

Working together to deliver a resilient winter

System roles and responsibilities

The NHS England operating framework describes the roles that NHS England, integrated care boards (ICBs) and NHS providers should play, working alongside our partners in the wider health and care system. It outlines our collective accountabilities and responsibilities to ensure we deliver a health service that maximises outcomes for patients.

As we continue planning for winter it is important that we are clear on the actions that each part of the NHS system must now take to ensure that we are collectively pulling in the right direction to deliver for patients.

To support this, we have developed a set of recommended winter roles and responsibilities for each part of the system, which are included in this document, largely taken from existing guidance and recovery plans. These build on the core objectives outlined in the winter letter and provide a platform for systems to be clear on how actions are taken in all areas to deliver a resilient winter period.

The roles and responsibilities are designed to be supportive and provide clarity but are by no means exhaustive – each system should use these to develop their winter planning return and consider how these relate to the circumstances within their individual system.

Integrated care boards

- Ensure that the system winter operating plan incorporates all the high-impact interventions and actions for the entire health and social care economy. This should include specific operating actions for all system partners across acute, community, mental health, primary care as well as links with local authority services. Systems should ensure that plans reflect the needs of all age groups, including services for children and young people.
- Facilitate partnership working – ensuring that all system partners are pulling in the same direction to deliver a resilient system this winter, and appropriately manage risk to ensure that it is balanced across the entire system, ensuring all parts of the system are held to account for delivery of their responsibilities.
- Be accountable for the delivery of capacity in line with agreed 2023/24 ICB Operating Plan – including additional capacity identified via the winter planning exercise.
- Ensure that arrangements are in place to lead the system through winter – including:
 - maintaining 24/7 oversight of system pressures through the System Co-ordination Centre (SCC)
 - implementing the revised SCC specification to ensure appropriate structures, systems and process are in place to maintain operational oversight and delivery
 - implementing the revised Operating Pressures Escalation Levels (OPEL) Framework in a consistent manner across all acute sites as the key clinical safety indicator of system pressure
 - leading the development of a comprehensive winter operating plan underpinned by a locally agreed operating model.
- Ensure infection prevention and control (IPC) colleagues are involved in winter planning and that they continue to be involved in responding to winter.
- Lead the liaison and engagement with the voluntary, community and social enterprise partners to ensure that they are fully engaged in winter planning and their support maximised.
- Ensure the continued workforce supply through early planning of actions to mitigate any loss of education and training during the periods of greatest winter service pressures.

Lead the delivery of high-impact interventions 5-10

- **Care transfer hubs:** In partnership with local authorities, implement a standard operating procedure and minimum standards for care transfer hubs to reduce variation and maximise access to community rehabilitation and reablement

services and prevent unnecessary re-admission to a hospital bed. Improve the operation of current care transfer hubs from the baseline assessment, including operation throughout the winter holiday period.

- **Intermediate care demand and capacity:** With local authorities, commission sufficient capacity to meet projected demand for step-down care, including both home-based and bed-based care, to facilitate the timely discharge of patients from across acute and community hospitals and services.

Make effective use of the Better Care Fund, including the Discharge Fund, to support patients to leave hospital with a package of care where needed.

Ensure that capacity and resource gaps are escalated, and actions progressed; all data is submitted for all commissioned beds to the Community Discharge and Acute Discharge SitReps and the Capacity Tracker.

Ensure data sharing arrangements are in place to enable rehabilitation/recovery plans to be shared by partners providing services and to streamline pathways and reduce duplication.

Embed mechanisms to enable monitoring of the impact of intermediate care interventions on people's functional outcomes and their long-term care needs.

- **Virtual wards:** Be accountable for the delivery of virtual ward capacity and maximising virtual ward use, ensuring 80% occupancy across VWs is maintained over the winter period. Systems should ensure appropriate step-up and down capacity is in place at scale for frailty, respiratory and for heart failure, ensuring capacity is tightly aligned to winter flow priorities. This includes:
 - All step-up virtual wards should be accepting admission alternative referrals from care homes, ambulance trusts, primary care, and urgent community response ahead of winter and should ensure there are clear agreed processes in place between partners.
 - **Urgent Community Response (UCR):** Ensure full geographical coverage with a minimum of 7 days a week and 08.00-20.00 operating times – going beyond the 9 clinical conditions/needs set out in the national specification to meet all appropriate community-based demand. Ensure, through working with the ambulance service, that plans are in place for most clinically appropriate Cat 3 or 4 calls to be diverted to UCR or community-based falls services.
 - **Advanced clinical support:** You should also ensure that care homes have access to advanced clinical decision-making support outside of UCR operational hours (eg 8pm to 8am) to ensure residents receive treatment and care in the right setting, and to enable clinical risk sharing across the system.
 - **Single point of access:** driving standardisation of urgent integrated care co-ordination which will support whole system management of patients into the right care setting, with the right clinician or team, at the right time. This includes

increasing the number and breadth of services profiled on the directory of services (DoS) and ensure steps are in place to maximise the use of the DoS.

- **Acute respiratory infection (ARI) hubs:** support consistent roll out of services for adults and children and young people, prioritising acute respiratory infection, to provide same day urgent assessment with the benefit of releasing capacity in emergency departments and general practice to support system pressures.
- Through commissioning actions, ensure that **NHS 111** clinical input is prioritised where it will have most impact – in particular, maximising the assessment of NHS 111 Category 3 or 4 ambulance dispositions. Ensure that robust workforce plans are in place for NHS 111 service advisors, health advisors and clinical advisors. This should include using home working opportunities to the full.
- Support the delivery of key actions from the **Primary Care Recovery Plan** that will support winter pressures, including over the Christmas/New Year Period by improving access to general practice – particularly:
 - Increasing support for self-directed care
 - Expanding community pharmacy services
 - Implementing modern general practice by:
 - engaging and nominating their practices and PCNs to join the national [general practice improvement programme](#)
 - supporting practices to move to cloud-based digital telephony and to access the right digital tools
 - improving online patient journeys, including practice websites
 - understanding general practice transformation maturity and support needs, via completion of the support level framework to enable ongoing local support to continue improvement:
 - to make online channels easy to use
 - to enhance navigation and triage processes
 - to improve the experience of access
 - to understand and better match demand and capacity.

Increasing capacity with larger multidisciplinary teams, including over the Christmas period

Improving the primary-secondary care interface.

Acute and specialist NHS trusts

Lead the delivery of high-impact interventions 1-4

1. **Same day emergency care (SDEC):** Reducing variation in SDEC provision by providing guidance about operating a variety of SDEC services for at least 12 hours per day, 7 days per week.
2. **Frailty:** Reducing variation in acute frailty service provision. Improving recognition of cases that could benefit from specific frailty services and ensuring referrals to avoid admission.
3. **Inpatient flow and length of stay:** Reducing variation in inpatient care and length of stay for key integrated urgent and emergency care (iUEC) pathways/conditions/cohorts by implementing in-hospital efficiencies and bringing forward discharge processes for pathway 0 patients. This includes through:
 - a. Delivering improvements in ambulance handover times
 - b. Ensure documented internal professional standards are in place for rapid specialty in-reach to urgent and emergency care pathways 24/7 – ensuring that patients requiring admission are moved from the emergency department in line with these standards. Put in place mechanisms to monitor performance against these standards and take action to course correct delivery where required.
4. **Community bed productivity and flow:** Reducing variation in inpatient care and length of stay by maximising therapeutic interventions to reduce deconditioning and bringing forward discharge processes.
 - Ensure that general and acute beds are available and open in line with the agreed 2023/24 ICB Operating Plan – including escalating the number of beds as needed in line with the winter addendum to this plan. This includes monitoring and reducing occupancy in the run up to Christmas.
 - Focus on improving performance against the four-hour standard for type one attendances, to contribute to the overall A&E performance target of 76%.
 - Continue focused efforts on patients attending A&E who spend more than 12 hours in department from arrival to discharge, admission or transfer.
 - Ensure clear arrangements for early referral to care transfer hubs where patients are likely to require step-down care following hospital discharge. Align processes and protocols with standard operating procedures for care transfer hubs to reduce variation, minimise discharge delays, maximise access to community rehabilitation and reablement and optimise 7-day working. Provide timely data where needed by care transfer hubs to support governance,

operational grip and decision-making and to support intermediate care capacity and demand planning.

- Ensure that sufficient capacity is in place to protect the elective pathway for both adults and children and young people – with clear triggers in place to open additional non-elective capacity in line with the winter addendum to the 2023/24 Operating Plan.
- Ensure actions to improve the primary and secondary care interface set out in the Primary Care Access Recovery Plan are implemented with system wide understanding of pressures across the totality of the UEC pathway including primary care.
- Ensure that robust workforce plans are in place to respond to an increase in demand over the winter period, including planning annual leave to maintain a continuous physician presence throughout the Christmas/New Year period. This should include planning for a possible increase in staff sickness associated with an increase in winter illness, including Covid-19 and influenza.
- Implement flexible mechanisms for staff pooling and utilisation of resources across organisational boundaries, including increasing use of staffing banks to onboard both health and care workers to the right part of the pathway utilising ‘mutual aid’ arrangements where needed and supplemented by digital solutions.
- Ensure that a robust plan is in place for the vaccination of staff, volunteers and patients against influenza and that plans are in place to rapidly respond to any other vaccination programme recommended by the Joint Committee on Vaccination and Immunisation (JCVI)

Primary care

Ensure plans are in place to maintain access to primary care services between 18 December 2023 and 8 January 2024, including ensuring Bank Holiday cover in line with primary care national contracts is in place, so that patients can access services in primary care settings over the Christmas and New Year period.

- Ensure tools are in place to understand demand, activity and capacity in primary care, eg operational pressures escalation levels (OPEL) reporting. This should be shared across the system to give a comprehensive view of primary care pressures and where support may be required that could alleviate pressure on primary care and on the UEC pathway.
- Through working with the ICB and other system providers, ensure additional capacity is in place to respond to a surge in demand for primary care services – including through the development and provision of hot hubs and/ or acute respiratory infection hubs.
- Ensure proactive identification and management of people with complex needs and long-term conditions, so care is optimised ahead of winter and that people are supported to better manage their health, to reduce demand on primary and secondary care.
- Work with the ICB to develop system plans and communication strategies to maximise the role of general practice and community pharmacy.
- Lead delivery of actions from the Primary Care Recovery Plan that will support winter pressures, particularly:
- Support the delivery of key actions from the **Primary Care Recovery Plan** that will support winter pressures, including over the Christmas/New Year Period by improving access to general practice – particularly:
 - Increasing support for self-directed care
 - Expanding community pharmacy services
 - Implementing modern general practice by:
 - engaging and nominating their practices and PCNs to join the national [general practice improvement programme](#)
 - supporting practices to move to cloud-based digital telephony and to access the right digital tools
 - improving online patient journeys, including practice websites
 - understanding general practice transformation maturity and support needs, via completion of the support level framework to enable ongoing local support to continue improvement:
 - to make online channels easy to use



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Children and young people (CYP) services

Winter plans should reflect the needs of the local children and young people's population, with actions in place to manage pressures in paediatric services.

- **High-impact interventions for children and young people:** ICBs should ensure commissioning arrangements are in place to support scaling of age-appropriate virtual ward models and ARI hubs; building on pilots and plans and targeting areas of greatest needs to effectively manage winter pressures and increases in respiratory infections.
- **Whole-system planning:** embed whole-system approaches to winter planning for paediatric services, linking to paediatric critical care surge planning and Level 2 bed provision expansion, led by operational delivery networks (ODNs) with paediatric ARI hubs and virtual ward development. Disaggregate datasets should be available at ICB level to permit monitoring of CYP data, pressures across paediatric services, as well as the wider system and patient pathway, including primary care, acute and mental health services, immunisation, and school attendance.
- **Paediatric critical care surge planning:** ICBs and ODNs should work in partnership to co-ordinate, implement and oversee robust winter and surge planning, including mitigations to manage the impact of surges in paediatric respiratory infections on CYP services. This should include mutual aid arrangements at regional and national level, particularly for Level 3 paediatric intensive care unit (PICU) bed provision and for children on long term ventilation.
- **Mutual aid:** ensure local winter plans include mutual aid considerations across paediatric and adult teams, between providers within the system, and across systems.
- **Protecting elective capacity for children and young people:** ensure preservation of the standard clinical pathway for CYP elective surgery, critically ill children, emergency, general and specialist services and continue to reduce disparity in elective recovery between adults and CYP. Ensuring close monitoring of paediatric surgery cancellations.
- **Vaccination uptake:** ensure that a robust plan is in place to maximise uptake of childhood and flu vaccinations as part of winter preparedness.
- **Supporting self-care and management of minor illness:** ensure targeted communication and paediatric advice is available to parents/carers. Ensure collaborative approaches with VCSE partners, embedding preventative approaches to support parents/carers in management of minor illness and navigating NHS services, particularly across areas with high attendances and communities that experience the greatest health inequalities.

Community trusts and integrated care providers

Lead and support the delivery of high-impact interventions 4-6

- **Community bed productivity and flow:** reducing variation in inpatient care and length of stay by implementing in-hospital efficiencies and bringing forward discharge processes. This includes:
 - ensuring actions from daily ward and board rounds have been implemented and are being recorded or escalated in the day
 - discharge planning takes place early on in admission and in conversation with the person and/or next of kin
 - screening, assessment and rehabilitation plans are in place and communicated to the person and/or their next of kin
 - protocols for mobilisation of the individual are in place
 - workforce planning to ensure rehabilitation needs are met with minimum delays.
- Ensure clear arrangements for early referral to **care transfer hubs** where patients are likely to require step-down care following hospital discharge. Align processes and protocols with standard operating procedures for care transfer hubs to reduce variation, minimise discharge delays, maximise access to community rehabilitation and reablement and optimise 7-day working. Provide timely data where needed by care transfer hubs to support governance, operational grip and decision-making and to support intermediate care capacity and demand planning.
- Ensure focus on **admission avoidance**, ensuring 24h access to palliative care services and enhanced join-up between primary, community and social care services through enhanced care in care homes.
- **Data sharing and submission:** Reducing variation in inpatient care and length of stay by implementing in-hospital efficiencies and bringing forward discharge processes.
 - Submit data for all commissioned community beds to the Community Discharge SitRep.
 - Ensure data sharing arrangements are in place to enable rehabilitation/recovery plans to be shared by partners providing services and to streamline pathways and reduce duplication.
- Ensure there are joint executive leadership and system agreements in place across partner organisations, to ensure shared decision making and governance arrangements.
- Ensure multi-professional teamworking and a partnership approach to discharge, and multi-agency working with local authority partners and the

independent and voluntary sector to review availability of resource, provide access to reablement/pathway services for ongoing recovery support at home, and ensure timely discharge from intermediate care for a person's ongoing and longer-term needs.

- Implement flexible mechanisms for staff pooling and use of resources across organisational boundaries, including increasing use of staffing banks to onboard health and care workers and deployment of therapy capacity to the right part of the pathway using 'mutual aid' arrangements where needed and supported by digital solutions.
- Implement solutions to release therapist time and increase rehabilitation capacity, including through use of digital solutions, admin capacity, streamlining referral processes and utilising support workers to undertake tasks where appropriate.
- Implement data and operational dashboards, including daily oversight of capacity and demand and blocks in the pathway including:
 - demand for therapy workforce to deliver rehabilitation assessment and interventions
 - working with acute hospitals to proactively plan for demand, support timely discharge and enable flexible resource utilisation plans across partners and organisations
 - working with systems to undertake the self-assessment exercise as part of the system maturity evaluation and progress agreed actions to maximise delivery of services through winter.

Ambulance trusts

- Ensure a greater number of deployed hours on the road over winter in line with agreed recruitment and resourcing plans.
- Increase the clinical assessment of calls in every emergency operations centre to deliver the navigation and validation of Cat 2 calls, as well as increasing clinical input to Cat 3 and 4 calls.
- Ensure efficient electronic processes are in place for the transfer of patients who do not need a face-to-face response to services more appropriate for their needs, including urgent community response, urgent treatment centres and SDEC. Note the responsibility for other parts of the system to maximise the number of cat 3 and 4 calls responded to by UCR and falls services.
- Establish sufficient call handling capacity and finalise arrangements for the use of the 'Intelligent Routing Platform' in times of surge.
- Ensure mental health professionals are embedded in all emergency operation centres ahead of winter.
- Use the ambulance auxiliary service when needed.

Mental health provider pathways

Lead and support the delivery of high-impact interventions 3, 4 and 9 across mental health provider pathways

- Ensure plans are in place so that individuals know how to access mental health services with access to effective assessment and help in a timely manner and that crisis alternatives are in place to help reduce reliance on A&E (recognising that A&E is still an appropriate way of seeking help and people presenting with mental health issues also may have urgent physical health care needs). This should include making reasonable adjustments to pathways and therapeutic interventions for people with a learning disability and autistic people who seek mental health support.
- Where individuals do seek help for mental health issues via A&E, ensure processes are in place for assessment and onward support, including adjustments to meet the needs of autistic people and people with a learning disability. Ensure there are clear escalation processes for A&E where there is considerable delay in receiving specialist support.
- Mental health, learning disability and autism services should ensure maximum uptake of vaccinations for their populations, both inpatient and community. This is vital given the high incidence of COPD and other co-existing long-term conditions such as diabetes which can compromise response to flu and Covid-19.
- Ensure tools are in place to understand demand, activity, workforce and capacity in mental health provider pathways. This should be shared across the system to give a comprehensive view of mental health pressures and where support may be required that could alleviate pressure on both mental health and UEC pathways.
- Ensure access to emergency housing funds to enable discharge of patients with no fixed abode (NFA) to ensure that they can be supported with follow up crisis / community care and support.
- Lead delivery of actions from the NHS Long Term Plan and Delivery Plan for Recovering Urgent and Emergency Care Services that support winter pressures, particularly:
 - Strengthen ambulance response to mental health by deploying multidisciplinary professionals to support 999 mental health demand and preparing for the rollout of mental health response vehicles.
 - Optimising flow through mental health inpatient settings through system-wide focus on reducing delayed discharges and avoidably long length of stay in mental health inpatient settings. Work collaboratively with social care and other system partners who play a key role in timely discharge.
 - Continuing to raise profile of all-age 24/7 urgent mental health helplines and other complementary crisis support services – including those for people with a learning disability and autistic people, such as intensive support teams, ensuring delivery of

- NHS 111 'select mental health option' and working towards crisis text line implementation.
- Supporting children and young people with mental health needs in acute paediatric settings by adopting the [new integration framework](#) for systems to support children and young people with mental health needs within acute paediatric settings, and to take up NHS England (Workforce, Training and Education directorate) commissioned CYP crisis telephone training to support crisis mental healthcare staff.
 - Maximise the uptake of training on learning disability and autism appropriate to their role, to ensure preparedness to be able to meet the needs of autistic people and people with a learning disability.

Local authorities and social care

Local authorities should continue to work with ICBs to ensure an integrated approach across health and social care.

This includes:

- commissioning intermediate care services that help keep people well at home, prevent avoidable hospital admissions and support timely and effective hospital discharge.
- areas keeping under review their Better Care Fund (BCF) capacity and demand plans for intermediate care, in line with the BCF Policy Framework and planning requirements, considering trends in demand.
- improving data flows where the BCF capacity and demand plans showed limited data or insights available to support local areas' ability to accurately forecast demand for these services throughout the year.
- supporting NHS winter surge planning, including considering contingency arrangements for a significant flu or COVID-19 wave.
- deploying this year's Discharge Fund in ways that have greatest impact in patient safety and experience and in reducing delayed discharges, both to improve outcomes following hospital admission and help prevent avoidable A&E and ambulance delays for patients who need emergency care, alongside planning how to deploy next year's discharge funding.
- systematically embedding good practice in the use of care transfer hubs to manage discharges for patients with more complex needs, focusing on nine priority areas that will be set out as part of the upcoming support offer for the UEC Recovery Plan.
- ensuring systematic involvement of social care and community health providers in planning discharge services and in improving the operation of care transfer hubs.