanguards that the growth in emergency demand can be flattened, there is every prospect that, over the next 12 months, demand will continue to rise. Growing workforce shortages and lower levels of funding increases threaten the NHS' ability to match the capacity it provided last year. Some local systems are already reporting that the need for increased savings in 2017/18 is threatening much needed out of hospital and community capacity.

### Planning for next winter

The government's response has been to use the £1bn of extra 2017/18 social care funding announced in the March 2017 budget to try to reduce NHS social care related DTOCs and thereby free up 2,000-3,000 extra NHS beds.

Local authority budgets, which include provision for social care, have been cut by £18bn in real terms since 2010. They understandably argue that they are the best arbiters of how this extra investment should be spent. Faced with the need to ensure the investment was spent

in time, the government agreed that the extra 2017/18 social care investment could be spent in three ways:

- to support adult social care
- to support the NHS through delayed transfers of care
- to stabilise the social care market.

From the NHS perspective, this carries a risk of trying to spend the same £1bn twice, to get both a social care and an NHS benefit, and that the additional required NHS capacity cannot therefore be guaranteed. Now that local authorities are finalising how their extra social care funding will be spent, we can start to see how well and consistently government plans will work.

## Our survey

We surveyed trusts in late May. This gave us a snapshot of how the conversations locally were developing and the results show a mixed picture:

- Only 34% of trusts report that their local authorities are giving high priority to supporting the NHS reduce delayed transfers of care as opposed to meeting other/wider adult social care needs or stabilising their social care market.
- While 28% of all trusts have received a specific commitment that the extra social care money will be used to reduce delayed NHS transfers of care, 59% of trusts have not been able to secure such a commitment.
- Only 18% of NHS trusts are confident that the commitments they have received will help them meet the NHS England Mandate requirement to reduce DTOC levels to 3.5%, creating the required extra 2,000-3,000 beds.
- More positively 38% of acute providers feel that the extra social care funding will have a very positive or fairly positive impact.

We have translated this as meaning that the extra social care funding should help create the required extra NHS capacity in about a third of local systems but that, currently, it will not create the required capacity in the remainder.

Unsurprisingly, this will create a significant level of risk for the coming winter. Just 57% of trusts are confident they will be able to deliver safe, high-quality care this winter, while 10% are not confident – a much higher level than those overwhelmed by demand last winter. A worrying 33% are neither confident or not confident of their ability to provide safe, high-quality care. This suggests a significant level of risk, particularly if the NHS experiences the long periods of bad weather or widespread outbreaks of winter flu or norovirus it has avoided for the last three years.

The key factor underlying this risk is the lack of capacity to meet expected demand across local systems. In responding to the question “what level of capacity (physical and workforce) do you expect to have this winter?”, we had the following responses:

- Ambulance – 64% of respondents reported a significant or slight lack of capacity
- Acute – 71% reported a significant or slight lack of capacity
- Community – 76 % reported a significant or slight lack of capacity
- Mental health – 80% reported a significant or slight lack of capacity
- Social care – 91% reported a significant or slight lack of capacity
- Primary care – 92% reported a significant or slight lack of capacity.

## What action is needed?

If the government plan to create extra NHS capacity this coming winter through the £1bn of social care funding will help in around one third of local systems but not in two thirds of systems, there needs to be a different plan to manage the risk that trusts are clearly reporting. We held a member roundtable covering all four sectors of our membership – acute hospital, mental health, community and ambulance trusts – to identify what would most help the NHS frontline manage next winter, as well as using detailed responses to our survey.

The roundtable agreed that action needs to be taken on three time scales: immediate, short term and longer term. If the NHS does not embrace the longer-term perspective, our approach to managing winter pressures will remain ad-hoc and expensive.

### Immediate measures

An immediate next step is to continue to monitor how the extra social care investment is being spent and ensure as much as possible is spent on NHS delayed transfers of care. The Department of Health argues that its plans, supported by a new Care Quality Commission inspection exercise covering 20 systems, will work longer term. The issue for the NHS is a simple one – can trusts be sure that by the end of July/August 2017, the required extra capacity to manage this winter will be created?

### Short-term measures

Given that the current government plan looks like it will not create the required extra capacity, we clearly need an alternative means of creating it. Our proposals include:

#### **Funding and capacity**

- an additional £350m investment in the NHS to give targeted support to acute hospital, mental health, community and ambulance services, distributed to those areas of greatest need
- committed by the end of July/August 2017 at the latest
- Given the current £500-600m system level gap for the NHS in 2017/18, and the need to commit this money within the next two months, we suggest the funding should either

be a repayable advance or come from an early draw down on the extra £8bn committed in the Conservative manifesto

### **Workforce**

- increasing capacity by balancing the current approach on agency spending so that trusts have access to vital additional staff
- flexible approaches to staffing, for example boosting the nursing workforce, using a wider group of staff for some traditional nursing roles

### **Resilience planning**

- operational resilience planning across health and social care, with early checks from the national bodies to make sure plans are deliverable
- simplifying SITREP reporting to minimise diverting resource from the frontline
- a shift from assurance to support by national bodies to save time and help develop solutions.

## Long-term measures

At the same time we need to create a long-term sustainable solution to urgent and emergency care that avoids the annual cycle of winter crises. We need to see:

- an appropriately funded urgent and emergency care system, including social care, and investment in an infrastructure that needs to grow to reflect growing demand
- a comprehensive workforce strategy that takes account of what the NHS is being asked to deliver and an approach to immigration which facilitates recruitment to key shortages in health and social care
- consistent membership and remit of A&E boards, planning which focuses on prevention rather than crisis management and seven-day service provision across a whole local footprint.

One of the key findings in our survey was the latest date by which any decisions on extra capacity had to be taken to enable trusts to recruit and staff that extra capacity. The results clearly show that any such decisions should be taken by end July 2017.

It is clear that the whole system needs to work together. Against this backdrop the NHS has a month to make concrete decisions on whether the current approach will work or, as our survey shows, more is needed to manage these risks.

## WHAT HAPPENED LAST WINTER?

NHS trusts and frontline staff worked tirelessly to maintain and improve performance in the face of extremely challenging circumstances last winter. Although the NHS treated record numbers of patients over the winter, the increases in demand, from an ageing and more frail population, outstripped the available capacity.

With workforce shortages and severe funding pressures, it was not possible to increase capacity and, as a result, the NHS came under sustained pressure for a number of weeks. This manifested itself as a drop in performance and an increased risk to patients' safety with deteriorating performance against the 95% A&E target, a spike in the number of ambulance divers, and a significant increase in trolley waits.

This situation was amplified by insufficient capacity in all types of trust – acute hospitals, mental health, community and ambulance, – and exacerbated by increasingly high levels of delayed transfers of care.

### NHS performance between December 2016 and February 2017

Between December 2016 and February 2017:

- Performance against the A&E four-hour waiting time target continued to fall, with an average of 86.3% of patients seen within four hours against the 95% standard, compared to an average of 89.1% in the same period last year.
- The number of times patients diverted to another A&E departments due to a lack of capacity almost doubled compared to last year.
- The NHS had less than 85% bed occupancy on only three days in winter,<sup>1</sup> despite this being well recognised as a safe limit<sup>2</sup> and a third of all trusts had bed occupancy rates of 100% on at least one day over winter. On one day in January, one in seven trusts reported that all their acute beds were full, and for nearly 4 out of 10, 98% of their beds were occupied.<sup>3</sup>
- In one week alone (2-8 January 2017), the NHS had over 31,000 escalation beds open to cope with winter demand, the equivalent of opening an additional eight hospitals.
- Ambulances were unable to meet the target for response times for 999 calls in the face of increasing demand. For the three peak winter months Red 1 performance was an average of 67.5% and Red 2 performance was an average of 59.6%, both below the expected standard of 75.0%.

If these trends continue into this coming winter, performance will deteriorate further, meaning more patients will wait longer to be seen, treated and discharged, and frontline staff will experience increasing pressures as they seek to deliver care in very challenging circumstances.



## Delayed transfers of care are having a material impact on the NHS' ability to manage winter pressures

Many of last winter's problems were due to increased levels of delayed transfers of care (DTOCs). The ability to move patients quickly and safely out of one setting and in to another is crucial to ensuring patients are treated in the right settings at the right time. Delays in transfers of care prevent this, and they have been increasing sharply in recent years. Since the start of 2014/15, the DTOC rate<sup>4</sup> has increased from 3.5% to 5.6% at the end of 2016/17. In 2016/17 almost 630,000 more bed days were lost compared to 2014/15, a 39% increase, the equivalent of three 550-bed hospitals being full of DTOCs for the entire year.

Although the acute sector has the largest number of beds and, therefore, the highest number of delayed days in total, the DTOC rate is actually highest in community providers, peaking in January 2016 when, on average, 28.5% of beds were occupied by DTOCs.

DTOCs place a number of constraints on trusts, reducing their ability to use beds and space flexibly, preventing the flow of patients through services, and impacting on the ability of trusts to provide the right quality of patient safety and experience.



*Last winter was extremely challenging. Although the NHS as a whole made it through, some local healthcare systems did 'fall over' and those that managed had to rely disproportionately on discretionary staff effort which is unsustainable in the medium or long term.*

### **Flexibility and bed occupancy**

DTOCs can impact adversely on bed occupancy within the acute, community and mental health sectors as well as on ambulance transfers. NHS capacity across all these sectors is largely fixed in the immediate short term – it is usually impossible or very difficult to quickly increase capacity to meet short term spikes in demand.

For example, a lack of physical space, funding constraints and workforce shortages mean that increasing the number of beds or opening a new ward is often not a simple option. As one trust chief operating officer told us: "our walls are not elastic, and we are unable to simply flex capacity up or down".

**Patient flow**

High bed occupancy and lack of space have a knock-on effect on patient flow. A certain proportion of beds needs to be free for patients to flow through the system. When space is very tight, trusts may be forced to resort to a one in, one out approach to admission and discharge. This causes queues and backlogs elsewhere, such as ambulance handovers, emergency admissions, and transfers to other NHS settings. The link between these factors is underpinned by research which shows that those trusts achieving the four-hour target have lower bed occupancy levels across their acute beds.<sup>5</sup>

**Patient safety and patient experience**

It is widely accepted that persistently large numbers of trolley and 12-hour waits are a good proxy for significantly elevated risk to patient safety and potential for significant harm.<sup>6</sup> They also mean a much worse experience for patients – often one that no patient would want to have or any NHS staff member would want to provide. The same applies to persistently large numbers of long ambulance waits. Acute hospital bed occupancy is the most well recognised measure of capacity in the NHS. However, focusing solely on acute hospital beds masks capacity constraints in other parts of the system, including mental health, community and ambulance services. Having the appropriate resources in NHS 111 and 999 centres; the right number of community step down facilities; enough social care packages; and sufficient mental health out-reach and liaison teams, all impact on a system's overall capacity to meet patient demand. Insufficient capacity in any part of this system means that providers may not be able to provide care in a timely way. This can affect patient safety and patients' experience of care, and then cause knock-ons to the other parts of the system.

Last winter was extremely challenging. Although the NHS as a whole made it through, some local healthcare systems did 'fall over' and those that managed had to rely disproportionately on discretionary staff effort which is unsustainable in the medium or long term.

There has been widespread agreement across the NHS that the impact on staff and the risk to patient safety is not acceptable. This winter, where the weather has not been bad and the levels of winter flu and norovirus have been low, is a timely warning.

## NEXT WINTER - THE CURRENT PLAN

As soon as the pressures of last winter receded, there was a widespread call, spearheaded by NHS Providers, to start the process of managing risk for next winter and beyond, looking at both what needs to change now and tackling the underlying strategic issues.<sup>7</sup>

The government's response has been twofold: additional investment in social care and prioritisation of A&E performance.

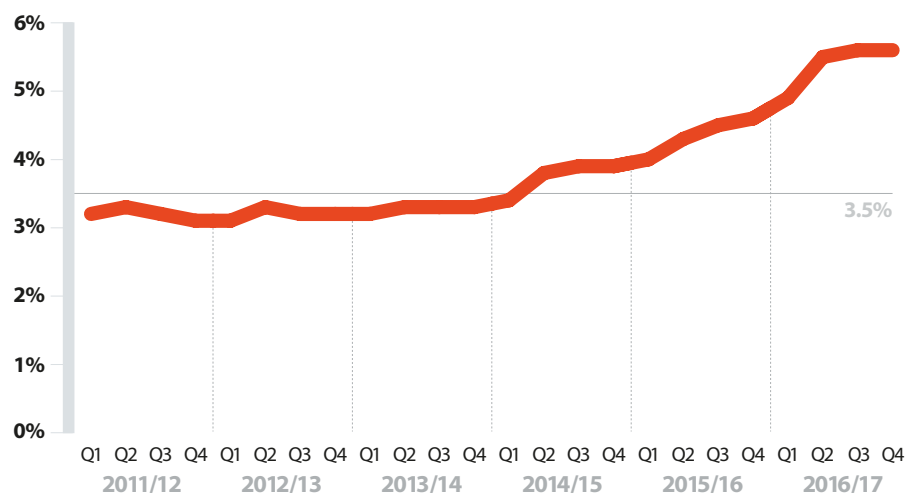
### Additional investment in social care

The March 2017 budget included an additional £2bn for adult social care, of which £1bn was given to local authorities in 2017/18 through the Improved Better Care Fund.<sup>8</sup> The conditions attached to the funding meant that councils were given discretion on which of three areas to spend it:

- adult social care
- reducing delayed transfers of care (DTOCs)
- stabilising the social care provider market.

At the time the NHS was concerned that these conditions would not be strong enough to ensure that sufficient funds would be spent on reducing DTOCs. However, given the proximity to the start of the 17/18 financial year, the government's decision was not to be overly detailed or directive as the money would not be spent in time.

**Figure 1**  
**Percentage of beds in England occupied by delayed transfers of care.**



Both NHS Improvement and NHS England expected this additional investment to prioritise alleviating pressure on the NHS, by funding additional social care packages and in turn reducing the number of DTOCs. This was designed to free up 2,000-3,000 extra NHS beds.

Local systems were asked to reduce delayed transfers of care from health to social care to 3.5%<sup>9</sup> and NHS Improvement wrote to all providers actively encouraging them to engage with their local authority(s) to discuss how this funding would be invested locally. However, it is worth noting that the NHS has not been able to meet a 3.5% DTOC level since quarter 1 of 2014/15 (figure 1 above), making it highly unlikely that the NHS will be able to meet this requirement by September 2017.

## Prioritisation of A&E performance

The *Next steps on the Five year forward view* document asked local systems to prioritise A&E performance, rather than non-emergency elective care, by linking the performance element of sustainability and transformation funding to meeting the four-hour A&E target.

As set out in the key deliverables for this year, by September 2017, over 90% of patients need to be treated, admitted or transferred in four hours. By March 2018, the majority of trusts are expected to meet the 95% standard, with full recovery by the end of 2018.

The national arm's-length bodies also asked that each local (A&E or urgent and emergency care) delivery board consider implementing a number of initiatives in advance of the coming winter to improve patient flow:

- implement a comprehensive front-door streaming model
- hospitals, primary and community care and local councils working together to avoid DTOCs
- specialist mental health care in A&Es
- strengthen support to care homes (e.g. through direct access to clinical advice and onsite assessment)
- implement the recommendations of the ambulance response programme
- standardise walk-in centres, minor injury units and urgent care centres
- roll out evening and weekend GP appointments
- increase number of 111 calls receiving clinical assessment.

For the provider sector the key question is whether these plans would go far enough to manage the risks particularly given that investment in reducing DTOCs could not be guaranteed over the other priorities identified for the additional social care funding.

# IS THE PLAN FOR NEXT WINTER WORKING? Evidence from the frontline

# 4

NHS Providers surveyed the NHS frontline to find out whether the plan was working and how well it would manage risk. We surveyed all types of provider trusts – acute hospital, mental health, community and ambulance – to understand, test and explore:

- the level and nature of provider involvement in discussions about how additional social care funding is being invested locally
- levels of confidence that additional social care funding will support the NHS to manage winter pressures this year, including the reduction in delayed transfers of care (DTOCs)
- the areas in the system where capacity will be most constrained this winter
- what additional support is required for all types of trusts and local health economy partners to manage winter pressures.

We had responses from 93 trusts which is 40% of the NHS provider sector. The survey has given us a snapshot view of how discussions are developing and how trusts are responding to the challenges.

The following two sections set out the results of the survey data:

- the first looks at how the additional social care funding is being spent, the discussions around this and the impact funding decisions will have on DTOCs
- the second looks at trusts' confidence in managing risk this coming winter.

## Survey results on additional social care investment

The first part of our survey looked at how the extra £1bn social care money for 2017/18 is likely to be spent and how local discussions were progressing.

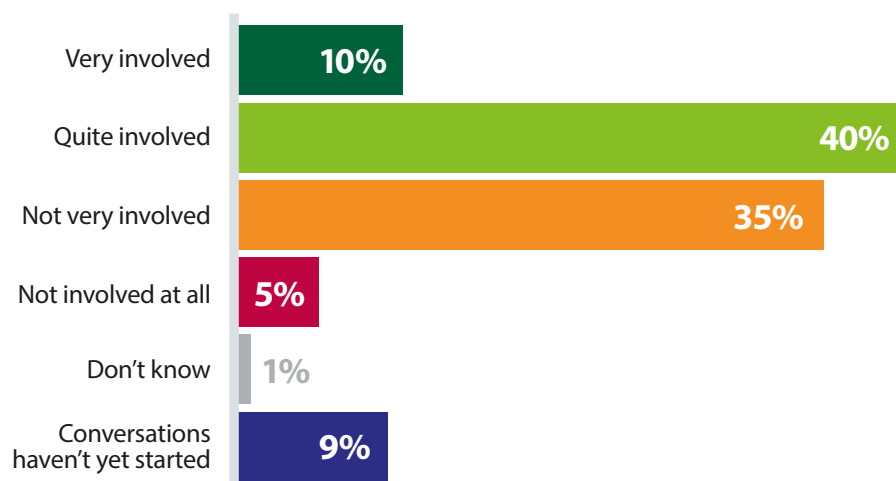
### Variation in the level of trust engagement in local discussions

Substantial emphasis has been placed on the importance of local systems working together to agree how the extra 2017/18 £1bn investment in social care can be deployed to best effect. However, as the evidence shows, provider engagement in the discussions is very variable. Only 50% of trusts felt involved in discussions with their local authority(s) about how the funding is going to be spent (figure 2).

Furthermore gaining access to discussions appears to be more challenging for mental health, community and ambulance providers, with only around a third (31%) indicating they are involved in discussions.

**Figure 2****How involved is your trust in discussions with your local authority(s) about how the additional funding for social care is going to be spent?**

(n=93)



The variability between and across providers and local authorities is particularly striking. Survey responses show one trust might have positive discussions with one local authority but have challenging discussions with the neighbouring local authority. At the same time, an acute provider might have constructive discussions with the same local authority that a mental health provider has found it challenging to engage with.

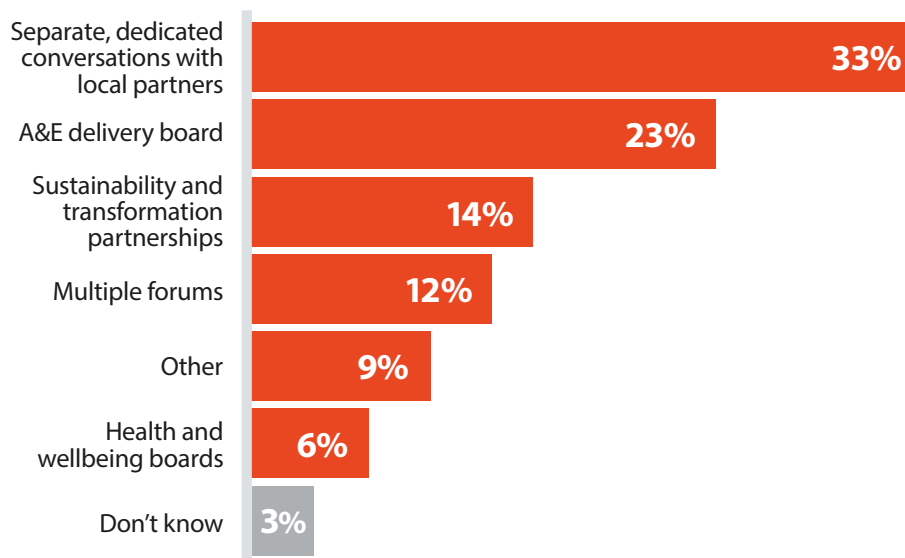
This variability might, in part, be a symptom of the delay in publishing the Improved Better Care Fund guidance for 2017/18. In the absence of clear guidance, the format and governance of discussions have been left to individual local health and social care economies to determine. It is, nevertheless, disappointing that three years in to the Better Care Fund, the key vehicle intended to bring health and social care together, there is still so much variability in the extent to which NHS organisations are brought in to these important discussions.

## Settings and structures in which the discussions are taking place

Discussions about the additional funding and how it will be spent are taking place in different ways across the country with over a third (33%) indicating that local partners were having separate, dedicated conversations (figure 3). Just over a fifth of organisations (23%) indicated that discussions were taking place at A&E delivery boards. Although across many local health and social care economies, these boards cover urgent and emergency care more broadly, the recent focus on A&E performance both nationally and locally, has potentially limited the involvement of community and mental health providers.

**Figure 3**  
**Please specify where the discussions about the additional funding are taking place?**

(n=93)



## How will the social care money be spent?

The guidance allows local councils to spend the extra £1bn for this year in three different ways:

- meeting adult social care pressures
- reducing pressures on the NHS
- stabilising the social care provider market.

There are clear and well-documented pressures on social care, and the need to give councils some flexibility around how the money is spent is understood. For example, the fragility of the social care market is well recognised: at the moment, one care home is shutting every week.<sup>10</sup>

Social care services are seeing increased demand, driven by the more complex needs arising from an ageing population; reduced funding; and increased costs due to the introduction of the national living wage. Like healthcare, the sector is also facing severe workforce shortages. For example, vacancy rates for social workers in the public sector rose from 7.3% in 2012 to 13.1% in 2015.<sup>11</sup> It is therefore understandable that some of the investment for social care needs to be targeted to support the social care market.

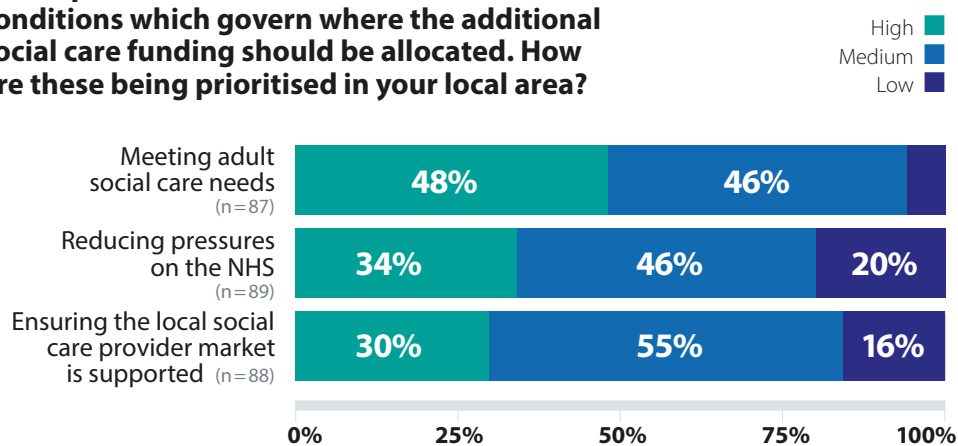
However, the Department of Health and its arm's-length bodies have also been clear that they expect to see a reduction in DTOCs from the NHS to social care as a result of this targeted investment. The proportion of the funding being dedicated to reducing

the pressures on the NHS, as opposed to the adult social care or the care home market support, will be key to delivering NHS plans to manage next winter.

We asked trusts how spending was being allocated across the three priorities.

**Figure 4**

**The improved Better Care Fund outlines three conditions which govern where the additional social care funding should be allocated. How are these being prioritised in your local area?**



From our survey results, around half of trusts indicated that funding is being spent to meet adult social care needs as a top priority in their local area, with 30% supporting the local social care provider market as their top priority (figure 4). Worryingly, reducing pressures was only a high priority identified by a third of trusts (34%), a medium priority in 46% and, most concerning, a low priority in 20%.

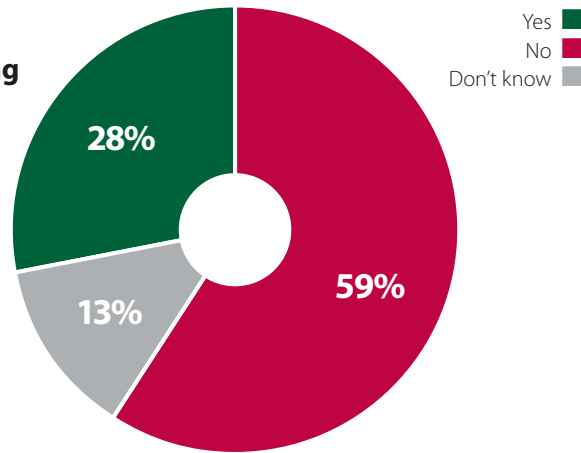
To gain further insights into how the social care funding would be used, we asked trusts if they had obtained a specific commitment for the funding to be spent in a way that reduced DTOCs, as the Department of Health plan intended.

Only around a quarter of trusts (28%) have had a specific commitment that the funding will help reduce DTOCs (figure 5), a percentage which increases slightly in the acute sector, with 38% reporting that they have received a specific commitment.



**Figure 5**  
**Have you had a specific commitment that the funding will be used locally in a way that will help reduce delays transferring patients from NHS care to social care?**

(n=93)

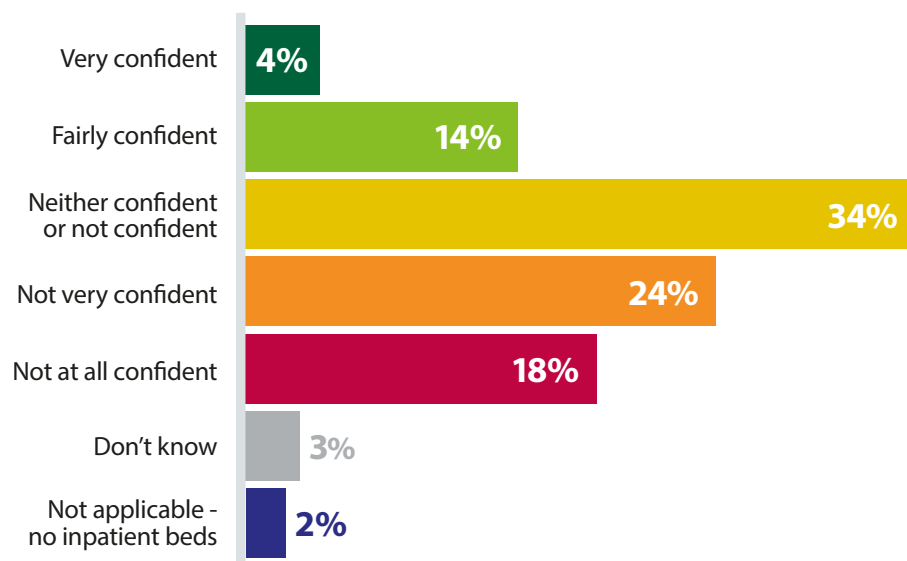


It is positive that 28% of all trusts and 38% of acute hospitals believe the money will flow as the Department of Health intended. However, it remains worrying that at the point the survey was completed, the remainder – around 60% - had not secured this commitment.

The key issue for the NHS is whether the extra funding will translate into reducing DTOCs to the extent required. We asked trusts whether the way in which the funding was allocated would support them to meet the NHS mandate target of reducing DTOCs to 3.5%.

**Figure 6**  
**How confident are you that the way your local authority(s) is allocating this funding will support you meeting the NHS mandate requirement locally?**

(n=91)



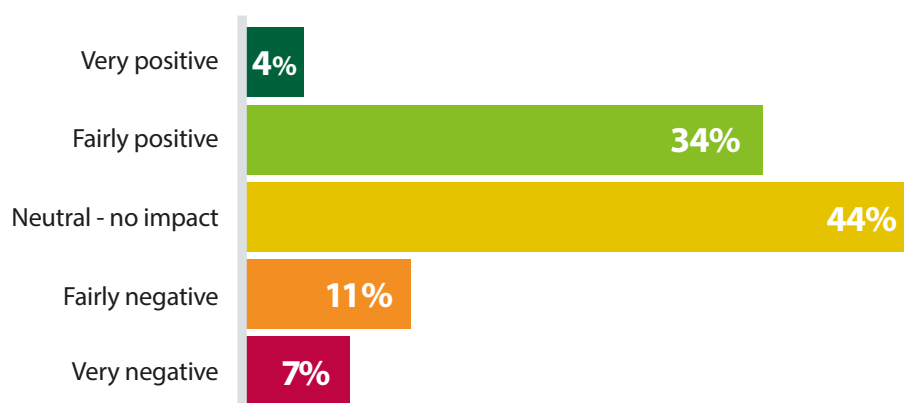
Again the survey results were worrying. Just under 20% of NHS trusts in our survey are confident that the additional social care investment going to local authorities will support them to reduce DTOCs. It is concerning that 42% were not very or not at all confident.

Finally, on social care funding, we asked more broadly about how the additional money is being invested will impact on trusts' ability to manage winter pressures (figure 7).

**Figure 7**

**What impact will the way additional funding for social care is being invested locally have on your ability to manage winter pressures?**

(n=89)



A number of reasons emerge for this lack of confidence in the efficacy of additional social care funding:

- After seven years of cuts in social care funding, alongside increasing demographic and cost pressures, the Local Government Association predicts a £2.6bn gap for social care by the end of the decade.<sup>12</sup> This means that the funding might, at best, only be able to hold services at their current level rather than lead to additional capacity in social care.
- Often schemes are funded on an ad-hoc and non-recurrent basis, but trust leaders are concerned that unless viewed as part of a wider joined-up system strategy for tackling DTOCs, they are unlikely to make a difference in isolation.
- Confidence in the funding is much lower among community and mental health trusts. Only 7% have been given a specific commitment to reduce DTOCs, which suggests that the focus is disproportionately on the hospital sector, at the expense of looking at the drivers of DTOCs across the system. This is at odds with what providers tell us they need: additional capacity in community, mental health and out of hospital settings.
- Discussions locally have tended to focus on inputs, rather than identifying the necessary outputs and outcomes required to reduce DTOCs.
- In previous years, discussions about planning additional capacity happened late and often without the necessary lead times to ensure best use of resources. As one trust explained "discussions about how the funding will be invested are so little and so late

in the day, that I have no way of knowing at this stage if there will be a positive or negative impact... I assume the worst case until I hear differently.”

It is positive that the survey shows there are a number of trusts and local systems – around a third – where it is likely that the social care funding will directly help reduce DTOCs. And, some of the spending on other priorities will provide extra care packages to meet adult care need and this should, by definition, help the overall health and care position in a locality, even if it does not directly reduce DTOCs.

However, overall, the survey results show that the NHS is unlikely to experience the gain in capacity – estimated at the equivalent of between 2,000-3,000 extra beds – that it needs. If we are to manage the risks of next winter, we will need to find alternative ways of generating the required extra capacity.

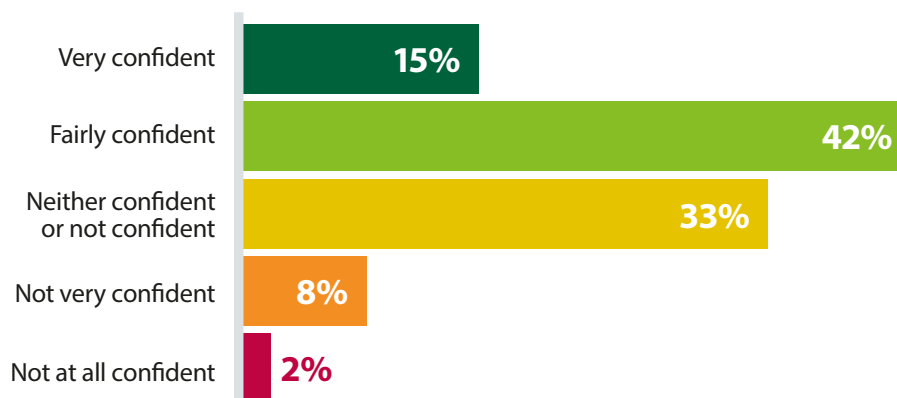
## Survey results on trusts' ability to manage risk this coming winter

The second part of our survey looked at the wider issues of frontline trusts' confidence in their ability to manage risk next winter.

We asked trusts about their confidence in their ability to deliver safe, high quality care this winter (figure 8). Although the majority of providers (57%) are confident, it is worrying that 10% are not confident, with 33% neither confident or not confident. This suggests that there will be significantly more trusts under pressure in the coming winter than there were last winter.

**Figure 8**  
**How confident are you that your trust will be able to deliver safe, high quality care this winter?**

(n=92)



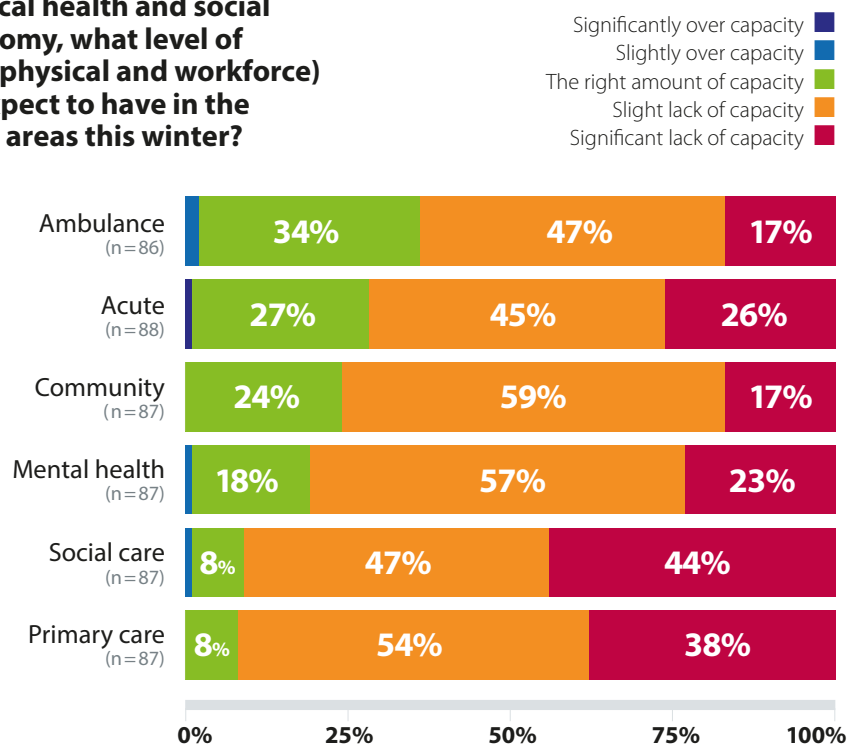
It also shows that the current plan for tackling winter pressures this year, in the form of additional social care funding and a national focus on improving A&E performance, is unlikely to be sufficient.

## Why are trusts not confident they can manage next winter's risk?

Our survey shows that, as with last winter, it is insufficient capacity across all parts of the health and care system that underlies this risk. It is striking that, when asked if their local system has the right capacity, trusts point to major capacity constraints across their whole system. As figure 9 shows:

- Ambulance – 64% of trusts report a significant or slight lack of capacity
- Acute – 71% report a significant or slight lack of capacity
- Community – 76 % report a significant or slight lack of capacity
- Mental health – 80% report a significant or slight lack of capacity
- Social care – 91% report a significant or slight lack of capacity
- Primary care – 92% report a significant or slight lack of capacity.

**Figure 9**  
**In your local health and social care economy, what level of capacity (physical and workforce) do you expect to have in the following areas this winter?**



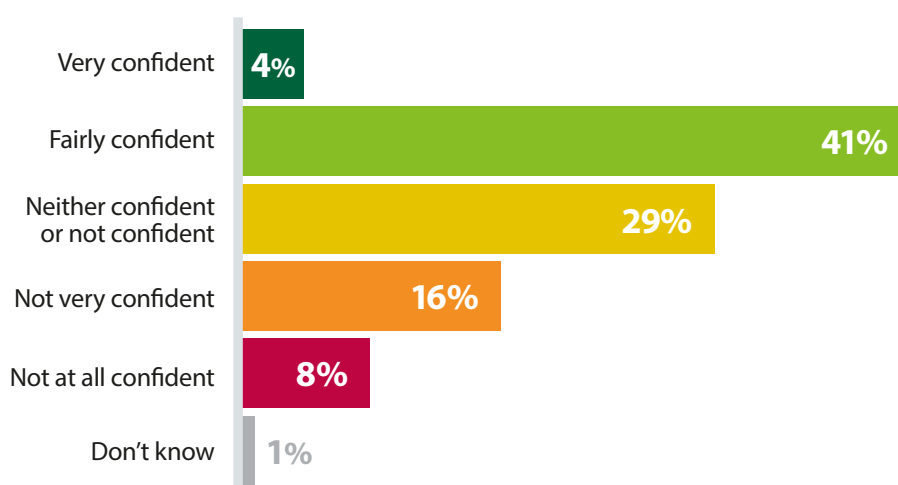
Clearly the highest levels of capacity concern focus on social care and primary care, reflecting the extent to which providers are heavily dependent on other parts of the health and care system. When capacity is constrained in these areas then the whole system faces real problems. A good example of the impact of this is in primary care.

### How much difference will the March A&E recovery plans and the *Next steps on the Five year forward view* document help to manage risk next winter?

Just under half (45%) of trusts were confident that the urgent and emergency care deliverables set out in the *Next steps for the Five year forward view* would have a positive difference to managing winter pressures locally (figure 10).

**Figure 10**  
**How confident are you that the deliverables above will make a positive different to managing winter pressures locally?**

(n=92)



Again, there are a number of reasons why trusts are concerned that many of these measures are unlikely to make a positive difference this winter, mainly focusing on wider system constraints such as capacity, funding and workforce. For example:

- One mental health trust commented that it is “all very well having mental health support in A&Es, however if the mental health inpatient units are full, we still will not be able to respond to the increase in demand.” This illustrates the importance of putting in place a system wide capacity plan, as additional resources in one part of the system might put pressure on another part of the system.

- There are substantial workforce constraints, limiting the ability of trusts to implement some of the initiatives, such as:
  - the challenges of rolling out GP streaming at A&E when there are already shortages in core primary care services
  - the need to implement additional ambulatory and frailty support when there are significant shortfalls in nurse recruitment
  - widespread recruitment challenges in the home care market.
- These changes will take time to bed in. Although national guidance is helpful, trusts still need the flexibility to design schemes and pathways which best meet the needs of their patients locally. One trust chief operating officer commented that “I don’t think we need more policy, just time to implement what we have, alongside room for local interpretation... we already have an innovative form of streaming to primary care and urgent care services... we want to go further to build a wider clinical hub adjacent to the emergency department, changing the model of care to reduce the likelihood of admission to hospital”.
- The recently allocated £100m capital funding for A&E is welcome, but many parts of the country might be unlikely to use it quickly enough to make a tangible difference this winter.
- Revenue support is required for many of the initiatives proposed in the key deliverables. For example, to fund GP streaming could cost around £0.5-1m per centre on a recurrent basis. Many trusts currently do not have this kind of surplus to support this initiative, and it will require funding from commissioners.

## The emerging picture for this winter

The traditional pattern for winter planning has been creating capacity to cope with peak demand in the winter months followed by relative respite during summer. However, this approach no longer applies and the system has needed to focus on year round operational resilience which is resource intensive.

Trusts will still work hard to ensure that they are creating as much free capacity as possible in preparation for the winter months. This in part relies on being able to recover performances after winter which may prove challenging this year.

In summary, our survey shows that the current plan of freeing up 2,000-3,000 NHS beds through the extra £1bn of social care funding is only likely to work in around a third of trusts. With 43% of trusts not confident they can manage next winter’s risk safely, more is needed.

# WHAT MORE DO NHS PROVIDERS NEED TO MANAGE RISK SAFELY THIS WINTER AND BEYOND?

# 5

Many of the risks facing the health service this winter are symptomatic of the wider challenges facing the NHS. So there are no silver bullets. However, structured conversations with provider trust leaders at a roundtable discussion in May 2017 and detailed responses to our survey questions have helped to identify a number of immediate and longer-term proposals to help manage this winter's risk. These proposals will support the NHS as it goes in to this winter and will also help to start the process of putting the whole urgent and emergency care system on a more sustainable footing for the future.

These proposals are set out below, offering immediate and longer term measures for the following three areas:

- funding and capacity
- workforce
- resilience planning and assurance.

## Funding and capacity

### Immediate measures

The NHS requires additional capacity urgently. Providers say this can only be delivered through an emergency cash injection in the form of winter resilience funding.

Trust leaders were asked what level of additional funding they would need to be confident of delivering safe, high-quality care this winter. NHS Providers analysis of this data shows that around £350m is required for the NHS provider sector to help manage next winter's risk.

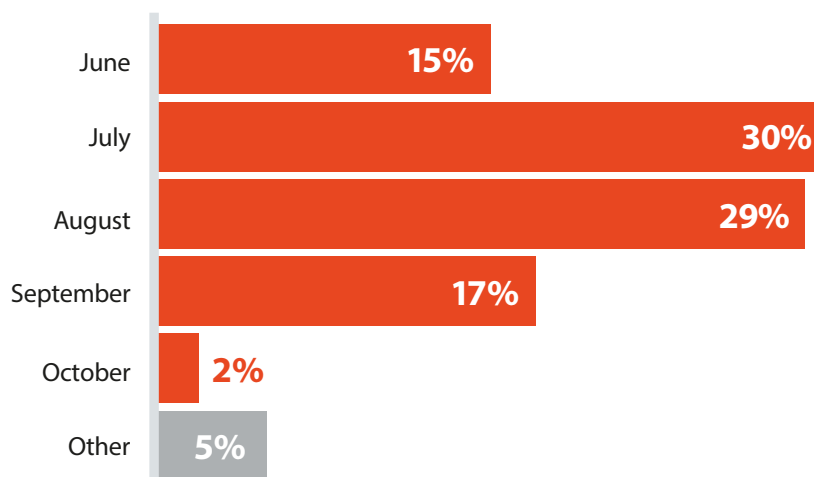
We asked trusts the latest date by which they need to know that additional funding or capacity would be received to make a positive difference during the coming winter (figure 11).

Over half of trusts said that they needed to know during July or August at the latest. Given the planning time required to commission and staff new capacity, decisions on additional investment need, ideally, to be made by the end of July or August in this timescale. The current workforce constraints mean trusts need as long as possible to find the necessary staff. The later the decision is made, the more money is likely to be eaten up in agency staffing fees.

**Figure 11**

**By when is the absolute latest that you need to know about any additional funding or capacity to make a positive difference this coming winter?**

(n=92)



## How would the additional investment be used?

When considering how to use additional investment to create capacity, it is critical to avoid a narrow focus on acute hospital capacity. Urgent and emergency care is a cross-system issue, and depending on the particular composition and challenges facing different areas, the money could be spent on:

- **Investing in bed capacity out of hospital**

Many trusts say additional bed capacity in the community and mental health sector is urgently required for this winter. This could help tackle pressure on acute bed capacity, for example by providing step-up facilities to keep patients out of hospital, or by providing assessment beds required to support the discharge to assess pathway. Several acute trusts are also looking to roll out virtual wards in the community to care for patients outside the hospital, which additional funding could support. Additional escalation beds in the acute sector will also be required, and this needs to be considered as part of a wider strategy to ensure sufficient bed capacity across the whole system.

- **Expanding ambulatory care**

Additional funding could support the further expansion of ambulatory care, allowing trusts to remove patients from acute medical units and emergency departments in a timely way, before their condition further deteriorates.



- **Recruiting medical, nursing and care home staff**

Employing temporary staff when there are already widespread vacancies in the permanent workforce is challenging. However, the early release of winter resilience funding will give trusts an opportunity to undertake the necessary recruitment well in advance of winter, rather than having to resort to expensive agency staff.

- **Investing in the ambulance sector**

Ambulance trusts play a crucial role in managing demand and improving patient flow in the urgent and emergency care system. Additional funding could, for example, support the expansion of hospital ambulance liaison officers at each major acute hospital to ensure smooth and timely handover of patients and minimise delays in emergency departments. Additional clinical staff, including advanced trained paramedics, nurses and mental health nurses, could also be placed in clinical hubs to further reduce the number of patients conveyed to emergency departments. Additional capacity in discharge and transfer ambulances could support discharging patients by conveying patients to step down facilities.

- **Creating additional packages of care and residential placements, including reablement**

Trust leaders are not confident that the additional social care funding will lead to sufficient social care provision, and at best might only be able to hold existing provision for this winter. Additional funding would help support trusts to work with local authority partners to put in place more social care capacity, including packages aimed at keeping people out of hospital in the first place.

- **Expanding mental health crisis care**

There is a strong case for ensuring that additional investment is used to ensure comprehensive 24/7 mental health crisis care across the country to prevent hospital admissions. Funding could also be used to support new models of care such as mental health street triage so that people are assessed in the community before their condition deteriorates and requires an inpatient stay.

- **Targeting support to primary care and social care**

Too many admissions to hospital still come from primary care and social care, where there is often a lack of confidence and capacity to keep people out of hospital. Investing in trusts to provide targeted support, whether remotely or physically, to nursing homes, care homes and primary care, could help increase capacity in primary and social care.

This range of options demonstrates that there is no single right answer to how extra money should be used to create capacity. The key is to ensure that local systems are empowered to make the decisions that best suit their needs.

## Principles for allocating funding

Allocating winter resilience funding in a fair and effective way is complex. The NHS has a long history with regard to winter funding and, up until 2014/15, additional funding was made available nationally, part way through the year, to sustain the urgent and emergency care system during winter. NHS Providers argued that this approach had two key disadvantages: it gave no planning certainty and the money often arrived too late during the year to spend with maximum effectiveness. We therefore argued that the money should be mainstreamed through the main NHS budget setting and planning process but with specific sums earmarked for winter resilience.

From 2015/16, the funding was incorporated in to CCG baselines, with the intention that this would enable systems to plan properly and early enough. However, very few trusts have continued to receive dedicated winter resilience funding, further exacerbating efforts to manage winter pressures.

In reality, dedicated winter funding has, in very many cases, been used for general funding. The proposed earmarking of funds has failed. Ultimately, significant amounts of extra capacity that were previously funded via winter pressures funding has no longer been commissioned at all.<sup>13</sup> This cannot be right.

Allocating funding midway through the year is not ideal. However, it is now urgently required to support the health and social care system this winter, alongside a commitment to pursue longer-term solutions to ensure sustainability and performance across the year as well as over winter.

A number of decisions would need to be made about the source of the additional investment. As a proportion of an annual budget of around £90bn for provider trusts, £350m is very small. However, given the extreme financial constraints the NHS faces – at June 2017, there is a £500-750m system level financial gap for 2017/18 – other approaches need to be considered. Given the speed with which the money is needed for 2017/18, it could be committed as a loan that would be paid back through other routes the following year. These routes could include recouping costs currently tied up in back office, administrative functions at a national level. Or the NHS could make an early draw down on the extra £8bn committed to the service in the Conservative manifesto.

Decisions also need to be made about:

- how to allocate winter resilience funding, including whether funding flows directly to providers, or through commissioners or another vehicle
- how to determine what level of funding providers receive, given that if purely allocated to emergency activity or performance alone, other parts of the urgent and emergency care system would lose out.

Key principles for the distribution of this funding need to include:

- **Immediacy**  
Any additional funding needs to be put in to the system immediately, if the NHS is to use it to best effect. Leaving it too late could leave organisations with limited opportunities to invest the money effectively.
- **Balancing simplicity with accountability**  
With any additional investment made in the NHS, it is important to demonstrate how it is being used to the benefit of patients. The need to provide assurance over how the additional funding is being spent needs to be balanced alongside the need to ensure that this funding is allocated in the simplest way possible, without substantial strings and conditions attached. This proposed additional investment is to plug an existing gap and mitigate existing risk. It is therefore a means of helping assure delivery of the performance levels that have been already set, not increasing them.
- **Cross-sector**  
Traditionally, the acute sector has benefitted most from winter resilience funding, at the expense of the mental health, community and ambulance sectors. That said, investment with an acute provider does not necessarily lead to more capacity in the acute sector alone, as we are seeing an increasing number of acute providers buying capacity to support the mental health, community and social care sectors. Resilience funding needs to reach all parts of a local system, rather than being made available on a bidding basis, which can overlook those most in need.
- **Recurrent and ring-fenced**  
To put the urgent and emergency care system on a more financially-sustainable footing, funding needs to be recurrent, and if it is incorporated into CCG baselines it also needs to be ring-fenced. Pressures on the NHS over winter will continue to grow in line with cost and demand growth. Therefore the response needs to be recurrent funding.
- **Transparency**  
Any additional investment in the NHS this winter needs to be allocated in a transparent way, so that there is a clear link between investment made locally and additional capacity bought. The only way to clearly demonstrate this would be through directly allocating to providers.
- **Tackling areas in most need**  
The maturity of local systems varies in terms of operational resilience planning. Suggestions to allocate the funding to sustainability and transformation partnerships or urgent and emergency care boards will only advantage those systems with mature relationships, and could mean that the very systems most in need would lose out. A simple approach is key to ensure that the NHS uses this funding in the most effective way possible.

## Long-term funding measures

In the future providers need:

- **An appropriately-funded urgent and emergency care system, including social care**

The payment system (the national tariff) fails to appropriately reimburse the costs acute providers face over winter and, combined with the continuation of penalties for over performance, leads to providers losing millions of pounds which could otherwise have been reinvested back in to patient care. We need to fix the financial imbalance between elective and non-elective care, and between acute and non-acute providers. Separate funding arrangements for other parts of the urgent and emergency care system, including mental health, community and ambulance, mean that incentives are not aligned to support effective financial planning at winter.

- **Investment in infrastructure**

Most hospitals are now treating tens of thousands more in their A&E department than originally planned. Trying to manage ever-increasing acute demand in hospital without increasing physical infrastructure is not sustainable. Hospitals need capital to reconfigure their emergency departments and improve flow and layout. The additional £100m capital investment announced earlier this year is helpful, but it is only designed to enable front door GP streaming. It doesn't help most providers undertake the broader transformation required. We need to recognise that continuing to restrict capital spending is preventing providers doing their best for patients.



*Allocating funding midway through the year is not ideal. However, it is now urgently required to support the health and social care system this winter, alongside a commitment to pursue longer-term solutions to ensure sustainability and performance across the year as well as over winter.*

## Workforce

The recruitment and retention of staff is now one of the biggest challenges facing NHS leaders. In our first *State of the NHS provider sector* report, 59% of trust leaders considered that they don't have the right staff numbers, quality and mix to deliver high-quality care.<sup>14</sup>

Being able to respond to winter pressures is only possible with the outstanding effort, commitment and professionalism of frontline NHS staff. However, staff are now often being required to work way beyond the reasonable call of duty to ensure patients are given high-quality and safe care. NHS professionals are working under greater pressure and intensity. In last year's staff survey, nearly two in five staff reported that they had been ill in the past 12 months due to work-related stress. This is true for nearly half (49%) of all ambulance staff.<sup>15</sup>

There are high vacancy rates in job groups critical to supporting the urgent and emergency care system, including A&E consultants, psychiatric nurses, home care workers and general practitioners.

We need to manage these pressures both for the coming winter and in the longer term.

### Immediate measures

- **Balancing agency spend with the need to increase capacity this winter**

With workforce shortages so widespread, trusts are often left with few alternatives other than to employ costly agency staff to increase capacity over the winter period. The agency cap has succeeded in pushing agency staff back in to permanent roles, however trusts still need to have the flexibility to access additional staff. The national arm's-length bodies must take a proportionate approach to the use of agency staff in the NHS this winter recognising that, in the short term, there will be a legitimate need to use temporary staff to increase capacity. In recent months, there has also been a disproportionate increase in the reporting requirements around agency staff. These arrangements need to be simplified as soon as possible to ease the burden on the already stretched frontline.

- **Bolstering the nursing workforce in the short term**

Trusts do their best to avoid using agency staff unless it is absolutely required. There are no quick fixes to the high vacancy rates in the nursing workforce, but trusts are looking to bolster the nursing workforce in the short term by using different staff such as allied healthcare professionals, pharmacists and physiotherapists to undertake a range of roles traditionally filled by nursing staff. This approach will require backing and support from NHS system leaders.

- **Flexibility over NHS staff**

The *Next steps in the Five year forward view* called for emergency performance to be prioritised over other areas such as non-emergency elective care. However, the NHS workforce is not currently set up in a way to enable this flexibility of approach – switching capacity between different priorities. We need to quickly identify what is needed to create the required flexibility, for example working with Health Education England and deaneries to support junior doctors to work more flexibly in trusts.

## Long-term measures

- **A comprehensive workforce strategy which takes account of what the NHS is being asked to deliver** and which facilitates recruitment to key shortages in urgent and emergency care.

- **Greater flexibility between NHS and social care workforce**

NHS staff are employed on different terms and conditions to social care workers and we need to simplify these arrangements so that our workforce can be used more flexibly to fill gaps. This will be challenging. But many trusts now recognise that they can support the social care market themselves, either by directly employing social care workers or by designing new models of care delivery, such as looking to health care assistants to work in domiciliary care settings. One northern trust is even looking at how to leverage social care staff in an acute setting, when someone with a social care package is admitted in to hospital. At the moment, when a patient with complex needs is admitted, their social care package is often disbanded and workforce re-allocated. This means that work has to start afresh to secure a new social care package for a patient when they are ready to be discharged. In future, when that patient is admitted, social care workers could be directly involved in supporting that patient in hospital, so that there is continuity of care and the resources ready for when that person is able to be discharged.

- **An immigration system which facilitates recruitment to key shortages in the health and care system**

It is clear that for the foreseeable future high-quality and sustainable health and social care services will continue to depend on workers from outside the UK. Extending the current work visa system for people outside the EEA to include those inside would not support this, as the existing system is not fit for purpose and poses too many barriers to recruiting sufficient numbers of staff. Any new system needs to take account of the value and contribution the health and social care sector provides to the UK economy and population, with public service value used as a key assessment of 'skill' as opposed to salary. This will enable recognition of the range of roles we will need to recruit.

## Resilience planning and assurance

Trusts have worked hard with NHS Improvement and NHS England to improve local system management, to empty beds in preparation for the period of greatest stretch and systematically improve performance. However, planning is still too variable across the country, and urgent and emergency care boards/A&E delivery boards are not yet working effectively across the country. To overcome this, providers need to see the following.

### Immediate measures

- **Early triangulation from the national bodies**  
An early check from arm's-length bodies on the deliverability of winter plans is required to ensure that those areas struggling to reach agreement on additional capacity are identified and providing them with support to create it.
- **Operational resilience planning across health and social care**  
Many trusts and local authorities are working more closely together on a week-to-week basis, which should be encouraged. For example, several local areas have set up weekly meetings with chief operating officers across the health and social care system to ensure that there is a good line of sight over whole pathways of care.
- **Move from assurance to support**  
Substantial senior management time is lost during winter to daily conference calls with the arm's-length bodies. As one chief operating officer told us, these calls "exist to provide assurance to the national level rather than develop solutions" to the challenges providers are facing on the ground. Another commented that the "culture of assurance has gone too far" with trusts spending a lot of time collating information for regulators, simply reporting the situation on the ground.
- **Simplify SITREP reporting**  
There is currently a high level of burden associated with SITREP reporting, with many trusts having to employ dedicated staff just to comply with the reporting procedures. One trust told us that the day they had to trigger an OPEL 3, the people required to generate all the paperwork were the same ones required to deal with the problem on the ground. This is counterproductive, and the process needs to be streamlined.
- **Greater alignment between national bodies**  
Trusts continue to report that the duplication in regulatory efforts between NHS Improvement and NHS England is significant, with different organisations working to slightly different timescales and for slightly different subsets of information. This needs to be simplified as a priority this year.
- **Proportionate regulation**  
Trusts are concerned that care homes are increasingly risk averse, due to perceived fears around the CQC taking regulatory action. We encourage the CQC to work with the care market to explore how this can be addressed.

## Long-term measures

- **Review membership of A&E boards**

The membership and remit of A&E boards across the country is still too variable. The recent focus on A&E has also meant that key providers in the urgent and emergency care pathway, such as mental health providers, have not been fully involved in operational resilience discussions.

- **Building relationships across the health and social care system**

In many parts of the country, relationships between health and social care are positive. However, we need to strengthen these further at every level – individually, institutionally and system wide. Trust between individuals in particular is necessary to both shore up admission prevention and to support the safe and timely discharge of patients. All evidence points in the direction of effective relationships being key.

- **Move planning focus from crisis management to prevention**

The limited funding available for resilience planning locally has often focused discussions on discharge, rather than prevention. In many parts of the country, there is emerging evidence around the effectiveness of new models of care, aimed at reducing demand trends and ensuring patients are seen in the most appropriate settings. Only by balancing the need to invest in discharge schemes, as well as prevention initiatives, will operational resilience planning be effective.

- **Providing a seven-day service across a local footprint**

Admission avoidance and timely discharge can only happen if all organisations in the urgent and emergency care pathway have services available seven days a week.



## CONCLUSION

What is clear from the survey and detailed conversations with NHS trusts on the frontline is that the health and care system needs to act now, and act together, to avoid a number of risks:

- risks to the quality of care patients and the public receive
- risks to the safety of services
- risks to the sustainability of services
- risks to the workforce and increasingly poor morale.

There needs to be an honest conversation at every level – institutional, local, regional, national – about how we plan to manage the immediate challenges we face and how we put in place measures and strategies to tackle demand and capacity issues in the longer term. This must involve every part of the provider sector: acute hospitals, mental health, community and ambulance services. Focusing solely on and prioritising A&E performance will be self-defeating when it is these other services, along with social and primary care, which are at the forefront of urgent and emergency care delivery.

The government's additional funding of £2bn for social care has been welcomed in every quarter. However there is a clear lack of confidence across NHS trusts delivering care on the frontline that the investment will be spent by local government in a way that overcomes the capacity challenges the NHS faces:

- only 18 % of NHS trusts are confident it will help them meet the NHS England Mandate requirement to reduce DTOC levels to 3.5%
- only 28% of trusts received a specific commitment that the money will be used to reduce DTOCs.

NHS Providers is calling for an additional investment of £350m to tackle the immediate problems. This money needs to be committed directly to the NHS by July or August, or it will not be used effectively or efficiently. At the same time there needs to be a national-level commitment to start work on the longer term strategies that will help solve the underlying structural and capacity pressures we are grappling with each winter.

If this does not happen, the coming winter and all those thereafter will be increasingly challenging, pressurised and most importantly risky. As one trust leader put it:

*"Our walls are not elastic,  
and we are unable to simply  
flex capacity up or down."*

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NHS Providers has 97% of all trusts in membership, collectively accounting for £70 billion of annual expenditure and employing more than 975,000 staff.



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