NHS Operational Plan

October 2023-March 24

Summary points for the Health and Wellbeing Board

Introduction

Background

In early May 2023, the Derby and Derbyshire ICB submitted the health system's operational plan for the financial year 2023/24. This plan set out a series of objectives for the year ahead, mostly in relation to improving access to care across the acute planned, cancer, urgent and emergency care and mental health, autism and learning disability portfolio.

In late July 2023, NHS England published its approach to winter and requested that systems review their operational plans and the core assumptions which underpinned them, particularly considering actual year to date delivery and any new risks emerging. Furthermore, all health systems were asked to ensure that the ten high impact interventions/areas to reduce hospital A&E demand and/or improve acute flow were going to be in place and deliver over the winter period.

In response to this, a time limited task and finish group, drawing on the input of NHS Delivery Board leadership and Provider organisations, was established to:

- *Review how performance was going in relation to the operational targets for planned care, cancer, and urgent & emergency care.*
- *Establish a forecast delivery position for these targets, for the period October 23-March 24, which involved a review and revision to the underpinning demand and capacity assumptions, as necessary.*
- *Set out the 'how', by summarising the key actions that necessary to secure these forecasts.*

Purpose

Against the backdrop of the ICB delivering a continuous, dynamic planning cycle, this presentation briefs the Health and Wellbeing Board on the current state of the operational planning works for the next six months – with a specific focus on the urgent and emergency care, planned care & cancer agenda.

Key messages for the HWB

We go into the final 6 months of the year following a period where we have seen improvement to various aspects of operational performance, within the urgent and emergency care and planned care & cancer programme.

1. **A&E 4hrs** - both Acute Trusts are delivering their plan and performance is better on a like for like basis too, in overall terms.

2. **Long acute stays**- there are have been fewer beds occupied by people staying longer than 7, 14 and 21 days on a like for like basis - with a respective reduction of 3%,5% and 7%.

3. **Ambulance turnaround –** there have been 1,980 fewer hours lost to ambulance handover delays on a like for like basis, despite there being more ambulance arrival demand.

4. **GP appointments –** overall GP appointment output has been 2.1% higher than plan so far this year. This is despite having fewer practice nurses and fully qualified GPs per head of population.

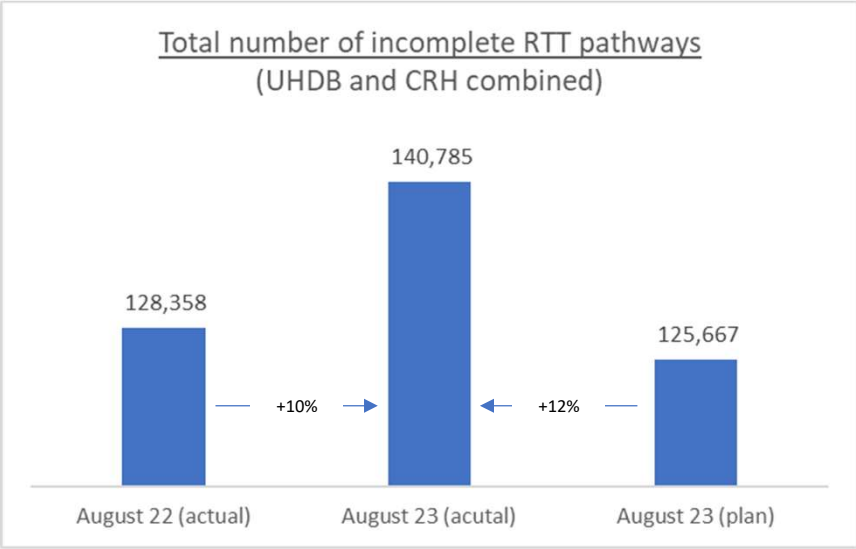
5. **Urgent Community Response–** over 80% of referrals that relate to an older person in crisis have been responded to within 2 hrs. This exceeds our target of at least 70% assumed in plan.

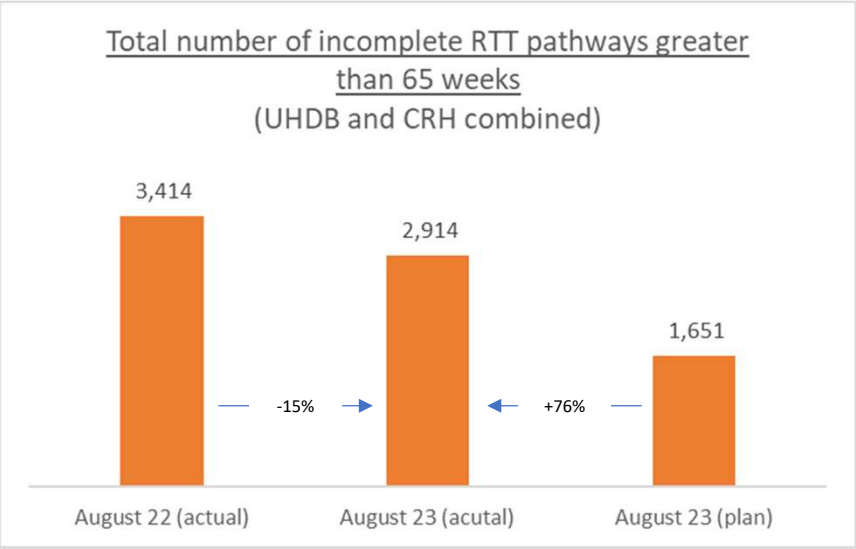
6. **Faster Cancer Diagnosis–** we've treated 7% more people in the process of diagnosing or ruling out cancer, with a greater proportion done within 28 days, on a like for like basis.

However, there are items where performance is not on track as planned - waiting lists...

1. **RTT waiting list (overall size)** - at the end of August 2023, the RTT waiting list was ~12% larger than what we had originally expected it to be and ~10% larger than the position in August 2022.

2. **RTT long waits (65+ weeks)** - Whilst the number of people waiting longer than 65 weeks was ~15% lower as at the end of August 2023 compared to August 2022, we are behind plan with 1,263 more patients waiting longer than 65weeks than we had expected.





long cancer waits…

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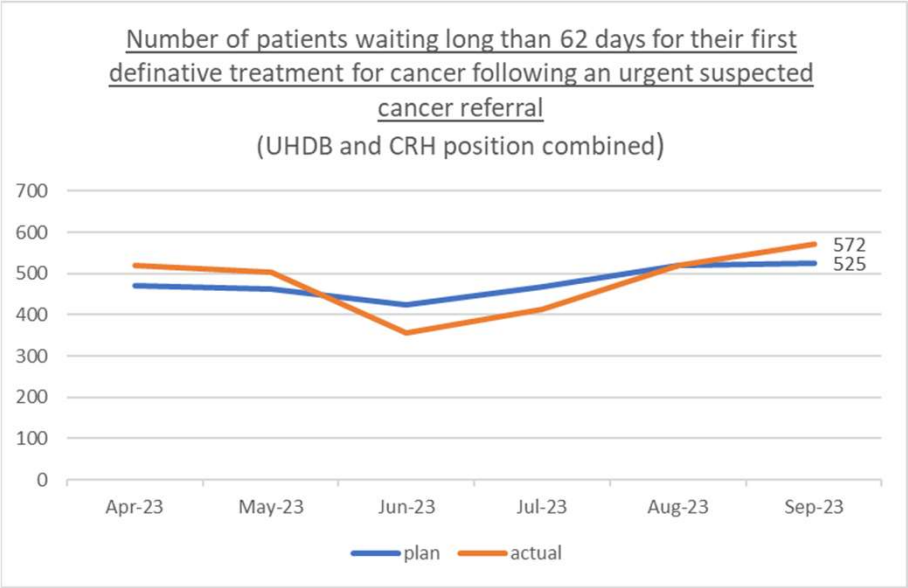
Number of patients waiting longer than 62 days for their cancer treatment - Performance which looked promising in June and July, where we were ahead of target, has deteriorated in the past two months and we are behind trajectory – equivalent to just under 50 patients.

Just over half of the total 62+ day wait volume sits in two cancer pathways – Lower Gastrointestinal and Urological.



…and category II response times.

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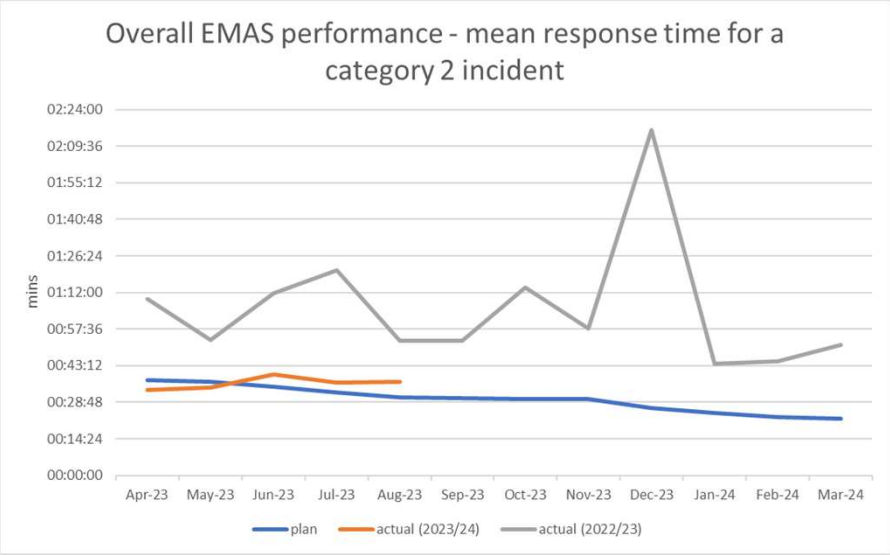
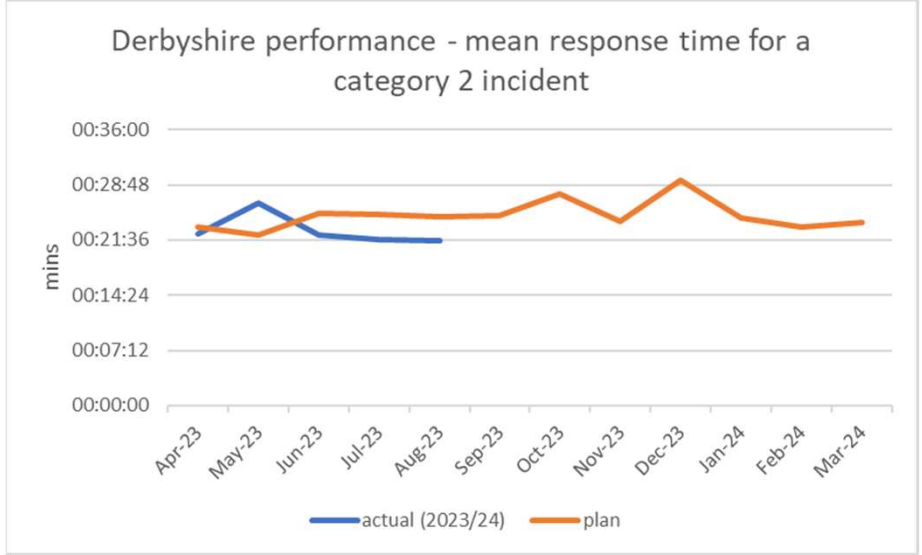
999 response (category 2 incident) - average response time from 999 call until the arrival of the ambulance at the scene

Whilst performance for EMAS' entire operation is currently operating higher than the 30-minute (mean) target level, the local position has held up reasonably well with performance operating within plan.





The ‘fundamentals’ of our plan for the next 6 months have not materially changed from that which was presented to the ICB Board at the start of the financial year. From an urgent and emergency care perspective this means…

We are aiming to achieve the following objectives

By the end of March 2024, at least 76% of people attending A&E will be discharged or admitted within 4 hours.

EMAS’ response to category 2 incidents will be 30 mins on average.

At least 70% of referrals to the urgent community response service will be responded to within 2 hours.

By delivering a plan to…

- Provide **virtual ward** capacity so that up to 255 patients can be managed at any one time, with at least 80% of the capacity used, so as reduce the demand on general and acute beds.
- Enhance the current ‘**Clinical Navigation Hub**’ from November 23, by creating MDT input from health and social care, with the aim of ensuring that patient needs are being met by the most appropriate service.
- Expand the geographic coverage of the **Community Based Falls Recovery Service (FRS)**, so that more Level 1 and 2 falls are responded to by the FRS instead of EMAS.
- Enhance the **care and support offering to people experience a mental health crisis** – thus reducing the need for the A&E to be considered as a place of safety. Enhancements include (i) a crisis house in Chesterfield, opened in Sept-23, to provide 24/7 residential support; (ii) a safe haven in Chesterfield that will open in Oct-23 and offer out of hours support on a self-referral basis and (iii) three crisis drop-in centres in Buxton, Ripley and Swadlincote.
- Increase **reablement at home support packages (‘P1’)** by 17% over the next 6 months compared to what we had in the first 6 months of this year - with DCHS expanding its Community Response Team capacity and Derbyshire County Council changing its in-house service offering - with the aim of reducing delayed discharges from acute and community hospitals.
- For EMAS, increase core **Double Crew Ambulance capacity** by 13% on a like for like basis and use temporary private ambulance services whilst the organisation builds its workforce resource.
- Achieve at least an average 20% reduction in the amount of **time lost to ambulance handover delays** over the next 6 months, relative to last year.
- Keep overall **general and acute bed occupancy** at between 92-93% on average over the period by (i) bringing on additional medical bed provision and (ii) ensuring the efficient use of medical beds by enhancing same day (non-admitted) emergency provision and front door frailty assessment.

For planned and cancer care this means…

We are aiming to achieve the following objectives

By the end of March 2024, there will be nobody waiting longer than 65 weeks for their treatment

By the end of March 2024, at least 75% of suspected cancers will be diagnosed or ruled out within 28 days.

By the end of March 2024, there will be no more than 311 patients waiting longer than 62 days for their first definitive treatment for cancer across both Trusts.

By the end of March 2024, 85% of people waiting for a diagnostic test will be waiting less than 6 weeks.

By delivering a plan to…

- **Protect elective inpatient bed capacity** over the next 6 months by ensuring better productive use of medical bed provision to reduce medical outliers.
- Achieve a minimum **theatre utilisation rate of 85%,** improving on the current situation (UHDB at 73.4% and CRH at 72.8% as at early September 23).
- Maximise the use of all available **outpatient capacity** – overbooking to mitigate the impact of DNAs.
- Use all the **independent sector's elective capacity** that is on offer.
- Utilise **consultant advice and guidance** to ensure that new acute RTT period demand is appropriate.
- **Insource endoscopy support** from the private sector to support with diagnostic waits.
- Utilise **premium rate incentives** for additional Echocardiography work in addition to insourcing physiologist capacity from the private sector.
- Continue the roll-out of the **Community Diagnostics Centre** programme.
- **Cancer Service capacity** will be **maintained** and **ringfenced** from operational pressures expected during the winter period.
- **Cancer specific pathway improvements** have been identified, specifically in relation to:
    - Urology – Straight to mp MRI diagnostics.
    - Upper and Lower GI – comprehensive use of the FIT in primary care.
    - Gynaecology – outsourcing activity to the private sector to reduce the Gynaecology ASI.

We are currently *active* in either preparing to deliver or delivering 9 of the 10 high impact interventions.

In NHS England's Winter Planning Letter (July 2023), all Health Systems were required to assess the relative level of maturity against 10 interventions/areas which contribute to reducing waiting times in A&E and improving flow in a hospital setting. As part of this exercise the Derby and Derbyshire health system has set two clear tests when it comes to assessing impact of these interventions (i) Do we plan to have additional capacity in place this year, compared to last; and (ii) Do we have a plan to improve the utilisation of this capacity over the next 6 months?

A summary of the national expectations and a local position statement is summarised below with supporting information at appendix A.

At the time of writing, we currently do not have a plan to implement action 10 –Acute Respiratory Infection Hubs, due to financial constraints.

National expectations

Action	
1.	**Same Day Emergency Care**: 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 (acute)**: reducing variation in inpatient care (including mental health) and length of stay for key iUEC pathways/conditions/cohorts by implementing in-hospital efficiencies and bringing forward discharge processes for pathway 0 patients.
4.	**Community bed productivity and flow**: reducing variation in inpatient care and length of stay, including mental health, by implementing in-hospital efficiencies and bringing forward discharge processes.
5.	**Care transfer hubs**: implementing a standard operating procedure and minimum standards for care transfer hubs to reduce variation and maximise access to community rehabilitation and prevent re-admission to a hospital bed.
6.	**Intermediate care demand and capacity**: supporting the operationalisation of ongoing demand and capacity planning, including through improved use of data to improve access to and quality of intermediate care including community rehab.
7.	**Virtual wards**: standardising and improving care across all virtual ward services to improve the level of care to prevent admission to hospital and help with discharge.
8.	**Urgent Community Response**: increasing volume and consistency of referrals to improve patient care and ease pressure on ambulance services and avoid admission.
9.	**Single point of access**: driving standardisation of urgent integrated care co-ordination which will facilitate whole system management of patients into the right care setting, with the right clinician or team, at the right time. This should include mental health crisis pathways and alternatives to admission, eg home treatment
10.	**Acute Respiratory Infection Hubs**: support consistent roll out of services, prioritising acute respiratory infection, to provide same day urgent assessment with the benefit of releasing capacity in ED and general practice to support system pressures.

Local position statement

Intervention	Does this intervention currently feature in our plan?	Do we plan to have additional capacity in place this year compared to last?	Do we have a plan to improve the utlisation of this capacity over the next 6 months?
Same Day Emergency Care	Yes	No	Yes
Frailty	Yes	Yes	Yes
Inpatient flow (Medical bed provision and productivity)	Yes	No	Yes
Community bed productivity	Yes	No	Yes
Care transfer hubs	Yes	No	No
Intermediate care capacity	Yes	Yes	Yes
Virtual wards	Yes	Yes	Yes
Urgent Community Response	Yes	Yes	Yes
Single Point of Access	Yes	Yes	Yes
Acute Respiratory Infection Hubs	No	No	No

However, there are specific issues and/or areas of risk arising over the next 6 months.

Demand

- Our current operating assumption is that non-elective demand - both in terms of volume and complexity - is no greater and/or complex than last year.
- This applies equally to COVID-19 and influenza inpatient hospitalisation rates, where we are assuming to mirror last year's position.

Capacity

- Our current operating assumption is that sickness absence over the next 6 months will be no worse than the same period last year.

- A series of interventions that are critical to this plan requires recruitment of staff to deliver the capacity - for example, the additional P1 capacity to be supplied by DCHS, the expansion of virtual ward capacity, the expansion of the FRS and the Clinical Navigation Hub.

- To deliver all the asks of the acute sector over the next 6 months requires a level of bed provision which goes beyond the core capacity of both Trusts. This means that an average occupancy rate of between 99%-106% needs to be lowered to around 92-93%. Whilst both Trusts have plans to bring on additional medical beds, over half of the medical bed provision required must be brought about by internal action to reduce utilisation - by fully utilising VW capacity and bolstering front door same day emergency care provision, amongst other measures.

- Despite additional 'P1' capacity over the next 6 months, we anticipate to still be operating at a deficit level – equivalent to an average of 73 starts per month across the county's provision and an average of 20 starts per month across the city's provision. We therefore anticipate there to be discharge delays over the period, albeit not at the scale of last year all other things being equal.

Prioritisation

- Over the next 6 months we will prioritise clinically urgent care need.
- From a hospital discharge perspective, our approach will be focussed on prioritising home care over using bedded care to reduce discharge delays.

Industrial action

- Our current operating assumption is that there will be no further episodes of industrial action. If we do have further events, there is a high likelihood that the RTT and cancer targets will not be met, given the hit to elective output that we've experienced during the previous four.

We will have a set of robust controls in place to help manage the situation.

The situation last winter provided learning about the relative value of 'system-based' co-ordination, control and support works. As preparation for the next period, several actions are being taken to strengthen our approach.

System Co-ordination Centre

Over the next six months, the Derby and Derbyshire System Co-ordination Centre (SCC) will build on the 'minimum viable product' that was put in place as part of the 2022/23 winter plan. The SCC will co-ordinate the ICS' response to the operational situation, using the Operating Pressure Escalation Level (OPEL) Framework alongside constituent ICS providers and ICB policies and will work to deliver three core outcomes:

- Improved visibility of operational pressures: senior operational and clinical leaders will have an aligned view of the operational pressures and risks across providers which will support collective action to improve patient safety.

- Real-time co-ordination of capacity and action: A system view of capacity across all providers will lead to a collaborative effort to improve performance to patients' benefit. In line with local policies and the OPEL Framework 2023/24, data sharing, as a core role of the SCC, will identify predictable and emergent activity to support forward planning and data will be visible to all key decision-making and co-ordinating personnel.

- Improved clinical outcomes: The SCC's unique position to oversee a suite of operational metrics in real time will enable it to provide a timely response at a system level, assisting local providers to deliver the right care at the right time.

Operational Pressures Escalation Levels (OPEL) Framework

NHS England have recently published a national NHS OPEL Framework which replaces the version that has been in operation since 2016 and provides a useful guide to assist us with refreshing our local OPEL framework. We are currently revising our local approach to ensure there is consistency with national expectations and expect to have finalised this work before the end of October.

Oversight of delivery

The work to specify and track the benefits of all related improvement work over the next six months and beyond continues and the pace of this work will quicken, as required. In addition, greater clarity will be sought on where accountability for delivery sits, particularly given the intersection of individual provider, the Provider Collaborative and PLACE.

Appendix A – Position statement against the 10 High Impact Interventions

High Impact intervention/area	What aspect of provision are we planning to operate differently over the next 6 months, compared to the same period last year?	What improvement impacts are we expecting over the next 6 months, compared to the same period last year?
Virtual Ward	We plan to have more virtual ward capacity in the second half of this year compared to the same period last year. As context, at the end of March 2023 we had capacity to manage up to 30 patients at any one time in a VW setting. During the second half of this year, we plan to have capacity to manage up to 255 patients at any one time.	The key focus for improvement is on enhancing the utilisation of the VW capacity available. This is a significant challenge to improve from the current utilisation (~60%) to achieve the 80% planned utilisation target in the last 6 months of the year. By enhancing utilisation, both Trust's overall G&A bed model assumes that G&A medical bed day demand will reduce (as a result of step-down length of stay reductions) equivalent to 14 G&A beds over the period (10 at UHDB and 4 at the CRH). This is a downgrade on the original assumption of 34 beds.
Medical bed provision and productivity	There is additional medical bed provision that is in place or planned to come into play at UHDB over the next 6 months, compared to the same time period last year. Specifically 23 overnight G&A medical beds at the FNCH. In addition, the Trust could bring on line up to 46 beds as part of its FCP but this is not additional given that FCP was in operation during the winter period last year. There is the potential to increase medical bed capacity at the CRH by 15 if funds can be found to support. The Trust is also planning to bring up to 28 beds on line as winter surge if required, but this is not additional as these beds were open during last winter.	Both Trusts have indicated a number of other improvement impacts over the period, with the CRH planning to make specialty LOS improvements (equivalent to 11 beds) and reduce internal delays (equivalent to 14 beds). The UHDB have indicated that they will increase MAU discharges which will result in less use of overnight beds (equivalent to 1 bed), reduce internal delays (equivalent to 2 beds) and also anticipate the impact of DCHS' bariatric unit at St Oswald's Hospital which will reduce LOS (equivalent to 4 beds).
Intermediate Care provision and productivity	We plan to bring on more reablement and rehabilitation capacity over the next 6 months, particularly across the County Council jurisdiction (as per the BCF plan). This will be a result of the Local Authority's in-house service reconfiguration combined with an enhancement to the DCHS Community Response Team offering. This also involves the continuation of the CHS offering for the remainder of the year. The combined effect of this action will create capacity to provide an additional 61 starts per month by the end of March 24, relative to the first 6 months of this year. There are risks to this plan, with the benefit of the inhouse change in the LA being pushed back to February 24 (the plan still assumes December 23) and the additional CRT capacity dependent on recruitment. However, despite this additional capacity, we anticipate there still to be a gap in provision relative to the demand expected. In terms of overall bedded care (P2a and P2b), we anticipate there to be a gap in provision – relatively small across the Derby City jurisdiction (a gap of ~4 starts per month over the period) and a bit bigger across the Derbyshire County (a gap of ~41 starts per month over the period).	The focus is on improving the reablement care offering for people discharged from hospital (acute and community), with reference made to the following action: (i) Continuing to secure the service of CHS Healthcare's brokerage input. This doesn't provide any additional carer capacity above and beyond what we have now. (ii) Investment in DCHS' Community Response Team to provide additional P1 care packages. (iii) The impact of Derbyshire County Council's change to P1 provision from January 24. (iv) Investment in VSCE provision to support patient's transition back home. Furthermore, both acute trusts are assuming that D2A delays reduce over the period so that the equivalent of 14 overnight G&A beds are 'freed-up' (3 across UHDB and 11 at the CRH).
Community bed productivity	There is currently no additional capacity planned to come on line in the second half of this year compared to the same period last year. The JUCD strategy over winter is focussed on increasing P1 provision and we are therefore not pursuing the procurement of additional P2 beds. We anticipate that with additional P1 capacity coming online, this will not only reduce delayed discharges from acute beds, but also from our community beds as well.	As we are not increasing the overall stock of beds available, the efficient utilisation of P2 bedded capacity is therefore required this winter. To that end several actions will be taken: (i) Our community hospital provider has developed a process to track all delays within the community hospital beds (rolled out this month) to have better oversight and control of flow through the beds, this is anticipated to reduce the number of delays out of our beds and enable earlier discharge planning. (ii) We are rolling out process to improve transport, so discharges take place earlier in the day within community hospitals, 75% of discharges now happen in the mornings (compared with 57% pre intervention), this is also reducing the number of failed discharges from the acutes into beds due to transport (since roll out at CRH all transport booked through new process have occurred, previously failed discharges due to transport were a daily occurrence leaving capacity in community beds unused). This is reducing the number of lost bed days within our community hospitals and supporting system flow (iii) In Q3 our Community hospitals are rolling out increased staffing at one unit to support the enhanced care needs of some patients. This will reduce delays out of the acute (as patients with enhanced needs tend to wait in delay until a bed in an increased supervision bay is available). These roles will also aim to reduce the LOS for this cohort, as often they have complex needs that require review for discharge. However, they will be staffed through agency staff as the funding is non-recurrent so this is a risk to delivery. (iv) Our P2a beds in residential settings were consolidated in Autumn this year, with the same number of beds over fewer units, improved staffing and better process of review. This is anticipated to reduce the LOS and increase the number of new starts per week (v) The Derbyshire Local Authority are recruiting into brokerage roles to support the discharge of patients out of bedded care into care at home, this is a main point of delay out of our community beds

High Impact intervention/area	What aspect of provision are we planning to operate differently over the next 6 months, compared to the same period last year?	What improvement impacts are we expecting over the next 6 months, compared to the same period last year?
Single point of access	A single point of access to UEC pathways will be operational in November 2024. Whilst we had the constituent services in play last year, we did not have the co-ordination of provision (delivered by a newly formed MDT) that the SPA is planning to give us this year.	From a service perspective, the benefit of moderated/managed demand is expected to arise with the flow of demand being recalibrated between services and providers. However, there is no detail of what type of demand the SPA is aiming to reduce/reassign/recalibrate over the period and it appears that key service activities e.g. ED attends, EMAS cat 3 and 4 calls, UCR contacts have not been adjusted.
Care transfer hubs	Both Acute Trusts will have care transfer hubs in place, operating at a scale and scope similar to last year and have been rated as 'mature' by NHSE.	There are no additional improvement impacts/benefits planned over the next 6 months.
Urgent community response	There is currently no additional capacity planned to come on line in the second half of this year compared to the same period last year.	The over-performance seen so far this year against the 2hr response target is assumed to continue for the rest of 2023/24.
Same day emergency care	Both Acute Trusts will continue to deliver SDEC services, operating at a scale and scope similar to last year.	The focus for improvement is on increasing the utilisation of SDEC services. UHDB are anticipating that this will reduce the demand for overnight beds (equivalent to 2 beds) over the period. The CRH anticipate a significant improvement to its frailty/SDEC offering over the next 6 months (equivalent to 19 beds).
Frailty	Both Acute Trusts will continue to deliver frailty assessment and streaming services, operating at a similar scale and scope to last year. From a community perspective, there will be an expansion of the Falls Recovery Service across the patch, although according to different timescales r.e. transition to full compliance with the Enhanced Falls Recovery Service Specification. These plans are currently being reviewed and ratified by the PLACE Executive. It is unclear at this stage as to what the plan is to reduce level 3 falls and the frailty inducted fracture falls rate as indicated.	From an acute perspective, the improvement focus is on enhancing access to frailty assessment teams. Both Trusts anticipate that their improvement work will bring about a reduction in the demand for overnight beds (either avoiding admission or reducing LOS) equivalent to freeing up 16 beds in total (14 at the CRH and 2 across UHDB). From a community perspective, it is assumed that the FRS will (i) contribute to delivering up to 90% of incidents that EMAS respond to in relation to L1 and 2 where they see and treat; and (ii) 50% for the see, treat and convey cohort. No Provider plans (UHDB, CRH, EMAS) have been amended to incorporate this impact. From a level 3 community falls perspective, UHDB are assuming that a downstream benefit of less acute admissions of patients with a frailty-induced fall - equivalent to freeing up 13 overnight G&A beds.
Acute Respiratory Infection Hub	We currently do not have a plan to implement an Acute Respiratory Hub. Last year, we had 8 'hubs' in operation to provide additional General Practice capacity, to service all types of demand - include respiratory. Between December 22-March 23, capacity was made available to provide up to 12,000 appointments, of which 9,000 were actually provided. This provision was supplied by DHU and cost £362,230, so approx. £40 per appointment (funded via non-recurrent COVID-19 monies). Whilst there is an intent to create a similar offering this year, no financial resource has been identified to fund it.	None - given that the intervention is not planned to come into play. The benefits which were reported to have been secured last year, e.g. providing additional GP appointments for practices operating at level 3/4 OPEL will presumably not be replicated.