Our plan for the winter

November 2022 – March 2023

Executive Summary

Context

- We go into this winter on the back of a spring and summer period which has seen key aspects of health and care service provision operating at full capacity and levels of escalation similar to the last winter period – with little opportunity to reduce.
- This is an unpreceded situation, with:
    - The level of ‘exit-block’ from our acute hospitals being the key structural issue which is driving front end acute pressures (over-crowding, long waits for admission and ambulance delays in the ED) and a has a direct opportunity cost of lost elective operating time.
    - General practice delivering more appointments than any previous period recorded – with close to half of this output servicing on the day demand.
    - Community Nursing Teams are serving more demand of a complex nature.
- Whilst this plan is not focussed on the actions that are necessary to put these services, and others, on a more sustainable trajectory in the long term, it is focussed on creating a greater level of operational resilience over winter which hopefully provide a spring board going into 2023/24.
- In August 2022, NHS England published its expectations on how Integrated Care Boards (ICBs) should be increasing capacity and operational resilience in urgent and emergency care ahead of this winter. This was supplemented with extra guidance in October 2022, focussing on further action that ICBs should be taking.
- The plan is our response to these documents and details the action that we will take to deliver the 6 key priorities for the ICB over the winter period.

1. Protecting people for COVID-19 and Influenza
2. Supporting people in their own homes
3. Providing an urgent response for those most in need
4. Enhancing the resilience of General Practice
5. Reducing discharge delays from hospital
6. Reducing the backlog for elective and cancer care

What happens if we ‘do nothing’:

Some of the impacts of the do nothing scenario...

- Both hospitals will continue to use >200 more overnight G&A beds than we planned for. This will make it increasingly difficult for us to deliver our elective operating objectives.
- Our community ‘discharge to assess’ services will continue to operate with a deficit level of capacity – short of ~45 step down nursing beds with rehabilitation and reablement and short of ~460 packages of home support per month.
- We will continue to lose around 36 hours of productive paramedic time per day because of ambulance handover delays.
- Opportunities for improving secondary prevention of disease will be missed – specifically for diabetes, hypertension, dementia and poor physical health outcomes for people with severe mental illness.

So what action will we take?

1 Protecting people for COVID-19 and Influenza

- ~43,000 people across Derby and Derbyshire receiving a C-19 booster vaccination.
- 100% of the eligible population offered an influenza vaccination, with uptake at least matching he high levels of uptake achieved in 2021/22 .

2 Supporting people in their own homes

- The **Urgent Community Response Service** will see around 800 people per month, with 70% of referrals being responded to within 2 hours – which represents an improvement on current performance levels.
- The PCN led **Home Visiting Service** will increase its reach across Derby and Derbyshire, delivering a minimum of 2,000 visits to some of the most vulnerable housebound people.
- We will implement an **enhanced community falls service**, with full geographic coverage, operational by the end of December. This will focus on responding to 90% of the see and treat incidents that EMAS are currently dealing with and at least 50% of the see, treat and convey incidents as well
- We will improve the diagnosis of **dementia**, with at least 65% of the relevant population being correctly diagnosed, an improvement on the 62% level currently seen.
- We will improve the diagnosis of **hypertension**, where we will close the gap between observed and expected diagnosis rate by 2.5% by the end of the winter period.
- We will refer more people who are **pre-diabetic** to the Diabetes Prevention Programme – moving from 62% of population referred to at least 75% by the end of the period.
- We will see a 10% improvement in the proportion of people with a **Severe Mental Illness** receiving a physical health check by the end of the winter period.

What action will we take?

3 Providing an urgent response for those most in need

- A new **'push' operating model will be implemented at both acute hospitals**, with the guiding principle of reducing ambulance handover delays and freeing up crews - so as to reduce clinical risk in the community as well as decompressing Emergency Departments.
- The construct of the model will be based on the following parameters:
  - Early MFFD for pathway 0 patients with early discharge (Home or discharge lounge) No patient on a pathway 0 to occupy ward bed after 12:00.
  - Hourly movement from the Emergency Department to Assessment Units continuously over the 24-hour period irrespective if there is a bed available.
  - Every hour between 08:00 and 20:00, Hourly movement from Assessment units will be transferred to the wards totalling the medical take
  - By 22:00 each evening the Assessment units have an agreed number of empty beds
- Continue to operate Crisis House, Safe Haven and Crisis cafe within Derby for people who are in need of support, and promote the use of the mental health helpline and support service, 24/7 for those in emotional and mental health CRISIS.
- Ensure effective utilisation of resources within Crisis Resolution Teams/Home Treatment Teams, providing intensive home treatment, ensuring effective gatekeeping of inpatient capacity and supporting the discharge process.

4 Enhancing the resilience of General Practice

- We will see a **10% increase** on the number of on-the-day appointments that we have delivered to date.
- 4 county wide **Acute Respiratory and Infection Hubs** will be implemented, to reduce the burden of acute respiratory illness on primary care and reduce nosocomial transmission.
- There will be renewed focus on **simplifying working arrangements across the primary – secondary care interface** to include: (i) removing non-value adding steps to the consultant to consultant referral process (ii) fit notes (iii) supply of medicine on discharge (iv) reducing patients bouncing between sectors when it comes to the testing/diagnostic process.
- Capital investment in **cloud-based telephony services** across General Practice – currently subject to NHSE review/approval.

What action will we take?

5 Reducing discharge delays from hospital

- We will **increase step-down capacity** – including:
  - Contracting with CHS Healthcare to provide the clinical workforce necessary to staff 14 beds at the Ilkeston Hospital.
  - Opening 23 beds at the Florence Nightingale Community Hospital.
  - Opening 10 interim beds across Derbyshire County Council estate.
  - Opening 4 additional beds at the Ashgate Hospice.
  - Putting 200 virtual beds into operation by April 2023, with 120 coming on line through December and the remaining 80 throughout quarter 4.
  - Contracting CHS Healthcare to provide supported discharge capacity to the RDH and CRH.
- It is anticipated that the cumulative effect of these measures will help reduce the demand on General and Acute overnight beds - equivalent to around 72 over the period.
- We will also enhance medical and surgical **Same Day Emergency Care (SDEC) services and frailty assessment services** at both acute sites, with the anticipated benefit of reducing demand on beds – equivalent to around 14 over the period.

6 Reducing the backlog for elective and cancer care

- We will use **clinical urgency** (based on the P1-6 construct) and **chronology** (amount of time waited) as the two prime criteria for deciding who receives elective care.
- We will **reduce the number of 78 week waits to 0 by the end of March 2023, by protecting a minimum of 100 overnight elective beds** across both acute sites, fully protecting the use of day case units and continuing to operate full outpatient services.
- Whilst we **will not reduce the 62+ day cancer waiting list** to the pre-pandemic level by the end of the winter period, we will continue to reduce it and maintain performance against the 28 day faster diagnosis standard over the winter period at the very least.

Does it meet NHS England's expectations?

Key deliverables	Compliance *Does our plan meet NHSE's requirements?*	Planned impact *What is the scale of planned impact?*	Degree of confidence *In terms of delivery*	Rationale – planned impact and degree of confidence
Reduce the number of 78 week waits to 0 by the end of March 2023				Whilst we have set out a compliant plan with the expected level of impact, there is uncertainty on deliverability – particularly given that (i) the number of 78+ weeks wait is currently on an upward trajectory and (ii) we don't have a fully mitigated G&A bed position (see page 9) which therefore poses risk to our ambition to ringfence elective beds.
Reduce the 62+ day cancer waiting list to the pre-pandemic level by the end of the winter period				The number of 62+day waits is on a downward trajectory but impact of new referral demand on capacity not yet understood.
Roll out the booster vaccination to the eligible population				We are ahead of trajectory in terms of vaccination numbers.
At least match last year's high uptake rate for the influenza vaccination				Confidence level based on the quality of our historic performance.
Ensure 70% of urgent community response referrals are responded to within 2 hours				Planned impact rated high given that we are submitting a compliant plan. Confidence is rated as high as we are currently within target range.
Implement a community based falls service				Impact is rated as high given the service plans to deal with a large majority of the demand for level 1 and 2 falls that EMAS are currently dealing with. The confidence level is based on the specificity of the plan and the fact that it doesn't rely on a significant number of new staff.

Does it meet NHS England's expectations?

Key deliverables	Compliance *Does our plan meet NHSE's requirements?*	Planned impact *What is the scale of planned impact?*	Degree of confidence *In terms of compliance and/or planned impact*	Rationale – planned impact and degree of confidence
Increase community capacity				Whilst we plan to increase community step down capacity, it is not of a sufficient level to meet demand and have a significant impact on reducing discharge delays - particularly P1 package of cares. Confidence is rated as medium, given that sourcing staff has a degree of uncertainty to it.
Increase the number of virtual wards in operation				Whilst there is a reasonable level of confident that some provision will be in place from December, there is uncertainty as to the scale of what will be available given that the initiative relies on recruitment of c85 WTEs and many posts are still out for advert.
Improve category II 999 response times				Given the size of the gap between current category II response times compared to target, it is highly unlikely that we are to overturn the deficit in performance. This is based on two factors (i) EMAS are unable to source new crew capacity and (ii) there is insufficient evidence at this stage as to what level of crew capacity the new push model will release by reducing ambulance delays.
Increase general practice capacity				A 10% increase in on-the-day appointment capacity is sizable, particularly given the level of demand which is displaced to other parts of the system which is much less than this. Furthermore, the 'standing-up' of acute respiratory hubs, meets NHSE's requirements and will play an important role in enhancing the resilience of general practice over the winter. Confidence is rated as medium given that sourcing staff has a degree of uncertainty to it.

What are the risks?

1 Workforce

- Ability to recruit – particularly pertinent to the VW initiative and staffing community surge beds.
- Increased sickness absence – no significant change to current absence rates have been assumed.
- Staff availability due to industrial action – no adverse impacts incorporated into Provider plans.
- Stability of the PVI sector – degree of uncertainty particularly given financial constraints.

2 COVID-19

- Burden of COVID-19 on bed occupancy exceeds plan. Current plans are predicated on COVID occupancy being at between 5-8% over the winter period.

3 Safety

- Given that this plan does not make a material impact on category II response times, cancer long waits and delayed discharges, the risks to clinical safety associated with this has not been fully mitigated.