Derbyshire
A&E Delivery Board
Health and Social Care System
Winter Plan 2018/19

Version:	1.5
Dates reviewed by A&E Delivery Board:	01/08/18 16/08/18 29/08/18
Name of originator/author:	Sam Alder
Name of responsible committee/ individual:	Operational Resilience Group
Date finalised by committee:	29/08/18
Review date:	April 2019 – A&E Delivery Board
Distributed via:	Email

Version Control Sheet

Version	Version/Description of Amendments	Date	Author/Amended by
1.0	New Document (Greater Nottingham Plan used as a template)	25/07/18	Sam Alder
1.1	Comments from Operational Resilience Group (ORG)	30/07/18	Sam Alder
1.2	Further input following A&E Delivery Board and ORG workshop	14/08/18	Sam Alder
1.3	Final draft for ORG	22/08/18	Sam Alder / Catherine Bainbridge
1.4	Final draft for A&E Delivery Board	23/08/18	Sam Alder / Catherine Bainbridge
1.5	Final submission – amendments following feedback from A&E Delivery Board	30/08/18	Sam Alder / Lynn Wilmott-Shepherd

Contents

1. Summary

1.1 Plan Statement

Background

It is an expectation of NHS England and NHS Improvement that a robust system wide plan is in place for each winter. The A&E Delivery Board must have assurance that all commissioners and providers' plans evidence both individual organisation and system wide resilience.

Winter places a significant extra burden on health and social care systems. Performance against the national 4 hour standard for A&E departments is fragile both nationally and locally and robust winter plans are needed to maintain performance and provide a safer and effective service to patients.

Winter 2017/18 saw significant pressure across the Derbyshire system, particularly for both Acute Hospitals resulting in daily escalations and Operational Resilience Group calls. Throughout the winter period, the high acuity of patients coming into and staying within the acute Trusts, compromised patient flow, activating full capacity plans - mostly activated at UHDB Derby Campus. The high number of influenza, norovirus and D&V and high demand for HDU/ICU beds also challenged the system. This was mitigated and managed by effective working between the critical care network and Acute providers ensuring safe delivery within critical care. Furthermore, the pressure faced by the Acute Trusts resulted in significant cancellations of elective activity. This is highlighted within the Acute capacity section of this plan.

Timelines

Interim report to A&E Delivery Board	Wednesday 1st August
Interim report submitted to NHSE	Monday 6th August
Final Winter Plan agreed by Operational Resilience Group (including a system-wide demand and capacity plan)	Wednesday 22nd August
Final winter plan reviewed by A&E Delivery Board	Wednesday 29th August
Final winter plan submission	Thursday 30th August

Statement

It is the expectation that the A&E Delivery Board will take all reasonable steps to ensure that all organisations can maintain or return to business as usual after a disruption to business continuity, after a critical incident or after major incident/emergency. The Winter Plan is operationalised through our Derbyshire Escalation Plan which describes in more detail the tiers and triggers of incidence and response.

Responsibilities

Compliance with the plan will be the responsibility of all members of the A&E Delivery Board with their respective organisations.

Training

Directors/Managers across organisations will be responsible for ensuring that all appropriate staff have appropriate training in line with this plan.

Resource implication

Resource implications have been considered at the A&E Board and recommendations for a system wide approach to non-recurrent investment have been escalated to the Chief Executives Group and Joined-up Care Derbyshire. There has also been an allocation of £381K from the STP Transformation Fund for Urgent Care, this has been used to address areas which were decommissioned as part of the financial recovery plan although later identified as important to continue via the Newton Europe work. As a Derbyshire system it was agreed to use the transformation money to ensure these services are able to continue.

1.2 Plan Interdependencies

This Winter Plan 2018/19 should be read in conjunction with the following cross organisation documents:

- Major Incident Response Plan (IRPs)
- Multi Agency Pandemic Flu Plan
- Derbyshire Escalation Plan
- Multi-Agency Adverse Weather Plan
- Local Transport Plan
- Individual Organisation Winter Plans, Business Continuity Plans, Outbreak Plans, Infection Prevention Policies as appropriate.

We are clear locally about the expectations of NHS England and the NHS Improvement on our winter response, particularly in relation to:

- Preventative measures including flu campaigns and pneumococcal immunisation programmes for patients and staff
- Joint working arrangements between health and care – particularly to prevent admissions and speed of discharge
- Ensuring operational readiness (bed management, capacity, staffing, bank holiday arrangements and elective restarts)
- Delivery of critical and emergency care services
- Delivery of out of hours' services
- Working with ambulance services – particularly around handover of patient care from ambulance to acute trust and strengthening links with primary care and A&E
- Strong and robust communication across the system.

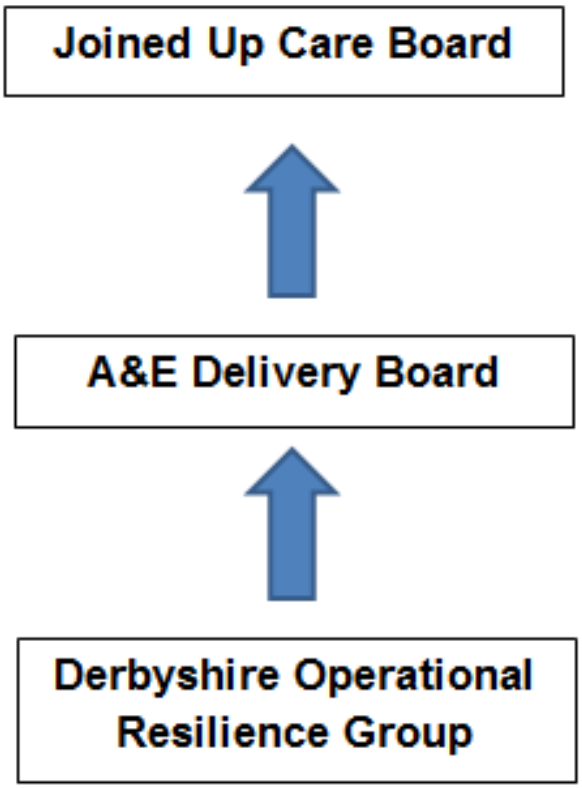
The Plan is underpinned by the principles of integrated emergency management (IEM):

- **Anticipate** – be aware of new hazards and threats facing the health economy.
- **Assess** – the hazards and threats for likelihood of occurrence and their impact.
- **Prevent** by taking a range of actions to limit the likelihood of occurrence, and the effects of any threats.
- **Prepare** by having appropriate planning arrangements and management structures.
- **Respond** by managing the immediate consequences of an incident or emergency.
- **Recover** by having plans to return to normal activity following an interruption.

At a high level, our response to winter is to ensure that we:

- Minimise the risk to patients/service users during a period when the service is under increased pressure
- Maximise the capacity of our resources (staff and physical capacity) by working systematically and effectively in partnership
- Maximise the safety of the public by promoting personal resilience e.g. seasonal flu vaccination, and choosing the right service through the communications campaign and community engagement processes
- Maintain critical services, if necessary, by the reduction or suspension of other activities

1.3 Governance



1.4 Distribution List

NHS England

NHS Improvement

Public Health England

Clinical Commissioning Groups

- *NHS Southern Derbyshire Clinical Commissioning Group*
- *NHS North Derbyshire Clinical Commissioning Group*
- *NHS Hardwick West Clinical Commissioning Group*
- *NHS Erewash Clinical Commissioning Group*

Referred to collectively as 'Derbyshire CCGs'.

Chesterfield Royal Hospital

- *Chief Executive*
- *Chief Operating Officer*
- *Executives*
- *Emergency Planning Leads*
- *On-Call Director/Management Team*
- *Site Managers (full cascade across staff).*

University Hospitals of Derby and Burton

- *Chief Executive*
- *Director of Operations*
- *Trust Board (Directors)*
- *Emergency Planning Leads*
- *On-Call Director/Management Team*
- *Site Managers (full cascade across staff).*

Derbyshire Community Health Services;

- *Chief Executive*
- *Director of Operations*
- *Trust Board (Directors)*
- *Emergency Planning Committee*
- *On-Call Director/Management Team*
- *General Managers (full cascade across staff).*

Derbyshire Healthcare Foundation Trust;

- *Chief Executive*
- *Director of Operations*
- *Trust Board (Directors)*
- *Emergency Planning Leads*
- *On-Call Director/Management Team*
- *General Managers (full cascade across staff).*

East Midlands Ambulance Service (EMAS)

East Midlands Ambulance Service (EMAS) - Patient Transport Service

Derbyshire County Council

- *Adult Care Services*
- *Children's Services*
- *Public Health*
- *Emergency Planning Unit*

Derby City Council

- *Adult Care Services*
- *Children's Services*
- *Public Health*
- *Emergency Planning Unit*

DHU Healthcare

One Medical Group

Continuing Healthcare (Arden and GEM CSU)

1.5 Lessons Learned Winter 2017

The lessons learned report details the experience and performance of the Derbyshire urgent care system during winter 17/18. The Derbyshire Operational Resilience Group held two half-day sessions in April and May 2018, facilitated by Derbyshire CCGs, to evaluate the system response to winter 17/18 and effectiveness of winter funding schemes.

Themes have been collated and the lessons learned document was shared at the A&E Delivery Board on 4th August 2018. The lessons learned report is included as an appendix.

2. Anticipate

2.1 NHSE Cold Weather Plan

The national Cold Weather Plan provides advice for individuals, communities and agencies on how to prepare for and respond to severe cold weather. It is supported by the Met Office Cold Weather Alert Service. Each member of the A&E Delivery Board has been asked to ensure they are clear on their roles and responsibilities during periods of cold weather.

The Cold Weather plan and its associated supporting documents and action cards are available on the PHE website at www.gov.uk/government/collections/cold-weather-plan-for-england , accompanied by a cover letter from the Department of Health, PHE, NHS England and the Local Government Association.

The NHSE Cold Weather Plan is included in the appendices.

The plan details the escalation and likely actions following notification of a Severe Weather Event. It ensures that a consistent approach to severe weather is taken, linking specifically to other pre-existing plans, triggers and actions. Specifically regarding winter, the plan details actions for cold weather/heavy snow risk and for storms and gales risk.

Triggers are coordinated from the NHS Winter Weather warnings cascaded from Public Health England via the Met Office, aimed at the Health Sector. The NHS Winter Plan levels are as follows:

Level 0 – Year round planning
Level 1 – Winter preparedness and action. 1st November – 31st March
Level 2 – Severe Winter Weather forecast – Alert & Readiness (Mean temperature of 2°C and/or widespread ice and heavy snow are predicted within 48 hours, with 60% confidence).
Level 3 – Severe Weather Action (Severe winter weather is now occurring: mean temperature of 2°C or less and/or widespread ice and heavy snow).
Level 4 – Major Incident – Emergency Response declared by Central Government.

The Storms and Gales severe weather type does not have a plan written by another agency, and is the one weather type which may occur with little notice and significant community impact. The trigger for this event fits within the normal Met Office Severe Weather Warning methodology.

All providers have business continuity plans which support the system when we have severe weather. Last year, the Operational Resilience Group and Local Resilience Partnership worked well and managed the severe weather effectively. There was no evidence of impact on patient safety and the delivery of services was managed well.

2.2 Derbyshire Escalation Plan 2018/19

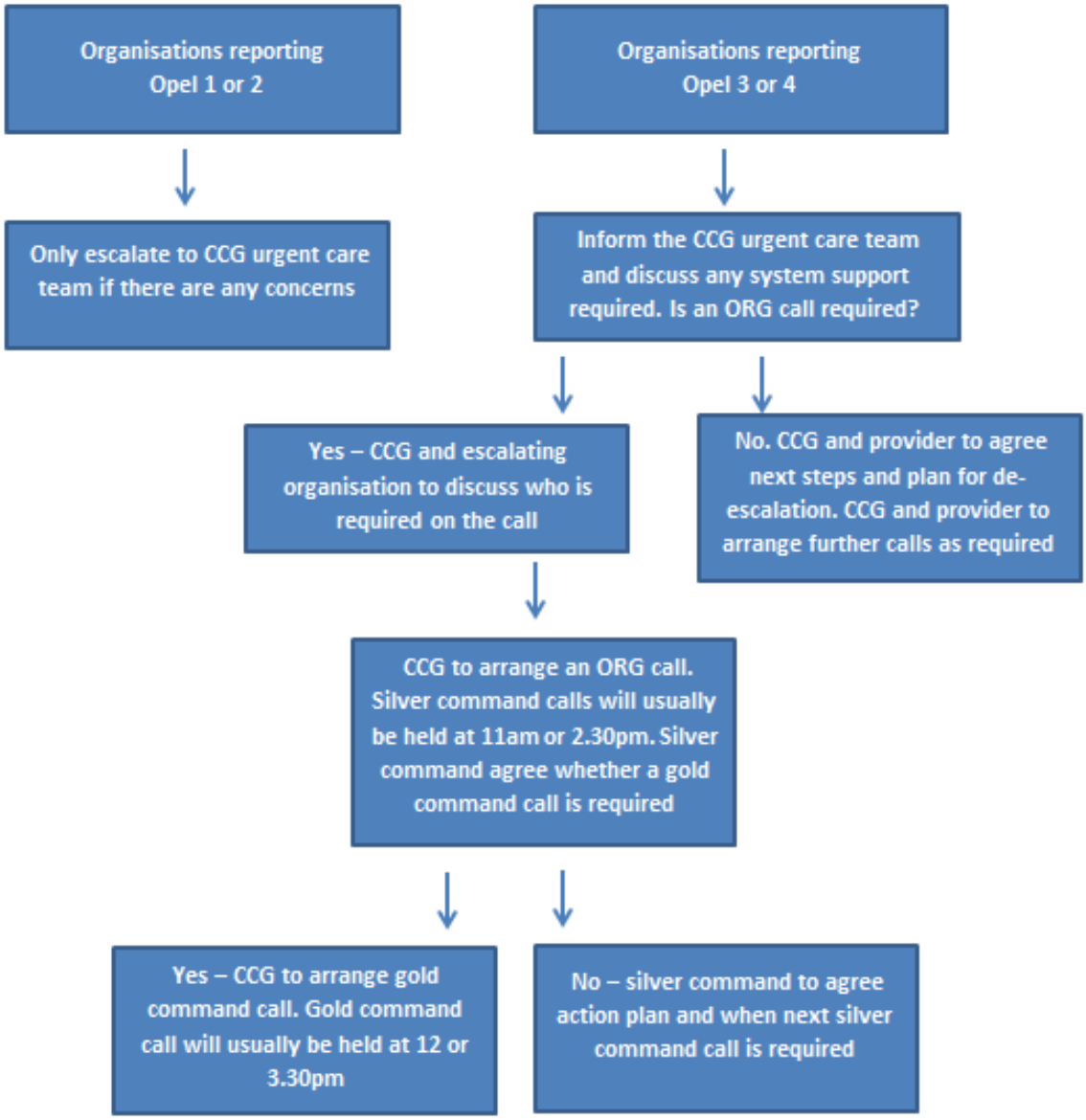
The Derbyshire Escalation Plan was updated during the summer of 2018 to ensure that the health and care partners in Derbyshire are coordinated to respond quickly and appropriately to any increased needs and/or service demands experienced within the area, which put pressure on the system. The Escalation Plan will be tested by the Operational Resilience Group throughout September and October.

This Escalation Plan describes how the health and care community will:

- Proactively make decisions to manage future demand
- Identify the assessment process used when making a decision with regard to the current system escalation level. Using escalation triggers to ensure an integrated and shared process between primary, community, secondary and social care providers
- Respond to periods of high demand caused for example by seasonal illness, local public events, infection control, flu, or adverse weather, by ensuring that there is a coordinated and planned response to create service capacity to meet additional need especially during the winter months.

The Derbyshire urgent care dashboard (updated daily) will be a key tool through winter, and will enable the system to understand demand and capacity issues arising in partner organisations. This process is overseen by the Derbyshire CCGs Urgent Care Team and forms a key part of our escalation process through winter – as set out in the Escalation Plan. Each provider uses the Escalation Plan to ensure it is delivering all appropriate responses in line with escalation levels at whole system level.

The Escalation process is as follows:



The Derbyshire urgent care dashboard is available at http://dashduc.nhs.uk/. All providers will update the dashboard daily by 10am to provide their OPEL status and a comment to outline any issues or areas of concern for the next 3 days. The CCG urgent care team are responsible for co-ordinating and chairing ORG escalation calls.

A task and finish group (as a sub-group of the ORG) are working to make improvements to the design and use of the urgent care dashboard and a revised version of this dashboard will be in place for winter 18/19.

The Derbyshire Escalation Plan is included as an appendix and includes contact details for gold and silver command.

2.3 Seasonally related illness

It is reasonable to assume that there will be an increase in seasonally-related illness (principally gastrointestinal or respiratory illness) between November and March. Each A&E Delivery Board provider organisation has an Outbreak Plan which details processes for managing seasonally related illness linked to their business continuity plans. The A&E Delivery Board has oversight of the Infection Control plan and will receive notification of any outbreaks.

As well as protecting against flu, the **NHS Stay Well This Winter campaign** will urge people over 65 or those with long-term health conditions, such as diabetes, stroke, heart disease or respiratory illness, to prepare for winter with advice on how to ward off common illnesses.

The NHS **'Stay Well This Winter'** campaign urges the public to:

- Make sure you get your flu jab if eligible.
- Keep yourself warm – heat your home to least 18C or (65F) if you can.
- If you start to feel unwell, even if it's just a cough or a cold, then get help from your pharmacist quickly before it gets more serious.
- Make sure you get your prescription medicines before pharmacies close on Christmas Eve.
- Always take your prescribed medicines as directed.
- Look out for other people who may need a bit of extra help over winter.

Public Health will circulate epidemiological information on disease outbreaks to system-wide Lead Nurses. These will be used by the system to monitor the seasonal illness position in the county.

The East Midlands Public Health England Communicable Disease Outbreak Management Plan is included in the appendices.

To summarise this plan does not cover routine communicable disease control activities undertaken by PH local teams, or specific major incidents such as a chemical attack or pandemic flu. It is for disease incidents where the threshold for internal management control by Public Health England (PHE) is exceeded and the coordination of an Outbreak Control Team (OCT) is required.

A communicable disease incident can be defined as:

• Any incident involving communicable or infectious disease which presents a real or possible risk to the health of the public and requires urgent investigation and management.

An outbreak can be defined as:

• Two or more persons with the same disease or symptoms or the same organism isolated from a diagnostic sample, who are linked through common exposure, personal characteristics, time or

location; a greater than expected rate of infection compared with the usual background rate for the particular population and period.

Examples of communicable diseases include:

- Single cases of rare or serious diseases such as diphtheria, rabies, viral haemorrhagic fevers or polio;
- Exposure of a susceptible group of people to a person with a serious disease
- Communicable disease infection, especially where there are limited options for treatment
- Suspected, anticipated or actual events involving the microbial contamination of food, water or the environment
- Healthcare associated infections where there may be an actual or perceived risk to the general public
- Outbreaks of zoonotic infection in animals which present a risk to human health
- Outbreaks and epidemics originating outside the local area which threaten the health of the local population.

There are a number of key **activities** which are essential to effective communicable disease control. These include:

- Notification of cases
- Routine (and enhanced) surveillance
- Detection
- Risk assessment
- Activation of special management arrangements
- Investigation
- Coordination
- Communication
- Application of public health control measures.

A variety of **interventions** are available to the Outbreak Control Team in planning the response and controlling the identified risks. Brief summaries of the main types of intervention are provided below:

- Public information
- Enhanced hygiene
- Restriction of movement
- Restriction of access
- Decontamination
- Vaccination
- Prophylaxis.

3. Assess

The work of the Operational Resilience Group and system-wide urgent care leads will contribute to the ongoing assessment of key risks to the delivery of the Winter Plan.

The A&E Delivery Board will be provided with full details of risks (via the Operational Resilience Group report) and A&E Delivery Board partners will ensure that any relevant risks are logged on their own organisation risk systems.

4. Prevent - by taking a range of actions to limit the likelihood of occurrence, and the effects of any threats.

4.1 Public Information

The provision of information to the public regarding services and accessibility is essential to ensure that we are able to more effectively manage demand through winter. CCGs across Derbyshire agreed to use the Winter Communications campaign (Stay Well This Winter) in order to support demand reductions through winter. The communications messages were tailored to the different audiences and public communications were based on the Stay Well This Winter campaign, as well as any messaging promoting/responding to appropriate use of services, particularly urgent care.

During 2017/18 the Winter Communications campaign aimed to:

- provide a consistent identity to promote the range of NHS services available to local communities
- explain to the public how their local NHS services fit together
- make it clear to the public that A&E and 999 services are for life-threatening and serious incidents only
- promote self-care and the use of high street pharmacies for common complaints
- Build on learnings from 2016's campaign, including a focus on secondary prevention messages, a broadening of the campaign's appeal to younger people, carers, 65+ and LTCs, and strengthening of the flu call to action

The 2017/18 marketing campaign ('Stay well this winter') is being evaluated and the lessons learned will inform any campaign plans for 2018/19. Further information will be issued in due course and resources can be downloaded from https://campaignresources.phe.gov.uk/resources/

To build on these aims, the Derbyshire campaign will also:

- meet the needs, engage communities of interest to promote winter and Choose Well messages
- work with voluntary and community sector organisations to promote awareness, patient education and acceptance
- join up working across Derbyshire to share best practice and enjoy economies of scale;
- focus on pressure points in the system, such as bank holidays and outbreaks of illnesses (e.g. flu) which put additional pressure on services

- have the potential to be rolled out at any time of the year to support appropriate usage of urgent care services.

Furthermore, it is crucial to understand that any communications campaign misses a crucial component if, staff are not targeted to support and advise patients, and their friends/relatives. This will be included in the above campaign, and the A&E Delivery Board will have a key role in ensuring that we maximise the use of the campaign at all levels across our health and care economy.

During November 2018, the schedule of opening hours for services for the Christmas and New Year holidays across the health and care community will be agreed and published. The A&E Delivery Board will ensure that this information is shared across its partners, and will be seeking assurance that each organisation is sharing the information with its staff. The Derbyshire Communications and Engagement Plan is included in the appendices.

System Communications Group

There is a 'Seasonal Pressures Communications Group' which will reconvene in September to support planning for winter 17/18. Communications representatives from all local partners and providers meet to discuss and agree key seasonal priorities and coordinate activity.

This group is nominally coordinated by Derbyshire CCGs and will report on progress to the Derbyshire A&E Delivery Board and weekly Operational Resilience Group conference calls. The group meet following ORG meetings to allow actions to be taken forward at pace.

4.2 Flu Prevention

The National Flu Immunisation Programme is a key element of the prevention agenda for winter. This plan sets out a coordinated and evidence-based approach to planning for and responding to the demands of flu across England taking account of lessons learnt during previous flu seasons. It provides the public and healthcare professionals with an overview of the coordination and the preparation for the flu season and signposting to further guidance and information. In addition, the A&E Delivery Board will be seeking assurance that procedures are in place within community service providers for ensuring vaccination of the housebound patients and staff.

A 2017/18 flu assurance and action plan has been implemented and includes a specific focus on the priority areas as well as continuing to increase uptake across other groups. In addition to the priorities, the action plan includes objectives for those 65 and over, housebound individuals, care homes, carers, pregnant women, individuals with egg allergies, primary school age children, 4 year olds, children in special schools, those in prison and detention.

In addition local council, NHS Providers/Commissioners have pro-actively contacted their own front line health and social care staff to promote the uptake of flu vaccination. The plans for communicable

diseases (seasonal flu) and Public Health Annual Flu Programme information are included in the appendices.

In summary the focus of the flu programme is to address the roles, responsibilities, planning and response procedures for all organisations throughout Derbyshire in preparation for and during an influenza pandemic.

An influenza pandemic arises when a new strain of influenza virus emerges to which most people are susceptible. A new strain of virus is likely to transmit more easily to people if it contains genetic material from a human influenza virus. Important features of pandemic influenzas include:

a) Ability to spread widely.
b) Unpredictability.
c) Likelihood of arising outside the UK and spread to the UK within as a little as 4-8 weeks.
d) Likelihood of spreading rapidly once in the UK to all major population centres within 1-2 weeks, peaking possibly only 50 days from initial entry.
e) Possibility of subsequent waves of illness weeks or months apart.

The framework details the use of antivirals, specific guidance to schools and care homes, restrictions on public gatherings/use of public transport etc. The World Health Organisation (WHO) will identify at an international level the various phases of a pandemic influenza (i.e. Detection, assessment, treatment, escalation and recovery).

All NHS organisations have to report to NHS England through the Emergency Preparedness, Resilience and Response Core Standards their ability to respond to pandemic flu.

5. Prepare - by having appropriate planning arrangements and management structures

5.1 System Capacity

A) General Practice

From the 01 September 80% of practices across Derbyshire will be working together to provide Extended Access rising to 100% for the 1 October. This will cover 100% of the Derbyshire population registered with a Derbyshire GP. Pre bookable and same day appointments will be available 6.30pm-8pm Monday to Friday including Bank Holidays and a minimum of 3 hours on both Saturday and Sundays at hub sites across Derbyshire providing a minimum of 30 minutes per 1000 population.

B) Admission Avoidance

During winter 2017/18, the health and social care system managed admission avoidance effectively though prioritising and working to ensure patients avoided admission where possible. This worked well and this practice will continue for winter 18/19.

Additionally, the Place Programme are implementing various initiatives which will reduce demand on urgent and emergency services over the winter period. All of the 8 Derbyshire Place Alliances are implementing admission avoidance schemes which are planned to have an impact on non-elective admissions towards the latter half of winter. These schemes cover various initiatives including the development of integrated health and social care community services as an alternative to acute admission, improving EMAS pathways to reduce conveyances to hospital etc. The programme is also promoting the use of social prescribing to support patients and reduce reliance on acute services.

The Newton Europe analysis undertaken by the Derbyshire system identified the need for more preventative actions. A workshop is being held on 10th September 2018 with key frontline staff, clinicians and managers to review the outcome of the Newton Europe work. The emphasis will be on 'quick wins' for the 2018/19 winter and more sustainable change for 2019/20. Work will be focused around three distinct areas:

1. Preventing Admission
2. Hospital Efficiency
3. Effective Discharge

These three areas are the work streams within the Derbyshire STP Urgent Care Programme.

C) Acute hospital capacity

Chesterfield Royal Hospital (CRH)

Managing the Front Door:

Primary Care Streaming – the service is fully operational and the service currently operates 7 days per week 0800-2300hrs. The Primary care facility which is operated by DHU is currently collocated within the ED in a purpose built area. Numbers of attendances at the primary care streaming service have increased, particularly at weekends which have had a positive effect in ED. The service has facilitated ED staff to focus on patients with higher acuity within their department by reducing primary care activity within ED.

Ambulatory Care – The Trust already has well developed ambulatory care pathways that comply with national guidance. There is further work being undertaken around the current workforce model to ensure compliance with the service being available 14 hours per day.

Mental Health – The Trust experiences a number of significant delays for mental health patients in the Emergency Department. Despite the initial response from Mental Health Liaison, long delays often occur for patients undergoing mental health act assessments and for those who require a mental health bed.

Front Door Redesign - The Trust has recently been successful in redesigning the accommodation in Majors assessment and has increased cubicle capacity by 50% as well as having a dedicated Admission Avoidance (AAT) area. The Trust is awaiting confirmation on whether further monies have been allocated as part of the Urgent Care Village proposal which the STP are sighted on.

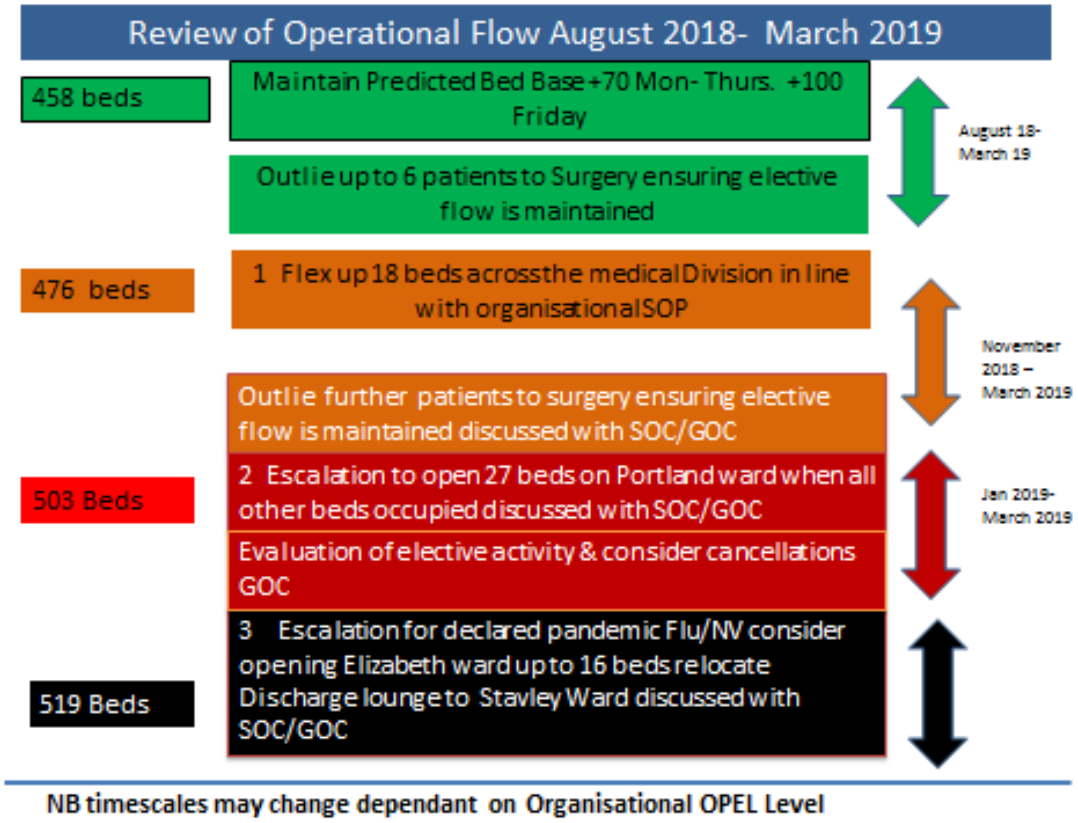
Bed Base and Escalation:

CRH aim to maintain General & Acute (G&A) bed occupancy below 87% except for the peak of winter where the aim is to keep it below 90% (see chart 1 below).

The Trust has 452 core G&A beds across a mixture of specialties (adults & children), 9 overnight discharge beds and a potential for 27 escalation beds that are specifically targeted to provide extra capacity for non-elective medical admissions. This is the maximum physical bed capacity the Trust is able to open, and safely manage. If a decision is made to cancel elective activity to maintain the non-elective pathway then there is also the capacity for up to 12 medical outliers in the surgical bed base.

SAFER is implemented across all Adult in patient wards. This is monitored via the whiteboard and Red to Green operational dashboard.

Chart 1



Escalation stage 1 - Medicine. 6 beds closed on 3 ward areas, staged re-opening as required

Escalation stage 2 - Medicine. On standby from 22nd December (planned opening 27th December) 16 Beds on Portland ward.

Full capacity (27 beds) escalation Portland ward

Elective surgical activity – The organisation will proactively manage elective activity, the ambition to increase activity up until October allowing for a reduction in the 3 key months of Jan – March 2019. The organisation is also scoping outsourcing of surgical activity over the winter period.

University Hospitals of Derby and Burton – Royal Derby Hospital and London Road Community Hospital

For 18 / 19 bed modelling has been conducted to assess the anticipated demand and capacity. The model assumes 4% growth in non-elective activity, which is typical of recent winters and is modelled on achieving 90% occupancy.

Medicine, Cancer and DME:

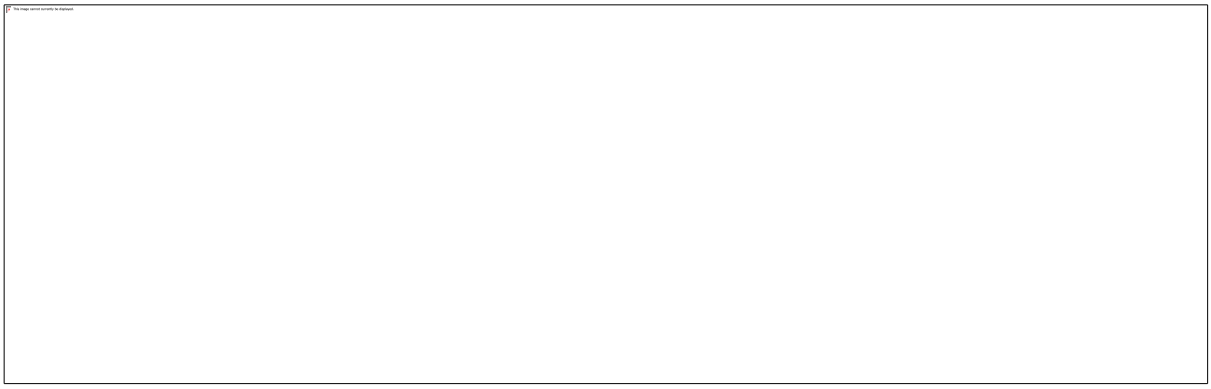
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total
2014/15	16,476	16,363	15,744	15,586	15,644	14,730	15,785	15,422	16,554	16,896	14,410	15,417	189,027
2015/16	15,648	16,147	15,026	15,304	15,344	14,893	16,118	15,874	16,305	17,477	16,604	18,091	192,831
2016/17	16,855	16,796	15,930	16,487	15,530	16,089	16,336	16,748	17,464	18,838	16,079	17,736	200,888
2017/18	16,667	16,221	15,815	15,699	16,097	16,607	17,176	16,770	18,400	18,509	16,584	18,846	203,391
2018/19 Plan	***17,533***	***17,271***	***16,604***	***16,837***	***16,540***	***17,099***	***17,525***	***17,531***	***18,755***	***19,534***	***17,082***	***19,130***	***211,439***
2018/19 Actual Occupied Beds	***16,468***	***16,428***	***15,928***										
Variance Plan to Actual	***1,065***	***843***	***676***										
Original Plan													
Required Beds @ 90% Occupancy and In-Week Variance	677	647	642	631	621	661	656	677	700	728	706	713	671
Core Beds	594	594	594	594	594	594	594	594	594	594	594	594	594
Planned Bed Surplus/Deficit	***-83***	***-53***	***-48***	***-37***	***-27***	***-67***	***-62***	***-83***	***-106***	***-134***	***-112***	***-119***	***-77***
Updated based on actual Occupied Beds													
Required Beds @ 90% Occupancy and In-Week Variance	638	617	618										
Core Beds	594	594	594										
Actual Bed Surplus/Deficit	***-44***	***-23***	***-24***										
Variance Bed Surplus/Deficit	***-39***	***-30***	***-24***										

The model reveals a significant bed deficit of up to 134 beds at its peak in January 2019. The actual activity data for April – June shows the deficit to have been lower than the model predicted, but we cannot forecast whether this will continue. Even if it does, the Derby Campus will still have a 4 ward deficit at its peak in January. The modelling does not include the potential impact of the >21 day length of stay reduction initiative.

The Trust has plans to partially close this gap by providing additional bed capacity for medical patients:

- The Trust's capital programme includes the construction of additional beds to extend 9 wards to the Main Hospital front elevation that will provide 73 beds and an additional ward on the roof of the Kings Treatment Centre that will provide 24 beds. Total = 97 beds.

- An additional 5 beds on Ward 302 and 5 beds at LRCH can be opened during winter. There is no other closed bed capacity. All other bed capacity across the Derby Campus is open and in use throughout the year. Total = 10 beds.
- Existing bed stock used by other specialties will be reallocated to medicine. Total = 58 beds.



Unfortunately the timeline for the capital works will not start to deliver additional bed capacity until mid-January 2019 and achieving this delivery date is not without its risks, e.g. capital funding allocation, planning permission, design and building to time. As a result, significant outlier bed capacity will be needed in the run up to winter and through in to February. Even then we will not be able to make sufficient outlier bed capacity available to achieve 90% occupancy and this will naturally present challenges for patient flow and exit block from ED during periods of peak demand.

Not until March when demand starts to drop a little and all of the new bed capacity comes on line will it be possible to reduce outlier numbers and start to get back to normal elective operating schedules.

The natural consequence of reallocating such a significant number of surgical beds for use by medical outliers will be a severely compromised elective service. The Trust will not have recovered the damage done to RTT performance from winter 2017/18 before winter 2018/19 arrives and elective activity is curtailed once again. This position is unsustainable and the Trust will either:

- Need significant additional community and bed capacity from partner agencies to help reduce the bed deficit or
- Serious consideration will have to be given to reducing or closing to referrals for some specialties where the Trust will simply not have the capacity to service the demand for elective services. Such decisions will need to be taken at least 18 weeks in advance of the downturn of elective capacity, which starts to present an immediate need to resolve the deficit.

A well-established standard operating procedure is in place to ensure the appropriate and timely clinical management of any Medical or DME patients outlied from MAU to any ward other than those belonging to the specialty to which the patient was allocated.

The safer bundle is implemented across all wards and this is monitored through the transformation bed utilisation work stream.

Elective pacing - as part of the trust winter plan UHDB will look to use some surgical beds to accommodate medical patients. The Trust will therefore downturn some of their elective work in order to accommodate these outlying patients in a planned way, ensuring these patients are medically managed. At present the bed deficit shown in the bed modelling will require us to significantly downturn our elective activity. UHDB will look at case mix and put as many patients as possible through the day case and nurse led discharge routes to ensure the Trust are utilising as much of the theatre activity as possible.

Under times of pressure and raised escalation the trust senior team will review all patients the day before or at the latest on the day of TCI to determine if any further cancelations need to be made to support the non-elective flow. UHDB would however endeavour to avoid on the day cancelations.

Merger with Burton – the merger is not expected to have any impact for this winter. There are no plans for patients transferring between the Trusts therefore the bed modelling and capacity within the Trust would not be affected.

Primary Care Streaming

Primary Care Streaming is in place at both Acute Trusts from 8am-11pm 7 days a week. The service is streaming approximately 10% of patients at Derby Hospital and approximately 25% of patients at Chesterfield Royal Hospital. This is a modest assumption based on current practice. However, the current contract for front door streaming at UHDB has been extended to the end of December to allow market testing, with the intention of getting a more robust model in place with the longevity of a 3 year contract.

D) Effective Discharge

Following the analysis by Newton Europe and work undertaken by the Discharge to Assess Board it was agreed to revise the capacity within the system to allow effective and appropriate discharge to the right pathway. It has been shown that at present patients are often discharged to the wrong pathway owing to capacity issues. Whilst this will not be at the aspirational levels for winter 2018/19 there will be a move towards the aim which is 60% to Pathway 1; 30% to Pathway 2 and 10% to Pathway 3. Owing to the differential levels of capacity and transformation throughout the County the modelling has been split City and County. The percentage split between pathways reflects the capacity and transformation within each area.

Pathway 1 (P1) is the assessment, recovery and rehabilitation at home. This incorporates:

- Able to return home with initial support from a Rapid Response Team
- May require ongoing assessment of needs
- May require a longer term package of care

Pathway 2 (P2) is the assessment and rehabilitation in a residential setting. This incorporates:

- Home is not an option at point of discharge from acute care

- Patient needs can be met in a residential setting
- May require ongoing assessment of needs and reablement
- Permanent residential care is not inevitable
- Aim to step down into Pathway 1 or home without support

Pathway 3 (P3) is assessment and rehabilitation in a nursing setting. This incorporates:

- Home is not an option at point of discharge from acute care
- Patient has complex nursing needs
- May require ongoing assessment of needs including CHC
- May require long term placement or package of care
- Permanent care placement is not inevitable
- Aim to step down into Pathway 1

System capacity:

Modelling assumptions:

- Modelled using the highest discharge month per place, including growth to ensure that modelling is for worst case scenario
- P1 figure includes 10% of P3 requiring P1 on discharge
- P1 assumes 34% of patients require health only, 58% require social care only, and 8% require a joint response. This % split is based on D2A data.
- P1 DCHS capacity includes admission avoidance - 40% to P1 (75% County and 25% to City)
- P1 health assessment capacity is based on 18 assessments per day of which 60% are admission avoidance and 40% D2A. This has been set through modelling ability to meet demand 85% of time. Whilst this shows an element of potential over capacity this is a very small part of the therapy work for these teams that work across the city/county. The therapists flex capacity as necessary, between this urgent/same day work and more planned work. Evidence from last winter demonstrates that this worked effectively.
- P2 length of stay of 14 days for City and 20 days for County
- P2 assumes 34 (city) and 62 (county) beds available
- P3 length of stay of 20 days
- P3 beds are assumed NOT to be area specific - P3 assumes 95 (city), 76 (south) and 55 (north) beds available. Overall potential additional capacity of 37 beds. The 55 beds in the north assumes that none of the proposed 22 bed reductions (according to Better Care Closer to Home plans) is planned to start before 1st April 2019, as supported by A&E Delivery Board. The 76 beds in the south have been difficult for DCHS to plan due to uncertainty around bed numbers commissioned at Ilkeston Community Hospital.

Derby City

	Worst case month incl. % under 65 and growth	10% complex	P1 41%	P2 24%	P3 35%	
Derby City	1602	160	66	38	56	
10% P3 to P1			6			
Total patients			**71**	**38**	**56**	
Total bed nights				**538**	**1121**	
Capacity bed nights				**867**	**2423**	**85% occupancy**
Gap bed nights				329	1301	
Gap bed numbers				11	43	

	Demand	Capacity	Gap
Health	30	60	30
Social care	47	78	31

Derbyshire County

	Worst case month incl. % under 65 and growth	10% complex	P1 40%	P2 20%	P3 40%	
Amber Valley	833	83	33	17	33	
Bolsover and NE Derbyshire	1080	108	43	22	43	
Chesterfield	712	71	28	14	28	
Derbyshire Dales	547	55	22	11	22	
Erewash	597	60	24	12	24	
High Peak	354	35	14	7	14	
South Derbyshire	273	27	11	5	11	
10% P3 to P1			18			
Total patients	4397	440	193	88	176	
Total bed nights				1759	3517	
Capacity bed nights				1581	3341	85% occupancy
Gap bed nights				-178	-177	
Gap bed numbers				-6	-6	

	Demand	Capacity	Gap
Health	81	120	39
Social care	128	116	-12

Mitigations

Derby City:

1. A great deal of transformation has taken place since winter 2017/18 to optimise resources
2. Excellent system working to allow greater flow - this is considerably improved since last winter
3. Length of stay is modelled at an average of 14, although this is currently around 11 which will allow more P2 capacity
4. A whole system approach is essential to ensure that demand can be met
5. The number of P2 beds in the City supported by therapy input has reduced since last year as last year winter funding was used to increase the therapy support available for these beds. This could be mitigated by some STP transformation funding being used to enable the Integrated Discharge Team to in-reach into Perth and Arboretum

Derbyshire County:

1. Any shortfall in P2 capacity will be mitigated by the use of Residential Care beds whilst patients await the correct pathway, however these beds will not have therapy input and the majority of P2 patients do require therapy.
2. There is potential to utilise City P2 beds for patients on the border. An agreement is already in place.
3. P1 is based on capacity for 116 people per day which is an average on the Track and Triage data. However, this can be flexed considerably using domiciliary care staff.

A further 'confirm and challenge' session is planned for early September to thoroughly test the data and assumptions used to complete the modelling. The session will include data analysts, members of the Operational Resilience Group and members of the A&E Delivery Board.

Changes made for winter 18/19:

- Implementation of the 'Better Care Closer To Home' work in the north of the county
- Derby City Council infection control changes:
    - Uplifting all carpeted areas to lay washable flooring.
    - Removal of all kitchenette areas and provision of new.
    - Removal of all old sluices/shelving and provision of new.
    - Removal of all soft furnishings i.e. cushions/curtains
    - Work being done with Facilities Management around increasing domestic provision
    - Current further training/refresher training on infection control – in house and provided by RDH/DCHS
    - Daily audits in place for infection control
- Derby City Council have undertaken a transformation programme allowing a reduction in bed numbers, but a higher throughput of patients with a shorter length of stay and increased occupancy rate of 85%. The Derby City Council plan is included as an appendix.
- Greater system working through the Operational Resilience Group and the A&E Delivery Board
- The Derbyshire County Council bed model above shows a reduction in overall beds, but is an increase in beds with therapy. Derbyshire County Council's direct care service is moving towards a short term provider model which will support throughput and keep length of stay at minimal levels.
- Reinforcement of the 'home of choice' policy to ensure patients understand that P2 and P3 are not home and patients may not be close to home during this recovery period.
- Introduction of a single handling team at both Acute hospitals with the aim of reducing the need for double up care packages.

E) EMAS capacity

The East Midlands Ambulance Service NHS Trust (EMAS) has historical and predictive data which identifies increased operational demand across the whole winter period. The analysis identifies peaks in activity related to many factors including weather, winter seasonal illnesses mass gatherings at festivities and pre planned events.

EMAS has developed robust plans to manage the predicted demand. The core elements of the plan therefore are:

1) Maximising resources – Divisional Management Teams are taking full accountability for staff resourcing. The Divisional Management Teams are minimising staff absence and providing a robust sickness management

2) Maximise the efficiency of the call handling process and the use of “hear and treat” and “see and treat”. The Trust’s Emergency Operations Centre (EOC) Management Team will ensure call handling, call triage, and Clinical Assessment Teams are rostered in line with predicted demand.

3) EMAS is working with key stakeholders to ensure effective and timely patient handovers, and proactive joint problem solving where delays occur EMAS has systems in place to ensure any delays are escalated immediately to key stakeholders, Commissioners and the wider NHS

4) EMAS has a new communication strategy that ensures effective communication with key stakeholders. This includes sending key messages to the wider NHS or patients to inform them of issues affecting EMAS

5) The Regional Operations Manager role provides further command and control support within the EOC 24/7, focusing on problem solving and proactive escalation, spikes in demand and crew or resource management

6) The EMAS Operational Bridge Plan is designed to address the key areas that create the greatest risk to delivery of performance on a consistent basis, these include workforce, fleet, vehicle off road planning and handover delays.

Derbyshire activity 178/18 and predictions 18/19:

	National Tariff Calls	NTPS Hear And Treat	National Tariff See And Treat	National Tariff See Treat And Convey	ORH Predicted Response Volume	Difference to Previous Year
November	**16136**	**2079**	**3040**	**7940**	**11220**	**240**
Derbyshire	**16136**	**2079**	**3040**	**7940**		
NHS Erewash CCG	1591	187	298	782		
NHS Hardwick CCG	1719	233	323	807		
NHS North Derbyshire CCG	4382	511	821	2200		
NHS Southern Derbyshire CCG	8444	1148	1598	4151		
December	**19584**	**2970**	**3760**	**8706**	**12741**	**275**
Derbyshire	**19584**	**2970**	**3760**	**8706**		
NHS Erewash CCG	1869	256	368	855		
NHS Hardwick CCG	2119	298	418	967		
NHS North Derbyshire CCG	5464	819	981	2375		
NHS Southern Derbyshire CCG	10132	1597	1993	4509		
January	**17569**	**2513**	**3735**	**8360**	**12369**	**274**

Derbyshire	**17569**	**2513**	**3735**	**8360**		
NHS Erewash CCG	1553	189	350	770		
NHS Hardwick CCG	1939	245	416	965		
NHS North Derbyshire CCG	4953	775	986	2285		
NHS Southern Derbyshire CCG	9124	1304	1983	4340		
February	**16441**	**2358**	**3243**	**7434**	**10920**	**243**
Derbyshire	**16441**	**2358**	**3243**	**7434**		
NHS Erewash CCG	1490	202	276	671		
NHS Hardwick CCG	1748	235	389	791		
NHS North Derbyshire CCG	4378	606	858	1988		
NHS Southern Derbyshire CCG	8825	1315	1720	3984		
March	**17925**	**2668**	**3401**	**7969**	**11625**	**255**
Derbyshire	**17925**	**2668**	**3401**	**7969**		
NHS Erewash CCG	1718	245	302	816		
NHS Hardwick CCG	2002	280	430	867		
NHS North Derbyshire CCG	4644	655	889	2109		
NHS Southern Derbyshire CCG	9561	1488	1780	4177		
Grand Total	**87655**	**12588**	**17179**	**40409**	**58875**	**1287**

F) DHU Derbyshire Out Of Hours

For 2018/19 DHU has taken a consistent approach to demand and activity as per previous winter periods. The Out of Hours service has undertaken a retrospective activity trend analysis over the winters of 2016/17 & 2017/18 to identify the expected % activity increase for this forthcoming 2018/19 winter. This has identified the following predicted increase in activity within the Out of Hours service. Further internal analysis internally will identify the specific increase trends across the services provided. i.e. Home Visits, Clinician Telephone Advice or within Primary Care Centres across Derbyshire. Predicted activity and demand analysis is also undertaken within the DHU NHS 111 service. The monthly predicted increase in patient activity per month is below:

	Total Consultations	Predicted %	Total Cases	Predicted %
Consultation Month	**01.09.2018-31.03.2019**	**Increase**	**01.09.2018-31.03.2019**	**Increase**
September	23,343	25.9%	14,275	17.4%

October	24,512	17.5%	15,578	12.5%
November	23,545	14.5%	14,726	9.5%
December	35,321	22.0%	21,965	18.2%
Total	**106,611**	**19.9%**	**66,402**	**14.5%**
January	27,114	8.4%	17,908	8.2%
February	25,568	16.7%	16,078	12.9%
March	31,446	26.4%	19,370	21.2%
Total	**190,289**	**18.4%**	**119,527**	**14.2%**

G) DHU NHS 111

Consultation Month	Total Calls (Offered)	Total Calls (Offered)	%	Total Calls Projected
Total	**01.09.2016-31.03.2017**	**01.09.2017-31.03.2018**	**Increase**	**01.09.2018-31.03.2019**
September	22,002	24,738	12.44%	27,815
October	25,263	26,965	6.74%	28,782
November	24,260	26,103	7.60%	28,087
December	31,427	34,835	10.84%	38,613
Total	**102,952**	**112,641**	**9.41%**	**123,297**
January	29,738	32,394	8.93%	35,288
February	25,142	30,135	19.86%	36,120
March	25,964	32,619	25.63%	40,980
Jan-Mar TOTAL	**80,844**	**95,148**	**17.69%**	**112,388**
Sep-Mar TOTAL	**183,796**	**207,789**	**13.05%**	**235,685**

Derbyshire NHS 111 calls offered increased by 16.94% from 2016/17 to 2017/18. If the trend continues over the forthcoming 2018/19 winter the above volumes are projected. If the 2018/19 winter trend replicates the May 2018 (23%), June 2018 (30%) & July 2018 (22%) increases then activity will be potentially higher still above the predicted trends.

Activity within the NHS111 contract has significantly increased through 2018, largely as a result of an NHSE media campaign in January, with calls offered at least 7% above plan and clinical calls 44% above plan. This step change in activity has further impacted on provider performance. As a result, proposals for Year 3 (Oct 18 – Sept 19) focus on getting an accurate activity plan in place, thereby allowing DHU111 to plan their staffing appropriately in order to deliver against their contract KPIs. The current year 3 proposal for Derbyshire provides for 6.0% more calls offered and a 7% increase in clinical calls based upon the Year 2 forecast outturn. This investment is mirrored by the other counties within the contract, and should provide a much more robust 111 service across the whole of the East Midlands.

In addition, we continue to commission a Category 3 validation service from DHU111, and this has seen a significant number of potential ambulance dispatches prevented, thereby freeing up resources within EMAS.

NHS 111 Online recently launched, giving patients another route when accessing 111. Whilst data is limited, initial uptake has been strong and it is likely that NHSE will promote this new option in early 2019 once it is implemented nationally. This should reduce pressure on the non-clinical Call Handler element of the DHU111 contract.

Finally, North Derbyshire CCG continue to work with DHU and NHSE on delivery against the agreed Recovery Action Plan. This clearly identifies trajectories for all of the key areas where performance is currently falling short of contractual requirements. Commissioners have asked for more detail to be included to allow closer monitoring and stronger management.

Predicted outcomes for DHU Out of Hours and NHS 111 provided as an appendix.

H) Derbyshire Healthcare NHS Foundation Trust

DHcFT mental health services include urgent response elements within the Crisis Teams, Mental Health Liaison Teams and Neighbourhood area teams. Teams will all prioritise on the basis of clinical risk and patient need on an ongoing basis.

An Emergency Department assessment to admission pathway has been developed and actions have been identified within flow charts for Actions to be taken for potential ED breaches by mental health patients, these give full and comprehensive escalation protocols throughout the 12 hour period. The ED assessment to admission pathway flow chart is included as an appendix.

Inpatient services work to the Full Capacity Plan model outlined below.

In the event of no DHcFT inpatient acute mental health bed being available the following checks and actions are implemented.

Action required	By whom	Escalation
Review of use of all leave beds within the appropriate unit • *Are we utilising all available leave beds safely and appropriately in accordance with guidance* • *Are there any delays in setting up appropriate leave for patients that can be urgently rectified*	Bleepholder/ Senior Nurse RMO	SLM
Review of use of leave beds within sister unit • *Are we utilising all available leave beds safely and appropriately in accordance with guidance* • *Are there any delays in setting up appropriate leave for patients that can be urgently rectified*	Bleepholder/ Senior Nurse RMO	SLM
Review leave arrangements for existing patients • *Is it appropriate for any patient leave to be extended*	Bleepholder/ Senior Nurse RMO	SLM
Review leave arrangements for existing patients within sister unit	Bleepholder/ Senior Nurse	SLM

• *Is it appropriate for any patient leave to be extended*	RMO	
Review of pending discharges within unit and make referral for Home Treatment /In reach if appropriate	Bleepholder/ Senior Nurse RMO	SLM
Review of pending discharges within sister unit and make referral for Home Treatment /In reach if appropriate	Bleepholder/ Senior Nurse RMO	SLM
Review of any pending transfers of care [Rehab/Nursing home etc] with a view to bringing forward	Bleepholder/ Senior Nurse RMO	SLM
Review of any pending transfers of care within sister unit[Rehab/Nursing home etc] with a view to bringing forward	Bleepholder/ Senior Nurse RMO	SLM
Ensure that staffing levels permit all possible commissioned beds are to be operationalised	SLM	GM
Review if any patients are appropriate for step down facility	Senior Nurse	SLM
Review if pending admission is suitable for Crisis House	Home Treatment Team	SLM
Consider out of area facility	Bleepholder	SLM & GM
Communicate bed pressures to all mental health acute assessment services [e.g. Crisis/Liaison]	SLM	GM
Communicate bed pressures to all Neighbourhood Services	SLM	GM

I) Patient Transport Services

EMAS Non-Emergency Patient Transport Service (NEPTS) capacity - UHDB

East Midlands Ambulance Service NHS Trust (EMAS) has historical data which identifies increased operational demand across the whole winter period. The analysis identifies peaks in activity related to many factors including weather and winter seasonal illnesses.

EMAS NEPTS has developed robust plans to manage the predicted demand. The core elements of the plan therefore are:

1) Resources – The NEPTS Divisional Management Team proactively manage all elements of resourcing within Patient Transport Services. This includes:-

- Staffing Adjustments in rota requirements to align with operational demand both current and predicted. This also includes all staff sickness absence and annual leave allocations managed using EMAS policies and Procedures.
- Fleet – We work in close liaison with our fleet department to ensure that vehicles are maintained and MOT's are completed within the summer months. And ensuring all vehicles have relevant equipment for working in poor weather conditions.

2) EMAS NEPTS is working with key stakeholders to ensure effective and timely patient discharges where applicable. This includes pre planning rather than on the day requests.

Proactive joint problem solving, where delays do occur EMAS NEPTS has systems in place to ensure any delays are escalated immediately to key stakeholders, Commissioners and the wider NHS

3) EMAS NEPTS have a comprehensive on call and incident management desk function. Providing further command and control support 24/7, focusing on problem solving and proactive escalation, spikes in demand and crew or resource management.

4) EMAS NEPTS will continue to review historical data and resourcing levels to proactively deploy 3rd party resources in line with peaks in demand around busy periods, such as the lead up to and after public holidays.

	OTD 2016/17	OTD 2017/18	Diff OTD	% Diff	2018/19 OTD
Sept	1076	1180	106	8.9% +	1190
Oct	1064	1201	137	11.4 % +	1337
Nov	1119	1267	148	11.68% +	2712
Dec	1163	1275	112	8.78% +	1386
Jan	1343	1440	97	6.73% +	1536
Feb	1129	1279	150	11.72% +	1428
March	1166	1276	110	8.62% +	1385
Totals	8060	8918	858	9.62% +	10974

Mitigation

1) Increase in our staff establishment over the last six months to include x20 extra staff
2) Realigning of our core rota's to match demand
3) Extra funding applied for to increase 3rd party provision by x2 vehicles 12:00 - 20:00 daily to increase hospital to point of care capacity. January to March 2018 this capacity moved an extra circa 850 patients

Arriva – CRH

The Trust currently has a robust NEPTS transport contract managed by ARRIVA. The service works across 7 days 364 days a year. Arriva has its own adverse weather contingency plan, which mirrors the wider system plan. It is envisaged that the current contract will be able to manage the predicted demand through winter. The Trust also has a list of trusted third party transport providers which can be utilised at times of extreme pressure.

5.2 Risks and mitigations

The key risks from the winter plan and lessons learned from 17/18 have been developed by the Operational Resilience Group and highlight the mitigating actions. The Operational Resilience Group

meet on a weekly basis and will continually monitor the risks, escalating any areas of concern to the A&E Delivery Board.

Risks	Mitigating Actions	Risk rating post mitigation (RAG)
No additional funding received to support Winter	Escalated to JUCB and A&E DB as a risk. The top 10 system winter schemes are embedded within the winter plan. STP Transformation Funding has partially mitigated this risk	Amber
Infection Control Issues at Perth House	Plans in place to mitigate against this for this Winter, which will include changes to the building, additional training from UHDB, increasing domestic staff and daily audits. Public Health working with health and social care to agree a revised Infection control policy Further system action required to agree Infection control support to all P2 beds	Amber
Severe weather	Plans are in place, and included within the Winter Plan. ORG will support when at an escalated level through silver and gold command. Worked well last year.	Green
UHDB bed deficit	The UHDB bed modelling has not included the >21 day LoS reduction which we expect to have a positive impact. The system is working hard to achieve sufficient levels of P1, P2 and P3 capacity to meet demand and achieve effective flow. There is ongoing transformation work within the Trust focusing on length of stay and admission avoidance, such as red2green. This work is led by the Chief Operating Officer.	Amber
Pathway 1 and 2 deficit	Work has taken place with Adult Care to look at additional capacity and the ability to flex with domiciliary services. Transformation funding to support discharge hub to ensure timely planning.	Amber
Cancelling Elective Activity	UHDB – as part of the trust winter plan UHDB will look to use some surgical beds to accommodate medical patients. The Trust will therefore downturn some of their elective work in order to accommodate these outlying patients in a planned way, ensuring these patients are medically managed. At present the bed deficit shown in the bed modelling will require them to significantly downturn elective activity. UHDB will look at case mix and put as many patients as possible through the day case and nurse led discharge routes to ensure the Trust are utilising as much of the theatre activity as possible. CRH – The organisation will proactively manage elective activity, the ambition to increase activity	Amber

	up until October allowing for a reduction in the 3 key months of Jan – March 2019. The organisation is also scoping outsourcing of surgical activity over the winter period.	
NHS 111 spike in calls	DHU activate the Business Contingency Plan when they receive an unexpected spike in calls. Short term spike actions (amber alert) include reallocation of staff within the organisation to support. Sustained periods of increased demand (red alert) would lead to the Silver on Call being contacted/instigating the following actions: • Requesting staff for additional support. • Assistance from our contingency provider. • The Out of Hours Service (OOH) to support receiving streamed calls from the NHS 111 clinical queue allowing clinicians to front end calls. • Suspending validation of Cat 3 & 4 ambulances.	Green
Patient transport on-day booking	Ensure there is a focus on pre-booking discharges. EMAS have evaluated demand from last winter and altered their rotas accordingly to better match demand.	Amber

5.3 Managing delays

Chesterfield Royal Hospital:

The multi-agency discharge hub will manage delays on a daily basis within the acute trust CRHFT, DCC and DCHS collaboratively working to maintain patient flow through the health and social networks. CRHFT and DCC hub managers will meet daily to review all DTOCs within the acute trust and make appropriate escalation decisions as required. When the acute trust demonstrates OPEL 3 bed pressures, the required escalation measures will be taken. Senior managers across all health/social partners will meet via conference call to assist with the freeing of patient flow and increasing community bed capacity as required.

Super stranded patients will be reviewed weekly by the hospital leadership team to support with any internal/external escalation requirements and proactively manage the reduction of stranded patients.

CRHFT and transport partners follow well-rehearsed processes to facilitate the discharge of patients. An escalation plan is in place to manage potential delays to discharge as a result of transport requirements and potential delays.

University Hospitals of Derby and Burton:

Delayed transfers of care will be managed jointly by the Health and Social care Integrated Discharge Team. A daily multi-agency face to face meeting will take place where all DTOC's and internal acute delays are discussed, escalated and actioned. When the Acute trust is in escalation a robust

and well-rehearsed escalation call will be used. This will have senior managers and decision makers from all partners in the system on a conference call to unblock issues and create extra community capacity if needed. Super stranded patients will be reviewed by the hospital leadership team to support with any internal/external escalation requirements and proactively manage the reduction of stranded patients.

DCHS

DCHS will continue to work in partnership with Adult Social care and CHC providers to pro-actively manage discharges in order to minimise Delayed Transfers of Care (DToC) and maintain patient flow. This will include the following actions:

1) Daily review of ALL patient discharge plans
2) Increase from weekly to twice weekly Top Delay meetings (DCHS & DAC)
3) Continued robust application of the Transfer of Care protocol
4) Weekly DToC Conference Calls – to support the management of DToCs and potential DToCs- (DCHS & Social Care)
5) Monthly multi-agency Senior DToC Management Meeting (DCHS, DAC, DCC & CHC)
6) Produce daily DToC reports which enables health & social care senior managers to provide additional support to resolve identified delays
7) Support the implementation of the D2A strategy enabling patients as appropriate to be discharged from acute hospitals home (Pathway 1) for assessment of their on-going needs

Out of area Acute Trusts

Derbyshire County Council and DCHS work together to support discharges for Derbyshire residents/patients accessing care and treatment in acute trusts surrounding Derbyshire. Some of these trusts are significant in terms of the amount of Derbyshire residents/patients they support and include Nottingham University Hospitals NHS Trust, Kingsmill Hospital, Sheffield Teaching Hospital, Stepping Hill Hospital, and Tameside General Hospital. Levels of escalation and demand from out of county hospitals will impact on Adult Care and DCHS and this is managed by internal prioritisation of resources to support discharges and admission to those areas, alongside the demand from Derby Teaching Hospital Foundation Trust and Chesterfield Royal Hospital Foundation Trust.

Discharge figures include all surrounding feeder Trusts and capacity/demand modelling is based on the totality.

5.4 Winter funding

In previous years, funding has become available at a late stage (December) and schemes have been developed quickly, have been based on what can be implemented now rather than what will have the greatest impact, and have often alleviated pressure on the system until March due to the late notification of funding. For this reason, many schemes have not been monitored and evaluated in the most effective way.

For winter 18/19 the A&E Board will oversee proposals for investment that have a system impact. Whilst there is no guarantee of winter funding preparations are in place for scoping schemes and the system may agree to 'go at risk' via the CEO Group/JUCD Board.

A full list of winter funding proposals is included as an appendix. The top 10 prioritised schemes are listed below:

	Scheme	**Impact**
1	Dedicated Hospital to Point of Care NEPTS capability (Supporting D2A programme)	Last year's scheme saw an average of 280 patient journeys (excluding Escorts/Aborts/Cancellations) per month - based on 5 days per week
2	Home First Community Night Service Link to DHU proposal DHU Overnight Sitting Service	Minimum of 15 calls per night in Derby City. Provision of up to 6 calls per 24 hour period from Home First. Facilitate hospital discharge, admission avoidance and to prevent need for admission to care home. Benefit to customers eg suffering delirium episode, maintained at home and minimising disruption to routine. Not a 'night sitting' service. Reduction in social admissions and the subsequent difficulty to discharge from hospital. Continued care for patients in their own home where more appropriate. i.e. palliative care patients, basic nursing care, support for appropriate patients experiencing acute confusion that do not require hospital based care.
3	Social Worker based at LRCH	Increased capacity in Mental Capacity Assessments and Best Interest. Reducing numbers in P3 beds at LRCH. Increasing flow of customer from LRCH.
4	Additional support for Perth & Arboretum Pathway 2	Maintain P2 capacity in Derby City to assist flow out of RDH / KPI's: Improved flow - **1)** Reduced LOS for pts in Perth and Arboretum **2)** More timely initial assessment - referral to F2F **3)** Reduction of pts waiting for P2 beds in Derby City
5	Increased PI assessment slots in Derby City	**1)** More timely initial assessment - referral to F2F **2)** Reduction of pts waiting for P1 capacity in Derby City
6	8 more P2 Beds (DCHS)	Additional capacity if required
7	Increase P2 beds Amber Valley	Improved flow- **1)** Reduced LOS for pts in P2 beds in Amber Valley **2)** More timely initial assessment - referral to F2F **3)** Reduction of pts waiting for P2 beds in Derbyshire County South.
8	Additional beds Buxton	Maintain flow out of CRH - **1)** 85% + occupancy from Jan to March **2)** Reduced number of patients in CRH in delay awaiting County P3 beds (as limited north bed flex)

9	PoCT Flu machines	Improved length of stay. Appropriate patient pathways for conformed flu cases.
10	CHC process LRCH	All DST completed within 5 days of checklist, reduction in DTOC and increased flow through LRCH.

5.5 Transformation funding

The Derbyshire urgent care system has received £381,000 transformation funding. This will fund:

- Support to the Integrated Discharge Team at both UHDB and CRH – reducing length of stay and DTOCs, and ensuring success of D2A.
- Derby City social worker to support the Radbourne Unit – assisting discharges and reducing DTOCs.
- Acute front door support at both UHDB and CRH – aiming to reduce admissions, the team will consist of social workers, mental health nurse, FEAT nurses, EMAS clinical navigator and DHU nurse.
- An enhanced OPAT service at UHDB incorporating a new respiratory pathway – reducing long hospital stays.

5.6 Maximising the availability of staff

Each provider has a business continuity plan that is agreed as part of their contract.

(a) Annual leave

All providers have robust plans in place for managing workforce coverage and annual leave (both clinical and managerial) throughout the winter period, including Bank Holidays. All providers will ensure that annual leave planning has taken place to ensure staffing levels are maintained and capacity is maximised.

(b) Sickness absence

It is expected that there will be an increase in sickness absence due to flu and each partner organisation is working to deliver a flu vaccination campaign for their frontline staff, and other staff critical to its operations. Provider uptake rates for flu vaccine will be monitored by the A&E Delivery Plan as part of overseeing delivery of this Plan.

(b) Industrial Action

Each of the A&E Delivery Board partner organisations has developed business continuity plans through which it will test a range of scenarios which impact on the availability of key staff. These plans include scenarios dealing with the impact of industrial action.

(c) Working in Different Ways

Organisations are continuing to develop their clinical leaders, recognising our workforce as our greatest resource and developing staff to work in a dynamic, changing environment. As a health and

care system we are empowering them to make autonomous decisions at the time e.g. to prevent delays in patient care, which maximise efficiency and productivity and drives service improvement

The absence of staff caused by other absences will be considered by all partners, for example adverse weather, school closures etc. Each provider is aware of and has an adverse weather plan or process that supports staff to deliver its activities. Provider Business Continuity Plans cover staff absence that reaches a critical level.

(d) Seven day working for critical services

All providers have plans for 7 day working for critical services, particularly to support continuous discharge of patients from hospital to avoid blockages to patient flow.

Chesterfield Royal Hospital are compliant with all 4 clinical standards. The Trust have made considerable progress made on clinical standard 2 (time to first consultant review within 14 hours) and are achieving over 90% on access to diagnostics and access to consultant directed interventions.

Royal Derby Hospital have embedded the four priority standards across all specialties in the Trust and in an April audit, Derby achieved 82% compliance to clinical standard 2 and achieved over 90% for the other three priority standards.

Individual provider workforce management plans are provided as an appendix.

5.7 Transformational plans

A) Digital Minor Illness Referral Service (DMIRs)

- A service has been running successfully in North East England since December 2017 where various low acuity calls to NHS 111 are referred to community pharmacies. This is known as the Digital Minor Illness Referral Service (DMIRS).
- The service is now being extended to include the geography covered by NHS 111 provider DHU (Nottinghamshire, Derbyshire, Leicestershire, Lincolnshire, Northamptonshire). The service is funded through the Pharmacy Integration Fund. The service will go live in October 2018.
- The purpose of the Digital Minor Illness Referral Service (DMIRS) is to reduce the burden on urgent and emergency care services by referring patients requiring low acuity advice and treatment from NHS 111 direct to community pharmacy. Its aim is to ensure that patients have access to the same if not better levels of care, closer to home with a self-care emphasis and unnecessary visits to GP practice or to Urgent / Emergency Care settings are avoided.

- The agreement is for the pharmacy to provide self-care advice and support, including printed information, to all individuals referred to the pharmacy by NHS 111 on the management of specified low acuity conditions.

B) NHS 111 Online

The East Midlands region has worked collaboratively to implement NHS111 Online across all 20 CCGs and went live on 24th July 2018. The NHS111 Online service uses NHS Pathways, which is already profiled and assured for use in the NHS111 Telephony service. The online platform interacts with the DoS using the same technology and criteria when searching. NHS111 Online allows users to answer a series of questions about their condition and receive self-care advice or be connected to a healthcare service. The content has been reworded to make it suitably presented for online use and has been clinically assured to be confident that the clinical intent is the same as for the 111 telephony service.

The user's journey looks as follows:

- Users access the service via an online platform, entering postcode to direct them to the correct geographical area
- An introduction page and explanation of what the user can expect
- User confirms this is not an emergency
- User enters gender and age
- User defines symptoms by either searching or selecting from a list
- User answers a series of questions relating to their condition
- User is presented with a disposition
- Dependent on the disposition, the user has the option to look up a service
- For some dispositions the users has the option to confirm their contact details and request a call-back from a care provider (for the East Midlands region this would be DHU or the Lincolnshire CAS)

Internal communications were shared with Providers. There has been no marketing to the public, by agreement with our 111 Providers, to allow the system to embed and any issues to be resolved. There is no intention at this point either from Commissioners or NHSD to publicise the service, however NHSE may market it as part of the winter plans promotions.

Future developments:

- To signpost to the online service users will hear an Interactive Voice Response (IVR) advising them of access to NHS111 Online, this is played on the national platform before calls are transferred to individual 111 providers, which will minimise the numbers of abandoned calls. This is not activated currently and will be reviewed as activity increases

- There will also be the option for callers to receive an SMS on the originating number, giving landline callers the opportunity to input a mobile number or receive speech conversion texts. Callers can receive a URL that is dedicated to the area the call is made from. All East Midlands Commissioners and DHU have agreed to this solution, which is at no cost to either party. This again will be monitored and activated at a later stage
- Phase 3 implementation is in the planning stages which sees online users request a call-back from additional survives (i.e. Out of hours GP services, Emergency Dental, Emergency Mental Health services)
- Ongoing monitoring of activity data
- Investigations into the management of A&E and 999 dispositions
- Work ongoing by the NHSD Development team to improve the patient journey
- A national User Forum is being established to share local experiences and progress developments

C) UHDB Improvement programme - Lean principles

UHDB was selected as one of seven Trusts to launch this new programme from NHS Improvement. The goals of this programme are:

- To enable an NHS improvement practice
- To help transform and continuously improve the delivery of what patients want and value with the best use of resources founded on Lean Principles and Systems Thinking
- To promote improvement stream unification around a common target of an NHS Improvement Practice

For the Trust this is a prize opportunity at this key point in time of merger to set in place the beginnings of a new improvement culture and practice for the benefit of patients and staff.

The first point of the launch process was a two day “Visioning Event” at which the new Trust Executive Team together with a few other very senior leaders met with the NHS Improvement Practice team to put the practice into the Trust context, identify initial objectives and receive improvement practice training. An important principle of the approach is that none of the staff do anything that has not been asked of their leaders. This event took place July 23 and 24.

Following the Visioning Event a “Value Stream Analysis” takes place around 8 weeks later. This will be a concentrated activity looking at a whole patient, high volume, pathway and will involve a wide representative sample of staff from both the Trust and external agencies; hopefully there will also be patient representation. From this activity will spring a programme of smaller projects looking at improving discrete elements across the pathway and provide a conduit to start embedding the practice within the organisation.

Balancing the important emphasis of senior leader engagement and support is an equally important priority of grass roots engagement. Put simply the long term goal for this aspect of the approach is for

the majority of staff “practicing” improvement (i.e. doing something) for 20 minutes a day. It is through this regular habit that over time the Trust will move towards a true culture of continuous improvement.

D) Newton Europe actions

The Newton Europe findings are included as an appendix. There is a key system-wide meeting on 10th September to develop action plans to take forward the recommendations from this work that can be implemented for winter 18/19 and 19/20.

6. Respond - by managing the immediate consequences of an incident or emergency

The local health economy has acknowledged that peaks and troughs in demand and capacity fluctuations are no longer a purely “winter” phenomenon and have relevance all year round. Additionally, various mechanisms have existed historically to manage these issues depending on the cause of the fluctuation e.g. increased demand on acute services, adverse weather, and pandemic influenza.

The A&E Delivery Board has recognised the benefits and need for the development of a single, year round, system wide escalation plan. Our Escalation Plan details the arrangements and procedures that the A&E Delivery Board partners in Derbyshire will utilise in the event of surge and capacity issues, irrespective of cause, affecting one or more partners in order to sustain the provision of high quality responsive care. Within this plan, escalation trigger levels, actions and responsibilities are clearly defined and shared amongst key stakeholders.

Derbyshire on-call directors are responsible for both proactive and reactive management of capacity issues (escalation or winter planning) and therefore will be involved in the management of critical incidents and major incidents, taking a lead role where these incidents affect patients registered to a Derbyshire GP and a supporting role for patients in the wider area.

NHS England will lead (command) the response to wider area incidents and emergencies and take a strategic overview of surge and escalation issues, providing support to CCGs where it can add value.

The Operational Resilience Group are holding a Mass Casualty Rapid Decant workshop in September 2018 to discuss a co-ordinated response to discharge 20% of the acute bed base in the event of a mass casualty incident.

6.1 Testing the Winter Plan

Each year following the winter period the Operational Resilience Group reviews the effectiveness of the winter plan in relation to quality, performance and cost. Lessons are learned and this helps to inform improvements to the plan the following year. Successful capacity arrangements and other initiatives have been funded and / or will be repeated or expanded upon this year in any case.

Following submission of the final Winter Plan in August 2018, the Operational Resilience Group will test and oversee the plan before, during and after winter. The group will test the Winter Plan and the Derbyshire Escalation Plan by exploring scenarios to ensure an effective system-wide response whether we experience a surge in activity on a weekday, or a weekend. The CCG will be providing a training session for all CCG on-call directors on how to effectively manage periods of escalation, including arranging and chairing system-wide conference calls.

The A&E Delivery Board provides system-wide, multi-agency, director level challenge into the winter planning process.

7. Recover - by having plans to return to normal activity following an interruption

During the winter period the health and care economy will, through the A&E Delivery Board, review and learn continually to ensure that the highest quality care can be provided locally.

The A&E Delivery Board is aware that there is an increased likelihood that planned activity may be displaced by the potential actions taken locally. Therefore, our A&E Delivery Board will ensure effective monitoring in order to manage the potential risks to patients should services need to be deferred. The Surge and Escalation Plan includes arrangements for escalation and de-escalation and link to escalation communications outside Derbyshire.

8. Key Contacts

The Winter Plan was created by the Derbyshire Operational Resilience Group:

Organisation	Name	Email	Phone number
Derbyshire CCGs	Lynn Wilmott-Shepherd Catherine Bainbridge Sam Alder	l.wilmott-shepherd@nhs.net Catherine.bainbridge@nhs.net Sam.alder@nhs.net	07824343440 07500 762 897 07881 035 667
Derbyshire County Council	Tanya Henson	Tanya.henson@derbyshire.gov.uk	07917077971
Derby City Council	Julie Knight	Julie.knight@derby.gov.uk	07812301179
Derbyshire Community Health Services	Jane Warder	Jane.warder@nhs.net	07787261622
Derbyshire Healthcare Foundation Trust	Michelle Hague	Michalle.hague1@nhs.net	07917461237
DHU Healthcare	Ian Truby-Ware	Ian.Truby-Ware@DHUHealthCare.nhs.uk	07393 187696
East Midlands Ambulance Service	Craig Whyles	craig.whyles@emas.nhs.uk	07969230622

Chesterfield Royal Hospital	Mike Hayward Claire Lambie-Fryer	claire.lambie-fryer@nhs.net	07584594836
University Hospitals of Derby and Burton	Rob Walker Laura Brown	Rob.walker1@nhs.net Laura.brown8@nhs.net	 07827283087
One Medical Group	Emma Williams	Emma.williams@onemedicalgroup.co.uk	07496 097917
East Midlands Ambulance Service – Patient Transport	James Oldham	James.Oldham@emas.nhs.uk	07773 035729

All switchboard phone numbers for director on-call purposes, as well as Gold and Silver command contacts, are provided in the Derbyshire Escalation Plan.

9. Appendices

1.	Winter lessons learned report	 ORG- Winter Lessons Learnt Report - V4 (F
2.	Derbyshire Escalation Plan	 System escalation plan 1819.docx
3.	NHSE Cold Weather Plan	 NHSE Cold_weather_plan_2
4.	Communicable Disease Outbreak Management Plan	 CommDiseaseOutbreakMgtPlan_EM_v1-2_2
5.	Derbyshire Communications and Engagement Plan	 Winter Pressures - Self care.docx
6.	Public Health Annual Flu Programme information	 Annual_national_flu_programme_2018-20

7.	Derby City Council proposals for the Home First service, and support for Discharge to Assess.	 Derby City Council - planning for winter.pp
8.	EMAS activity 17/18 and predictions 18/19	 Derbyshire (Activity and ORH Response P  Derbyshire Expected Capacity Ouput.docx
9.	DHU Out of Hours and NHS 111 predicted outcomes	 111 Derbyshire and Out of Hours Derbysh
10.	Mental health ED assessment to admission flow chart	 Mental Health - ED assessment to admiss
11.	Provider workforce coverage plans	 Provider workforce management plans wi
12.	Winter Funding proposals	 Winter funding proposals v.3.xlsx
13.	Newton Europe report	 Newton Europe - Derbyshire System Fl