Integrated Care System
Nottingham & Nottinghamshire

Nottingham City Council | Nottinghamshire County Council | NHS

Integrated Care System Board

Meeting held in public

Wednesday 9 October 2019, 13:30 – 15:15
Rufford Suite, County Hall, Nottingham

AGENDA

	Time	Agenda Items	Paper	Lead	Action
1.	13:30	Welcome and Introductions:	Verbal	Chair	To note
2.	13:35	Conflicts of Interest	Verbal	Chair	To note
3.	13:40	Minutes of 12 September 2019 ICS Board meeting and action log	Papers A1-2	Chair	To agree
4.	13:45	Patient Story - Redthread	Paper B	Rich Collinson	To discuss
Outcomes Framework, Prevention and Inequalities					
No items on the workplan					
Strategy and System Planning					
5.	14:00	Estates Strategy and Checkpoint Process	Paper C1-2	Helen Pledger	To agree
6.	14:15	Update on the ICS Innovation Exchange with the East Midlands Academic Health Science Network (EMAHSN)	Paper D	Andy Haynes	To agree
7.	14:25	Winter Plans: • Greater Nottingham Response to Drivers of Demand Report and Winter Plan • Mid Nottinghamshire Winter Plan	Paper E1-5	Tracy Taylor and Richard Mitchell	To discuss
8.	14:50	Update from ICPs: • City – to discuss • South – to note • Mid – to note	Paper F1-3	Ian Curryer	To note
Oversight of System Resources and Performance Issues (including MoU)					
9.	15:00	ICS Integrated Performance Report - Finance, Performance & Quality.	Paper G1-2	Andy Haynes and Helen Pledger	To discuss

	Time	Agenda Items	Paper	Lead	Action
Governance					
10.	15:10	Governance Issues for Consideration	Verbal	Chair	To agree
15:15 Close					

6 November 2019, 9am – 12pm, Rufford Suite, County Hall

Integrated Care System Board

Meeting held in public

Thursday 12 September, 09:00 – 12:00
Rufford Suite, County Hall, Nottingham

Present:

NAME	ORGANISATION
Alex Ball	Director of Communications and Engagement, Nottinghamshire ICS
Amanda Sullivan – items 1-6	Accountable Officer, Nottinghamshire CCGs
Andrew Haynes	Clinical Director, Nottinghamshire ICS
Claire Ward – items 1-15	Vice Chair, Sherwood Forest Hospitals NHS Foundation Trust
Colin Monckton – items 1-15	Director of Strategy and Policy, Nottingham City Council
David Pearson	ICS Independent Chair
Eric Morton	Chair, Nottingham University Hospitals NHS Trust
Eunice Campbell-Clark – items 1-14	Chair, Nottingham City Health and Wellbeing Board
Gavin Lunn	Clinical Lead from Mid Nottinghamshire Representing PCNs Clinical Chair, Mansfield and Ashfield CCG
Helen Pledger	Finance Director, Nottinghamshire ICS
Jon Towler	Lay Chair, Nottinghamshire CCGs
Lyn Bacon	Chief Executive, Nottingham CityCare
Melanie Brooks	Corporate Director Adult Social Care and Health, Nottinghamshire County Council
Richard Henderson	Chief Executive, East Midlands Ambulance Service
Richard Stratton	Clinical Lead from Greater Nottingham representing PCNs GP, Belvoir Health Group
Simon Crowther	Executive Director of Finance, Nottinghamshire Healthcare NHS FT
Steve Vickers – items 1-12	Chair, Nottinghamshire County Health and Wellbeing Board
Thilan Bartholomeuz	Clinical Lead from Mid Nottinghamshire Clinical Chair, Newark and Sherwood CCG
Tracy Taylor	Chief Executive, Nottingham University Hospitals Trust
Wendy Saviour	Managing Director, Nottinghamshire ICS

In Attendance:

Joanna Cooper	Assistant Director, Nottinghamshire ICS

Tom Diamond	Director of Strategy, Nottinghamshire ICS
Jane Laughton – item 9	Chief Executive, Healthwatch
Neil Marshall – items 1-4	Regional Manager NHS Services (Central), Connect Health
Steven Smith – items 1-4	Head of Planned Care – Greater Nottingham CCP

Apologies:

Dean Fathers	Chair, Nottinghamshire Healthcare NHS FT
Elaine Moss	Chief Nurse, Nottinghamshire CCGs and ICS
Ian Curryer	Chief Executive, Nottingham City Council
John Brewin	Chief Executive, Nottinghamshire Healthcare NHS FT
John MacDonald	Chair, Sherwood Forest Hospitals NHS FT
Richard Mitchell	Chief Executive, Sherwood Forest Hospitals NHS FT
Tony Harper	Chair, Nottinghamshire County Council Adult Social Care and Health Committee

1. **Welcome and introductions**

Apologies received as noted above.

DP welcomed LB to the Board.

2. **Conflicts of Interest**

No conflicts of interest in relation to the items on the agenda were declared.

3. **Minutes of 8 August 2019 ICS Board meeting and action log**

The minutes of the ICS Board meeting held on 8 August 2019 were agreed as an accurate record of the meeting by those present. The action log was noted.

4. **Patient Story**

Steven Smith and Neil Marshall attended the meeting to present the circulated patient story on MSK services.

Board thanked Steven and Neil for their presentation and valued the upstream focus on prevention and personalisation. DP welcomed speed in developing a single standardised model which engages with the developing PCNs, and invited SS to escalate to the Board if the collaboration required is not forthcoming.

5. **Urgent and Emergency Care Deep Dive**

AS presented the circulated paper on urgent and emergency care performance.

Board discussed the paper and noted the following:

- AS confirmed that A&E Delivery Boards have responsibility for delivery of Urgent and Emergency Care targets. This will need to be reviewed as the system architecture develops.
- RS raised concerns about the expectations from PCNs which are not statutory functions. Once mature PCNs will be able to work together as community providers, alongside community and acute providers.
- EM raised concerns about the impact of transformation funding.
- TT highlighted the importance of Transformation Boards in ensuring consistency with the Clinical Services Strategy in developing new models and ways of working to support transformation.
- AH emphasised the importance of the drivers of demand work (item 17) for A&E Delivery Boards to have a true understanding of urgent and emergency care. A&E Delivery Boards need to consider both performance data and data for analysis to work effectively.

6. Terms of Reference for the Greater Nottingham Transformation Steering Group

AS presented the circulated paper on the development of the Greater Nottingham Transformation Group. Steering Group have proposed that Keith Girling is appointed as Chair for 12 months, and asked that there is ICS Board representation as part of the membership.

Board discussed the paper and noted the following:

- MB supported the need for this group but raised concerns about the pace of the South ICP, and servicing an additional group and the supporting governance. AS provided assurance that work is underway to map and streamline groups in place and to utilise a common reporting mechanism to avoid duplication.
- CM asked that the Terms of Reference clarify the relationship between the ICPs and the Transformation Group. The Transformation Group should be delivering for the mutual benefit of the ICPs as the system develops.

Board approved the formation of a Greater Nottingham Transformation Steering Group and additional recommendations from the Steering Group. Board members are to identify and confirm appropriate membership of the group from organisations and ICPs ensuring that there is ICS Board representation included within the nominations.

ACTIONS:
AS to ensure that the Greater Nottingham Transformation Steering Group Terms of Reference are amended in line with the discussion at the ICS Board.
Board members to identify and confirm appropriate membership of the group from organisations and ICPs ensuring that there is ICS Board representation included within the nominations by the end of September.

7. ICS Outcomes Framework – operationalising the framework

TD attended the meeting to provide Board with an overview of development of the ICS Outcomes Framework.

Board discussed the paper and noted the following:

- There is limited resource across organisations to support the development of the Outcomes Framework and engagement with ICPs and PCNs. This is resulting in difficulty in attaining an Outcomes Framework that is fully populated and live.
- LB noted the importance of the Outcomes Framework as providing a strong narrative for transformation for patients and staff.

ACTIONS:
TD to provide an estimation of the timeline to develop and embed the outcomes framework based on the current levels of resourcing and what impact additional capacity and capability could have on this.

8. ICS Five Year Plan update

HP presented the circulated report on the developing 2019/24 plan, highlighting where progress was behind our local timetable and the actions being taken to address. HP provided the following updates to the Board:

- CCG Commissioning Intentions – the process will be aligned to the five-year plans with letters issued to providers that include the draft plan and the detailed practical steps the commissioners will take to implement year 2 (2020/21) of the five year plan.
- Estates assurance meeting has been held with NHSI/E following the submission of the estates checkpoint document, awaiting formal response. A report will come to the next meeting of the ICS Board.
- First assurance meeting will be 10th October, this is expected to be a detailed programme level discussion.

Board noted the update on progress and challenging timeframe to develop the plan coupled with the absence of detailed guidance. Planning Group continue to have oversight of the development of plans.

Statutory organisations are asked to note the requirement for their Boards to be kept engaged in the lead up to the submission of the plan. An extraordinary Board meeting has been convened on 14 November to endorse the five year system plan, following approval by the individual statutory organisations that constituent the ICS.

Board Development session on 16 September to discuss the system plan in greater detail.

ACTIONS:
HP to provide Board with an update on estates at the 9 October meeting.

9. Local engagement on NHS Long Term Plan - update

AB and Jane Laughton presented the circulated paper on engagement activity on the NHS Long Term Plan. Jane welcomed the opportunity for Healthwatch to work directly with the system on this work.

The full report is available on the ICS website.

Board approved the proposed approach for Phase Three of the communications and engagement plan to support the implementation of the Long Term Plan.

10. People and Culture Strategy – impact of initiatives

LB presented the circulated paper providing an update on progress of the delivery of the People and Culture Strategy.

Board noted the developments since the 9 May ICS Board meeting and impact of initiatives to date.

Board agreed the recommendations in the report.

11. Update on System Staff Engagement and Organisational Development

AB presented the report on staff engagement and organisational development linked to People and Culture Strategy and led by Julian Eve.

Board noted the report and work to date, and agreed the recommendations.

12. Developing an ICS Strategy for Data, Analytics, Information and Digital Technology

TD presented the report on the approach to Data, Analytics, Information and Digital Technology and revised governance approach to bring work together.

AH confirmed that the work to develop a Digital Collaborative for Nottingham and Nottinghamshire is included within the revised governance approach.

Board approved the revised timetable for strategy development and the governance arrangements for Data, Analytics, Information and Digital Technology and strategy development.

13. The Development of Primary Care Networks for Nottingham and Nottinghamshire

GL presented the circulated paper on behalf of Nicole Atkinson and Helen Griffiths.

Board discussed the paper and confirmed support for the development to date for each PCN for Nottingham and Nottinghamshire.

JT asked for Board to be given clarity on how the transition in commissioning for localised services (tactical commissioning) would move from the Strategic Commissioner to ICPs and PCNs in the future system architecture. Board recognised this as a barrier to progress and asked that the ICS Team work with AS to develop an approach to progressing this transition over the course of the next month.

ACTIONS:
ICS Team to work with AS to develop an approach to devolving "tactical commissioning" to ICPs and PCNs.

14. Update from ICPs

AH presented the circulated update report from the Mid Nottinghamshire ICP.

Board noted the reports from City ICP and South Nottinghamshire ICP.

15. ICS Integrated Performance Report - Finance, Performance & Quality.

WS presented the circulated Integrated Performance Report. Areas of concern highlighted as follows

- System in escalation for Urgent Care in Greater Nottingham.
- Cancer position deteriorating
- Mental Health, in particular Out of Area Placements

WS highlighted the letter from Fran Steele following the System Review Meeting on 16 August. System Review Meetings are predominately focused on performance and differ from the previous ICS Stocktake meetings.

Performance Oversight Group needs to be considered as part of the work to strengthen the ICS governance arrangements. The role and membership of this group need to be strengthened to support future System Review Meetings with more detailed briefings. HP asked that the review consider a wider remit for this group to avoid duplication in conversations between performance, planning and finance.

MEETING NOT QUORATE FROM ITEM 16

16. 2019/20 Financial Sustainability – NHS System Control Total

HP presented the circulated report on system financial sustainability and progress to date, including review by the ICS Financial Sustainability Group and ICS Finance Directors Group. HP highlighted the actions being taken forward under each of the three areas (organisational recovery actions, ICP transformational schemes and system wide recovery actions) and the importance that we maintain pace and focus to complete recovery plans by the 30th September.

Forecast to deliver the System Control Total but with significant risk. All system partners to continue to take forward the actions during September and to provide updated plans by the end of September.

Board members recommended that the proposed next steps be agreed and identified no further actions. Decision to be ratified.

ACTIONS:
All organisations to maintain pace and focus to develop a recovery plan (with all three areas) by the end of September
HP to provide a report on system financial sustainability to the ICS Board on 9 October.

17. Update on drivers of demand in urgent and emergency care in Mid-Nottinghamshire

Board noted the report.

18. First draft of winter plans – Mid Nottinghamshire

Report deferred to the meeting in October.

19. Governance Matters for Approval

DP and JC presented the circulated report and clarified the recommendations to the Board.

Board members recommended that:

- The membership of the ICS Board be amended to include the non-Executive Chair of the CityCare Board and Chairs of the Nottingham City and Nottinghamshire County Health and Wellbeing Boards.
- Voting arrangements for ICS Board members is included as part of the work to review and strengthen ICS governance.
- The requirement to input to the scope for the work to review and strengthen the ICS governance by the end of September be noted.

- The recommended approach to sharing papers with Board members be approved.
- The System Architecture Group be stood down.
- ICS membership of the Rural Health Alliance be noted.

Decision to be ratified.

MB asked that further work be undertaken to understand the relationship between Board and Health and Wellbeing Boards, and to consider District Council membership of the Board.

ACTIONS:
DP to discuss support for the work to review and strengthen ICS governance with NHSE/I.
JC to circulate information on the Rural Health Alliance to Board members.

20. Any other business

Board noted that this was WS's final meeting. DP thanked WS for her valuable contribution to the ICS and the citizens of Nottingham and Nottinghamshire.

Time and place of next meeting:
9 October 2019
13:30 – 16:30
Rufford Suite, County Hall

Integrated Care System
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ICS Board Action Log (October 2019) **Item 3. Enc. A2**

ID	Action	Action owner	Date Added	Deadline	Action update
B137	To identify resources available to support the development of the implementation plans to deliver the Mental Health Strategy.	John Brewin and Lucy Dadge	15 March 2019	TBC	Resource has been identified to develop the implementation plans to deliver the Mental Health Strategy. Development of the plans is well underway with a first iteration planned for completion by the third week in May.
B159	To make the required amendments to the approach to Best Value Decision Making.	David Pearson/Lucy Dadge	9 May 2019	TBC	
B175	To identify necessary leads from the respective Local Authorities to support health and social care integration for End of Life care	Jonathan Gribbin/Colin Monckton	12 July 2019	31 August 2019	Representatives for Nottinghamshire County Council identified to support this work.
B174	To ensure that EMAS progress actions to embed an automated solution to accessing end of life care plans and the roll out of the ReSPECT Tool.	Richard Henderson	12 July 2019	30 September 2019	
B180	To lead a piece of work with all system partners to: 1. ascertain the impact of actions in place to improve cancer performance and identify further actions to improve and maintain 62 day performance in year. 2. model activity and actions over 5 years as cancer is a key part of the Five Year Plan.	Richard Mitchell	12 July 2019	30 September 2019	

ID	Action	Action owner	Date Added	Deadline	Action update
B191	All organisations to confirm approval mechanisms for the Long Term Plan to ensure approval of the plan prior to 13 November	All	8 August 2019	30 September 2019	Organisations to confirm their approval mechanisms by 30 September
B202	To identify and confirm appropriate membership of the Greater Nottingham Transformation Steering Group from organisations and ICPs ensuring that there is ICS Board representation included within the nominations by the end of September.	Board Members	12 September 2019	30 September 2019	Reminder email has been shared with key contacts of the GNTSG to check and confirm membership with respective ICS Board representatives.
B206	To maintain pace and focus to develop a recovery plan re 19/20 Financial Sustainability and NHS System Control Total (with all three areas) by the end of September	All Organisations	12 September 2019	11 October 2019	Joint financial assurance meetings held in September with NHSI/E. Financial recovery plans to be reviewed at Financial Sustainability Group on 11 October.
B201	To ensure that the Greater Nottingham Transformation Steering Group Terms of Reference are amended in line with the discussion at the ICS Board.	Amanda Sullivan	12 September 2019	25 October 2019	Terms of Reference to be amended in accordance with ICS Board discussion. Final version to be presented to GNTSG meeting scheduled for 25th October.
B194	To confirm that their organisation / ICP endorses the ICS MOU and confirm how they will contribute to the delivery of priorities	Organisation Leads and ICP Leads	8 August 2019	31 October 2019	Organisations and ICP Boards to confirm to the ICS Board that they will contribute to the delivery of the ICS MOU in 2019/20 through submitting a brief statement of commitment.
B198	To liaise with Sarah Bray to ensure that future performance reports include benchmarking data for key metrics	Helen Pledger	8 August 2019	31 October 2019	

ID	Action	Action owner	Date Added	Deadline	Action update
B199	To develop the Board Assurance Framework in line with the discussion at the Board	Elaine Moss	8 August 2019	31 October 2019	
B179	AS to lead conversations on the alignment of resources during Autumn reporting back to the October ICS Board for a wider discussion	Amanda Sullivan	12 July 2019	6 November 2019	The ICS Executive Group will consider this in the first instance and report recommendations to the ICS Board.
B189	To prepare a report on Five Year Plan for the 6 November ICS Board meeting.	Helen Pledger/Tom Diamond	8 August 2019	6 November 2019	
B207	To provide a report on system financial sustainability to the ICS Board on 9 October.	Helen Pledger	12 September 2019	6 November 2019	Item deferred to the 6 November meeting.
B203	To provide an estimation of the timeline to develop and embed the outcomes framework based on the current levels of resourcing and what impact additional capacity and capability could have on this.	Tom Diamond	12 September 2019	30 November 2019	
B205	To work with AS to develop an approach to devolving “tactical commissioning” to ICPs and PCNs.	ICS Team	12 September 2019	30 November 2019	Initial discussion held. Proposal to be discussed by the ICS Executive Group.

ID	Action	Action owner	Date Added	Deadline	Action update
B197	To ensure that ICPs, Clinical Leads and Commissioners work together to develop a business case for Nottinghamshire to test a new model for EMAS. RH to provide a report on progress to the Board at a future meeting	Richard Henderson	8 August 2019	31 December 2019	
B188	To lead the development of a governance review for the ICS.	David Pearson	8 August 2019	31 December 2019	Work underway to define arrangements to review and strengthen ICS governance. ICS Board members to shape the scope of work.

ENC. B

Meeting:	ICS Board
Report Title:	Patient Story - Redthread's Hospital Based Youth Violence Intervention Programme (YVIP) at the Queen's Medical Centre (QMC), Nottingham
Date of meeting:	Wednesday 9 October 2019
Agenda Item Number:	4
Work-stream SRO:	
Report Author:	Rich Collinson, Business Development Manager
Attachments/Appendices:	Attachment 1 – Patient Story - Sarah

Report Summary:

East Midlands Today, 26 September 2018 – video focused on Redthread at the QMC – https://www.youtube.com/watch?v=_xglZZ76_pc

Youth violence is becoming an even greater pressing issue in the UK, estimated to cost the NHS £2.9 billion a year and society £29.9 billion. Knife crime is on the rise. Redthread's Youth Violence Intervention Programme (YVIP) at the QMC is an innovative, solution focused programme that contributes to addressing this as part of the public health approach to violence. The YVIP at the QMC, integrated care at its core, launched in March 2018, the first hospital outside of London to establish the programme.

Redthread youth workers aim to meet every patient aged between 11 and 24 who attends hospital with a violence related injury, or where there is any suspicion or concern around exploitation, abuse or vulnerability. Embedding the team within the hospital enables Redthread's trauma-informed youth workers to capitalise on the 'teachable moment'. Redthread works closely with community agencies, making relational referrals and advocating on the patients' behalf, to ensure they are well supported in the short and longer term.

The benefits of the programme are numerous and varied. It's contributing towards reducing patients' re-attendance at hospitals, and reducing young people's involvement in violence and criminal behaviour. The impact on patients' lives can be significant, in the short term on providing high quality, personalised, holistic care, improving their emotional health, wellbeing and confidence, improving patients' hospital experience, improved feeling of safety, and risk of harm reduction. Appropriately connecting them to community agencies is invaluable. As a result of the support, patients can choose to make positive behavioural life changes to benefit their health, and the rest of their lives. Clinical staff are able to spend more time on patients' medical needs, and benefit from training from Redthread on violence and exploitation related cases.

Key Measured Outcomes, April 2018 – March 2019 (see statistics in main body, paragraph 8)

- 96% of patients maintained or reduced their risk of participating in further criminal behaviour
- 92% of patients felt as safe if not safer than when their work with us began

- 81% of our patients saw their risk of harm from others drop and 56% saw their risk of harm to themselves fall
- 55% saw a drop in their risk of harm from others

Cost Benefit Analysis – Home office data suggests that a 'break even' analysis that Redthread would only need to reduce recidivism for 6 patients per annum to pay for itself. (£205,104/£34,729 = 5.9). At the QMC in 2018/19 Redthread supported over 213 young people.

A large proportion of the funding has come from The Health Foundation. However sustainable funding is required to continue the programme from 2020/21. In addition, there are developmental possibilities with the existing team. The programme has been shown that it can be replicated at other hospital sites. Redthread operates other services, namely The Well Centre and Kings Adolescent Outreach Service (KAOS) that have the potential to be adapted in other areas.

Redthread would like to raise awareness to ICS Board members of Redthread YVIP at the QMC and to connect with Board members to discuss working together. Redthread is organising a strategic partnership sustainability meeting at the QMC in November and would like to invite ICS Board members to attend.

Action:

☒ To receive
☐ To approve the recommendations

Recommendations:

Key implications considered in the report:

Financial	☒	Costs and funding for the programme
Value for Money	☒	Link made to cost savings to society
Risk	☒	References to risk of harm reduction for patients
Legal	☐	
Workforce	☒	Team structure outlined and redundancy ramifications of no funding
Citizen engagement	☒	Patients appreciate and welcome the support Redthread offers, as shown in the Patient Story
Clinical engagement	☒	References to benefits to hospital staff
Equality impact assessment	☐	

Engagement to date:

Board	Partnership Forum	Finance Directors Group	Planning Group	Workstream Network
☐	☐	☐	☐	☐
Performance Oversight Group	Clinical Reference Group	Mid Nottingham-shire ICP	Nottingham City ICP	South Nottingham-shire ICP
☐	☐	☐	☐	☐

Contribution to delivering the ICS high level ambitions of:	
Health and Wellbeing	☒
Care and Quality	☒
Finance and Efficiency	☒
Culture	☒

Is the paper confidential?

☐ Yes
☒ No

Note: Upon request for the release of a paper deemed confidential, under Section 36 of the Freedom of Information Act 2000, parts or all of the paper will be considered for release.

Redthread's Youth Violence Intervention Programme (YVIP) at the Queen's Medical Centre (QMC), Nottingham

September 2019

Redthread's YVIP

1. East Midlands Today, 26 September 2018 – video focused on Redthread at the QMC – https://www.youtube.com/watch?v=_xglZZ76_pc

2. Youth violence is becoming an even greater pressing social issue in the UK.

   - Tragically in 2018, 103 young people were fatally stabbed in the UK; 91 were young men, and 12 were under 16 (FOI, local authorities).
   - The Office for National Statistics (ONS, 2018) showed violence resulting in an injury accounted for 512,631 offences in 2017/18.
   - In addition figures for violence related crime offences involving a knife or sharp object rose by 24% to 40,184 offences between 2010 and 2018 in England and Wales.
   - Assault with injury and assault with intent to cause serious harm rose by over a third (ONS, 2019).
   - In the Home Office's Serious Violence Strategy 2018, it states, knife crime nationally rose 36% from 2013/14 to 2016/17, while firearms offences rose 31% in the same period.

3. Violence is estimated to cost the NHS £2.9 billion and society £29.9 billion annually (North West Health Observatory, 2012). Behind each of these statistics is a young life lost, a family traumatised, and a community left reeling. To understand the Nottinghamshire context Sarah's story in appendix 1 shows an example of the impact locally.

4. There is no consistent service across the NHS that fully addresses the holistic needs of patients presenting with a violence or exploitation related reason. Redthread has built a good reputation for its YVIP, across seven hospitals in Nottingham, Birmingham and London, filling this gap, addressing these patients' holistic needs over the last 13 years, since 2006 when the programme was launched at King's College Hospital, London.

5. At the invitation of the QMC, Redthread were invited to establish Redthread's YVIP and be Redthread's first hospital outside of London to host the YVIP. This was only possible with £500,000 funding from The Health Foundation and other funding sources, to pilot Redthread's YVIP at the QMC and two hospitals in Birmingham. The programme launched in March 2018.

6. Redthread youth workers aim to meet every patient aged between 11 and 24 who attends hospital with a violence related injury, or where there is any suspicion or concern around exploitation, abuse or vulnerability, criminal or otherwise. Embedding the teams within the hospital enables Redthread's health-informed and trauma-informed youth workers to capitalise on the

'teachable moment', reaching young people at a moment of vulnerability while they may be open to change. The team meet patients off the back of an ambulance, whilst they are receiving life-saving emergency treatment in the resuscitation bay, in an A&E waiting room or once they have been admitted to a trauma ward following major surgery. The specialist youth workers can do this as they are key members of the hospital team, they have honorary contracts, full access to clinical records, a small office space within the department and move freely around the hospital.

7. The intervention is bespoke to each patient and their individual needs, but can include any combination of the following:

    - Building trust and rapport by being a welcoming and friendly, non-medical worker
    - Explaining medical treatment and advocating to staff on their behalf to access appropriate healthcare
    - Bespoke action plan to address immediate risks and needs
    - Safety planning within the hospital
    - Holistic risk and needs assessment
    - Relational referrals to statutory agencies and other professionals
    - Coordinating multi-agency teams, supporting other professionals, 'scaffolding' key relationships
    - Advocating on a patient's behalf (for example with housing associations or social care)
    - One-to-one casework around issues such as healthy relationships and managing difficult emotions
    - Goal-setting and aspirational exercises
    - Support in (re-)engaging with education, training and employment

8. The team consists of a Programme Manager, Team Leader, two Youth Workers and a Programme Co-ordinator. The Programme Manager manages the team and a variety of projects. The other team members cover a working pattern of Mondays to Fridays from 7.30am to 9pm with alternate Saturdays / Sundays covered.

9. From April 2018 to the end of March 2019, essentially the first year of the programme, the below shows some of the key statistics of the YVIP at the QMC:-

    - 213 patients were supported
    - 126 of these patients were assessed as being at highest risk and received an intensive intervention
    - 87 received support around risk assessments, safety planning, signposting, and general advice and guidance
    - 44% were under 18 years old, 56% were 18 years and over
    - 30% female, 70% male
    - 58% were from Nottingham City, 26% Nottinghamshire, others from neighbouring counties

- Presentations to the Emergency Department:
  - 30% knife related assault
  - 42% non-knife related assault
  - 11% exploitation related cases
  - 10% domestic violence
  - 7% with other forms of violence or exploitation

10. The cost of the programme at the QMC is just over £200k per annum. It is currently funded by the main funder, The Health Foundation (the largest health charity in the UK), Nottingham Crime and Drugs Partnership (CDP) through funding from the Nottinghamshire Office for Police and Crime Commissioner (OPCC, £35k), and the Home Office (£48k). Redthread is hopeful that the CDP and Home Office will continue to fund the programme at the same level as 2019/20. However, until this is confirmed this cannot be relied upon. The Health Foundation's grant specifically for funding the pilot ceases in April 2020.

Patient Story

11. Please see Appendix 1 for Sarah's account of her positive experience of Redthread, the opportunities that have arisen for her, and the positive difference it has made to her life.

Key Messages and Learning

12. The benefits of the programme are numerous and varied for the Integrated Care System. From Sarah's story, from the support she was given by Redthread, she is less likely to re-attend hospital, and be involved in further violence. With the support of Redthread she has channelled her situation positively and is less likely to be costing the system as much as she could have been without support. Patients like Sarah need an integrated approach to tackling youth violence.

13. The impact on patient's lives can be significant, in the short term on providing personalised holistic care, improving their emotional health, wellbeing and confidence, improving patient's hospital experience, risk of harm reduction and improved feeling of safety, connecting them to appropriate community agencies, and longer term attitudinal and behavioural change benefiting their health and broader life situations.

14. The programme is contributing towards reducing patients' re-attendance at hospitals, and reducing the chance of young people being involved in violence and criminal behaviour. Staff are able to spend more time concentrating on patients' medical needs. As a result of Redthread's presence, training and team work, hospital staff's confidence, skills and knowledge in dealing with patients who are victims of violence and exploitation has increased. Patients are better connected with community agencies ensuring that they are able to maximise the support and opportunities available.

15. Key Measured Outcomes, April 2018 – March 2019:
    - 96% of patients maintained or reduced their risk of participating in further criminal behaviour
    - 92% of patients felt as safe if not safer than when their work with us began
    - 81% of our patients saw their risk of harm from others drop and 56% saw their risk of harm to themselves fall
    - 55% saw a drop in their risk of harm from others

16. Cost Benefit Analysis - Using Home Office data the conservative financial and social estimated costs per violent incident crime is £34,729 (Heeks et al, The economic and social costs of crime, 2nd Edition, Research Report 99, July 2018),
    - The cost of the Redthread programme at the QMC in 2019/20 is £205,104
    - A 'break even' analysis suggests that Redthread would only need to reduce recidivism for 6 patients per annum to pay for itself. (£205,104/£34,729 = 5.9)
    - At the QMC in 2018/19 Redthread worked with over 213 young people
    - A more in depth economic evaluation completed by an external consultancy is due to be completed by end of 2019.

Next Steps

17. Funding situation - Redthread's YVIP at the QMC is funded until 31st March 2020. £200,000 funding needs to be secured to continue the programme in 2020/21. Funding applications have been submitted to the Big Lottery and various trusts and foundations. Redthread is working with the Crime and Drugs Partnership and Home Office to confirm 2020/21 funding. Likewise, Redthread has good relationships with the personnel involved in the recently established Nottinghamshire Violence Reduction Unit (VRU), and is hopeful of funding contributions from the VRU. The funding has a direct impact on staff's job security, Redthread would like to continue to work with these passionate and skilled personnel.

18. Engagement with Partner Organisations - There has been fantastic engagement within the hospital trust at a clinical level. Redthread would like to build stronger relationships with Clinical Commissioning Groups, Public Health personnel, senior management of the Nottinghamshire University Hospitals Trust (NUH), Nottingham City Council and Nottinghamshire County Council.

19. Existing Team Development Opportunities - Once funding has been secured to continue the work, Redthread would like to explore development of the team at the QMC to meet the demand on the service. There is a need for a specialist in domestic violence and young women's work. An Independent Domestic Violence Adviser (IDVA) and Young Women's Worker would meet this need. In Redthread's London teams these workers are an integral part of the team.

20. Developing new opportunities - As a result of specific short term funding from the Early Intervention Youth Fund (EIYF) Redthread is about to commence a scoping exercise at King's Mill Hospital, Mansfield, analysing the demand on the existing service, developing referral pathways, sharing learning from the QMC, and training staff. Redthread would be interested in being involved in developing programmes in other areas where there is a need. As a deliverer, in an advisory or training capacity, or other model.

21. Disseminating Learning – Redthread is able to share learning across the Integrated Care System. Redthread can help partners in the police, health, social care, and education, understand youth violence in Nottinghamshire. Redthread is part of Nottingham's Ending Youth Violence Network.

22. Other Service Opportunities - The YVIP is the focus currently but there are other services that Redthread delivers in London that can be adapted in other contexts. The Well Centre, a youth health hub in Streatham, whereby youth workers, GPs and a counsellor work in partnership to support and guide 11 – 20 year olds on a variety of health and wellbeing issues. Separately specialist youth workers provide much needed personalised and holistic age appropriate support to vulnerable 13 to 25 year old patients on hospital wards at King's College Hospital, London. KAOS identifies areas of vulnerability overlooked by clinical teams and allows for individualised interventions which can improve the patient's experience and address specific developmental, psychological and social needs.

Conclusion

23. Youth violence is becoming one of the most pressing issues in the UK, estimated to cost the NHS £2.9 billion a year. Knife crime is on the rise. Redthread's YVIP at the QMC is an innovative, solution focused programme that contributes to addressing this problem as part of the public health approach to violence.

24. Redthread's YVIP, supports the needs of young patients who are victims of violence or exploitation, hospital staff and community agencies, filling a gap in NHS provision, enabling clinical staff to spend more time concentrating on patients' medical needs, and appropriately connecting patients with community agencies ensuring they are able to maximise the support and opportunities available.

25. Integrated care is at its core ensuring that patients receive high quality personalised, holistic care. It is contributing towards reducing patients' re-attendance at hospitals, and reducing young people's involvement in violence and criminal behaviour. The benefits of the programme are numerous and varied. Redthread's model is cost effective as it saves the NHS and society money while helping change lives for the better.

26. Funding is required to continue the programme from 2020/21. In addition, there are developmental possibilities with the existing team, such as specialist skilled workers. The programme has been shown that it can be replicated at other hospital sites. Redthread operates other services, namely The Well Centre and KAOS that have the potential to be adapted in other areas.

27. Redthread would like to connect with ICS Board members to discuss how Redthread could work together. Redthread is organising a strategic partnership sustainability meeting at the QMC in early November and would like to invite ICS Board members to attend.

Rich Collinson, Business Development Manager
Richard.collinson@redthread.org.uk

Appendix 1 – Patient Story – Sarah

1. Please explain what happened to you? Why you were admitted to Queen's Medical Centre?

   In October last year I was assaulted in a night club by a group of young men under the influence of a mixture of drugs and alcohol. I had my jaw broken in two places and a cracked tooth, a head injury, and internal abdominal injuries.

2. What treatment and care did you receive from the hospital staff?

   I received surgery to repair my broken jaw. They put three metal plates in my jaw and removed the cracked tooth. I had a CT scan for my internal damage but luckily it was just bruising so was put on medication to protect the area.

3. How did the Redthread team support you while you were in hospital? What did they do? How did this make you feel?

   Redthread approached my bedside at a time I was feeling very vulnerable, alone and worthless due to my lack of family support. Redthread after giving consent talked to my Aunty at times she needed including. They chased up external agencies that had been failing me previously, and supported me during an awful experience. They let me know I wasn't alone and what happened to me wasn't okay, as in my eyes this was just another assault by another man, so was normal for me. They gave me a friendly face and someone to liaise with regarding the police and medical staff.

4. What support did the Redthread team offer with accessing support from any community agencies, and what help was offered to you outside of hospital?

   Redthread helped me access well needed and well over due therapy at a high time of crisis and chased external agencies that should have been involved with me prior to my assault for other matters happening at the time. Redthread also kept a check on my well-being after being discharged from hospital even when I retreated from their support due to my poor mental health at the time.

5. What was the result of this support?

   Agencies got involved to make me feel safe from my previous situation. Therapy helped me deal with prior issues; also my assault as it was a massive trigger for me.

6. What has happened to you since you were in hospital? What opportunities have you been offered since your time in hospital?

   Since my time in hospital I have been given numerous opportunities by Redthread, including chairing youth participation meetings. Below are some examples of activities I have been involved in:

- Chairing QMC youth participation meetings to help shape the future of the service
- Attending 10 Downing Street for a Positive Opportunities event reception with the Prime Minister
- Talking about Redthread and my experience at the NUH's Annual Public Meeting at City Hospital
- Attending a Redthread supporter event at City Hall and doing a speech on my experience
- Speaking with different Redthread funders
- Attending a Redthread Board meeting to speak about my experience
- Being interviewed as part of The Health Foundation's funded Redthread short film
- Being offered an opportunity to attend an interview at the Ministry of Justice to be on the Victims panel, which was a good practice for me for future interviews
- Sitting on the interview panel for future Redthread employees

7. What difference has Redthread made to your life? How does that make you feel?

   I have been able to move forward from a horrific experience in a better way than I ever have before with previous horrific experiences. I finally have an outlook on life of what I want to be doing and who I am. I have not had a trigger for my previous struggles with depression in the longest period than ever before. I feel constantly supported and have someone to come to when I struggle with situations in my life. I feel empowered and listened to, not only by Redthread, but everyone they introduce me to.

8. Please share any recommendations you have to hospitals about caring for young people who have been victims of violence

   - Don't jump to conclusions
   - Understand how scared a young person may be as to why they may be acting a certain way
   - Ask them if they are okay instead of assuming they are fine because they're not saying anything
   - Take note of what the young person has been admitted for, so their needs are met, to save them the frustrations of constantly repeating themselves. Redthread staff do, or help with, these.

9. Would you like to add anything else about your experience of Redthread?

   I'd just like to say thank you to Redthread for all they have done helping me on my journey and for everything they do for other young people like me. Their support is imperative for the problems in today's society and is a much needed and long overdue service.

ENC. C1

Meeting:	ICS Board
Report Title:	ICS Estates Strategy and Checkpoint Process
Date of meeting:	Wednesday 9 October 2019
Agenda Item Number:	5
Work-stream SRO:	Simon Crowther
Report Author:	Marcus Pratt
Attachments/Appendices:	Enc. C2. Appendix 1: *Estates round-table discussion record*

Report Summary:

Following the submission of the ICS Estate Strategy in July 2018 the Nottingham and Nottinghamshire ICS received a rating of **improving** (national scale: fair, improving, good or strong).

In order to access system-level capital funds the ICS will need a rating of good or strong. This includes the ability to access potential STP Wave 4 capital for the expansion of critical care at NUH.

All systems with a rating of fair or improving were required to submit an additional process, in advance of the 5 year plan. The Estates Checkpoint asked systems to submit additional information and progress updates in areas that were identified as requiring further clarification in the original strategy. It is not a resubmission of the draft estates strategy or early draft of 5 year plan.

On 11 April 2019, the ICS Board delegated the submission of the Estate Strategy Checkpoint to the ICS Planning Group. Throughout summer 2019 the ICS have worked with NHS England and Improvement colleagues through this checkpoint process to provide an update on estate strategy progress and respond to specific feedback.

The recommendation from this process is that the Nottingham and Nottinghamshire ICS Estate Strategy rating is **upgraded to good**. This recommendation will be discussed by the NHS England and Improvement Strategic Estates Planning Board.

This paper provides detail on this process including the governance followed and next steps.

Action:

☒ To receive
☐ To approve the recommendations

Recommendations:

1.	The ICS Board is asked to **NOTE** the latest position on the Estates Checkpoint process and that confirmation of a revised rating is expected in October 2019.
2.	The ICS Board is asked to **NOTE** that the 5 year plan (Long Term Plan) will include a draft system capital plan, taking into account the feedback from this process.

Key implications considered in the report:		
Financial	☒	Access to capital funding
Value for Money	☒	Best use of limited capital resources
Risk	☒	Addressing estate risk within the ICS
Legal	☐	
Workforce	☐	
Citizen engagement	☐	
Clinical engagement	☐	
Equality impact assessment	☐	

Engagement to date:				
Board	Partnership Forum	Finance Directors Group	Planning Group	Workstream Network
☐	☐	☒	☒	☒
Performance Oversight Group	Clinical Reference Group	Mid Nottingham-shire ICP	Nottingham City ICP	South Nottingham-shire ICP
☐	☐	☐	☐	☐

Contribution to delivering the ICS high level ambitions of:	
Health and Wellbeing	☐
Care and Quality	☒
Finance and Efficiency	☒
Culture	☐

Is the paper confidential?

☐ Yes
☒ No

Note: Upon request for the release of a paper deemed confidential, under Section 36 of the Freedom of Information Act 2000, parts or all of the paper will be considered for release.

Integrated Care System
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Estates Strategy Update

October 2019

Background & Context

1. On 29 June 2018 the Nottingham and Nottinghamshire ICS approved its estates strategy. This was submitted to NHS England in July 2018, subsequently receiving an improving rating. Ratings range from fair at the lowest end through improving and good to strong.

2. Alongside the estates strategy the ICS submitted 7 bids for capital funding. The value of bids submitted by all systems was considerably higher than the resources available at a national level and only 1 local bid, for the Nottingham University Hospitals Emergency Pathway, was successful. This bid had 3 elements:
   - Expansion of the emergency department at QMC
   - Development of step down beds at Nottingham City Hospital (St. Francis Wards)
   - Expansion of Critical Care Unit at QMC – 8 additional beds.

3. The first two elements were completed in 2018/19 using funds to support winter capacity. A business case for critical care expansion is currently under review by Nottingham University Hospitals and the ICS Planning Group.

4. **Funds for this business case and any future system transformational funds will only be granted should the system estates strategy be upgraded to good or strong**. In addition, the ICS needs to demonstrate that any business cases are aligned to the system strategy and demonstrate value for money i.e. have considered all options available to the system.

Current Position

5. On 28 November 2018 the ICS received feedback from NHS England and Improvement in relation to the submitted strategy. The main themes addressed in the feedback were:

   - Additional detail needed in relation to estate efficiency approach
   - System alignment between the estate strategy and clinical services strategy
   - Governance arrangements supporting capital and estates decisions
   - Progress required to meet Carter estate efficiency targets
   - Plan to realise disposal opportunities and challenges to meet national targets

6. Following receipt of the feedback all fair and improving systems were requested to respond through an estates checkpoint process culminating in a submission to NHS England and Improvement on 15 July 2019.

7. The purpose of this process was to understand progress made by systems, addressing the feedback received and provide an opportunity for re-grading to good or strong.

8. On 11 April 2019 the ICS Board agreed to delegate the sign-off of the checkpoint document to the ICS Planning Group. In addition, an Estates Task and Finish Group was put in place to develop the output. The group is comprised of estates and planning representatives from all ICS partners and reports to the ICS Planning Group.

9. A checkpoint document was submitted on 15 July 2019. Following this, an assurance process took place led by the NHS England and Improvement National Strategic Estates Programme Team. This culminated in a presentation by the ICS and round-table discussion on 4 September 2019. The ICS was represented by:

    - Helen Pledger – ICS Finance Director and Chair of the ICS Planning Group
    - Simon Crowther – Nottinghamshire Healthcare Finance Director and ICS SRO for Estates
    - Marcus Pratt – Programme Director for Finance and Estates
    - Duncan Hanslow – Programme Director for Clinical Services Strategy
    - Lynne Sharp – CCG Associate Director of Estates (for Nicole Atkinson)

10. A record of this discussion can be found in appendix 1. Note in particular the agreed actions from the meeting as follows:

    - The ICS to confirm processes for reviewing capacity and capability on a continuous basis and ensuring adequate allocation for developing plans and delivery
    - The ICS to provide a programme plan for clinical review(s)
    - Clinical plans interaction with estates plans to be shown within a programme plan with delivery points – also to include learning and adjustment points (learning and process improvement)
    - Estates delivery plan to include named lead persons and accountability to ICS for delivery
    - ICS to resubmit Disposals section of 2019 Checkpoint to ensure good and full representation of on-going work and achievements/plan to develop a robust disposal pipeline (showing delivery and system wide ambition)
    - The ICS agreed to provide information around development of primary care business cases (approach and how/ capacity and capability)
    - NHSI team to try and obtain feedback on unsuccessful capital bids, and ICS to feed learning into on-going business case development

- Reposition capital plans to recognise plans addressing critical infrastructure risk and those addressing transformation (local and national schemes), through the submission of the 5 year plan.

11. On the basis of the checkpoint process, Martin Rooney, NHS England and Improvement Director of Partnering and chair of the meeting, will be recommending that the ICS estates strategy rating is moved from **improving to good**. This decision is to be discussed by the Strategic Estates Planning Board in October 2019.

12. For clarity the governance ICS process followed and timescales are as follows:

ICS Draft Estates Strategy Approved by STP Board	29 June 2018
ICS Estates Strategy Submission July 2018	
7 bids for STP Wave 4 Capital Funding Submitted	July 2018
Estates Strategy Feedback received	28 November 2018
Notification of award for NUH emergency pathway bid (subject to agreed FBC)	December 2018
ICS Board delegated agreement of the ICS/STP estates checkpoint process to ICS Planning Group	11 April 2019
Draft version of the document presented to ICS Planning Group – delegated detailed review to small sub group of ICS Planning Group (all partners given opportunity to attend)	3 July 2019
Final version reviewed at agreed for submission by sub group	12 July 2019
Checkpoint submission	15 July 2019
Feedback received from checkpoint submission	2 September 2019
Roundtable discussion with NHS England and Improvement	4 September 2019
Final decision on ICS Strategy re-grading	Expected October 2019

Next Steps

13. At this stage there is little clarity over the availability of transformational capital funds. However, in order to implement the recommendations from the ICS estates strategy process and put the ICS in the strongest possible position to access capital funds when they become available, the Estates Task and Finish Group has been formalised as the Strategic Estates Planning Group reporting into the ICS Planning Group.

14. A clear workplan has been agreed focussing on ensuring a consistent and collective understanding of the Nottinghamshire estate, driving forward the estates efficiency programme and aligning future capital investment to the ICS Long-Term Plan and Clinical Services Strategy.

Recommendations

15. The ICS Board is asked to NOTE the latest position on the Estates Checkpoint process and that confirmation of a revised rating is expected in October 2019.

16. The ICS Board is asked to NOTE that the 5 year plan (Long Term Plan) will include a draft system capital plan, taking into account the feedback from this process.

Marcus Pratt
Programme Director for Finance and Estates
marcuspratt@nhs.net
1 October 2019

Summer 2019 Estates Strategy Check-in - Round table discussion record

STP Name	**Nottinghamshire**	**Date of Round Table discussion**	**5 September 2019**
SEP Team assessor	**Martin Rooney**		
Key Lines of Enquiry (established from the Stage 1 Assessment)		**Evidence**	
Governance • Can you explain how the ICS is linking and embedding its approach to estates governance with the wider ICS decision making/accountability framework. • How does the ICS intend to further support the development of capacity and capability to ensure the estates programme is driven forward, particularly to ensure that key projects are achieved e.g. W1-4 **Clinical/estates strategy linkage** • Can you describe how the ICS is ensuring that there are effective links between clinical programmes and the capital plans currently in place/being developed for the future. • Is the ICS able to demonstrate evidence of a strategic programme approach which demonstrates activity and timelines? • Can the ICS describe how plans for the reconfiguration of the QMC are being delivered and linked to the wider estates programme? **Primary Care** • How does the ICS plan to further develop its approach to the delivery of Primary Care Estates Strategies? • Capital Plan – how does the STP intend to develop and deliver the detail in relation to projects identified e.g. they simply talk about a total value of £75m **Disposals** • Can you tell us about your Disposal delivery programme, particularly how you will ensure that a more comprehensive data set is established and verified		**Governance**: System wide governance is complex but assured that senior level leadership in place and continuing to ensure delivery linkages and accountability, recognising System v Place requirements. Strengthened Estates Planning Group and Estates elevated as a key priority rather than just an enabler. System sustainability and estates cost goes hand in hand (including other enabler cost drivers i.e. workforce). Have aligned the ICS 'ask' across organisations' own 'ask' (creating commonality of objectives). ICS has oversight of how organisational delivery contributes to ICS delivery. *Is there enough capacity and expertise to do more than the BAU (delivery and forward and wider thinking)?* **Clinical/Estates Strategy**: Clinical reviews planned initially with 5 priority areas (to be completed Oct 19), followed by a further 15 (5 per quarter over the following 9 months) aligned to local and LTP priorities. System workshops underway (as part of the development of LTP) to review all service/care areas to avoid fragmentation and support the development of a comprehensive bottom up system plan. System recognises the difficulty in delivering transformation in a financially restricted system with a large BLM challenge (which will remain priority) but focus will be on both financial and non-financial benefits. Prioritisation will require a review in line with the current 5 year plan work and any further capital opportunities. **Primary Care**:	

• How do you plan to ensure momentum is maintained and sites are delivered to the market and transacted in a timely way? **Efficiency** • Can you tell us how you are proposing to deliver against the Carter efficiency targets which appear to be either static or worsening e.g. estate running costs • What plans are in place to reduce running costs across the estate? • How does the ICS plan to address issues around critical infrastructure costs, particularly in relation to NUH? • Is the ICS able to describe its plans for the reinvestment of estates efficiency savings into frontline services? Is there a plan describing how capital investment will lead to revenue savings? How are energy efficiency and environmental sustainability contributing to efficiencies?	CCG merger has enabled more consistent approach to review of ownership models; priorities were carried forward from individual CCG estates strategies. Nottinghamshire is a selected pilot for Primary Care data project to establish a robust premises information set which will enable effective decision making in the future. System have funding to develop PCES. Indicative total project costs currently but will be firmed up in future. Next step is to further understand delivery requirements. **Disposals**: Current data limited so ICS to develop a better collective understanding and articulate how they will drive delivery forward. Is there adequate capacity and capability to deliver i.e. wider regeneration scheme to deliver benefits beyond potential receipt? Disposals will become a key workstream within the Estates Planning Group reporting to the ICS Planning Group. **Efficiency**: Reduction of running cost - Substantial LIFT and PFI footprint, RPI impact on Sherwood Forest and therefore to consider separation / breakdown between PFI and FH fixed cost and delivery targets. 20 buildings identified as fixed points for clinical services across Nottinghamshire. The strategy is to maximise the utilisation of these sites enabling rationalisation elsewhere. Addressing critical infrastructure risk – NUH Fire risk (and other statutory issues) implications to be understood by ICS in 'do nothing' option including service closures.
System presentation – key points for recording	
As outlined above. Financial deficit position: System shows significant ambition though constrained by the financial pressures Focus: Cost Base issues, Productivity, Sustainability	

Clear vision for clinical review aligned to estates principles around investment, divestment and optimisation of estate, including identification and buy-in to 20 key fixed delivery sites.	
Key Challenges for the system (in taking forward estates ambition)	**Key opportunities for the system (in taking forward estates ambition)**
Deficit system therefore only loan funding available (unable to generate capital locally), so focus on BAU at expense of transformation Continuing to develop and embed complex Governance structure NHS PS premises data and cost – lack of control of some elements of the estate	Joining up approach to OPE partnership opportunities Continuing to develop transformational vision and readiness to take future funding opportunities as they arise Investment Notts (back-office reconfiguration) could bring early wins and embed partnership approach
Next steps/Actions arising from assessment and discussion	
• ICS to confirm process for reviewing capacity and capability on continuous basis and ensuring adequate allocation for developing plans and delivery • ICS to provide programme plan for clinical review(s) • Clinical plans interaction with estates plans to be shown within a programme plan with delivery points – also to include learning and adjustment points (learning and process improvement) • Estates delivery plan to include named lead persons and accountability to ICS for delivery • ICS to resubmit Disposals section of 2019 Checkpoint to ensure good and full representation of ongoing work and achievements/plan to develop a robust disposal pipeline (showing delivery and system wide ambition) • ICS agreed to provide information around development of primary care business cases (approach and how/ capacity and capability) • NHSI team to try and obtain feedback on unsuccessful capital bids, and ICS (Marcus with Alastair) to feed learning into ongoing business case development • Reposition capital plans to recognise plans addressing critical infrastructure risk and those addressing transformation (local and national schemes)	
Other notes for recording	SEP Support: Informed client on Primary Care Estate Strategy commission and delivery Assessing programme plan initiative/scheme plans Support on how to set up pilot (geography) – (was this linked to a sustainable estate approach with both financial and non-financial delivery and benefits emphasis?) Identify potential items for OPE funding access Robust review of disposal programme Share information and good examples of how prioritisation was done in other areas ICS vs STP: benefit and advantages within the estates and capital environment; Round table: process very useful and better understanding of the ask and required focus Strategy Process 2018: Somewhat faceless re process and assessments

	Webinars: Lack of clarity on the purpose of the exercise Template: unable to focus on key local priorities – not able to reflect the picture and flow across; ICS added own Exec Summary in three pages to address some of this Future Planning interaction will be helpful

Attendees:

Alistair Fleming, Senior Finance Manager, North Midlands
David Roberts, Asset Efficiency, Office of Government Property, Cabinet Office
Duncan Hanslow, ICS Clinical Services Programme Director
Helen Pledger, ICS Finance Director, ICS Finance & ICS Planning Committee Chair
Jude Wildgoose, Estates Strategy Programme Director
LeeAnne Green, Strategic Estates Advisor, SEP NHS E/I
Marcus Pratt, Finance and ICS efficiency Programme Director
Martin Rooney, Director Partnering, SEP NHS E/I – Chair
Matthew Ward, Area Director, SEP NHS E/I
Dr Nicole Atkinson, CCG Chair and ICS Clinical Services Strategy SRO
Riana Relihan, Area Director, SEP NHS E/I
Simon Crowther, CFO, NHFT and ICS Estates SRO

ENC. D

Meeting:	ICS Board
Report Title:	Update on the ICS Innovation Exchange with the East Midlands Academic Health Science Network (EMAHSN)
Date of meeting:	Wednesday 9 October 2019
Agenda Item Number:	6
Work-stream SRO:	Dr Andy Haynes
Report Author:	Rebecca Larder
Attachments/Appendices:	Appendix 1: Assessment and recommendations relating to the local adoption of the EMAHSN portfolio of innovations.

Report Summary:

At the 13 June 2019 meeting, ICS Board received a paper from the East Midlands Academic Health Science Network (EMAHSN). This paper confirmed the opportunity for the ICS to further collaborate with the EMAHSN, embedding a more consistent and strategic approach to research and innovation for the benefit of the local population.

The Board noted the EMAHSN's portfolio of innovation projects and agreed, in principle, to support the full adoption. The Board asked Dr Andy Haynes, ICS Clinical Lead, to co-ordinate an Innovation Exchange with representatives from the EMAHSN, ICPs and other interested parties, to take oversight of the proposed innovations.

An inaugural Innovation Exchange has been arranged for 1 November 2019 and the focus of the initial event confirmed. Recognising the focus on research and innovation, the two local universities (Nottingham University and Nottingham Trent University) have been invited to form a third arm to the Exchange alongside the ICS and EMAHSN.

Members of the ICS Clinical Reference Group (CRG), ICP management teams, and system wide programme leads have been invited to the Exchange. In addition support has been requested from the ICS workforce programme lead and CCG Programme Management Office (PMO) in order that any impact, arising from the innovations discussed, on workforce and finance can be fully understood.

In preparation for the Exchange, work has been completed to review the EMAHSN list of innovations as shared with the Board. This review has concluded that:

- In many instances, where the EMAHSN has assessed gaps in the local adoption of their innovations, the ICS and / or ICPs have alternative initiatives and improvement programmes in place. In some instances these programmes are more encompassing than the EMAHSN innovation.
- The ICS and ICPs would benefit from EMAHSN support in evaluating the impact of the innovations especially where varying models of delivery are in operation. Such evaluations would inform any commissioning decisions on

the requirement for consistency of approach across the ICS going forward and also support the case for innovation adoption and spread.

- A small number of the initiatives are only partially deployed across the ICS but with system awareness and work underway on considerations, including workforce and finance, impacting full adoption.

It is proposed that going forward the functions of the ICS CRG, chaired by Dr Andy Haynes, should now include the clinical approval mechanism for the adoption of EMAHSN / Innovation Exchange initiatives into the ICS.

Action:

☒ To receive
☒ To approve the recommendations

Recommendations:

1.	Note progress in arranging an inaugural Innovation Exchange with the EMAHSN.
2.	Confirm constituent organisation research and innovation leads to be invited to the Innovation Exchanges.
3.	Agree that the ICS CRG provides the clinical approval mechanism for the adoption of EMAHSN / Innovation Exchange initiatives into the ICS.

Key implications considered in the report:

Financial	☐	
Value for Money	☐	
Risk	☐	
Legal	☐	
Workforce	☐	
Citizen engagement	☐	
Clinical engagement	☐	
Equality impact assessment	☐	

Engagement to date:

Board	Partnership Forum	Finance Directors Group	Planning Group	Workstream Network
☒	☐	☐	☐	☒
Performance Oversight Group	**Clinical Reference Group**	**Mid Nottingham-shire ICP**	**Nottingham City ICP**	**South Nottingham-shire ICP**
☐	☒	☒	☐	☐

Contribution to delivering the ICS high level ambitions of:

Health and Wellbeing	☒
Care and Quality	☒
Finance and Efficiency	☒
Culture	☒

Is the paper confidential?

☐ Yes
☒ No

Note: Upon request for the release of a paper deemed confidential, under Section 36 of the Freedom of Information Act 2000, parts or all of the paper will be considered for release.

Integrated Care System
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Update on the ICS Innovation Exchange with the EMAHSN

9 October 2019

Introduction

1. This paper updates the Board on the good progress achieved in establishing an Innovation Exchange with the East Midlands Academic Health Science Network (EMAHSN) as a means of improving innovation into practice for the people of Nottingham and Nottinghamshire.

2. The paper proposes that, going forward, the ICS Clinical Reference Group (CRG) provides the clinical approval mechanism for the adoption of EMAHSN / Innovation Exchange initiatives into the ICS.

Background

3. At its 13 June 2019 meeting, the Board received a paper from the EMAHSN. This paper confirmed the opportunity for the ICS to further collaborate with the EMAHSN, embedding a more consistent and strategic approach to research and innovation for the benefit of the local population.

4. The Board noted the EMAHSN's portfolio of innovation projects and agreed, in principle, to support the full adoption.

5. The Board asked Dr Andy Haynes, ICS Clinical Lead, to co-ordinate an Innovation Exchange with representatives from the EMAHSN, ICPs and other interested parties, to take oversight of the proposed innovations.

Innovation Exchange

6. An inaugural Innovation Exchange has been arranged for 1 November 2019. It is proposed that this session will provide a structured process to bring together the EMAHSN with key stakeholders from across the ICS. The plan is for the initial session to focus on:

    - Socialising the role of the EMAHSN and its portfolio of innovation projects.
    - Considering a small number of the innovations determining how they are best implemented including through the Integrated Care Provider (ICP) and Primary Care Network structures.
    - Sharing the issues and priorities of the ICS to inform the EMAHSN's future support offer ensuring alignment with our local needs and ambitions. NB: only eight of the 18 AHSN innovations shared are

nationally prescribed with considerable opportunity to shape their work-programme.

7. It is anticipated that there will be value in holding a series of 3-4 Innovation Exchanges per annum with the EMAHSN invited to both showcase their innovations as well as acting as a convenor in bringing the ICS together with wider partners (from across sectors) that have potential to support Nottingham and Nottinghamshire in developing, testing and spreading solutions to local priorities.

8. Recognising the focus on research and innovation, it is also considered advantageous to invite the two local universities (Nottingham University and Nottingham Trent University) to form a third arm to these Exchange sessions alongside the ICS and EMAHSN. Contact has been made with the universities for this purpose.

9. Details for the first Innovation Exchange have been shared with members of the ICS CRG, the ICP management teams together with system work-stream programme leads. There is opportunity to also extend the invitation to constituent organisation research and innovation leads through ICS Board members.

10. Support has been requested, for the Innovation Exchange, from the ICS workforce programme manager and CCG Programme Management Office (PMO) in order that any impact on workforce and associated costs arising from this work can be fully understood.

Status of the EMAHSN Innovation Portfolio

11. In readiness for the first Innovation Exchange, the CRG has supported work to review the portfolio of EMAHSN innovation projects as presented to the ICS Board.

12. Subsequently, the EMAHSN has shared information on 15 further innovations predominantly relevant to acute trusts and for which NHS England funding is available to enable adoption. This list is yet to be reviewed by the CRG but it has been shared with Nottingham University Hospitals NHS Trust and Sherwood Forest Hospitals NHS Foundation Trust. It is proposed that this list of innovations is also incorporated into the Innovation Exchange process.

13. The review of the initial portfolio of 18 innovations, as detailed in Appendix 1, has confirmed the following points:

    - In many instances, where the EMAHSN has assessed gaps in the local adoption of their innovations, the ICS and / or ICPs have alternative initiatives and improvement programmes in place. In some instances these programmes are more encompassing than the EMAHSN innovation.
    - The ICS and ICPs would benefit from EMAHSN support in evaluating the impact of the innovations especially where varying models of delivery are in operation. Such evaluations would inform any commissioning decisions on

the requirement for consistency of approach across the ICS going forward and also support the case for innovation adoption and spread.

- A small number of the initiatives are only partially deployed across the ICS but with system awareness and work underway on considerations, including workforce and finance, impacting full adoption.

Next Steps

14. It is proposed that going forward the functions of the ICS CRG, chaired by Dr Andy Haynes, should now include the clinical approval mechanism for the adoption of EMAHSN / Innovation Exchange initiatives into the ICS.

Recommendations

15. The ICS Board is asked to:

i. Note progress in arranging an inaugural Innovation Exchange with the EMAHSN.
ii. Confirm constituent organisation research and innovation leads to be invited to the Innovation Exchanges.
iii. Agree that the ICS CRG provides the clinical approval mechanism for the adoption of EMAHSN / Innovation Exchange initiatives into the ICS.

Rebecca Larder
Programme Director
Nottingham and Nottinghamshire ICS

Appendix 1: Assessment and recommendations relating to the local adoption of the EMAHSN portfolio of innovations

Project summary	AHSN 'must do'	AHSN assessment of Notts adoption status	Our assessment of adoption status	Recommendations
Atrial fibrillation – East Midlands AF Advance Programme to detect and treat AF by distributing mobile electronic devices to GP practices along with more effective prescribing of anti-coagulation medication and testing of patients in their local community.	☑	Deployed across four of the six Nottinghamshire CCGs (devices not currently in use in Mansfield and Ashfield CCG and Newark and Sherwood CCG)	Work is underway to improve the detection and management of AF across the whole ICS / all ICPs. The AF Advance Programme is not being deployed in Mid Notts but an alternative model of improvement is in place.	Recommendation that the Innovation Exchange raise awareness of differential models of delivery including the potential for the AHSN to support an evaluation.
Emergency Laparotomy Collaborative: reducing deaths associated with emergency laparotomy (complex emergency abdominal surgery). It uses collaborative working to embed quality improvement – bringing together dozens of staff from Emergency Departments, radiology, acute, admissions units, theatres, anaesthetics and intensive care	☑	Deployed across all hospitals in Nottinghamshire where Emergency Laparotomy procedures are performed	AHSN assessment validated with confirmation of full deployment.	No actions required
Falls prevention and management: multi-agency collaboration (NHS, social care, third sector and technology providers) to develop a service model to reduce falls through early identification of risk, early intervention and proactive management – improving patient management and supporting self-management by patients	☒	Currently in demonstrator phase in Leicester, Leicestershire and Rutland. Full evaluation will be available Q2 20/21	Local projects are in place on falls prevention and management, including through proactive care projects for people with frailty and the work of the clinical navigators	Recommendation that the ICS await the evaluation of the demonstrator in order to determine any opportunities to strengthen local initiatives for fall prevention and management
Safety in Care Homes (LPZ): LPZ (Landelijke Prevalentiemeting Zorgkwalitet) is an audit tool developed in the Netherlands to measure common problems in nursing and residential homes such as falls, pressure ulcers and hydration. East Midlands care homes have taken part in the audit providing consistent recording of data to support and measure improvements in quality of care, and enable cost savings.	☒	Deployed across 27 care homes in Nottinghamshire	Conformation that Nottingham/Nottinghamshire is now implementing a more comprehensive safety and improvement programme in this area through 'Significant Seven' / Enhanced Support to Care Homes.	No actions required
The 'Scarred Liver' programme: This innovative diagnostic pathway is proven to more effectively detect chronic liver disease at an early stage, when it can be halted or even reversed. It combines identification of patients who are at risk (as a result	☒	Deployed in Nottingham City and South Nottinghamshire CCGs	AHSN assessment validated that this service is not available within Mid Nottinghamshire.	Recommendation that commissioners consider evidence on the extent to which benefit has been derived from the 'scarred liver' programme in informing their

Project summary	AHSN 'must do'	AHSN assessment of Notts adoption status	Our assessment of adoption status	Recommendations
of their lifestyle) with a diagnostic test using a mobile scanner that highlights the degree of liver scarring.				commissioning response to the ICS alcohol priority.
ESCAPE-Pain: NICE approved programme provides group rehabilitation for people with chronic pain. It uses self-management to help people cope, with exercise tailored to each person. It is delivered via physiotherapists or health trainers away from clinical settings such as leisure centres and work places.	☑	Currently in deployment phase in four community settings in Nottinghamshire (including Bulwell Riverside Centre, King's Mill Hospital, Mary Potter Health Centre and Newark Hospital)	AHSN assessment confirmed that this is deployed and available across Mid Nottinghamshire. Confirmation that equivalent services are available in community MSK/Pain services across Greater Nottingham.	Recommendation that the Innovation Exchange raise awareness of differential models of delivery including the potential for the AHSN to support an evaluation.
COPD Discharge Bundle: This programme focuses on the facilitation and spread of the British Thoracic Society's Chronic Obstructive Pulmonary Disease (COPD) discharge bundle, which outlines high impact actions with the aim of improving care and reducing readmissions.	☒	To be rolled out in the city / county during 2019 via East Midlands respiratory network	Local assessment has confirmed the COPD discharge bundle is in place across the ICS	No actions required.
ChatHealth: Safe and secure text messaging service that puts secondary school pupils in touch with a school nurse using their own mobile phones.	☒	Available across Nottinghamshire	Confirmation that Chathealth is provided across Nottinghamshire but a similar service is not currently available within Nottingham City.	Recommendation that City commissioners consider evidence on the extent to which population benefit and return on investment has been achieved to inform their commissioning intentions for Children and Young People.
Transforming ADHD Care: In the East Midlands over 76,000 young people have Attention Deficit Hyperactivity Disorder (ADHD). QBTest uses technology to assess core symptoms of ADHD, supporting faster and more effective diagnosis.	☒	Not currently deployed in Nottinghamshire. Originally pioneered in Nottinghamshire	AHSN assessment validated with confirmation that this innovation is not currently deployed across the ICS however the CCG is currently considering its whole service offer (not just the assessment element) in respect to ADHD services for adults.	Recommendation that the CCG consider this innovation as part of their ADHD commissioning strategy with the opportunity – where helpful – to request support from the EMAHSN in determining whether there is an 'invest to save' opportunity from the deployment of this innovation.
Group Psychoeducation for Bipolar Disorder: NICE-approved group therapy for people with bipolar disorder delivered in mental health provider organisations. Patients receive information on their illness and work with family members to develop personalised coping strategies.	☒	Deployed in Nottinghamshire via Nottinghamshire Healthcare NHS Foundation Trust, which was the lead site for the intervention.	AHSN assessment confirmed that this is deployed across Nottinghamshire.	No actions required.

Project summary	AHSN 'must do'	AHSN assessment of Notts adoption status	Our assessment of adoption status	Recommendations
Serenity Integrated Mentoring (SIM): Integrates mental health care and policing, focusing on patients with complex mental health needs. It trains a police officer in high intensity behaviour, risk management and basic clinical theory and parachutes them into a community mental health team to help with the most challenging cases.	☑	Not currently deployed in Nottinghamshire.	Local assessment has confirmed that the City ICP has Street Triage which is an integrated mental health service with police teams, Framework etc. Additionally Mid Notts ICP is commencing a 9-month pilot with Mansfield District Council where mental health nurses will be working alongside the police. These services are being targeted to specific population needs.	Recommendation that the AHSN be asked to support evaluations of the varying initiatives to inform future commissioning models and spread.
Digital outpatient appointment management: This project is currently at testing phase and will put in place a digital outpatient management system across a number of acute NHS trust clinical specialties, integrating with the trust's existing IT systems. It will help move scheduling of outpatient appointments to a needs, rather than time, basis.	☒	Currently in demonstrator phase within Nottingham University Hospitals NHS Trust across three clinical specialties. Full evaluation will be available Q4 2019/20.	Local confirmation that NUH are trialling the 'Doctor Doctor' model. An alternative outpatient appointment management system is in operation at Sherwood Forest Hospitals.	Recommendation that consideration be given to the varying systems once the Nottingham University Hospital evaluation is available.
PINCER: Pharmacist-led **IN**formation technology intervention for Reducing **C**linically Important **ER**rors is software that helps GPs review patient caseloads and highlight risk of prescribing errors – particularly for people with complex combinations of medicines. This enables action to reduce risk of errors.	☑	Deployed within all Nottinghamshire CCG areas. Currently used in 100 out of the 134 GP practices (74%)	Local assessment has confirmed Nottinghamshire is a pioneer in this area and that GP practices are supported in reducing prescribing errors by the CCG Medicine Management Team. Two limiting factors are preventing full routine coverage i.e. GP time and Medicine Management Team capacity	The Medicines Management Team has held a training session for current PCN clinical pharmacists to embed this support function within the new pharmacist role. It is recommended that the AHSN be asked to support further 'train the trainer sessions' as more PCN clinical pharmacists are recruited enabling full support coverage to GP practices.
Unit Dose Close Loop Medicines Management: Uses robotics to individually package medicines for patients in acute NHS hospitals. The system coordinates the entire process – cutting, bagging and labelling with unique barcodes for each patient. Automated storage cabinets on wards automatically fill medicine trolleys.	☒	Under evaluation in University Hospitals of Leicester NHS Trust	Confirmation that acute providers are awaiting the evaluation of the Leicester innovation.	No actions recommended at this time whilst the innovation is evaluated in Leicester.

Project summary	AHSN 'must do'	AHSN assessment of Notts adoption status	Our assessment of adoption status	Recommendations
Transfer of Care Around Medicines (TCAM): When people move between care providers or are discharged from hospital, mistakes can be made about medication. TCAM ensures ongoing local pharmacist support, so they have the right medicines and take them appropriately. It leads to significant reductions in hospital length of stay and re-admissions.	☑	Deployed in Nottingham University Hospitals NHS Trust and Sherwood Forest Hospitals NHS Foundation Trust	Local assessment that TCAM is fully deployed at Nottingham University Hospitals. The innovation is in place at Sherwood Forest Hospitals but with upgrades required to IT systems to enable full deployment. In addition, ongoing engagement with community pharmacists is in place to support them in actioning the referrals received.	No recommendations beyond and above work underway.
Polypharmacy: Polypharmacy (where people are prescribed many medicines) can lead to errors and unintended side effects. This projects reviews people's medicines and provides information and advice for clinicians to identify patients at risk, and for people to understand their conditions.	☑	Frailty pathway in demonstrator phase at Nottingham University Hospitals NHS Trust and a new Social Prescribing Tool will be available in Nottinghamshire in late 2019	Local confirmation that the ICS has a comprehensive programme relating to Polypharmacy which includes the frailty population group. This work is led by the CCG Medicines Management Team with links to / support from the AHSN through the local Medicines Optimisation Programme Board of which the AHSN is a member.	No action needed.
Maternal and Neonatal – PreCePT (**PR**eventing **C**erebral Palsy in **P**re-**T**erm labour): Prescribes magnesium sulphate to mothers in pre-term labour.	☑	Deployed across all of the maternity units in Nottinghamshire (about to commence at Nottingham University Hospitals NHS Trust)	Local assessment has confirmed that PreCePT is deployed across all maternity units.	No action needed.
Diabetic foot service digital solution: Hand-held 3D camera assesses diabetic foot ulcers over time. The system shares wound imaging, measurements and electronic clinical notes in real time across care teams. Patients can have follow up appointments in the community, which is more convenient and reduces waiting times.	☒	Deployed in Nottingham University Hospitals NHS Trust	AHSN assessment validated. Work is underway across the ICS to improve diabetes services, including the establishment of a diabetic foot prevention team through podiatry.	Recommendation that an evaluation be undertaken of the benefits of the 3D camera service at Nottingham University Hospitals to inform whether there would be benefit in incorporating into local diabetes service developments for the whole ICS population.

ENC. E1

Meeting:	ICS Board
Report Title:	Greater Nottingham Response to Drivers of Demand Report and Winter Plan
Date of meeting:	Wednesday 9 October 2019
Agenda Item Number:	7
Work-stream SRO:	Amanda Sullivan
Report Author:	Caroline Nolan and Simon Frampton
Attachments/Appendices:	Enc. E2 - Response to Report on the Drivers of Demand Enc. E3 – Greater Nottingham Winter Plan.

Report Summary:

The purpose of this report is to provide an update on the key lines of enquiry being explored and early results regarding the drivers of demand in the Urgent and Emergency Care system in Greater Nottingham. The work is being managed through the A&E Delivery Board.

Building on lessons learned from Winter 2018/19, the Greater Nottingham system has implemented a series of initiatives to enable it to be fully prepared for predicted patient activity through Winter 19/20. These initiatives include;

Additional Acute beds – right sizing capacity to meet demand, including:
• 70 escalation bed converted into extra core beds that will be open and appropriately staffed throughout winter
• 30 extra assessment beds at QMC to address current shortfall in Acute Medicine
• Opening three extra critical care beds
• Use of St Francis for acute beds to create additional medical capacity

Community efficiency in beds – supporting people to get home and stay at home:
• Intensive Support at Home Service (ISaH) supporting more complex patients to be discharged directly home without need for a community bed to be operational from October 2019, this will provide 10 packages of care per week.
• Call for Care – providing a 2-hour rapid response for care within the community from Q3 19/20 with the capacity to support circa 240 episodes of care each month
• Integrated Community Respiratory Service – Will strengthen community respiratory services leading to a stronger focus on prevention, structured chronic disease management and care planning.
• Increasing the use of community beds to allow for 1287 patients Oct 19 – March 20 (compared to 1097 seen during Oct 18 – March 19) by increasing bed utilisation to 88%

Integrated Discharge Team (IDT) process improvement:
• Commissioning a single integrated leadership model which will integrate front and back door
• Review Transfer of Care (TOC) to enable 'trusted assessment' and develop a community-led 'pull' approach to discharges

• 7-day working
• Developing a 'Ready to Go' daily report that will encompass main delay reasons attributable across system partners
• Streamlining the discharge processes

ED changes for flow UTU (Urgent Treatment Unit) and assessment areas:
• UTU - Introduction of UTU steering, leadership and streaming groups which will optimise the work that it does. Enabling patients to be seen, treated, discharged or admitted in a safe and efficient way
• CAS / IUC – The clinical assessment service integrated with the Out of Hours. This will increase current clinical assessment rates of ED dispositions from 18% to 50%, thereby reducing the volume of patients directed to ED for treatment
• Revised pathways to LJCDU (Clinical decision unit) to reduce the time patients wait for transfer to the unit (and thereby time in ED)
• Frailty in-reach service based in ED which will reduce the time older patients stay in ED and for those that need to be admitted, will reduce their overall LoS (Length of Stay)

London Road UCC (Urgent Care Centre) increased capacity:
• The London Road UCC has undertaken a programme of staff upskilling which now enables them to see and treat from age 0
• Additional training opportunities provided which will ensure that all staff are able to suture

An updated system surge and escalation plan is also embedded into the winter plan. Both this and the winter plan are live documents and as such will be continually updated throughout winter as required and learning is obtained. There are at the time of presenting to the ICS Board three embedded plans due to be updated by the end of October 2019 (Communications, NHT and DHU) in line with the annual refresh cycles for those plans.

Action:		
☒ To receive ☐ To approve the recommendations		
Recommendations:		
Key implications considered in the report:		
Financial	☐	
Value for Money	☐	
Risk	☐	
Legal	☐	
Workforce	☐	
Citizen engagement	☐	
Clinical engagement	☐	
Equality impact assessment	☐	
Engagement to date:		

ICS Board	Partnership Forum	Finance Directors Group	Planning Group	Workstream Network
☒	☐	☐	☐	☐
Performance Oversight Group	Clinical Reference Group	Mid Nottingham-shire ICP	Nottingham City ICP	South Nottingham-shire ICP
☐	☐	☐	☐	☐

Contribution to delivering the ICS high level ambitions of:	
Health and Wellbeing	☐
Care and Quality	☐
Finance and Efficiency	☐
Culture	☐

Is the paper confidential?

☐ Yes
☒ No

Note: Upon request for the release of a paper deemed confidential, under Section 36 of the Freedom of Information Act 2000, parts or all of the paper will be considered for release.

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Greater Nottingham Response to Report on the Drivers of Demand

1.10.19

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Contents

- Emergency Care Report July 19
- The drivers of demand
- Key Themes and Summary Findings so far
- Areas of Focus and Opportunity
- Next steps

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ICS Emergency Care Deep Dive July 2019 Summary

- NUH attendance (type 1 ED) demand increase between 17/18 and 18/19 of 2.1%
- National increase of 2.0% same period, Kingsmill 5.7%.

- NUH admission increase of 7.1%, largest increase in 0 day Length of Stay (LOS).
- National growth of 4.8% same period.

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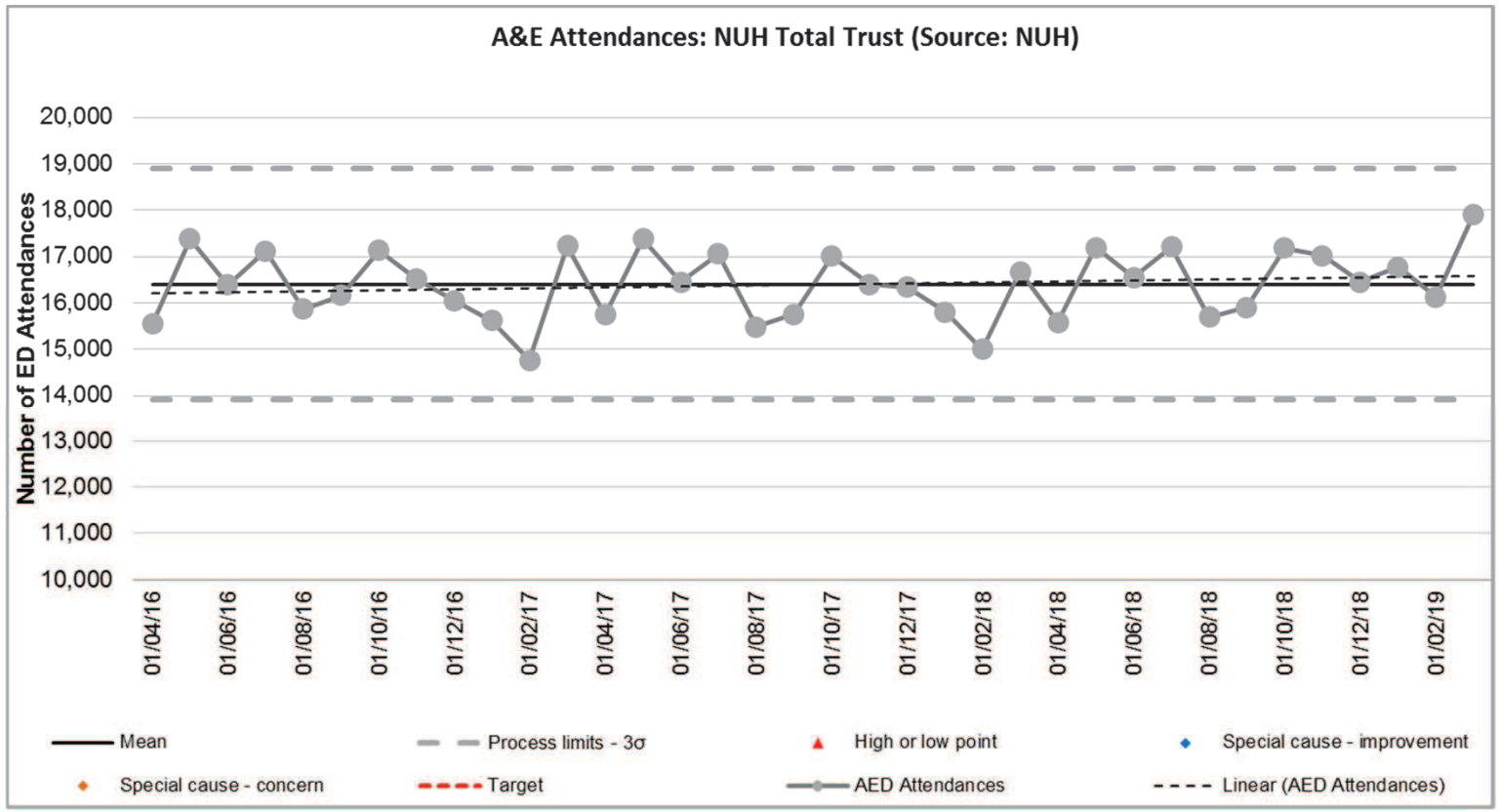
Attendance demand increase between 17/18 and 18/19 of 2.1%



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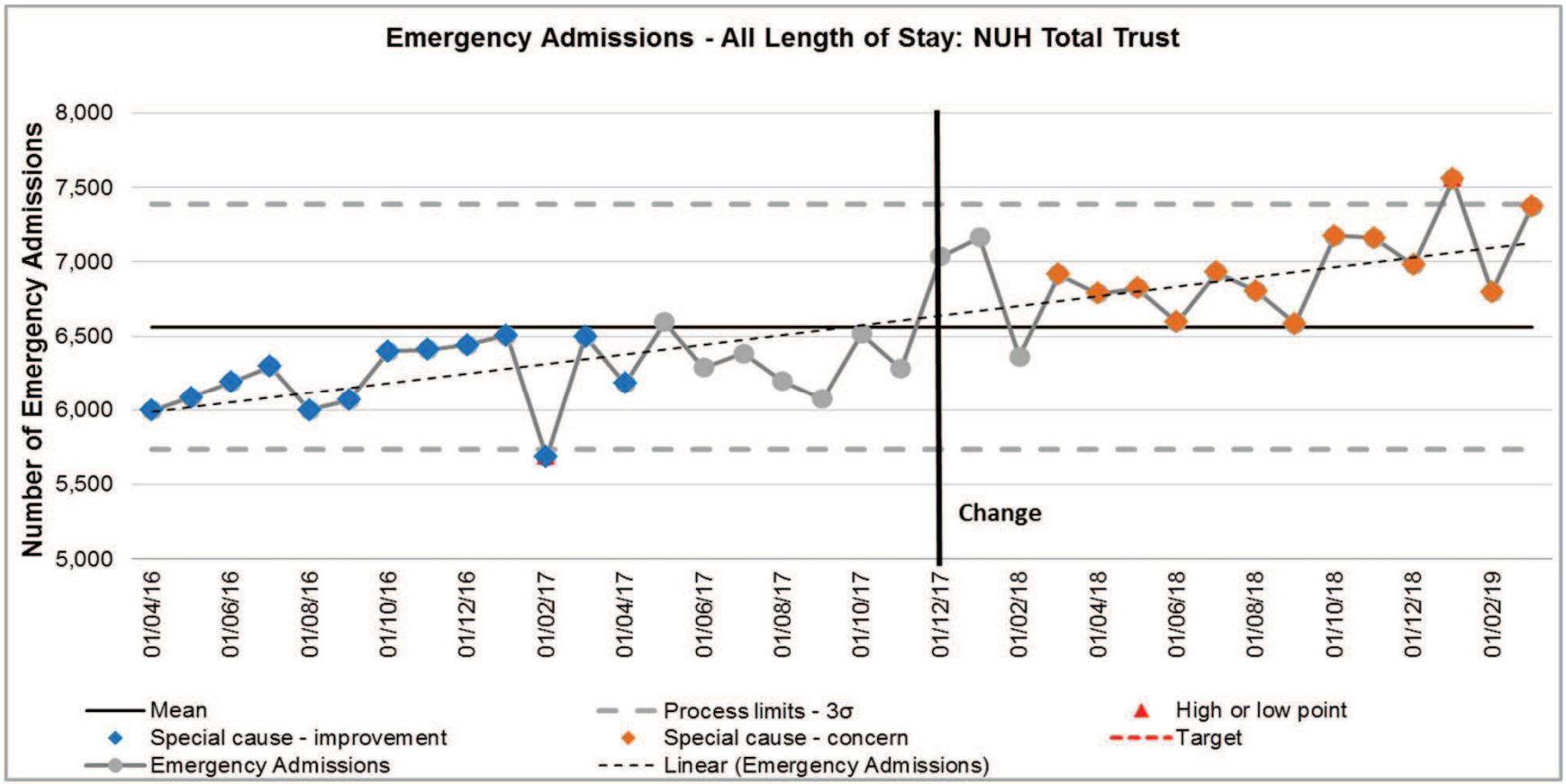
NUH admission increase of 7.1%, largest increase in 0 day LOS.



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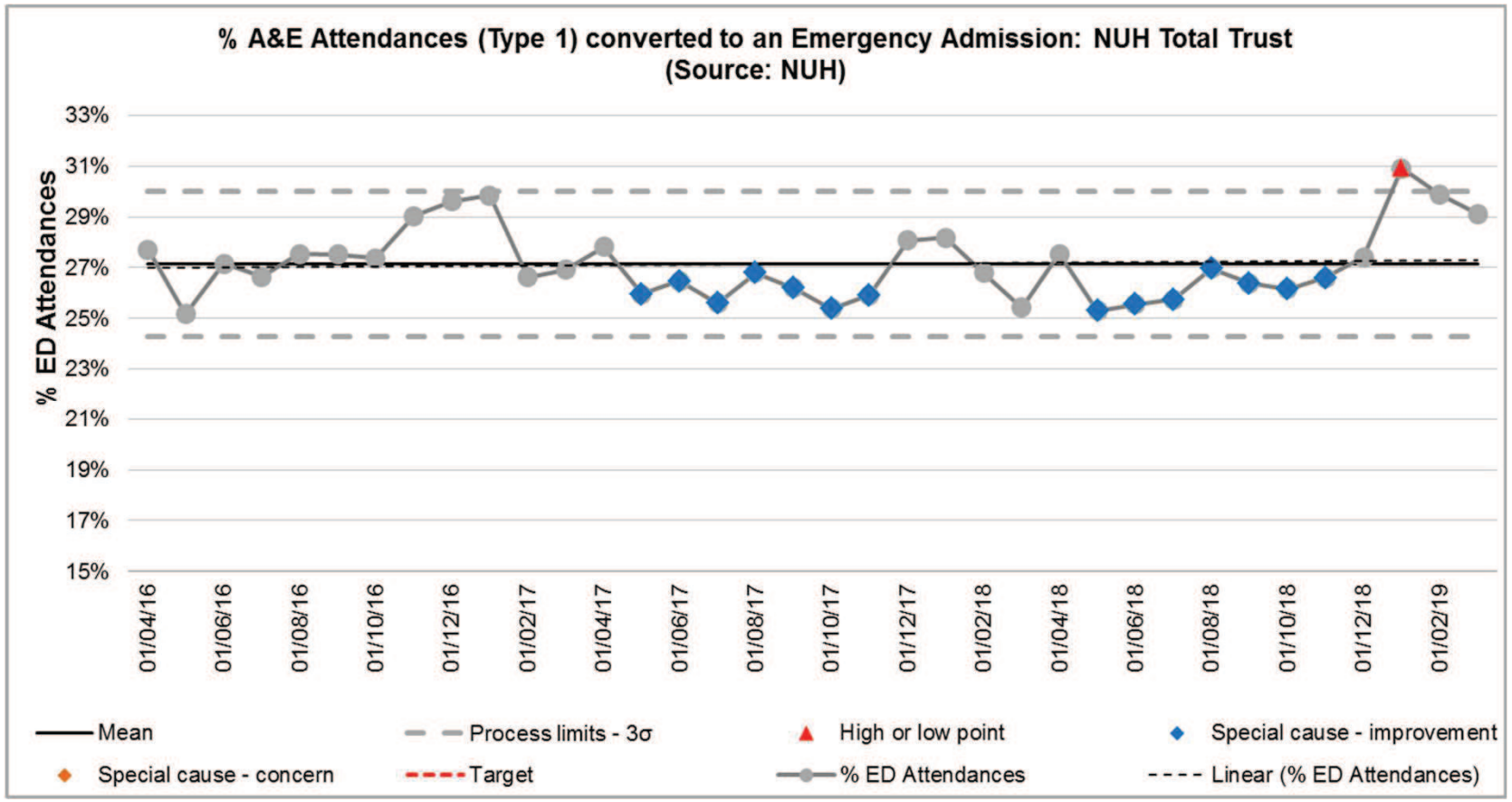
Emergency admission conversion



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The drivers of demand Greater Nottingham – need to understand more

- Increase in attends all ages but 0-4 years and 10-44 years particularly.
- The ageing population impact, with increased prevalence of multiple long-term conditions.
- Deprivation impact.
- Increase in Zero LOS admissions, understanding impact of same day emergency care other initiatives
- 111 - 12% increase in advised to attend ED and 18% increase in ambulance dispatch in Nottinghamshire (17/18 to 18/19)
- EMAS increase in conveyance 3.1% (17/18 to 18/19)

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Themes we are exploring further and groups undertaking

Driver of demand theme	Group responsible
Increase in attends all ages	ED Patient Survey and UTU Steering Group
Ageing population	Public Health Insights added to deep dive review
Deprivation impact	
Increase in Zero LOS admissions	Clinical Audit findings –to demand avoidance work stream
111 Increase in ED attendance and ambulance requests	UTU steering Group and Integrated Urgent Care Programme Board
EMAS increase in conveyance	Demand Avoidance Work stream

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Survey of patients within UTU in ED

- Survey completed over 3 days 23rd, 26th and 28th September.
- Survey based on East of England why you came to UTU in ED?
- Early Results (based on 23rd and 26th September n=417)

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Survey Next steps

- Full analysis of the 3 days , aiming for large sample - half of all adult UTU attends
- Themes from findings to influence future plans, share with stakeholders
- Explore further through public health insights work on why particular groups are attending
- Nudge with relevant communications
- Consider how UTU is set up to divert, see and street etc. offers of alternatives etc.

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UTU Focus - Primary Care and Divert

- Increase in attendances minor illness or injury not resus or majors. (graph next page)

Focus on :

- Primary care stream increasing numbers seen and discharged by NEMS
- NEMS & NUH trialling diversion of patients out of ED at first contact
- Supporting leaflets on how to access other services e.g. for repeat prescriptions, sick notes at first contact
- See and Street pilot –senior clinician rapid divert trial

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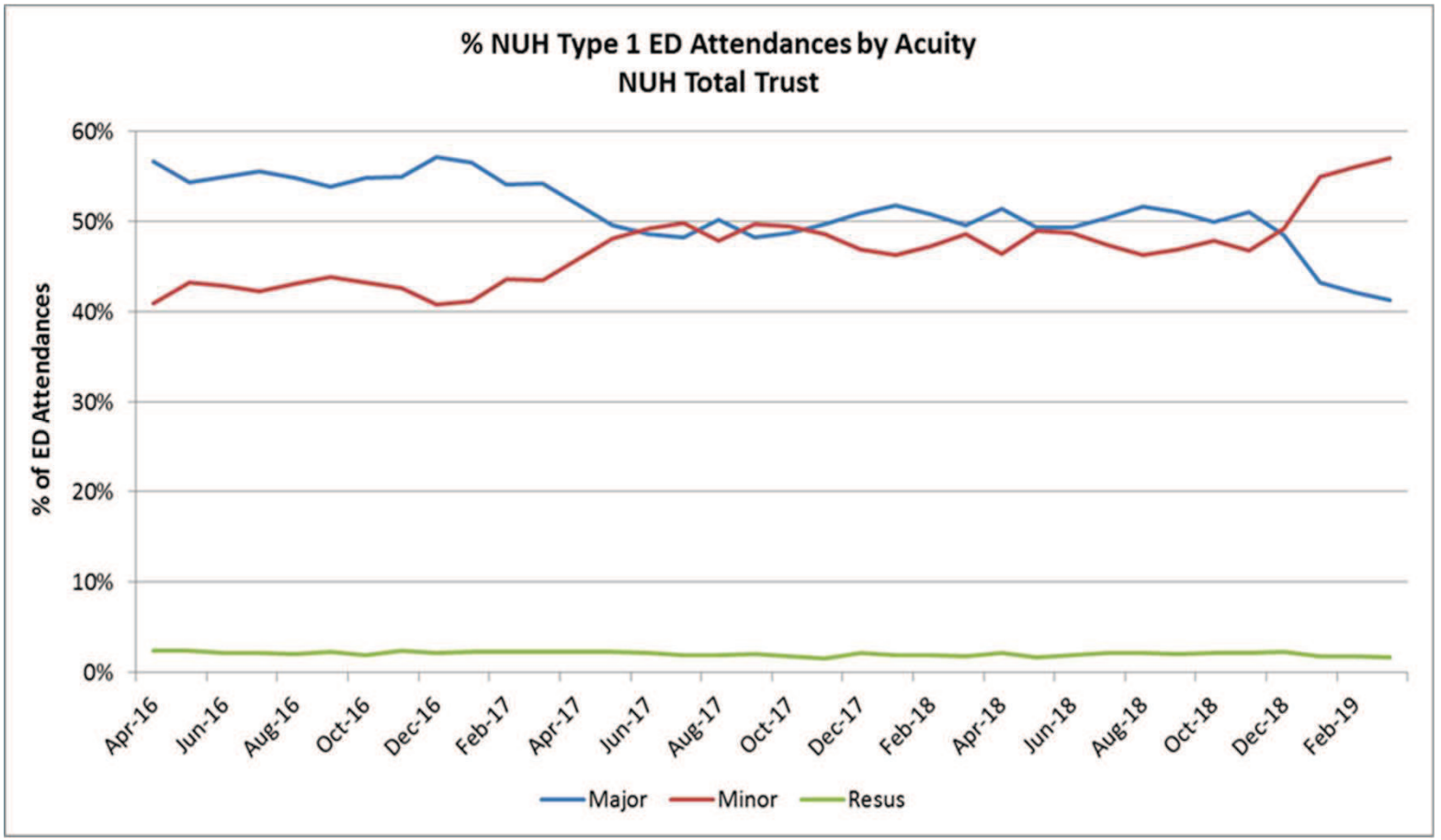
Minors – UTU increase



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Public Health understanding of growth

- Group led by Public Health convened to explore-

- What can public health insights add to the activity data insights, analysis in the context of local population demographic and social changes, to help 'explain' more gradual, year-on-year increases in ED attendance.
- Work in progress combining public health data and NUH ED data.
- Initial reporting is due end October 2019.

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Admissions demand, Increase in 0 day length of stay

- Having re-organised our ED pathways we have created different ambulatory care pathways, we need to understand what is happening, as it is affecting our admission numbers, and making year on year comparisons difficult.
- Using trust data (SLAM) and clinical audit to understand further what is related to pathway change and same day emergency care initiative development and what is true growth.
- Outputs to influence demand avoidance work.

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EMAS Conveyances Insight and actions

Insights

- Increase in 999 call demand translates into increased number of interventions required by the ambulance service to manage this demand including; hear and treat, see and treat and see, treat and convey
- EMAS conveyance rate (% of calls conveyed) has remained relatively stable but the increase in demand leads to an actual attendances at A&E
- Service change group - EMAS and CCG established
- Actions agreed to deliver a reduction in conveyance of 1.5% by Q4 to 59% conveyed/ 41% Non Conveyed.
- A joint post system and EMAS to focus on reducing conveyance is being recruited to.

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EMAS Conveyances Insight and actions

Demand Management Initiative	Rationale	Target & Timeframe
Increase referral to community pathfinder	Community pathfinder is Notts wide and delivers a 91% referral to an alternative to A&E Ave. calls per month = 384	12% increase on 18/19 baseline 1st Oct – 31st Dec = 124 calls 6% increase on 18/19 baseline 1st Jan – 31st March = 68 calls
Increase conveyances to London Road UCC (Greater Nottingham)	Current referral rates v. low > 1 Offers an alternative to QMC	Average of 5/month from 1st Oct – 31st Dec Average of 10/month 1st Jan – 31st March
First Response Vehicle pilot to low acuity (CAT3) ambulances	Increasing see and treat for low acuity calls to enable paramedics to attend more complex calls	Project go live July 2019

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EMAS Conveyances Insight and Actions

Project	Rationale	Delivery Timeline
Develop and implement a clinical pathway with SFHT and NUH for acute clinical advice for patients with fallers/head injury patients	Clinical advice from acute trust expertise on head injuries can support paramedics to manage clinical care on scene and reduce conveyance	Project initiated with trusts Implementation date TBC
Attendance of the relevant EMAS frequent caller case manager at MDT meetings	Where patients are frequent users of services, EMAS case managers to be invited to MDTs to inform/develop care plan	Attendance from July 2019

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DHU 111 Insights and Actions

Insights

Use of 111 overall in Nottinghamshire is increasing with 33% call growth since 2016 population which equates to 385,000 calls per year

Nottinghamshire are now the largest county user of 111 in the region

Ambulance referral rates from 111 peaked in July 2019 at 15.4% for Nottinghamshire but have reduced to 13.2% for the month of August in line with the regional position . Key lines of enquiry being reviewed are

Nottinghamshire has a higher average rate of older people compared nationally

and deprivation impact

Actions being taken to address ambulance referrals from 111

- Increase in CAT 3 & 4 assessment of clinical validations – 70% of available calls to be clinically assessed from October.
- Recruitment of additional nurse practitioners to increase the validation rate to 70%.

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Deep Dive gap-
GP Demand -Access to Primary Care

- Data historically difficult to access **new national GP Workload** Tool has been developed nationally as set out in the GPFV. First release due September 2019

Stats from Kings Fund 2017

- The total number of GP appointments and telephone consultations have increased 7.5% over the past two years.
- Number of telephone consultations had increased by 24**%** over and the number of face-to-face appointments increased by 2.8**%** - totalling a 7.2% increase in overall patient contacts.
- This was at a faster rate than the average increase in list size – 6.2% - suggesting that patients are increasing how often they use GP services.

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Next Steps

- Feedback from public health insights to inform/support focus of demand avoidance work with wider stakeholder s
- Full review of patient survey
- Oversight of drivers of demand work to report into the demand avoidance work stream of the A&E Delivery Board to maintain focus.

Greater Nottingham A&E Delivery Board

Health and Social Care System Winter Plan 2019/20

Version:	2019v2.0
Ratified by:	A&E Delivery Board
Date ratified:	TBC
Name of originator/author:	Gemma Beaumont – Urgent Care Project Officer Updated for winter 2019/20 by: Simon Frampton – Deputy Director of Urgent Care Liz Ashley – Urgent Care Programme Support Officer
Name of responsible committee/ individual:	Tracy Taylor, Chief Executive Nottingham University Hospital NHS Trust Chair, A&E Delivery Board
Date Approved by committee:	TBC
Date issued:	TBC
Review date:	September 2019 – A&E Delivery Board
Target audience:	Nottingham University Hospital NHS Trust Nottinghamshire County Health Partnership Nottinghamshire Healthcare Trust Nottingham CityCare Partnership Nottingham City Council Nottinghamshire County Council East Midland Ambulance Service Derbyshire Health United (111) NEMS Arriva (PTS) NHS Nottinghamshire CCP NHS England/Improvement
Distributed via:	Email

Version Control Sheet

Version	Version/Description of Amendments	Date	Author/Amended by
0.1	New Document	28.06.17	Gemma Beaumont
0.2	2.2 Updated and added Surge & Escalation Plan following System Review/Exercise. 4.1 STP Winter Communications Plan added. 5.1 (a) Supplementary Winter Actions added. 5.1 (c) Red Bag Scheme Narrative added. 8. Key contacts updated.	04.10.17	Gemma Beaumont
0.3	Update of narrative and system plans received to date. 4.2 Annual National Flu Programme Update 2018 5.1(c) CityCare Winter Pressures Plan 5.1(e) City Council Winter Plan 2018 5.1(g) EMAS Escalation Plan 2018 5.1(i) NHFT Winter Plan 8. Key Contacts updated	16.04.18	Gemma Beaumont
0.4	Update to 8. Key Contacts	21.07.18	Gemma Beaumont
2018 v1	Updated provider plans added STP Communications Plan added	25.09.18	Vicky Ball
2018 v2	Updated Seasonally related illness to include 2018/19 Help Us Help You campaign.	03.10.18	Vicky Ball

Version	Version/Description of Amendments	Date	Author/Amended by
	Action Cards included in Appendix 1		
2018 v3	Updated Notts HC Plan added Added Flu briefing	08.10.18	Vicky Ball
2018 v4	Updated Governance Structure for the A&E Delivery Board and updated DHU 111 Winter Plan inserted	17.10.18	Vicky Ball
2018 v5	Update EMAS section and addition of CityCare to the distribution list	18.10.18	Vicky Ball
2018 v6	Added 3 EMAS documents	26.10.18	Vicky Ball
2018 v7	Added amended NUH Winter Plan	26.11.18	Vicky Ball
2019 v1	Update Surge and Escalation Plan and revised text for 2019/20	22.03.19	Vicky Ball
2019 v1	Updated Target Audience 2.1 Embedded the updated NHSE Cold Weather Plan for England	30.07.19	Liz Ashley
2019 v2	2.3 Embedded the Communicable Disease Outbreak Management - Operational guidance 4.1 Public Information – Updated the narrative 5.b Updated narrative for NUH Elective Admission 5.1c Embedded CityCare 2019/20 Winter Pressure Plan 5.1c Updated narrative for Discharge to Assess 5.1d Updated Primary Care Capacity 5.1e Embedded NEMS 2019/20 Winter Plan 5.1f Embedded both Nottingham City and Notts County Council 2019/20 Winter plans 5.1h Embedded the ATSL 2019/20 Winter plan 8. Updated Key Contacts for the following; NUH, DHU 111, Nottingham City Council. 5.1h Embedded the ERS Transport 2019/20 Winter plan 5.1e Embedded NEMS revised 2019/20 Winter Plan 5.1h Embedded EMAS 2019/20 Winter plans **Appendix 1** - Inserted revised Triggers for Community Bed based capacity. **Appendix 1** – Inserted revised Triggers for NEMS OOH and NEMS UTU **Appendix 1** – Inserted revised NEMS Opel level 2 Action card **Appendix 1** – Inserted revised NEMS Opel level 3 Action card	23.08.19 24.09.19 26.09.19 30.09.19	Liz Ashley

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2. Anticipate	NHSE Cold Weather Plan Greater Nottingham Surge & Escalation Plan Seasonally related illness
3. Assessing Risk	Summary of Identified Risks to delivery of the Greater Nottingham System Wide Winter Plan
4. Prevent	Public Information Flu Prevention Business Continuity
5. Prepare	5.1 System Capacity (a) Acute Care (b) Elective Admission (c) Discharge to Assess (d) Primary Care Capacity (e) Local Authority Plans (f) Critical Care Capacity (g) East Midlands Ambulance Service/Arriva (h) Derbyshire Health United (111) (i) Mental Health Support 5.2 Maximise Availability of Staff (a) Sickness absence (b) Industrial Action (d) Working in different ways 5.3 Excess Winter deaths
6. Respond	
7. Recover	
8. Key Contacts	
Appendix 1	System Action Cards and Triggers

1. Summary

1.1 Plan Statement

Background

It is an expectation of NHS England/ 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 congruence and resilience. This system wide plan builds on the lessons learned and history of recent years. This Plan provides an overview of the key strands of our operations and provides the framework for partner organisations to work together.

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 Greater Nottingham Surge and 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 each of their organisations.

Training

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

Dissemination

All organisation's websites

Via E-mail

Resource implication

Resources across organisations have been committed via the A&E Delivery Board to ensure winter resilience.

1.2 Plan Interdependencies

This Winter Plan 2019/20 should be read in conjunction with the following cross organisation documents:

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

We are clear locally about the expectations of NHS England / 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 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):

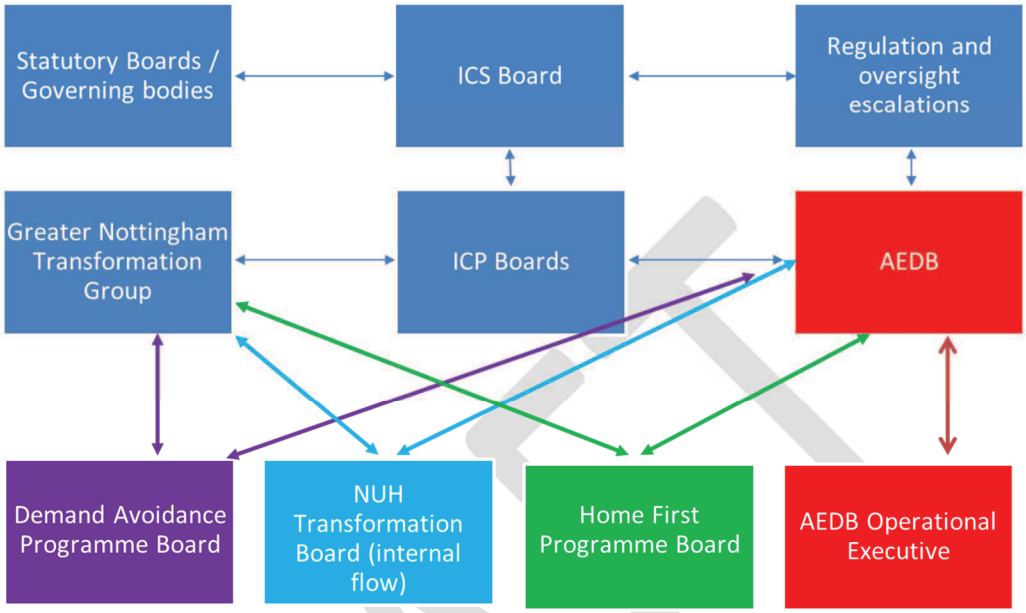
- **Anticipate** – be aware of new hazards and threats facing the health economy.
- **Assess** – the hazards and threats for likelihood of occurrence and the impact.
- **Prevent** by taking a range of actions to limit the likelihood of occurrence, and the effects of any threats.
- **Prepare** by having 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 we:

- Minimise the risk to patients/service users during a period when the service is under increased pressure
- Maximise the capacity of staff 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

Maximising impact of the Programme Boards (key relationships for AEDB governance only*)



* These programmes will inform / align with the Clinical Services Strategy and Long Term Plan

1.4 Distribution List

NHS ENGLAND / IMPROVEMENT

Public Health England

Nottingham Clinical Commissioning Partnership

- *Chief Executive*
- *CCP Board*
- *System Delivery Director*
- *Deputy Director of Urgent Care*
- *Emergency Planning Leads / On Call Management Team*

Nottingham University Hospitals NHS Trust (NUH);

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

Nottingham CityCare Partnership

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

Nottinghamshire Healthcare 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)

Arriva – Patient Transport Service

Nottinghamshire County Council

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

Nottingham City Council

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

Derbyshire Health United - 111 Service

NEMS

1.5 Lessons Learnt Winter 2018/19

What went well?

- Revised OPEL reporting process and related actions made escalation clearer across the system.
- Visibility of gaps (Staffing and service availability), improved throughout the winter period and allowed organisations to cross cover more effectively.
- Use of St Francis beds to allow for increased flow from the acute, also shared learning between acute and community staff in this location was well received.
- Pre winter additional social care funding enabled greater capacity in this market.
- Much improved data over previous years.

What didn't go well?

- Lack of automatic information sharing.
- Lack of proactive modelling meant the system was always reacting to pressure as it happened – big example of this was patient transport where it was very difficult to increase capacity on the day if demand was higher than the capacity already in place.
- System escalation calls were not focused on specific issues and repeated themes e.g. transport.
- System not working effectively in early morning.
- Escalation of issues in the out of hours period – communication issues and visibility of on call staff between organisations.

Actions to improve winter experience for 19/20

System workshops took place during September 2019 to further review and improve the OPEL framework as well as surge and escalation plans in the same way that the well-received workshops in 2018 were run. These workshops allowed for the testing of the updated 2019 winter plans and responses in line with both the updated system structure as well as new ED standards to ensure all organisations escalation actions and triggers were aligned, and that escalation actions are appropriate for the situation in hand.

An automated OPEL reporting system is being developed for deployment in November 2019 to support system information sharing. This system is web based with each provider having a log in that takes them to their section to update the KPIs requested and a comments box. This system includes the option for any system partner to escalate issues to a call, as well as enabling regular capacity updates to be shared. The system updates can be viewed both on a web page as well as automatically emailing the information to a distribution list.

A workforce workshop is being planned for October 2019 in line with similar events the previous year that were well received by system clinicians. This event will focus on the following areas to share knowledge prior to winter:

- Caring for a patient with a respiratory condition in the community – increase your knowledge and awareness of respiratory illness to continue to care for our patients in the community setting
- Sepsis – increase your knowledge and awareness of sepsis and understand your role to ensure our population are cared for safely and effectively
- Effective discharge planning from an acute and community provider perspective
- Exploring our approach to risk management through the Home First Agenda
- Exploration of wider health and social care triggers and how we can impact from our roles working across health and social care

Utilisation of the community bed base is being reviewed to enable re-specification. This re-specification is designed to allow for a more flexible bed base for patients requiring a community bed, allowing more complex patients into community beds than they are current setup to deal with.

An intensive at home service is also being setup with ICP monies to facilitate people going directly home for a comprehensive assessment of need, rather than an admission to a community bed. The new service is intended to go live in October 2019.

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 Surge & Escalation Plan developed for Greater Nottingham sets out organisational responses and actions in detail such as identification of vulnerable patients and staff rotas.

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 attached: (Current plan is embedded, updated plan expected October 19)

The Cold Weather Plan for England - 20:

This 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.

2.2 Greater Nottingham Surge and Escalation Plan 2019/20

The Surge and Escalation Plan contains the System Escalation Triggers and Action Cards. The Triggers and Action Cards can be found at the end of the document for ease of reference.

The Surge and Escalation Plan was initially developed during the summer of 2017 to ensure that the health and care partners in Greater Nottingham 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 plan has been updated following system workshops during the winter period of 18/19, to include revised system triggers and action cards, this plan will be further tested and updated during system workshops in September 2019.

This surge and 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.

This Plan includes the sharing of information across the system in the form of a daily report.

The daily System Report 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 Urgent Care Team and forms a key part of our escalation process through winter – as set out in the Surge and Escalation Plan.

Greater Nottingham
Surge and Escalation

Each provider uses the Surge and Escalation Plan to ensure it is delivering all appropriate responses in line with escalation levels at whole system level.
The system wide urgent care leads will be responsible for initiating any operational changes needed and reporting them to the A&E Delivery Board.

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. Public Health teams in Nottinghamshire County Council working with Public Health England provide a range of oversight functions dependent upon the provider setting. 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 **Help Us Help You** brings together a family of campaigns incorporating messages about flu, staying well in winter, NHS 111, pharmacy and extended GP.

The campaign series aims to help people understand how to navigate the NHS and get the right help and advice they need in the most timely and appropriate way. It encourages people to take appropriate actions – whether that's getting the flu vaccination or accessing the most appropriate service – to better enable the NHS to help them.

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 attached:

CommDiseaseOutbreakMgtPlan_EM_v2-0_

Communicable Disease Outbreak Gui

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 3 Delivery Groups and 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 within the System via the Risk Log that will be shared at the A&E delivery board on a monthly basis to ensure all actions are being delivered. The risk scores will remain and will only be revised when the A&E Delivery Board has been assured that mitigating actions have taken place. 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 support our providers in managing demand through winter. CCGs across Nottingham and Nottinghamshire are working with system wide communication and engagement colleagues to agree a ICS Urgent Care Communications Plan 2019/20 in order to support demand reductions through winter through the NHS England campaign "There`s no place like home" campaign.

Urgent Care Communications Plan

Comms plan for 2019/20 in progress with draft to be finalised ready for sign off in October, the above Communications Plan will be replaced with this 19/20 version once signed off during October 2019.
During November 2019, 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.

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.

This Flu plan sets out a co-ordinated 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 will aid the development of robust and flexible operational plans by local organisations and emergency planners within the NHS and local government. It provides the public and healthcare professionals with an overview of the co-ordination 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.

The Service Improvement Team meets regularly and will be meeting with national and local communications teams in order to ensure a co-ordinated approach.
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 CCP has developed a 10 point plan with its GP Execs.

The plans for communicable diseases (seasonal flu) are attached within section 2.3 of this winter plan.

Below are details of the National Flu Immunisation programme for 2019/20. Any further GN documentation will be added to this document as they are produced.

Annual_national_flu_
programme_2019_to_

In summary the focus of the flu programme is to address the roles, responsibilities, planning and response procedures for all organisations throughout Greater Nottingham 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.

4.3 Business Continuity Plans

Business continuity plans are seen locally as a key vehicle for ensuring that quality and access to services is maintained through periods of system pressure and as the result of specific local circumstances and incidents.

Locally commissioners, through their contractual relationships with providers, ensure that business continuity plans are in place and up-to-date. All contracts held by Greater Nottingham CCGs are based on the NHS Standard Contract. CCGs work closely with commissioners in Nottinghamshire County Council, Nottingham City Council, Nottinghamshire Healthcare Trust and City Care on the commissioning of care home provision, reablement and home care services. Again, the contractual standards for business continuity plans are a key element of the contract documentation. There are references throughout this Plan to the elements of business continuity plans which have a strong link to winter.

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

5.1 System Capacity

(a) Acute Care

The attached policy describes how NUH will manage patient flow through its beds to ensure safe, timely and effective care. It describes how hospital capacity and flow is managed and monitored, including an escalation process and associated actions to be taken when capacity is limited.

NUH Winter Plan 2019-20:

NUH Winter Plan 2019-20 v1 (draft).pc

(b) Elective Admission

Elective admission will be arranged by Divisions in line with clinical urgency and access targets. Cancellation on the day due to bed availability is to be considered as a last resort and any decision to cancel is to be confirmed by Silver on call.

In escalation, patients will be prioritised for available capacity in the following order:

- Clinical urgency including Cancer

- Previous cancellation on the day of admission
- RTT waiting time

Improving assessment and access for patients

Strengthen streaming processes for patients are in place following the wide-scale front door service redesign in Winter 2018/19. The UTU receive ambulatory patients with non-ambulatory patients seen in either the majors area or resuscitation. First contact processes are in place in both the UTU and majors to ensure patients are seen in accordance with clinical urgency. Within the UTU there is an integrated primary care service 24/7 run by Nottingham Emergency Medical Services (NEMS). Additional same day emergency care pathways are being implemented for Healthcare of the Elderly and Acute Medicine and pathways for Surgical patients are being reviewed.

(c) Discharge to Assess

Greater Nottingham CCP is proactively working with health and social care partners to ensure services are able to cope with additional demand through winter and that a discharge to assess policy is facilitated.

Nottingham CityCare Partnership Independence Pathway Winter Pressures Plan:

1920 CityCare winter pressures plan.pdf

Discharge to Assess

Discharge to Assess model has been in place since October 2017.

Partners are committed to moving care closer to home to promote independence, well-being and living well with frailty and ill health following an acute hospital stay.

Through the partnership working of health, social care, housing, and external care providers, 'no-body waits' to return home or to a short term community accommodation

Further development of the Integrated Discharge Function (IDF) with the following key priorities underway;

1. Leadership; Commission a single MDT integrated leadership model which integrates front door and back door
2. Review Transfer of Care (TOC) to enable 'trusted assessment' and develop a community-led 'pull' approach
3. 7-day working
4. Develop a 'Ready to Go' daily report that will encompass main delay reasons attributable across system partners
5. Streamline discharge processes

Re-design of community provision; Commission and develop the right services to meet the level of demand and complexity whilst promoting independence, with an Intensive Support at Home services to facilitate people going directly home for a comprehensive assessment of need, rather than an admission to a community bed. This is on track to 'go live' 1st October 2019.

Care Homes Red Bag Scheme

Greater Nottingham has followed the national implementation guidance to deliver red bag scheme that launched on 2nd October 2017. There have been a number of successful engagement events with care homes and system partners. The standardised documentation which goes with the red bag was implemented across care homes from September 2017.

(d) Additional Primary Care Capacity

CCGs in Greater Nottingham are working with their membership organisations to ensure that each practice is:

- Working hard to ensure that patients are educated about the importance of self-care and the appropriate routes for accessing care in different situations. National guidance disseminated to practices, raised on a PCN footprint
- Striving to improve its access. Delivering extended hours and extended access
- Ensuring that systems are in place to identify and discuss inappropriate A&E attendances with patients, CCP regularly review and discuss high intensity users and practices with particularly high A&E use raising issues at PCN meetings, share best practice etc.
- Effectively utilising any extended hours provision to support improvements in access.
- Ensuring they are taking all steps to reduce staff sickness through winter through maximising flu vaccinations for staff, significant work under way to increase flu vac uptake, including care home staff.
- Working with NHS England on any potential capacity and demand issues – particularly single-handed and small practices.

In addition, CCGs are working with NHS England to ensure that increasing demand in primary care is captured as part of the development of predictive modelling tools, which supports the NHS England GP Forward View. The development of the PCNS has a key priority of addressing demand management and how the CCG supports the PCNs to do this is key. NHS England has developed a General Practice Workload Tool, this tool sits within Practices clinical system and allows practices to review:-

- Appointment utilisation
- Patient demographics
- Multiple appointments/DNAs/cancellations
- Modes of access
- Wait times
- Next available appointment

State backed indemnity scheme

From April 2019, the new state-backed indemnity scheme will cover clinical negligence claims for all GPs, and all other staff working in delivery of primary medical services. It will automatically cover GP contractors/principals, salaried GPs, GP locums, nurses, AHPs and all other professional groups delivering those services (including affiliated work for local authorities, Public Health England, out of hours etc). It will also include the new network workforce.

(e) NEMS

NEMS provide the Greater Nottingham GP OOH`s and QMC based primary care in the UTU at Queens Medical Centre.

The attached plan outlines the key measures that will be put in place to ensure that NEMS can respond to expected and unexpected demand surges during the winter period in general and over the year-end Bank Holiday periods in particular.

NEMS Winter Planning 2019-20 - G

Christmas and New Year

Assurance will be sought via NHS England / Improvement teams on Christmas and New Year opening in GP practices and pharmacies. As such:

- A full listing of negotiated opening hours for pharmacies will be available in late November 2019 which will be communicated with the public.

Over the holiday period it is anticipated that all organisations will reduce the amount of activity undertaken in none essential services in order to provide critical services. Staffing will be reduced accordingly and therefore reallocated to cover escalation in other services and to aid cross-agency support.

(f) Local Authority Plans

Nottinghamshire County Council

The attached plan provides an overview of the winter initiatives, to prepare for and respond to winter pressures as an integral part of the Health and Social Care system. It outlines service response to any potential increase in demand at any time, including any winter pressures.

The plan supports business as usual plans in the continuance of delivery of safe systems of care with additional measures that can be implemented.

Winter PLan - N County Council - Aug

Nottingham City Council

This plan provides an overview of readiness and preparation to respond to winter pressures as a system partner of the Health and Social care system. The plan outlines the resilience within the general operating models and standards for supporting and maintaining flow within the system and identifying and preventing delays. The main purpose of the plan is to maintain timely service provision and movement across pathways embedded in a Home First approach.

N City Council -201920 W Plan .pdf

(g) Critical Care

The Management of surge and escalation in critical care services: standard operating procedures for adult critical care, paediatric intensive care, burns services, adult and child respiratory extra corporeal membrane oxygenation (ECMO) are found at:
https://www.england.nhs.uk/commissioning/ccs/

These national level plans operate on a tiered level of response from Level 0 to Level 3. A critical care network across the country operates to deliver critical care and the plans detail how these services are triggered via Emergency Preparedness, Resilience and Response (EPRR) routes and interface with locally delivered services. The appropriate REAP (Resource Escalation Action Plan) Action Cards for relevant agencies are detailed. For adult critical care, where NUH face capacity issues in their own adult CCU, they will liaise directly (on a consultant to consultant) basis with the Critical Care Network for adults (to include access to ECMO beds).

(h) East Midlands Ambulance Service/Arriva

EMAS are a key member of our local A&E Delivery Board. The current A&E Delivery Board dashboard includes EMAS performance and includes a focus on turnaround. This provides a tool by which the economy can understand capacity and demand and how the ambulance service works as part of the local system through periods of escalation.

Below are the EMAS winter plans for 2019-20.

EMAS Strategic Winter Briefing for Pa

EMAS Winter CONOPS 2019-20 v1.

2019 hospital activity predictions from EMAS are embedded below:

Hospital Predictions - new - EMAS.pdf

Ambulance Handovers

Within EMAS there are daily monitoring of hospital handovers and Regional Operations Managers (ROM) are based in control centres to escalate issues where appropriate and have site specific

conversations where required. There is an option to deploy an appropriate manager to specific sites when issues arise or in times of escalation when required.

Patient Transport Services

The current contract with Arriva Transport Solutions Limited (ATSL) ends on 30th November 2019. The new contract with ERS goes live 1st December 2019. In view of this, the ATSL Winter Plan for 19/20 has been embedded below.

ATSL Winter Resilience Plan 2019 2

The Winter Pressure Demand and Action Management Plan 2019/20 from ERS has been embedded below (As the go live date approaches ERS in conjunction with the CCG will assure that this captures and documents the systems specific needs as key stakeholders within the ERS plans and that it adopts a coordinated approach)

ERS Medical Winter Pressures 2019 2020

(i) Derbyshire Health United (DHU) – 111 (Provider)

The A&E Delivery Board Dashboard includes performance data for NHS 111 and through the contractual process commissioners will ensure that NHS 111 escalation plans are clear in terms of their communications into the system. The contractual route will also provide commissioners with the opportunity to test business continuity plans during times of surge, as well as daily information relating to demand and performance which will support the prediction of potential peaks in demand. The updated 2019/20 plan will be inserted here once completed in October 2019.

DHU111 Winter Plan 2018-19 v1.0 DH.doc

Directory of Services – 111

The Directory of Services is a national database of NHS services. It supports clinicians and non-clinicians in being able to make safe and effective referrals.

The Nottinghamshire Directory of Services is managed on behalf of the county by the local DoS team (DoS Lead/DoS Support Officer) working within the Urgent Care team. DoS service profiles are reviewed and kept up to date and shared widely across all member organisations of the local A&E Delivery Board. Technical developments will continue to be implemented to support patient journeys through the local integrated urgent care system.

(j) Mental Health Support

NHFT Trust Winter Resilience Plan 2018 :

The current plan has a review date internally for NHFT of October 2019; any updated versions will be embedded here if changes are made.

The embedded plan describes how Nottinghamshire Healthcare Trust will support the health and care system by offering the following services: -

- There is a 24/7 crisis service available to ensure psychiatric liaison and rapid response arrangements.
- Crisis Resolution/Home Treatment Teams will provide a normal 24/7 service over the holiday period. For the Bank Holidays, staffing levels will be based on those used at weekends.
- Staff will work with service users in the period up to Christmas Eve to maximise their ability to cope over the Christmas period. Other measures will be put in place as appropriate.
- Past demand for Trust services over Christmas and New Years are reviewed by all Directorates and plans are in place to ensure service levels match demand. Peak demand for Trust services is often in January/February and not at Christmas.
- All clinical departments maintain lists of vulnerable patients living in the community. Every client's care plan has an emergency contact number.

5.2 Maximising the availability of staff

(a) Sickness absence

Each partner organisation will be aware of the impact increased sickness absence has on its ability to deliver high quality services during the winter months.

It is expected that there will be an increase in sickness absence due to flu and each partner organisation, being cognisant of this fact, should be 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 considered 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 should 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 should also cover staff absence that reaches a critical level.

A&E Delivery Board partners are ensuring that annual leave planning has taken place to ensure that staffing levels are maintained and capacity is maximised.

5.3 Excess winter deaths and Wellbeing

Public Health with partners and providers aim to reduce excess winter deaths and improve well-being, and are adopting the Department of Health high impact interventions to address winter deaths and target vulnerable people in local communities. The Joint Strategic Needs Assessment (JSNA) topic on excess seasonal deaths is being updated and incorporated in to a wider topic on the environment, to provide additional evidence that underpins what needs to be done. Partner agencies will be working to support the implementation of the NICE guidance '*Excess winter deaths and illness and the health risks associated with cold homes'*, targeting vulnerable people.

The NHS, Social Care and Councils, with support from the voluntary and community sector, are identifying vulnerable patients and proactively targeting them with the following interventions to increase their resilience against the cold – particularly in relation to:

- Annual flu and pneumococcal vaccine
- Annual medicines utilisation review (MUR) and follow up support for adherence to therapy
- Full environmental assessments (including; equipment, telecare, insulation, support groups, access and transport)
- Assessment for affordable warmth interventions
- Regular review of benefits entitlement and uptake
- Assessment and support to prevent falls (Wellbeing Service)
- Promotion of healthy lifestyle and personal health promotion plan to include physical activity, hydration and nutrition – Every Contact Counts.
- Referral to telehealth/telecare,
- Addressing loneliness
- Referral for talking therapies for stress/low mood

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 around. 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 around, system wide surge and escalation plan. Our Surge and Escalation Plan details the arrangements and procedures that the A&E Delivery Board partners in Greater Nottingham will utilise in the event of surge and capacity issues, irrespective of cause, affecting one or more partner 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.

Greater Nottingham on-call directors are responsible for both proactive and reactive management of capacity issues (surge and 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 Greater Nottingham 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.

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 Greater Nottingham.

8. Key Contacts

The following people can be contacted regarding the local plans in partner organisations.

Name	Title	Contact
Greg Cox **EMAS**	General Manager – Nottinghamshire	Greg.Cox@emas.nhs.uk
Darren Clarke **Arriva**	Quality Manager	clarked@arriva.co.uk
Simon Smith **ERS Medical**	Head of Care Standards	simon.smith@ERSMedical.co.uk

Sue Batty **Nottinghamshire County Council**	Service Director South Notts	sue.batty@nottscc.gov.uk
Linda Sellars **Nottingham City Council**	Director of Quality and Change ASC	linda.sellars@nottinghamcity.gov.uk
Arwel Griffiths **NEMS**	Chief Executive	arwel.griffiths@nhs.net
Pauline Hand **DHU 111 (East Midlands) CIC**	Managing Director	pauline.hand@dhuhealthcare.nhs.uk
Lisa Kelly **Nottingham University Hospitals Trust**	Chief Operating Officer	lisa.kelly@nuh.nhs.uk
Lyn Bacon **City Care**	Chief Executive	lyn.bacon@nhs.net
John Brewin **Nottinghamshire Healthcare Foundation Trust**	Interim Chief Executive	John.Brewin@nottshc.nhs.uk
Amanda Sullivan **Greater Nottingham CCPs**	Accountable Officer	Amanda.Sullivan@nhs.net

Appendix 1 – System Escalation Action Cards

A system wide desktop review of the surge and escalation plan took place on September 17th 2019 where all escalation actions were reviewed and tested against the current system configuration. The below is the updated action cards and triggers:

Action Card for Escalation OPEL Level 1		
Current position	The local health and social care system capacity is such that organisations are able to maintain patient flow and are able to meet anticipated demand within available resources. The local A&E Board area will take any relevant actions and ensure appropriate levels of commissioned services are provided. Additional support is not anticipated.	
Organisation	**Actions that each organisation will take when the SYSTEM is at OPEL 1**	**Actions that each organisation will take when an INDIVIDUAL ORGANISATION is at OPEL 1**
Actions expected as routine for Primary Care and NEMS	• Daily demand review • Daily staffing review • Monitor system pressures and anticipate potential change	Business as usual
111		• Update escalations • Monitor call flows • Anticipate potential changes through available information and other providers • Escalate potential IT issues appropriately • Update stakeholders through agreed conference calls
Actions expected as routine for EMAS	• Review availability of resource (vehicles and staffing) • Monitor hospital turnaround and send an Operational Manager if required	Business as usual
Actions expected as routine for NUH	• Work towards delivery of discharge targets and maintain flow in the specialty areas including: o Patients with planned discharge dates tomorrow should have TTO and transport in place o Early use of discharge lounge for patients going home (both hospital transport and relative pick-up) o Ensure that bed space following a patient discharge is available for re-use within 15 minutes (up to 60 minutes if infection clean required) • Ensure that all patients requiring specialty input in ED are reviewed within 30 minutes • IDT to ensure plans in place to meet daily discharge targets and transport is available (to meet the demand) and booked for Pathway 2 and 3 patients in time for latest admission to the allocated community provider.	• Work towards delivery of discharge targets and maintain flow in the specialty areas including: o Patients with planned discharge dates tomorrow should have TTO and transport in place o Early use of discharge lounge for patients going home (both hospital transport and relative pick-up) o Ensure that bed space following a patient discharge is available for re-use within 15 minutes (up to 60 minutes if infection clean required) • Ensure that all patients requiring specialty input in ED are reviewed within 30 minutes IDT to ensure plans in place to meet daily discharge targets and transport is available (to meet the demand) and booked for Pathway 2 and 3 patients in time for latest admission to the allocated community provider.

Organisation	**Actions that each organisation will take when the SYSTEM is at OPEL 1**	**Actions that each organisation will take when an INDIVIDUAL ORGANISATION is at OPEL 1**
Actions expected as routine for Mental Health Trust	AMH • Daily demand review teleconference to support any capacity shortfalls • Systems and processes in place to anticipate changes to demand including daily oversight position to AMH senior team MHSOP • Daily Sit Rep outlining OPEL Status & Capacity and Demand • Wards complete daily MDT Board Round via R2G reporting • Community duty/triage staff to review daily R2G reporting systems to identify patients and liaise with wards to support timely discharge • Community calls to all wards Monday & Thursday each week to support patient flow & discharge via R2G report processes • Inpatient Service Manager weekly conference calls to social care re: delays to discharge case specific conversation	MHSOP • Daily Sit Rep outlining OPEL Status & Capacity and Demand for in-patient wards (communicated via email) • Wards complete daily MDT Board Round via R2G reporting • Community duty/triage staff to review daily R2G reporting systems to identify patients and liaise with wards to support timely discharge • Twice weekly, (Monday and Thursday) Community telephone calls to all wards to support patient flow & discharge via R2G report processes with full consideration and use of IRIS step up beds. <u>These calls will be focussed by the community team representative on patients currently on the ward from their locality by patient name.</u> • Inpatient Service Manager weekly conference calls to social care re: delays to discharge (DToC) case specific conversation • <u>Weekly</u> operational demand call chaired by the operational manager to confirm capacity and demand/staffing issues across all services
Actions expected as routine for community providers	Business as usual	
Actions expected as routine for Social Care for Nottingham City LA – Community Referrals	• Spreadsheet for packages required are sent out daily to all lead providers. • Spreadsheets for packages are sent out to Accredited providers if no offer from lead within 48 hours • Citizens are given a 'window' for a care call not an identified time.	• Spreadsheet for packages required are sent out daily to all lead providers. • Spreadsheets for packages are sent out to Accredited providers if no offer from lead within 48 hours • Citizens are given a 'window' for a care call not an identified time.

Organisation	Actions that each organisation will take when the SYSTEM is at OPEL 1	Actions that each organisation will take when an INDIVIDUAL ORGANISATION is at OPEL 1
Actions expected as routine for Social Care for Nottingham City LA – Acute Hospital Referrals	• Citizens are given a 'window' for a care call not an identified time • Spreadsheet for packages required are sent out daily to all lead providers. • Spreadsheets for packages are sent out to Accredited providers if no offer from lead within 48 hours	• Citizens are given a 'window' for a care call not an identified time • Spreadsheet for packages required are sent out daily to all lead providers. • Spreadsheets for packages are sent out to Accredited providers if no offer from lead within 48 hours
Actions expected as routine for Social Care for Nottinghamshire County Hospital Referrals	• Business as usual • Patients are provided with relevant services • Flow is managed through Opel dashboards and process	• Business as usual • Patients are provided with relevant services • Flow is managed through Opel dashboards and process
Actions expected as routine for commissioners	N/A	N/A
Actions expected as routine for Arriva	• Liaise with providers to establish possible numbers of expected on the day discharges and to establish ready times for all booked discharges where possible • Provide requested information into the system in relation to Opel status	• Midday call held Monday-Friday in order to review current days demand/pressures and the following days activity levels against resource availability • Maximise use of all available resource and minimise wastage through abortive. This includes automated forward text and calling ahead by operational and office based staff. • Ensure all crews feeding back information on any delays or operational issues to control managers

Action Card for Escalation OPEL Level 2		
Current position	The local health and social care system is starting to show signs of pressure. Organisations will be required to take focused action in showing pressures to mitigate the need for further escalation. Enhanced co-ordination and communication will alert the whole system to take appropriate and timely actions to reduce the level of pressure as quickly as possible. Local systems will keep NHS E and NHS I colleagues at sub-regional level informed of any pressures, with detail and frequency to be agreed locally. Any additional support requirements should also be agreed locally if needed. **Monitored/reviewed by Silver On Call within individual organisations**	
Organisation	**Actions that each organisation will take when the SYSTEM is at OPEL 2**	**Actions that each organisation will take when an INDIVIDUAL ORGANISATION is at OPEL 2**
Actions for NEMs	• Share System OPEL report with all NEMS staff • Make on-call aware	**OOH** • Call in any standby staff on the roster • Engage NEMS resilience team (home workers) • Optimise the utilisation of clinical assessment staff throughout the NEMS service in Notts to maintain response times • Offer Nottingham patients appointments at Mansfield or Newark bases, providing transport if required • Inform 111 to advise patients that there may delays in 'call back' times; this can reduce the number of 'repeat callers' and make total demand more manageable • Inform Urgent Care Centre – to raise awareness and attempt to reduce referrals from UCC to NEMS; and in event that NEMS patients default to UCC because they are unhappy to wait longer than usual **UTU** • Make clinicians aware that the department is busier than normal. • Identify if staff can be moved from other sites • Service managers to source additional nursing staff • Increase capacity of service if possible • Call in the standby GP's into OOH service • Liaise with NEMS Operational Management team to review OOH rota and identify potential to re-deploy clinicians from GP OOH service • Charge nurse/Service manager to work on the shop floor to ensure there is good flow. • Review the queue and identify patients that can be quickly discharged • Chase specialty reviews

Organisation	Actions that each organisation will take when the SYSTEM is at OPEL 2	Actions that each organisation will take when an INDIVIDUAL ORGANISATION is at OPEL 2
Actions for Primary Care and NEMs		• Offer Nottingham patients appointments at Mansfield or Newark bases, providing transport if required • Inform DHU (111 provider) to advise patients that there may delays in 'call back' times; this can reduce the number of 'repeat callers' and make total demand more manageable • Inform Urgent Care Centre – to raise awareness and attempt to reduce referrals from UCC to NEMS; and in event that NEMS patients default to UCC because they are unhappy to wait longer than usual •
111		• Attend daily calls ensuring appropriate representation from provider organisations • Review assurance from providers and ensure proactive plans are in place • Cascade raised alert level to stakeholders • Inform all staff on duty of escalation level • Ensure that all available call taking trained staff are taking calls • NHS 111 Shift Lead to Inform Senior Operations Manager/Director on call • Deploy clinical establishment • Deploy non-clinical establishment • Transfer calls from NHS 111 Pathways Queue to DHU OOHs after agreement • NHS 111 Shift Lead to contact OOH Providers to ask them to take streamed calls • Ask staff to start early/finish late and withdraw from breaks • Send SMS message to all staff requesting support • Initiate "comfort call" as soon as the Quality Standards time frame has been exceeded • Continual re-evaluation of processes, Key Pressure Points, key performance indicators, keeping close contact with Director On Call regarding decision to continue, escalate to RED ALERT or resume usual service delivery
Actions for EMAS	• Review Demand management Actions within the Capacity Management Plan • Consider deploying an Operational Manager if delays in main acutes	• Monitor Inbound screens and deploy managers to minimise handover delays • Duty manager to liaise with NIC to determine current and expected pressures

Organisation	Actions that each organisation will take when the SYSTEM is at OPEL 2	Actions that each organisation will take when an INDIVIDUAL ORGANISATION is at OPEL 2
Actions for NUH	• ED teams to follow escalation protocols relevant to their area including deployment of staff to manage pressures, identification of patients to transfer to other areas within ED and, monitoring of observations outside of cubicles	• Ensure all OPEL 1 actions have been taken • ED patients (for admission) awaiting diagnostic results to be transferred to receiving wards / specialty wards to await results if the result will not change their destination. • As directed by the ED Nurse in Charge and Consultant in Charge, the ED teams to follow escalation protocols relevant to their area including deployment of staff to manage pressures, identification of patients to transfer to other areas within ED and, monitoring of observations outside of cubicles • ED teams to pull patients from streaming if backlog increasing
Actions for NUH	• ED teams to pull patients from streaming if backlog increasing • Following Gold meeting, the Divisions will share the Trust 'Sitrep' and set out the required actions to address the area of pressure. Actions may include: o If necessary Divisions to consider the need to open additional escalation beds identifying staffing support and suitable patients o Matrons for specialties with bed waits exceeding 30 minutes to visit their specialty wards and provide a plan to the Site team / Divisional Bronze to take the patients awaiting a bed in ED within 30 minutes	• Following Gold meeting, the Divisions will share the Trust 'Sitrep' and set out the required actions to address the area of pressure. Actions may include: o If necessary Divisions to consider the need to open additional escalation beds identifying staffing support and suitable patients o Matrons for specialties with bed waits exceeding 30 minutes to visit their specialty wards and provide a plan to the Site team / Divisional Bronze to take the patients awaiting a bed in ED within 30 minutes o Following escalation by Divisional bronze, Matrons to walk their wards to ensure any blockages to timely patient flow are being actioned and to escalate any additional actions necessary to ensure beds are reallocated within 15 minutes of a patient discharge. o Extraordinary reviews of red to green delays • Initiate Trust response protocol for full adult ED including: patients going home today to go to the Discharge Lounge when TTO =2, wards with identified discharges (home today) to go 'one-over' normal bed numbers) • Consultants to review again all patients identified as 'maybe' home today to set a definitive plan by 3pm to confirm actual numbers which will convert, escalating any outstanding diagnostic requirements to the specialty Matron. • Divisions to identify potential routine non-urgent elective activity that is at <u>risk of</u> cancellation. • If necessary to support flow from ED, base ward outliers to be identified and moved into available capacity to create movement capacity for assessment areas

Organisation	Actions that each organisation will take when the SYSTEM is at OPEL 2	Actions that each organisation will take when an INDIVIDUAL ORGANISATION is at OPEL 2
Actions for NUH	○ Following escalation by Divisional bronze, Matrons to walk their wards to ensure any blockages to timely patient flow are being actioned and to escalate any additional actions necessary to ensure beds are reallocated within 15 minutes of a patient discharge. ○ Extraordinary reviews of red to green delays • Initiate Trust response protocol for full adult ED including: patients going home today to go to the Discharge Lounge when TTO =2, wards with identified discharges (home today) to go 'one-over' normal bed numbers) • Consultants to review again all patients identified as 'maybe' home today to set a definitive plan by 3pm to confirm actual numbers which will convert, escalating any outstanding diagnostic requirements to the specialty Matron. • Divisions to identify potential routine non-urgent elective activity that is at risk of cancellation. • If necessary to support flow from ED, base ward outliers to be identified and moved into available capacity to create movement capacity for assessment areas • IDT to ensure plans in place to discharge additional (above the daily discharge target) pathway 2 and pathway 3 patients 'tomorrow' including transport booked. • NEMS – request to open one hour later and re-open one hour earlier whilst in OPEL 2. ARRIVA – consider requirement for additional transport to support discharges	• IDT to ensure plans in place to discharge additional (above the daily discharge target) pathway 2 and pathway 3 patients 'tomorrow' including transport booked. • NEMS – request to open one hour later and re-open one hour earlier whilst in OPEL 2. ARRIVA – consider requirement for additional transport to support discharges

Organisation	Actions that each organisation will take when the SYSTEM is at OPEL 2	Actions that each organisation will take when an INDIVIDUAL ORGANISATION is at OPEL 2
Actions for Mental Health Trust	**AMH** • Review of all patients beyond IDD to take priority in red2 green meetings on wards • Review all patients waiting for beds • All LMHT's to review their current patients on acute wards and in CRHT to identify possible step down/transfer • Admission/discharge prioritisation plan escalated to AMH senior team for review • Urgent Review of any step ups in place of safety • Maximise home treatment options at gatekeeping using all Community options **MHSOP** • Daily Sit Rep outlining OPEL Status & Capacity and Demand • Wards complete daily MDT Board Round via R2G reporting • Community duty/triage staff to review daily R2G reporting systems to identify patients and liaise with wards to support timely discharge • Community calls to all wards daily? Instead of Monday & Thursday? If so a system required that doesn't overload staff to support patient flow & discharge via R2G report processes • Inpatient Service Manager weekly conference calls to social care re: delays to discharge case specific conversation • Daily (Mon-Fri 830am) conference call between Inpatient Service Manager, Operational Manager, General Manager and Service Director	**MHSOP** • As OPEL 1 and in addition; • Daily Sit Rep outlining OPEL Status & Capacity and Demand communicated via email and discussed during a daily operational demand call • Daily Community telephone calls to all wards to support patient flow & discharge via R2G report processes with a daily log of these calls shared with service managers and operational manager • Daily (Mon-Fri 830am) operational demand conference call between Inpatient Service Manager, Operational Manager, General Manager (and Service Director if appropriate). This will be informed by the daily Sit Rep templates and community daily summaries presented by the service managers.

Organisation	Actions that each organisation will take when the SYSTEM is at OPEL 2	Actions that each organisation will take when an INDIVIDUAL ORGANISATION is at OPEL 2
Actions for community providers	• As at opel 1 +…….. • Review Predicted Dates of Discharge in all areas • Expedite discharges when safe to do so • Review waiting list and move patients to alternative pathways where appropriate	• As at opel 1 +……. • Review predicted dates of discharge in all areas • Expedite discharges when safe to do so • Review waiting list and move patients to alternative pathways where appropriate • Review patients exceeding 3.5 hours in UCC
Actions expected as routine for Social Care for Nottingham City LA – Community Referrals	• Spreadsheet for packages required are sent out daily to all lead providers • Spreadsheets for packages are sent out to Accredited providers if no offer from lead within 48 hours • Citizens are given a 'window' for a care call not an identified time • Care Bureau to contact all lead and accredited providers to provide availability of calls across localities covered. • Colleagues asked to revisit package requests to identify if care calls can be adjusted to safely meet needs.	• Spreadsheet for packages required are sent out daily to all lead providers • Spreadsheets for packages are sent out to Accredited providers if no offer from lead within 48 hours • Citizens are given a 'window' for a care call not an identified time • Care Bureau to contact all lead and accredited providers to provide availability of calls across localities covered. • Colleagues asked to revisit package requests to identify if care calls can be adjusted to safely meet needs.
Actions expected as routine for Social Care for Nottingham City LA – Acute Hospital Referrals	• Citizens are given a 'window' for a care call not an identified time • Spreadsheet for packages required are sent out daily to all lead providers. • Spreadsheets for packages are sent out to Accredited providers if no offer from lead within 48 hours • Care Bureau to contact all lead and accredited providers to provide availability of calls across localities covered. • Where it is available citizens to be asked to move to existing community beds if capacity available. • Colleagues asked to revisit package requests to identify if care calls can be adjusted to safely meet needs	• Citizens are given a 'window' for a care call not an identified time • Spreadsheet for packages required are sent out daily to all lead providers. • Spreadsheets for packages are sent out to Accredited providers if no offer from lead within 48 hours • Care Bureau to contact all lead and accredited providers to provide availability of calls across localities covered. • Where it is available citizens to be asked to move to existing community beds if capacity available. • Colleagues asked to revisit package requests to identify if care calls can be adjusted to safely meet needs
Organisation	Actions that each organisation will take when	Actions that each organisation will take when an INDIVIDUAL

	the SYSTEM is at OPEL 2	ORGANISATION is at OPEL 2
Actions expected as routine for Social Care for Nottinghamshire County	• Business as usual • Patients are provided with relevant services • Flow is managed through Opel dashboards and process • Where no POC is available patients will be offered interim services. • Staff will revisit patients to ensure packages / offers are taken where appropriate	• Business as usual • Patients are provided with relevant services • Flow is managed through Opel dashboards and process • Where no POC is available patients will be offered interim services. • Staff will revisit patients to ensure packages / offers are taken where appropriate
Actions for commissioners	N/A	N/A
Actions for Arriva	• Participate in any further system calls where necessary • Liaise with Stakeholders around current workloads in line with expected on the day demand. • Liaise with stakeholders around any substantial delays experienced internally or externally. • Hold conversations with commissioners around increase/spike in pre-planned and on the day activity in relation to possible authorisation of additional resource to support system pressure. • Consider identification of additional crews and vehicles where appropriate to mitigate escalation to level 3 • Consider increasing resource availability via early start/late finish of existing staff	• Ensure all options have been explored in terms of covering staff shortfalls. • Proactive assurance on Vehicle Off road status and flex capacity across the county where necessary. • Flex resource to meet mobility requirements • Undertake assurance calls on accuracy of mobility requested

Action Card for Escalation OPEL Level 3		
Current position	The local health and social care system is experiencing major pressures compromising patient flow and continues to increase. Actions taken in OPEL 2 have not succeeded in returning the system to OPEL 1. Further urgent actions are now required across the system by all organisations Gold On Call, and increased external support may be required. Regional teams in NHS E and NHS I will be aware of rising system pressure, providing additional support as deemed appropriate and agreed locally. National team will also be informed by DCO/Sub-regional teams through internal reporting mechanisms **Urgent Care Director to chair a system wide call involving provider/organisations winter representatives/tactical leads at 10:00am**	
Organisation	**Actions that each organisation will take when the SYSTEM is at OPEL 3**	**Actions that each organisation will take when an INDIVIDUAL ORGANISATION is at OPEL 3**
Actions for NEMS	• Extend hours of service if possible • Call in standby GPs • Source additional staff • Assign NEMS Pathway Ambicorp Crew to NUH • Communicate OPEL status to all clinicians at NEMS including bed status and pressure areas • NEMS to send a reminder to EMAS to make use of Community Pathfinder	**OOH** • Inform CCG on-call • Where safe to do so, provide telephone advice and offer 'telephone follow up' to check if the patient is improving or worsening (instead of making a face to face appointment) • Where safe to do so, offer patients appointments that exceed the normal response times • Where safe to do so, send any appropriate clinician on a home visit; support visiting clinician on scene with telephone advice. (e.g. not all home visit patients care acutely unwell with complex conditions– just unable to attend an appointment) • Decline to verify death in a care home • Defer verification of expected death in a private residence – needs of the living come first • Inform evening and night nursing service: raise awareness of capacity issues in an attempt to reduce referrals and to explore potential for mutual aid • Inform EMAS 999 – raise awareness that NEMS capacity issues may lead some patients/cares to default to 999 if they are unhappy or concerned about not being seen 'face to face' • Inform EMAS Clinical Assessment Team – to raise awareness that NEMS has capacity issues in an attempt to reduce referrals to NEMS from EMAS • Inform ED – raise awareness that NEMS capacity issues may lead some patients to default to ED if they are unhappy or concerned about not being seen 'face to face' **UTU** • Inform and keep in close discussions with ED First Contact and Early assessment • All Clinical Managers to come on Site and work clinically • Ask all Staff that are currently working if they will extend their hours

Organisation	Actions that each organisation will take when the SYSTEM is at OPEL 3	Actions that each organisation will take when an INDIVIDUAL ORGANISATION is at OPEL 3
		• Inform EMAS Clinical Assessment Team – to raise awareness that NEMS has capacity issues in an attempt to reduce referrals to NEMS from EMAS • Inform ED – raise awareness that NEMS capacity issues may lead some patients to default to ED if they are unhappy or concerned about not being seen 'face to face`
111		• Inform all staff on duty of increased escalation level • Transfer calls from NHS 111 Pathways Queue to DHU OOHs after agreement • NHS 111 Shift Lead to contact OOH Providers to ask them to invoke streamed calls • Senior Operations Manager/Director on call to attend nearest site if appropriate • All Senior Operations Managers to attend nearest site if appropriate • Consider refreshments • Send SMS message to all staff stating contingency status and urgent attendance required, homeworkers to also log online • Notify EMAS/Acute Providers of effect of demand • Utilise all other available DHU resource & Internal, External Agencies (e.g GP Network, Other OOH Providers) • Cancel all non-urgent training and meetings to free up staff to cover the service • Senior Manager/Director on call to contact commissioner for area if required and await actions. Update and distribute as accordingly
Actions for EMAS	• Monitor Inbound screens and deploy managers to acutes to minimise handover delays • Duty manager to liaise with NIC to determine current and expected pressures. Attend bed meetings if required and feedback to Regional Operations manager • Inform operational staff of pressures via vehicle bulletin board and re-inforce alternative pathways • Consider contacting crews to see if they will extend shift time	• Monitor Inbound screens and deploy managers to acutes to minimise handover delays • Duty manager to liaise with NIC to determine current and expected pressures. Attend bed meetings if required and feedback to Regional Operations manager • Inform operational staff of pressures via vehicle bulletin board and re-inforce alternative pathways • Consider contacting crews to see if they will extend shift time

Organisation	Actions that each organisation will take when the SYSTEM is at OPEL 3	Actions that each organisation will take when an INDIVIDUAL ORGANISATION is at OPEL 3
Actions for NUH	• Ensure that all OPEL 2 actions have been taken • If necessary Paediatrics ED to receive support from Paediatric base wards, PICU, CNS/PDM to manage patients in ED • HCOP/Frailty team and Acute Physicians to contact / attend ED at 08.00 to agree support required • ED patients in RESUS – If flow out of RESUS is compromised relevant specialty to provide staff giving capacity for additional 1:1 cover for patient whilst bed is found • Following Gold meeting, the Divisions will share the Trust 'Sitrep' and set out the required actions to address the area of pressure. Actions may include: o Divisions review of own escalation protocols and options to divert resources to support flow. o In agreement with the Divisional Leadership Team / Site team, specialty consultants to conduct extraordinary ward round to discharge or transfer patients to create specialty specific capacity if required (e.g. Cardiology, Neuro, Gastro, Respiratory...) o Specialty consultants to conduct extraordinary ward round to discharge or transfer patients to create admission area capacity (including D57 and B3)	• Ensure that all OPEL 2 actions have been taken • If necessary Paediatrics ED to receive support from Paediatric base wards, PICU, CNS/PDM to manage patients in ED • HCOP/Frailty team and Acute Physicians to contact / attend ED at 08.00 to agree support required • ED patients in RESUS – If flow out of RESUS is compromised relevant specialty to provide staff giving capacity for additional 1:1 cover for patient whilst bed is found • Following Gold meeting, the Divisions will share the Trust 'Sitrep' and set out the required actions to address the area of pressure. Actions may include: o Divisions review of own escalation protocols and options to divert resources to support flow. o In agreement with the Divisional Leadership Team / Site team, specialty consultants to conduct extraordinary ward round to discharge or transfer patients to create specialty specific capacity if required (e.g. Cardiology, Neuro, Gastro, Respiratory...) o Specialty consultants to conduct extraordinary ward round to discharge or transfer patients to create admission area capacity (including D57 and B3)

Organisation	Actions that each organisation will take when the SYSTEM is at OPEL 3	Actions that each organisation will take when an INDIVIDUAL ORGANISATION is at OPEL 3
Actions for NUH	○ All patients requiring specialty input not reviewed within 30 minutes are transferred to STU1, 2 or 3 following discussion with Surgery Gold ○ Specialty teams (Specialty General Managers and Matrons) to attend ward 'huddle' and follow-up internal delays and blockages to flow. • Silver on site if specific actions are required to support flow and will maintain contact with the Site team. • Trust wide communications in place and discussions with system partners around wider messages to the public. • On-call Consultants (Out of Hours) to attend admission areas to discharge or transfer patients to create capacity overnight and at the weekends. • All available escalation beds are open and staffed where possible. • Review day cases and options to cancel routine cases that would enable the conversion of day-case beds to 24/7 beds that are then staffed overnight. ○ This would also include review of options to staff 5/7 wards / bays on a 7/7 basis and increase weekend capacity. • If required, Critical Care surge capacity created, using theatre recovery areas on sites to manage emergency activity, transfers from ED • All routine elective procedures are reviewed for cancellation to create outlying capacity (Urgent = Clinically urgent, Cancer patients, previous on the day cancellation and > 18 weeks) • Enact support from the corporate 'Runners' to undertake duties as set out by the site team. • IDT to deliver daily discharge target and work with community and social care partners to provide additional supported discharges per day whilst in OPEL 3. • NEMS – request to extend opening hours further whilst in OPEL 3. • ARRIVA – discuss options to have an additional crew 2pm to 10pm to support discharges whilst in OPEL 3.	○ All patients requiring specialty input not reviewed within 30 minutes are transferred to STU1, 2 or 3 following discussion with Surgery Gold ○ Specialty teams (Specialty General Managers and Matrons) to attend ward 'huddle' and follow-up internal delays and blockages to flow. • Silver on site if specific actions are required to support flow and will maintain contact with the Site team. • Trust wide communications in place and discussions with system partners around wider messages to the public. • On-call Consultants (Out of Hours) to attend admission areas to discharge or transfer patients to create capacity overnight and at the weekends. • All available escalation beds are open and staffed where possible. • Review day cases and options to cancel routine cases that would enable the conversion of day-case beds to 24/7 beds that are then staffed overnight. ○ This would also include review of options to staff 5/7 wards / bays on a 7/7 basis and increase weekend capacity. • If required, Critical Care surge capacity created, using theatre recovery areas on sites to manage emergency activity, transfers from ED • All routine elective procedures are reviewed for cancellation to create outlying capacity (Urgent = Clinically urgent, Cancer patients, previous on the day cancellation and > 18 weeks) • Enact support from the corporate 'Runners' to undertake duties as set out by the site team. • IDT to deliver daily discharge target and work with community and social care partners to provide additional supported discharges per day whilst in OPEL 3. • NEMS – request to extend opening hours further whilst in OPEL 3. • ARRIVA – discuss options to have an additional crew 2pm to 10pm to support discharges whilst in OPEL 3.

Organisation	Actions that each organisation will take when the SYSTEM is at OPEL 3	Actions that each organisation will take when an INDIVIDUAL ORGANISATION is at OPEL 3
Actions for Mental Health Trust	**AMH** • Service managers/matron/consultants to attend all acute wards and review all patients for potential leave/discharge • Inform all staff of Opel 3 status and deploy any capacity to areas of most need • Initiate 2 hourly calls to review position and actions via DDM chair • Invoke Business continuity plans in community teams / cancel non urgent work to support home treatment • CRHT to prioritise urgent cases and increase capacity for home treatment from other areas if possible • Oversight and support of any ED pressures for MH assessments and discharges • Regular updates to senior staff in LP **MHSOP** • Daily Sit Rep outlining OPEL Status & Capacity and Demand • Wards complete daily MDT Board Round via R2G reporting • Community duty/triage staff to review daily R2G reporting systems to identify patients and liaise with wards to support timely discharge • Community calls to all wards daily? Instead of Monday & Thursday? If so a system required that doesn't overload staff to support patient flow & discharge via R2G report processes • Inpatient Service Manager weekly conference calls to social care re: delays to discharge case specific conversation • Daily (Mon-Fri 830am) conference call between Inpatient Service Manager, Operational Manager, General Manager and Service Director • Additional actions? Any ideas? Eg increased input from all MDT members to expedite discharge processes? Daily calls to social care on-call services to ensure increased input to discharge processes	**MHSOP** • As OPEL 1 and OPEL 2 and in addition; • Daily (Mon-Fri 830am) operational demand conference call between Inpatient Service Manager, community service managers, Operational Manager, General Manager and Service Director • Service managers/matron/consultants to attend all acute wards and review all patients for potential leave/discharge • Inform all staff of Opel 3 status and deploy any capacity to areas of most need • Initiate twice daily calls to review position and actions via operational daily demand chair • Invoke Business continuity plans in community teams / cancel non urgent work to support IRIS capacity to facilitate discharges from in-patient areas • Oversight and support of any ED pressures for MH assessments and discharges • Regular updates to senior staff in LP

Organisation	Actions that each organisation will take when the SYSTEM is at OPEL 3	Actions that each organisation will take when an INDIVIDUAL ORGANISATION is at OPEL 3
Actions for community providers	• As at level 2 +……. • Senior clinicians to review all new referrals and in-patients to expedite discharges from services • Review and consider suspension of non-essential services as appropriate to re-allocate resources • Review patients exceeding 4 hours in UCC and escalate to senior manager • Provide additional support via extended opening hours in UCC where possible • In-reach to support increased patient flow • Offer additional hours to staff – seek support from fellow providers within greater Notts. • Senior management attendance on escalation calls / meetings • Liaise with NUH to increase UTU diverts to UCC	• Senior clinicians to review all new referrals and in-patients to expedite discharges from services • Review and consider suspension of non-essential services as appropriate to re-allocate resources • Review patients exceeding 4 hours in UCC and escalate to senior manager • Provide additional support via extended opening hours in UCC where possible • Offer additional hours to staff – seek support from fellow providers within greater Notts • Reduce the number of admissions to the unit affected • Ensure specialist review daily for any affected closed unit • Senior management attendance on escalation calls /meetings • Cancel training and attendance at conferences , etc • Cancel community clinics
Actions expected as routine for Social Care for Nottingham City LA – Community Referrals	• Spreadsheet for packages required are sent out daily to all lead providers • Spreadsheets for packages are sent out to Accredited providers if no offer from lead within 48 hours • Citizens are given a 'window' for a care call not an identified time • Care Bureau to contact all lead and accredited providers to provide availability of calls across localities covered. • Escalate to contracting department to request contact with all providers to escalate urgency for freeing up of capacity and increase pick up rates. • Colleagues asked to revisit package requests to identify if care calls can be adjusted to safely meet needs.	• Spreadsheet for packages required are sent out daily to all lead providers • Spreadsheets for packages are sent out to Accredited providers if no offer from lead within 48 hours • Citizens are given a 'window' for a care call not an identified time • Care Bureau to contact all lead and accredited providers to provide availability of calls across localities covered. • Escalate to contracting department to request contact with all providers to escalate urgency for freeing up of capacity and increase pick up rates. • Colleagues asked to revisit package requests to identify if care calls can be adjusted to safely meet needs.
Actions expected as routine for Social Care for Nottingham City LA – Acute Hospital Referrals	• Citizens are given a 'window' for a care call not an identified time • Spreadsheet for packages required are sent out daily to all lead providers. • Spreadsheets for packages are sent out to Accredited providers if no offer from lead within 48 hours	• Citizens are given a 'window' for a care call not an identified time • Spreadsheet for packages required are sent out daily to all lead providers. • Spreadsheets for packages are sent out to Accredited providers if no offer from lead within 48 hours

Organisation	Actions that each organisation will take when the SYSTEM is at OPEL 3	Actions that each organisation will take when an INDIVIDUAL ORGANISATION is at OPEL 3
Actions expected as routine for Social Care for Nottingham City LA – Acute Hospital Referrals	• Care Bureau to contact all lead and accredited providers to provide availability of calls across localities covered. • Escalate to contracting department to request contact with all providers to escalate urgency for freeing up of capacity and increase pick up rates. • Where it is available citizens to be asked to move to existing community beds if capacity available • Colleagues asked to revisit package requests to identify if care calls can be adjusted to safely meet needs. • Colleagues to discuss with family members if they are able to provide support at home while waiting for a care package • Citizens asked to move to existing community beds if available • Citizens asked to move to any additional funded bed capacity if available.	• Care Bureau to contact all lead and accredited providers to provide availability of calls across localities covered. • Escalate to contracting department to request contact with all providers to escalate urgency for freeing up of capacity and increase pick up rates. • Where it is available citizens to be asked to move to existing community beds if capacity available • Colleagues asked to revisit package requests to identify if care calls can be adjusted to safely meet needs. • Colleagues to discuss with family members if they are able to provide support at home while waiting for a care package • Citizens asked to move to existing community beds if available • Citizens asked to move to any additional funded bed capacity if available.
Actions expected as routine for Social Care for Nottinghamshire County Hospital Referrals	• Group Manager to check OPEL dashboard and identify key areas of concern • Group Manager to contact pressure areas and respond accordingly to ensure flow is maximised • Group Manager to ensure staff are proactive in maximising flow by chasing IDT for referrals • All patients who cannot access services will be offered appropriate alternatives.	• Group Manager to check OPEL dashboard and identify key areas of concern • Group Manager to contact pressure areas and respond accordingly to ensure flow is maximised • Group Manager to ensure staff are proactive in maximising flow by chasing IDT for referrals • All patients who cannot access services will be offered appropriate alternatives.
Actions for commissioners	N/A	• Twice daily system calls put in place • Provide appropriate sign off for expenditure of any additional resource (transport, staffing, spot purchase beds) • Co-ordinate system responses to regulatory requests
Actions for Arriva	• Consider cancellation of non-essential meetings and postpone training in order to create additional capacity to support system pressures • Consider the requirement of operational duties for first line managers to support system pressure. • Attend/dial into any system wide escalation calls • Consider the need for Arriva management presence at major Acute sites to assist patient flow • Engage with NHS partners to review travel priorities based upon NHS priority criteria, and cancel transport as directed.	• Cancel non-essential meetings and postpone training in order backfill substantial staffing shortfalls. • Consider the requirement of operational duties for first line managers if shortfalls demand. • Review options available to cover fleet shortage via lease arrangement • Hold conversations with commissioners around increase/spike in pre-planned activity and on the day activity in relation to possible authorisation of additional resource to support Arriva maintain patient flow. • Increased management presence in and around the control function • Review the need for additional internal escalation calls.

Action Card for Escalation OPEL Level 4		
Current position	Pressure in the local health and social care system continues to escalate leaving organisations unable to deliver comprehensive care. There is increased potential for patient care and safety to be compromised. Decisive action must be taken by the Local A&E Delivery Board to recover capacity and ensure patient safety. All available local escalation actions taken, external extensive support and intervention required. Regional teams in NHS E and NHS I will be aware of rising system pressure, providing additional support as deemed appropriate and agreed locally, and will be actively involved in conversations with the system. Where multiple systems in different parts of the country are declaring OPEL 4 for sustained periods of time and there is an impact across local and regional boundaries, national action may be considered. **A&E Board Members to be notified and asked to dial in to a system call to determine a System Wide Response**	
Organisation	**Actions that each organisation will take when the SYSTEM is at OPEL 4**	**Actions that each organisation will take when an INDIVIDUAL ORGANISATION is at OPEL 4**
Actions for NEMS	• All clinical managers to come on site and work clinically if agreed with system partners • Discuss feasibility of deploying NEMS drivers and vehicles to help with transporting patients out of hospital • Identify patients that are clinically safe to be transported from the UTU to be seen at UTC London Road. (Note: clinical protocol not yet in place) • Accept contingency calls from 111	**OOH** • Immediate briefing to senior execs • Inform CCG on call and ask permission to turn off DOS in NHS 111; patients with NHS Pathways dispositions normally directed to NEMS would be offered the next more suitable service in the DOS; this may lead to default use of A&E. • Work with DHU to continue to support patients with NHS Pathways recommendations indicating a home visit is needed. • Inform EMAS and evening and night nursing service that the 'direct dial' clinical hub service is severely restricted and we may not be able to provide timely advice to staff; this may lead to default use of A&E. • If sufficient clinical resources remain after visits are managed, redeploy to NEMS at the UTU to compensate for increased attendances. **UTU** • Immediate Briefing to senior execs • Obs to be repeated after long waits (length of time to be confirmed) • Liaise within UTU to discuss patient being transferred from NEMS clinicians

Organisation	Actions that each organisation will take when the SYSTEM is at OPEL 4	Actions that each organisation will take when an INDIVIDUAL ORGANISATION is at OPEL 4
111	• To refer patients to an alternative option on the Directory of Service when notified, wherever possible • To consider the deployment of the NHS 111 Clinical establishment • Increase staffing if appropriate, monitoring forecast and demand hourly	• CEO/Lead Directors have been involved and have agreed that a Black Alert level should be instigated • Continue to coordinate response across the whole system • Review best use of capacity and resources across the whole system and shift resources to meet demand and maintain patient safety • Inform all staff on duty of increased escalation level • Senior Manager/Director on call to call in all Senior Managers/Directors • NHS 111 Shift Lead to contact OOH Providers to tell them that we are sending over streamed calls • 111 Clinical Lead discussion/ approach re implementing of Early Exiting calls at the end of module 0 • Send SMS message to all staff stating contingency status and immediate attendance required • Contact homeworkers individually to request immediate support • Corporate management and staff to take on operation roles • Suspend local quality standards with agreement from Commissioners • Refuse all requests for short notice annual leave and request staff to cancel all pre booked annual leave for the coming week Director on call to contact commissioner for area and await actions. Update and distribute as accordingly
Actions for EMAS	• Monitor inbound screens and deploy operational manager to minimise handover delays • Operational manager to liaise with Nurse in Charge to determine current and expected pressures. Attend bed meetings if required and feed back to regional Operations Manager • Inform operational staff of pressures via vehicle bulletin board and re-inforce alternative pathways	• Review requirement for clinically trained managers to be available to respond (where possible on DCA) to provide transport capability • Review Demand Management Actions within the Capacity Management Plan • Divisional On-Call Team to work on instruction of Trust Strategic Command and provide locality presence • Review PAS resource and consider redeploy where required Consider cancelling training and deploying tutors and trainees Contact off duty staff to increase resource capacity/contact on duty staff to extend shift time
Organisation	Actions that each organisation will take when the SYSTEM is	Actions that each organisation will take when an INDIVIDUAL

	at OPEL 4	ORGANISATION is at OPEL 4
Actions for NUH	• Ensure that OPEL 3 actions have all taken place • • ED RESUS to get support from CCOT to manage patients if RESUS full and Critical Care surge capacity full • Re-prioritisation of ED senior nursing and medical staff to assist with patient streaming. • ED to raise the question of peripheral divert with Silver on Call and Gold for discussion with system • Gold on Call Director aware and Internal Incident declared • Silver on call to be on site supporting flow and timely decisions and ensuring patient safety. • Following Gold meeting, the Divisions will share the Trust 'Sitrep' and set out the required actions to address the area of pressure. Actions may include: o Stand down all non-urgent medical staff activity NECESSARY, including routine outpatient clinics, to <u>enable</u> increased medical staffing on wards and assessment areas to undertake <u>rolling ward rounds.</u> Divisions to plan and manage. o Stand down all non-clinical nursing time to support wards where necessary to manage patient safety (one-over bed numbers and no plan) o If all other options exhausted agree via the Divisional Gold the release of shifts to non-compliant agencies if staffing levels are impeding flow o Specialty specific beds held for control or infection purposes to be reviewed and made open for outlying patients where possible (includes: Orthopaedic beds on Harvey 1 and Edward 2)	• Ensure that OPEL 3 actions have all taken place • ED RESUS to get support from CCOT to manage patients if RESUS full <u>and</u> Critical Care surge capacity full • Re-prioritisation of ED senior nursing and medical staff to assist with patient streaming. • ED to raise the question of peripheral divert with Silver on Call and Gold for discussion with system • Gold on Call Director aware and Internal Incident declared • Silver on call to be on site supporting flow and timely decisions and ensuring patient safety. • Following Gold meeting, the Divisions will share the Trust 'Sitrep' and set out the required actions to address the area of pressure. Actions may include: o Stand down all non-urgent medical staff activity NECESSARY, including routine outpatient clinics, to <u>enable</u> increased medical staffing on wards and assessment areas to undertake <u>rolling ward rounds.</u> Divisions to plan and manage. o Stand down all non-clinical nursing time to support wards where necessary to manage patient safety (one-over bed numbers and no plan) o If all other options exhausted agree via the Divisional Gold the release of shifts to non-compliant agencies if staffing levels are impeding flow o Specialty specific beds held for control or infection purposes to be reviewed and made open for outlying patients where possible (includes: Orthopaedic beds on Harvey 1 and Edward 2)
Organisation	**Actions that each organisation will take when the SYSTEM is at OPEL 4**	**Actions that each organisation will take when an INDIVIDUAL ORGANISATION is at OPEL 4**

Actions for NUH	• Senior decision makers will be on all wards through the period reviewing patients and supporting flow
	• All routine elective procedures are reviewed for cancellation to create outlying capacity (Urgent = Clinically urgent, cancer patients, previous on the day cancellation and >26 week wait)
	• Enact support from the corporate 'Runners' to undertake duties as set out by the site team.
	• IDT to work with community partners to take a further 10 supported discharges per day whilst in OPEL 4 providing a clear plan to fill available beds within 48 hours.
	  o Include review to extend the cut-off time for admission to community beds and;
	  o Include ability to take patients up to the maximum number on a Saturday / Sunday if necessary to reach full capacity.
	• IDT to work with social care partners to provide additional supported discharges per day whilst in OPEL 4
	• ARRIVA additional crew in place to support discharges
	Discussion with NEMS to provide 24/7 cover until OPEL 4 is stood down
		• Senior decision makers will be on all wards through the period reviewing patients and supporting flow
		• All routine elective procedures are reviewed for cancellation to create outlying capacity (Urgent = Clinically urgent, cancer patients, previous on the day cancellation and >26 week wait)
		• Enact support from the corporate 'Runners' to undertake duties as set out by the site team.
		• IDT to work with community partners to take a further 10 supported discharges per day whilst in OPEL 4 providing a clear plan to fill available beds within 48 hours.
		  o Include review to extend the cut-off time for admission to community beds and;
		  o Include ability to take patients up to the maximum number on a Saturday / Sunday if necessary to reach full capacity.
		• IDT to work with social care partners to provide additional supported discharges per day whilst in OPEL 4
		• ARRIVA additional crew in place to support discharges
		• Discussion with NEMS to provide 24/7 cover until OPEL 4 is stood down

Organisation	**Actions that each organisation will take when the SYSTEM is at OPEL 4**	**Actions that each organisation will take when an INDIVIDUAL ORGANISATION is at OPEL 4**

Actions for Mental Health Trust	**AMH** • Immediate briefing to senior exes- link to system wide responses- consider major incident declaration • Cancel routine visits across all community teams to focus on home treatment capacity/crisis visits as required • Inform all staff of Opel 4 status – request any staff who are not at work to attend if they can to support • Initiate 1 hourly teleconference reviews to oversee deployment of business continuity plans • Cancel all non-urgent meetings and all senior staff to support front line services in managing demands and decision making **MHSOP** • Daily Sit Rep outlining OPEL Status & Capacity and Demand • Wards complete daily MDT Board Round via R2G reporting • Community duty/triage staff to review daily R2G reporting systems to identify patients and liaise with wards to support timely discharge • Community calls to all wards daily? Instead of Monday & Thursday? If so a system required that doesn't overload staff to support patient flow & discharge via R2G report processes • Inpatient Service Manager weekly conference calls to social care re: delays to discharge case specific conversation • Daily (Mon-Fri 830am) conference call between Inpatient Service Manager, Operational Manager, General Manager and Service Director • Additional actions? Any ideas? Eg increased input from all MDT and senior directorate members (CDs, Clinical Leads, and Service Managers) to expedite discharge processes? Daily calls to social care on-call services to ensure increased input to discharge processes, increase community capacity to support discharge and/or prevent admissions wherever safe to do so, RCA investigation to analyse capacity and demand - learn lessons – future proof and mitigate likelihood or reoccurrence	• Teleconference calls chaired by GM/DGM to include social care and police to agree joint actions – frequency to be determined on the day depending on nature of issues faced. • If required, deployment of CRHT staff to support DPM if pressures in ED If required, senior clinical staff to support reviews of all inpatients **MHSOP** • As OPEL 1- 3 and in addition; • Daily sit-rep from in-patient service manager circulated to all teams and in-reach telephone calls from community teams to ward teams to identify and expedite discharges where possible • Daily (Mon-Fri 830am) operational demand conference call between Inpatient Service Manager, community service managers, Operational Manager, General Manager and Service Director • Immediate briefing to senior executives - link to system wide responses- consider major incident declaration (general manager) • Comprehensive review of the current IRIS caseloads alongside the CMHT caseloads to ensure that (where appropriate and safe) cases are transferred and or the skills required are matched against the need of the patient (community service managers) • Focus on IRIS capacity and utilising crisis resolution home treatment where possible (community service managers) • Inform all staff of Opel 4 status – request any staff who are not at work to attend if they can to support • Initiate 1 hourly teleconference reviews chaired by the operational manager to oversee deployment of business continuity plans • Cancel all non-urgent meetings and all senior staff to support front line services in managing demands and decision making
Organisation	**Actions that each organisation will take when the SYSTEM is at OPEL 4**	**Actions that each organisation will take when an INDIVIDUAL ORGANISATION is at OPEL 4**

Actions for Community Providers	• As at opel 3 +…… • Review patients exceeding 6 hours in the UCC and informing CCG • Further explore all out of county assistance options inc. community bed utilisation • Initiate services to support any CCG decision to purchase an increased number of community beds • Contact agencies for staffing support • Provision of increased support to care homes to facilitate admission avoidance	• This will be a senior executive decision • No admissions into beds – inform CCG • Seek corporate staff with relevant professional registration to support clinical care • Cancel staff training and any conference attendance, etc • Contact agencies for staffing support • Review patients exceeding 6 hours wait in ucc – escalate
Actions expected as routine for Social Care for Nottingham City LA – Community Referrals	• Spreadsheet for packages required are sent out daily to all lead providers • Spreadsheets for packages are sent out to Accredited providers if no offer from lead within 48 hours • Citizens are given a 'window' for a care call not an identified time • Care Bureau to contact all lead and accredited providers to provide availability of calls across localities covered. • Escalate to contracting department to request contact with all providers to escalate urgency for freeing up of capacity and increase pick up rates. • Colleagues asked to revisit package requests to identify if care calls can be adjusted to safely meet needs.	• Spreadsheet for packages required are sent out daily to all lead providers • Spreadsheets for packages are sent out to Accredited providers if no offer from lead within 48 hours • Citizens are given a 'window' for a care call not an identified time • Care Bureau to contact all lead and accredited providers to provide availability of calls across localities covered. • Escalate to contracting department to request contact with all providers to escalate urgency for freeing up of capacity and increase pick up rates. • Colleagues asked to revisit package requests to identify if care calls can be adjusted to safely meet needs.
Actions expected as routine for Social Care for Nottingham City LA – Acute Hospital Referrals	• Citizens are given a 'window' for a care call not an identified time • Spreadsheet for packages required are sent out daily to all lead providers. • Spreadsheets for packages are sent out to Accredited providers if no offer from lead within 48 hours • Care Bureau to contact all lead and accredited providers to provide availability of calls across localities covered. • Escalate to contracting department to request contact with all providers to escalate urgency for freeing up of capacity and increase pick up rates. • Where it is available citizens to be asked to move to existing community beds if capacity available	• Citizens are given a 'window' for a care call not an identified time • Spreadsheet for packages required are sent out daily to all lead providers. • Spreadsheets for packages are sent out to Accredited providers if no offer from lead within 48 hours • Care Bureau to contact all lead and accredited providers to provide availability of calls across localities covered. • Escalate to contracting department to request contact with all providers to escalate urgency for freeing up of capacity and increase pick up rates. • Where it is available citizens to be asked to move to existing community beds if capacity available
Organisation	**Actions that each organisation will take when the SYSTEM is at OPEL 4**	**Actions that each organisation will take when an INDIVIDUAL ORGANISATION is at OPEL 4**

Actions expected as routine for Social Care for Nottingham City LA – Acute Hospital Referrals	• Colleagues asked to revisit package requests to identify if care calls can be adjusted to safely meet needs. • Colleagues to discuss with family members if they are able to provide support at home while waiting for a care package • Citizens asked to move to existing community beds if available • Citizens asked to move to any additional funded bed capacity if available.	• Colleagues asked to revisit package requests to identify if care calls can be adjusted to safely meet needs. • Colleagues to discuss with family members if they are able to provide support at home while waiting for a care package • Citizens asked to move to existing community beds if available Citizens asked to move to any additional funded bed capacity if available.
Actions expected as routine for Social Care for Nottinghamshire County Hospital Referrals	• Group Manager will escalate to appropriate Service Director and advise of situation • Group Manger will engage will system calls as per internal Opel system process • Group Manager will ensure that Service Director is engaged until de-escalation is established • Group Manager will work internally to ensure services are re-prioritised with market management and flow created by emergency commissioning if possible, Service Director to authorise	• Group Manager will escalate to appropriate Service Director and advise of situation • Group Manger will engage will system calls as per internal Opel system process • Group Manager will ensure that Service Director is engaged until de-escalation is established • Group Manager will work internally to ensure services are re- prioritised with market management and flow created by emergency commissioning if possible, Service Director to authorise
Actions for Commissioners	N/A	• Actions as per OPEL 3 level • Urgent Care team to facilitate and support system requests – normal meetings cancelled • Director on call to attend operational escalation meetings in person to facilitate system recovery
Actions for Arriva	• All non-essential meetings and training to be cancelled in order to create additional capacity to support system pressures • All first line managers to be engaged in operational duties to increase capacity to support system pressures • Mobilisation of all available resources to appropriate areas where additional capacity allows • Aid in facilitating transfers for out of county/contract patients in collaboration with other service providers where appropriate • Request authorisation of additional resources via commissioners in order to support system pressures • Engage Arriva management representation at major acute to assist in patient flow • Senior management participation in system escalation calls/meetings • Gain assurance that all remaining non patient flow journeys are still required, and cancel transport as notified.	• All operational managers to support operationally within their trained element to ensure appropriate level of resource is maintained • Engage assistance from 3rd party to assist in ensuring appropriate level of resource is maintained • Cancel all training and all meetings to ensure appropriate level of resource is maintained • Invoke Senior management led escalation calls at regular intervals throughout the day • Request authorisation of additional resource via commissioners should pre planned or on the day demand increase/spike excessively above the average activity levels, in order to support Arriva maintain patient flow

			OPEL 1	OPEL 2	OPEL 3	OPEL 4
Pre Hospital	Primary care capacity		Green – GP attendances within expected levels with appointment availability sufficient to meet demand	Amber - GP demand unable to be met by ordinary increase in appointment availability for 48 hours	Red – GP demand unable to be met by ordinary increase in appointment availability for 96 hours	N/A
	NHS 111		NHS 111 Calls answered within 27 seconds for > 1 hour **AND** NHS 111 Calls abandonment rate of <4% **AND** NHS 111 average wait for Clinician Call back (routine) <120 minutes **AND** NHS 111 average wait for Clinician Call back (urgent & emergency) < 10 minutes **AND** NHS 111 staffing >90%	Answered in >41 seconds, but <60 seconds continually for 3 hours **OR** Abandoned >2%, but <5% for 4 consecutive hour **OR** >30% but <40% of the NHS 111 Clinician Call back queue (routine) has an average wait of >120 minutes for 3 hours **OR** >40% but <50% of the NHS 111 Clinician call back queue (urgent) has an average wait of >30 minutes for 4 hours **OR** >40% but <50% of the NHS 111 clinician call back queue (emergency) has an average wait of >10 minutes for 4 hours **OR** NHS 111 staffing <90% for the day	Answered in >61 seconds but <80 seconds continually for 5 hours **OR** Abandoned >8% but <11% for 4 consecutive hours **OR** >20% but <30% of the NHS 111 clinician call back queue (routine) has an average wait of >120 minutes for 3 hours **OR** >30% but <40% of the NHS 111 clinician call back queue(urgent) has an average wait of >30 minutes for 4 hours **OR** >30% but <40% of the NHS 111 clinician call back queue (emergency) has an average wait of >10 minutes for 4 hours **OR** NHS 111 staffing <85% for the day	Answered in >101 seconds but continually for 5 hours **OR** Abandoned >11% for 5 consecutive hours **OR** <20% of the NHS 111 clinician call back queue (routine) has an average wait of >120 minutes for 3 hours **OR** >20% of the NHS 111 clinician call back queue (urgent)has an average wait of>30 minutes for 4 hours **OR** >20% of the NHS 111 clinician call back queue (emergency) has an average wait of >10 minutes for 4 hours **OR** NHS 111 staffing <75% for the day
	EMAS		10 Red and G1 calls or 40 calls of any trigger category being held	20 Red calls or 55 calls of any trigger category being held	Prolonged period of demand (not spike) or more than 70 calls being held	Initiated when a major incident is declared and all other actions have failed to mitigate the circumstances
	UCC		<3 hours waiting time No staffing issues	<3.5 hours waiting time 30% reduction in staffing	Breaching 4 hours 50% reduction in staffing	Breaching 6 hours 60% reduction in staffing
NEMS - OOH	1	Length of telephone queue (across Notts)	Weekday <50 Overnight <40 Weekend <100	Weekday <65 Overnight <50 Weekend <140	Weekday <80 Overnight <60 Weekend <180	Weekday >80 Overnight >60 Weekend >180
	2	GP cover	Full cover	1-2 shift gaps	3 shift gaps	>3 shift gaps
NEMS – UTU	3	Number of patients in department	<20	<25	<30	>30
	4	GP / Prescriber clinician cover	Full cover	1-2 shift gaps	3 shift gaps	>3 shift gaps

			OPEL 1	OPEL 2	OPEL 3	OPEL 4
Patient Tran	Arriva	OTD Booking %	50% or less of discharges booked on	51-70% of discharges booked	71-90% of discharges booked on the day	91% or more of discharges booked on the day

		Discharges	the day	on the day		
		% of Discharges requiring stretcher resource	Represent 40% or less of activity	Represents 41-55% of Booked activity	Represents 56-75% of Activity	Represents more than 75% of Actvity
		Resources used for contractual bookings outside regular patient flow	0-3	4-5	6-7	8 or over
Mental Health Services	Nottinghamshire Healthcare Trust		➢ Private/ out of area admission numbers are 20 service users or less ➢ No service users awaiting PICU step down ➢ Number of those requiring admission within 48 hours and planned discharges within 48 hours are equitable ➢ No service users stepped up to health based place of safety	➢ Private/ out of area admission numbers are 20-25 service users ➢ Fewer than 2 service users awaiting PICU step down ➢ The pending admission list for the next 48 hours is larger than the planned discharge list for the same time period	➢ Private/ out of area admission numbers exceed 25 service users ➢ More than 2 service users awaiting PICU step down ➢ The pending admission list for the next 48 hours is larger than the planned discharge list for the same time period and includes delays to admission that have wider system implications such as patients stepped up to 136 beds, patients in ED, or patients who are detained in the community with no available bed identified within 4 hours of request	Same as identified in OPEL 3 with the primary difference being that internal escalation and efforts to resolve have been unsuccessful and wider support is required to manage risk.
Community bed based capacity	Greater Nottingham		92% bed occupancy with planned discharges and admissions. Good staffing Good flow	95% bed occupancy with 1 or more of the following: • no planned discharges in next 24 hours • up to 15 patients on the waiting list for 24 hours or more • below 90% staffing	100% bed occupancy with 2 or more of the following: • No planned discharges in the next 48 hours. • Up to 25 people on waiting list for 24 hours or more • Below 85% staffing • Delays in discharges of up to 25 patients across both organisations • 1 unit closed	Director or Assistant Director declares Opel 4 due to 100% bed occupancy with two or more of the following: • No planned discharges in next 72 hours and above 25 patients on waiting list • Below 75% staffing • Delays in discharges of 25 or more patients across both organisations • 2 or more units closed
			OPEL 1	**OPEL 2**	**OPEL 3**	**OPEL 4**

Community Home based capacity	Community Nursing Services capacity	Meeting all patient needs both urgent & non urgent Good staffing	Reduced level of service – able to respond to medium and high priority patients 80% staffing	Reduced level of service – able to respond to high priority patients only Staffing 70%	Unable to meet the needs of all of the high priority patients Staffing below 50%
	Home Care Status Community Referrals – City LA Acute Hospital Referrals – City LA	 0-8 citizens waiting for Homecare 0-8 citizens waiting for Homecare	 9-20 citizens waiting for Homecare 9-20 citizens waiting for Homecare	 20 + citizens waiting for Homecare 20 + citizens waiting for Homecare	
	Reablement capacity - at home Community Services	Business as usual - meeting all patient needs both urgent & non urgent Good staffing	Reablement - No planned discharges in next 24 hours Less than 80% staffing 10 patients with a delay in transfer to external provider Up to 5 patients waiting for reablement	No planned discharges in next 48 hours. Less than 70% staffing Delays to external provider above 20 5-10 patients waiting for reablement	No planned discharges in next 72 hours. Less than 50% staffing Delays to external provider above 25 Over 10 patients waiting for reablement
	Community Nursing Services capacity (Leivers Court)	Able to maintain patient flow and meet anticipated demand within available resources. Assessment beds vacancies are available with a minimal number of beds occupied by residents with high needs in the assessment beds and in the wider home. No resident illnesses which would prevent admissions. Full staffing capacity for Assessment Beds – at least 90% of staff in work	Starting to show signs of pressure that could affect flow and focused action is required to reduce the level of pressure and mitigate the need for further escalation. 13 Assessment beds occupied with 0 planned discharges for the following 72 hours **OR** 1 case of flu	Experiencing major pressure compromising patient flow and urgent actions are required. 14 Assessment beds occupied with 0 planned discharges for the following 48 hours **OR** Significant number of high needs cases (2:1 staffing or equipment needs) that would prevent admissions of more service users with high needs **OR** 2 or more cases of resident illness which would close home in line with infection control procedures	Unable to deliver comprehensive care and all escalation actions taken Home closed due to resident illness for 3 or more days and no new referrals accepted **OR** All 15 assessment beds full and waiting list in place
	Domiciliary care capacity (County)	No patients waiting longer than 48 hours	Patients waiting 72 hours	Patients waiting 96 hours	One in one out service
	Domiciliary care capacity (City)	<25 External Care Packages	<50 External Care Packages	<75 External Care Packages	<99 External Care Packages

	OPEL 1	OPEL 2	OPEL 3	OPEL 4

Other demand variables	Infection Control issues		Affecting one clinical area / organisation	Affecting more than one clinical area / organisation	
	Staffing	No impact – all services delivered. Organisation functioning as normal. Staffing levels within normal parameters.	Slight disruption – some non-essential services suspended. Elevated sickness absence levels but pressures contained within individual areas.	Moderate disruption – all non-essential services suspended. Elevated sickness absence levels. Not all areas able to contain pressure and staff temporarily deployed as required.	Major disruption to all services. Widespread sickness absence across organisation and key areas unable to meet demand
	Weather	Cold weather / heatwave plan level 0 or 1	Cold weather / heatwave plan level 2	Cold weather / heatwave plan level 3 Adverse weather severely impacting on journey times, affecting capacity	Cold weather / heatwave plan level 4
	Industrial action	N/A	Industrial action taken reducing capacity across health and social care	Industrial action taken reducing capacity across health and social care	Industrial action taken with 0 capacity across health and social care
	Industrial action	N/A	Industrial action taken reducing capacity across health and social care	Industrial action taken reducing capacity across health and social care	Industrial action taken with 0 capacity across health and social care

A version of the NUH Triggers are below:

ED TRIGGERS	**Format**	Opel 1	Opel 2	Opel 3	Opel 4
Ambulance handover	minutes	<15 minutes	15-30 minutes	30-60 minutes	60+ minutes
Total numbers in ED	Patients	<70	70-90	91-130	>130
Time to be seen - first clinician	minutes	<60	60-75	75-90	>90
Numbers of patients in Resus	number	<8	8-9	10	>10
Numbers of patients Majors	number	<22	22-26	27-36	>36
Numbers of patients UTU	number	<30	30-45	46-60	>60
Fit to ward patients transfer time	minutes	< 30	31 - 60	61 - 90	>90
ASSESSMENT AREAS TRIGGERS		Opel 1	Opel 2	Opel 3	Opel 4
Fit to ward from assessment areas	Minutes	<90	91 - 120	121 - 150	>150
Assessment Spaces in AMRA	beds	8	4	2	0
Assessment Spaces in SRU	beds	8	4	2	0
Assessment Spaces in RAU	beds	8	4	2	0
INPATIENT AREAS TRIGGERS		Opel 1	Opel 2	Opel 3	Opel 4
Occupancy Queens	Percentage	<92%	93%-94%	95%-98%	99%+
Occupancy City	Percentage	<92%	93%-94%	95%-98%	99%+
Inflow/outflow (24hours	beds	0 - 10	10 - 20	21 - 30	>31

ENC. E4

Meeting:	ICS Board
Report Title:	Mid-Nottinghamshire Winter Plan
Date of meeting:	Wednesday 9 October 2019
Agenda Item Number:	17
Work-stream SRO:	Richard Mitchell
Report Author:	Helen Drew
Attachments/Appendices:	Enc. E5. Mid-Nottinghamshire ICP/A&E Delivery Board Winter Plan 19/20 Appendices: Further documents exist and are available upon request to Helen Drew or the ICS Admin Team.

Report Summary:

The 18/19 winter de-brief session which took place at the April 2019 A&E Delivery Board meeting concluded that winter 18/19 was a success against the system-wide winter plan, despite some significant challenges experienced by the network as a whole and some individual providers more than others. Poor weather and a severity of flu were noticeable by their absence and senior system leaders and staff surveys agreed that winter planning was more robust than in previous years, which is largely attributable to an earlier enactment of plans creating additional resource, capacity, and a cohesive system approach to escalation and de-escalation.

This 19/20 winter plan attempts to build upon the successes of 18/19 to offer a significantly more sophisticated response and to meet the continued demands of increased urgent care activity across the footprint. Because the seasonal and calendar boundaries and associated peaks and troughs in demand are no longer as defined as in previous years, this winter plan forms part of an overarching system-wide seasonal plan, which offers a high level overview of thematic challenges to and responses from the mid-Nottinghamshire system.

It is acknowledged that as a live plan, this document will continue to evolve as further information becomes available from provider planning rounds, as work streams progress towards targets and trajectories, and as the system continues to identify examples of best practice and lessons learned. Two crucial elements of this will be the final outputs of the ICS Drivers of Demand analysis and the NHIS led Demand and Capacity work streams, both of which have made a commitment to enable key system improvements ahead of the winter period.

Action:

☐ To receive
☒ To approve the recommendations

Recommendations:

1.	That the Board NOTES the proposed plan and offers comments as appropriate

Key implications considered in the report:

Financial	☐	
Value for Money	☐	

Risk	☐	
Legal	☐	
Workforce	☒	
Citizen engagement	☐	
Clinical engagement	☒	
Equality impact assessment	☐	

Engagement to date:

Board	Partnership Forum	Finance Directors Group	Planning Group	Workstream Network
☐	☐	☐	☐	☐
Performance Oversight Group	Clinical Reference Group	Mid Nottingham-shire ICP	Nottingham City ICP	South Nottingham-shire ICP
☐	☐	☒	☐	☐

Contribution to delivering the ICS high level ambitions of:

Health and Wellbeing	☐
Care and Quality	☒
Finance and Efficiency	☒
Culture	☐

Is the paper confidential?

☐ Yes
☒ No

Note: Upon request for the release of a paper deemed confidential, under Section 36 of the Freedom of Information Act 2000, parts or all of the paper will be considered for release.

NHS Mansfield and Ashfield Clinical Commissioning Group

NHS Newark and Sherwood Clinical Commissioning Group

NHS Sherwood Forest Hospitals NHS Foundation Trust

DHU Derbyshire Health United

NHS East Midlands Ambulance Service NHS Trust

NHS Nottinghamshire Healthcare NHS Foundation Trust

Nottinghamshire County Council

NEMS Community Benefit Services Limited

The Mid-Nottinghamshire ICP/A&E Delivery Board Winter Plan 19/20

Contents Page

Executive Summary

This document articulates the manner in which the mid-Nottinghamshire urgent care system and partners will respond to the anticipated and significant pressures of the winter 19/20 period. System partner flu and organisational winter plans have been embedded where these are available, and these have been reviewed and cross-referenced to avoid duplication and contra-indicative plans and actions.

The plan is a live working document, and as such will continue to be updated as further information, plans and outputs of work streams become available. The intention of this plan is that it should be read as an iterative 'updated to a point' in time document, the efficacy of which will be reviewed on an ongoing basis in monthly A&E Delivery Board meetings.

The plan details both business as usual and transformational schemes which will help to mitigate and proactively manage the demands of the period. The 3 main system-wide schemes which have been identified as having the biggest impact are summarised below.

Home First Integrated Discharge Scheme –

This project, currently in phase one, will further streamline and improve advanced discharge planning processes and timelines from a Home First – 'why not home, why not today?' ethos and discharge to assess (D2A) model.

Fundamental to this project is the HFID discharge hub; the hub underpins the HFID model with the following aims and objectives of the HFID model

- A daily system MDT meeting which identifies the appropriate discharge pathways for medically optimised and complex patients.
- A trusted decision making and pull approach to ensure patients are supported home first or as soon as medically fit for discharge
- The hub ensures that the admissions criteria principles for community bed stock are appropriately utilised,
- A dedicated system lead of the hub that can hold system parties to account for the delivery of the agreed principles within the Partnership Operating Model developed in collaboration. Currently this resource is provided by the CCG
- The hub will be supported by dedicated administration to track, monitor and manage patients being managed by the hub.

Phase 2 implementation of the model has already begun ahead of the August 2019 timeline will aim to re-configure the community bed base within the SFHFT bed stock.

Non-Conveyance Project Manager –

The 19/20 work plan for reducing conveyances includes the appointment of a dedicated Project Manager who will drive the work stream forward on behalf of the Nottinghamshire ICS. The post-holder, in a 12 month term will be employed by EMAS, but deliver non-conveyance service improvements and reductions on behalf of the two delivery systems. It is envisaged that this role, which is crucial to the success of the workstream will work closely with a number of organisations across the Nottinghamshire urgent care system and deliver transformational change.

Respiratory STOP FLU work stream

The STOP FLU campaign is based on promoting 5 key messages to patients, clinicians and their carers.

1. Flu Vaccination works and is safe
2. Stop Smoking
3. Hygiene stops the spread - wash hands, catch sneezes, do not touch your face
4. Eat healthily take Vitamin D everyday
5. Exercise regularly

The message is to be given to patients in all health care settings and social care. A fact sheet will be created and a video for call boards. Fact sheets will be issued with Flu invitations.

The Mid-Nottinghamshire ICP/A&E Delivery Board System Winter Plan 19/20.

Background –

This document articulates the mid-Nottinghamshire urgent care system's proactive and reactive planning response to the anticipated seasonal surge in demand in winter 19/20. Wherever possible lessons learned from previous seasonal surges and other system experiences are clearly identified. The format of the document follows the patient flow through the local healthcare system and it is acknowledged that business as usual activities will continue to deliver a positive impact on the delivery of services and mitigation of risk during the period. Specific winter management schemes will be identified in individual partner organisational plans, which can be found as an appendix to this document. These plans have been considered individually, and as part of a mid-Notts ICP and Nottinghamshire ICS approach to the period. Care has been taken to ensure that all system partner plans demonstrate an awareness of the key interdependencies between pathways and work streams, and that no obvious cross-organisational contra-indicative actions are evident. For clarity and transparency, narrative which relates to service improvements and transformation schemes which are new to the system for winter 19/20, but not specific to winter, are denoted in blue text. This is in response to feedback received on the 18/19 system winter plan.

Aims & Objectives

The aims and objectives of the plan are as follows –

- Ensuring that patients can continue to access safe and timely services during times of demand, system pressure and escalation throughout the winter period.
- Ensuring that providers are able to pre-empt, predict, identify, prepare for and respond to periods of escalation and de-escalation accordingly to ensure the robust and safe delivery of services.
- Ensuring that delivery and performance against national standards and trajectories continues to be maintained during these times.
- Providing Commissioners and regulators with assurance that individual organisations and as a system-wide network, the health and social care providers across Mid-Nottinghamshire are prepared to meet and can quickly recover from, the demands and pressures of winter 19/20.
- Ensuring that transparent system capacity is available across the network
- Ensuring that the Mid-Nottinghamshire system can strive towards a clear understanding of true urgent care demand, in order to fully comprehend both core and escalation capacity, and is subsequently aware of any gaps and has plans to address this.

A&E Delivery Board –

The ownership, governance and monitoring of the successful enactment of this plan sits with the executive health and social care system leaders who make up the mid-Nottinghamshire A&E Delivery Board (A&EDB), covering all system partners, regulators and CCG representatives. This membership allows for the senior level engagement, buy in and commitment required to drive and sustain the delivery of a system-wide plan of this nature. Members have the opportunity to hold each other to account on the delivery of the operational and strategic content which contributes to the deliverables that the system will be measured against. A key addition to the board membership during 18/19 was CCG Primary Care representation. The voice of Primary Care around the table has enabled more rounded and whole system conversations and planning to take place.

Winter 19/20 will remain a standing agenda item for Board meetings to gain assurance that the system performance and stability is being enabled and supported by the plan & its contents. There will also be a focus on continuous improvement to ensure that the plan is delivering the overarching aims and objectives of the plan in-year. Where there is a lack of assurance that the plan is providing sufficient resilience to winter pressures (either based on provider/system performance, or the operational experiences of staff) recovery actions will be delegated to the relevant organisation(s) & followed up for assurance virtually, to ensure a timely recovery is possible. System partners are committed to engaging in and recognising the urgency of these actions and any other necessary steps (e.g. Task & Finish Groups) that

may be required to remedy the position, and give full commitment on behalf of their organisation, to deliver this.

These conversations will be enabled by the new approach of the board to review performance by scrutinizing the previous month's data and performance in comparison to the month prior, and the same period in the previous year.

Membership of the Mid-Notts A&E Delivery Board

Organisation	Representative	Designation
SFHFT	Richard Mitchell	Chief Executive & A&E Delivery Board Chair
Mid-Notts CCGs	Amanda Sullivan	Chief Officer and A&E Delivery Board Deputy Chair
Mid-Notts CCGs	Elizabeth Cowley	Head of Urgent & Proactive Care
Mid-Notts CCGs	Helen Drew	Emergency Care Network Manager
Mid-Notts CCGs	Cathy Quinn	Deputy Director of Primary Care
SFHFT	Simon Barton	Chief Operating Officer
SFHFT	Andy Haynes	Medical Director
NEMS	Arwel Griffiths	Chief Executive
EMAS	Greg Cox	Divisional General Manager
Social Care	Mark McCall	Service Director
NHSE/I	Diane Gamble/Kerry Rainford	Regulator Assurance
Notts Healthcare Trust	Julie Hankin	Clinical Lead
Notts Healthcare Trust	Lisa Dinsdale	Director
DHU/111	Jenny Doxey	Clinical Director
DHU/111	Pauline Hand	Managing Director
DHU/111	Asif Khan	NHS 111 Service Delivery Manager
Mental Health – Mental Health Services for Older People (MHSOP)	Jo Horsley and John Burton	General Managers

and Adult Mental Health (AMH)		

19/20 A&E DB work plan & UEC Deliverables -

In 18/19 the mid-Nottinghamshire A&E DB had sight of the UEC deliverables via the NHSE monthly assurance return. This was populated by system leaders and the CCG collated the information, completed the return & submitted this to NHSE. The Urgent and Proactive Care Programme Board monitored and assured delivery of the plan with delegated authority from the A&E Delivery board, who received the completed template under the standing agenda item of 'NHSE Returns/Submissions'

In 19/20 this process will become significantly more robust as the UEC deliverables will form an integral part of the new 19/20 A&E Delivery Board work plan. A proposed draft plan including the deliverables indicators has been circulated to members with the ambition of plan and baseline position has been agreed. The inclusion of the UEC deliverables into the wider over-arching A&E DB work plan ensures that board members are clearly sighted on system-wide interdependencies between projects, and the impact upon the ultimate objective for the board of delivering performance against the national 4 hour A&E target, and ensuring system flow.

The CCG Urgent Care Teams will ensure that progress; risks and mitigations around deliverables are understood and clearly articulated to the board. The Board will review the progress of UEC deliverables projects via the monthly NHSE return. This will avoid duplication and ensure that all partners are signed up to one single version of the truth. The Boards will hold themselves and system partners to account.

Each of the developments within the programme maintains a monthly risk log detailing mitigations and actions taken to reduce risks. All high level risks are reported to A&E delivery board on the AEDB risk register

The Emergency Care Network (ECN) Manager will be a key conduit between work streams and the Delivery Board. In 19/20 as part of the new governance structure an Operational Delivery Group (ODG) has been established which will provide the system forum for the oversight of the performance of all intervention and pathways being delivered, tracking performance against the agreed KPI's and providing an additional escalation point for mitigation and management of risks.

An ICS response to the recently received Jeffrey Worrall letter which sets out regulator expectations around the delivery of the UEC deliverables has recently been signed off by the Board, and the documentation around this can be found as an appendix to this document.

The Urgent Care System: Resilience function.

The CCG's ECN Manager and Urgent Care team have oversight of system performance and resilience across mid-Notts. System-wide urgent care resilience teleconferences take place weekly on Mondays throughout the year, regardless of system escalation, with the opportunity to increase the frequency of calls if individual provider/system escalation requires this. These calls also take place ahead of national or local events which may impact the local system if not prepared for effectively, for example Bank Holiday weekends. Daily system resilience calls will be proactively scheduled between October and Easter but will be stood down if not required, to ensure the best utilisation of system resources. Representatives from all system partner organisations attend the call including Adult Mental Health (AMH) and Social Care colleagues which provides a holistic approach to services across the localities. As in winter 18/19 system calls will continue to take place following periods of de-escalation, but will be more sophisticated in their understanding of 'what worked well' by implementing a real time PDSA approach to actions undertaken. This will directly inform future escalations and enables system clarity on anticipated issues which may jeopardise recovery.

The CCG continues to adopt a much more strategic operational role with OPEL reporting ahead of winter 19/20, as OPEL processes and reporting are significantly embedded in business as usual resilience processes and are pivotal to daily activities of the team who will ensure that those partners whose OPEL position escalates as a result of supporting other partners are sufficiently supported to successfully de-escalate.

CCG On-call function

During the winter period weekend and Bank Holiday OPEL reporting is undertaken by the CCG on-call Manager. The urgent care team takes responsibility for training to ensure a consistent and measured response to in-hours and out of hours reporting, and there are plans to include specific OPEL reporting and system resilience training in the official Nottinghamshire ICS on-call Manager training, which urgent care team members will be involved in delivering. Currently across the ICS a slightly different approach is taken to reporting routes and processes.

The imminent CCG restructure, the formulation of a single ICS footprint urgent care team, and within that an ICS resilience hub offering has the opportunity to strengthen, streamline and simplify OPEL, resilience operational processes and on-call functions moving forward and further updates will be provided when these are available.

Resilience Demand Forecasting –

The sharing of individual organisational demand and capacity intelligence across the system in 18/19 allowed proactive resilience conversations to take place ahead of periods of surge. For example, on days where EMAS had forecasted a high number of ambulance arrivals at SFHFT several key actions were taken by system partners to prevent escalation, as opposed

to reacting to it afterwards to de-escalate. Whilst it's generally accepted that these activities were met with limited success due to the variance in forecasted vs. actual arrivals, it is hoped that lessons can be learned for 19/20 and a slightly more measured response can be instigated. Conversations are currently taking place around the availability of demand data and planning task and finish group meetings will be arranged. The outputs of these will be updated in this plan and the ambition is to utilise the task and finish group meetings as a means of undertaking a desk top test of the winter plan for efficacy.

Peaks in demand over weekends and Bank Holidays -

In readiness for peaks in demand at Bank Holiday periods, providers with bedded capacity and patient facing caseloads plan to expedite the safe discharge of patients as early as possible, including the community bed base and wrap around virtual ward bases. This is done via pre-planned MDT meetings. The acute trust will continue to adopt a 'Home First' focus to discharges to ensure that patients who are ready to be discharged from acute beds are not inappropriately transferred to another provider, which causes a bottle-neck elsewhere in the system.

Lessons learned from previous Bank Holiday periods would suggest that greater knowledge is required across the system as to what services are actually available during these times. A Make Every Contact count approach to promoting the utilisation of Call for Care will take place prior to the Christmas Bank Holidays periods to ensure that Healthcare professionals are aware of who to contact for service availability. System providers will also ensure that the DoS accurately reflects the services that are available to 111 for the onward dispositioning of patients.

Direct messages to patients will be picked up by the Comms and Engagement plan, and will include the publication of Pharmacy opening times across the localities. GP practices will be encouraged as always, to publically display their opening hours and appointment availability to patients, both in practices, via SMS messages and on their websites.

The CCG collates staffing and capacity information from system partners for the Christmas and New Year Bank Holiday periods, which has usually surpassed the requirements of the regulator return which is disseminated nationally. Pharmacy and Dentistry information will be shared across the system and with wider partners for example libraries, supermarkets etc.

OPEL reporting -

OPEL reporting and action cards are an integral element of the Mid-Notts Surge & Escalation plan. This plan forms a key element of the wider overarching winter plan and has also been amended following the experiences of 18/19. It was felt that the action cards should continue to address individual provider OPEL levels, as opposed to system OPEL levels, because addressing provider escalations can in effect, prevent system escalation. For example, if the 111 service reported OPEL 3 because staffing difficulties were preventing calls to be answered

in time, this could trigger NEMS to take calls from 111 as a contingency, and could trigger SFHFT to deploy additional admissions avoidance staff at the front door.

Individual provider OPEL levels will continue to be collated by the CCG and a system-wide report and OPEL level will be produced. Work has taken place to review organisational OPEL triggers, thresholds and corresponding mitigating actions, acknowledging an alignment to Greater Nottinghamshire processes wherever possible. A significant development in the OPEL actions prepared for winter 19/20 is shared resources and cross-organisational boundary working amongst health partners. This commitment will be key to the delivery of a successful plan and once again demonstrates the positive and cohesive system approach across the mid-Notts footprint. The review has also taken account of system leader feedback from 18/19, and remedial actions have been brought forward to lower OPEL escalations and provide distinct step up response to previous years.

In winter 18/19 the overall system OPEL level was signed-off by a CCG Director with A&E Delivery Board delegated authority, however it is hoped that in winter 19/20 the newly formed system OPEL matrix process which provides a consistent automated approach to the system level will be signed off in advance by regulators to alleviate demand on CCG Execs on a daily basis. The CCG urgent care team will continue to engage with Execs and on-call Managers around OPEL reporting, risks and mitigations.

Nottinghamshire Healthcare Trust colleagues have successfully engaged AMH and MSHOP services in OPEL reporting and system resilience functionality and are in the process of developing OPEL reporting for wider services, for example CAHMS. Urgent and Primary Care teams within the CCG are currently considering the possibility of operationalising Primary Care and care home OPEL reporting via PCN functionality. Whilst this may not result in deployment of resources, it will develop the local demand and capacity analysis and reporting on key triggers may allow the advance identification of increased urgent care demand.

Regulator & System reports –

The morning OPEL report will be shared with NHSE/I colleagues as per the daily requirement and for transparency, the same report will be shared across the system as part of a wider daily consolidated report which has evolved to include Greater Nottinghamshire system OPEL reporting, system partner service capacity, care home closures and more recently temperature and weather alerts in a bid to provide the network with a suite of valuable resilience intelligence. Receipt of this report by partners is the call to action to invoke OPEL action cards and respond accordingly to reports of escalation and de-escalation.

In 18/19 provider colleagues elected to submit an afternoon OPEL return which was solely for the use of the local system and has enabled organisations to better prepare evening/night services as to the pressures/issues that they may face. Discussions are underway as to

whether or not this process will continue in 19/20 as there is a need to balance the benefits of the reporting with the additional burden on providers during peak times.

It is acknowledged that in addition to this narrative report, regulators will send out an assurance template which requires specifics on resource and staffing levels of the relevant patient facing service teams across contracts, along with on-call/escalation arrangements and other key elements. The CCG will co-ordinate this return which will be signed off by the board.

Ad-hoc regulator reporting –

Any responses to ad-hoc requests in winter 19/20 will be co-ordinated and submitted by the CCG urgent care team to prevent duplication and to ensure consistency of reporting information. Ad-hoc winter reporting requests were much less frequent in winter 18/19 than in winter 17/18 and during the 18/19 period the mid-Notts system was deemed to be a system which 'consumed its own smoke' by regulators and Winter Room colleagues. Positive, trusting relationships were developed between the CCG urgent care team and regulators, which continue to evolve and it is felt that this regular dialogue and exchange prevented a high volume of ad-hoc information requests, enabling operational teams to continue to focus on service delivery.

Managing Demand – keeping patients out of hospital

Drivers of Demand Workstream –

The Nottinghamshire healthcare systems have experienced an unprecedented increase in demand in urgent care activity over the last 12 to 18 months. In response to this, the Nottinghamshire ICS has undertaken a deep-dive into the causes, and drivers of this demand. An initial piece of work has identified that there is not one single attributable driver, but has uncovered 9 key areas which require either immediate remedial action or further deep dives into activity. The deep dives will either rule out lines of enquiry or provide a granular focus for an ongoing piece of work. These actions are expected to be delivered at pace in order to deliver maximum impact for the winter period. The action plan for Drivers of Demand will form part of the 19/20 mid-Nottinghamshire workplan and will be monitored alongside the UEC deliverables programme. It is anticipated that initial analysis will be repeated as an ongoing exercise in order to monitor for efficacy and residual risk.

Comms and Engagement –

Both the winter and seasonal plans are accompanied by robust ICS Comms and Engagement plans which centre on proactive key messaging to the public ahead of and during the winter period. These include seasonal self-care messages (colds & flu) driven by the Self Care work stream and can help patients to make the most appropriate choice of healthcare access point for their condition. A flexible and reactive approach also exists, and as in previous years activities can be implemented immediately and flexed to address local demand surges.

A key change and improvement to this work ahead of winter 19/20 is the evolution of the ICS-wide comms and engagement function. This will enable a robust and consistent system response to messaging across health and social care partners, along with wider system colleagues, for example District Councils. This enables a Make Every Contact Count approach to local messaging and presents a unified single version of the truth across the system, which presents a greater opportunity for messages to be effective.

Self-Care Workstream –

The CCG Self-Care working group is made up of Pharmacists and Pharmacy Technicians whose objectives are to identify seasonal and proactive self-care themes and messages for dissemination to the public via a strategic comms plan, which forms an integral part of the seasonal plan. These messages align to the national guidance identified on the Area Prescribing Committee (APC) website and are reinforced by a whole system approach. These messages aim to direct patients to the lowest level medical care thresholds appropriate for their condition. For example, posters in GP surgeries which ask the question "Do you need a GP appointment, or could your local Pharmacist help? Also posters in secondary care venues asking the question "Do you need A&E or could your GP help?" The ambition of this is that patients at each point make better more appropriate choices for their healthcare which creates capacity in all services in the round.

Comms messages include how to self-treat coughs, colds, sore throats and other ailments that are common during the winter period, and recommend key first aid kit items that patients should purchase themselves and keep at home, in-line with paracetamol prescribing policies.

General Practice

Access to appointments in general practice is a key topic during any period of surge and demand and winter is no exception. Extended hours has 100% coverage across mid-Notts on a 1 hour per 1000 patient population PCN basis, allowing patients greater access to Primary Care services for longer and during weekends. The ambition of this is to reduce the numbers of patients attending PC24 due to exacerbations of conditions, or from convenience. Utilisation of appointment slots and DNAs are actively monitored as a pre-bookable service and the CCG Primary Care Team continues to work with practices to maximise utilisation and reduce wasted resource.

The Acute Home Visiting Service continues to be successful and is now delivered by one single provider across the mid-Notts footprint, with additional capacity for more appointments. This allows for greater economies of scale and consistency of service application. With this service GPs can ensure that patients with acute episodes receive home visits, while they themselves can prioritise the patients with long-term conditions who may benefit from the consistency of treating clinician.

Social Prescribing Link Workers (SPLW) will be in post by October 2019, with one member of staff in each PCN. This role will identify and work with patients face to face, whose use of the local health and social care system is driven by a social need and sign-posted/supported into relevant services, for example, Citizens Advice Bureau. The SPLW will link closely with the Network Navigators who will assist in the identification of patients using risk stratification tools, and the High Intensity Service User (HISU) lead at SFHFT. It is anticipated that secondary care discharge teams will be in a position to refer into this role in an attempt to expedite discharges of patients who are medically fit for discharge (MFFD) but have a social blockage to their discharge (hoarding etc.)

Clinical Pharmacists will be in place in each PCN during winter and will support practices with the medicines management of patients. Patient discharge letters from secondary care, e-healthscope exception reporting and GP referral are some of the methods of referral into these posts. These roles will ensure that prescribing and de-prescribing is appropriate in-line with best practice guidelines.

Flu vaccination remains a Primary Care QoF for the 19/20 period and practices will manage this process in a variety of ways. Early indications from Australia suggest that 19/20 flu patterns should align to those of 18/19, although leading strains and the start of the official flu season continue to be unknown variables which will be closely monitored. Potential issues with availability and supply of the vaccines remains a cause for concern. However the CCG and Primary Care Networks will aim to vaccinate maximally with specific focus on traditional at risk cohorts.

STOP FLU campaign

New for winter 19/20, the STOP FLU campaign is based on promoting 5 key messages to patients, clinicians and their carers.

1. Flu Vaccination works and is safe
2. Stop Smoking
3. Hygiene stops the spread - wash hands, catch sneezes, do not touch your face
4. Eat healthily take Vitamin D everyday
5. Exercise regularly

The message is to be given to patients in all health care settings and social care and a fact sheet will be created along with a video for call boards. Fact sheets will be issued with Flu invitations.

The following specific tasks are key to the successful delivery of the programme;

- FLU vaccinations will be offered in outpatient settings including ED for High intensity users, on discharge from hospital, paediatric out patients and maternity.

- PCNs will coordinate out-reach nurses to visit preschools and care homes.

- PCNs will provide a single email contact for community/SFHFT flu vaccination providers so all vaccinations are recorded on the patient record.
- Clinicians will visit schools and pre-schools in the week before vaccination visits to deliver the STOP FLU message.
- 'Fluathon' coordinated across Nottinghamshire for a single Saturday flu clinic.
- Standard consent forms and invitations will be re-written to account for the Mid Notts reading age.

Direct Booking -

The Mid Notts Primary Care Team and Urgent Care Team are working collaboratively to implement 111 direct booking into GP practice slots during extended hours and in-hours. This is an NHSE directive and the timelines for implementation are as follows;

- Direct Booking into extended hours by October 2019
- Direct Booking in-hours by March 2020

Mid Notts are on track with both trajectories as follows;

Extended hours

Direct Booking configuration is taking place in each of the PCN areas. During July 2019 the Newark Primary Care Network (PCN) went live with 3 appointment slots a week during extended hours (6.30pm – 8pm). Early indication shows that 75% of the slots were used and all referrals were appropriate and potentially diverted patients away from urgent care services. The next phase will be to roll out across the remainder 3 PCN areas, with all areas to be covered by October 2019.

In-hours

In-hours direct booking will require configuration in each GP Practice. The 6 practices across Mid Notts (3 M&A, 3 N&S) with the highest 111 calls during in-hours will be targeted first and will go live with in-hour direct booking by autumn (ahead of deadline) in order to make impact during winter.

It is acknowledged that whilst the slots made available to 111 during in-hours and extended hours is initially low this will expand over time and as a consequence will divert patients away from urgent care services during winter.

Care Homes and the Enhanced Health in Care Homes Framework

The Enhanced Health in Care Homes Framework (EHCH) was launched in 2016, and became a formalised mandated national must do in 2019. The ambitions of the framework which feature in the NHS Long Term Plan and 2019 GP contracts, stipulate 8 core elements and 18 sub-elements designed to provide support, development and stability to care homes for the benefits of staff, residents and the wider healthcare system. The 8 core elements range in

topic from MDT in-reach support to workforce developments and technological capabilities. Given the system interdependencies all of the 8 elements are applicable to system planning and the programme spans the 19/20 period. The framework is an indicator on the A&E DB work plan for 19/20 and some key projects have already been delivered.

- Red Bags for Care Homes was launched by the mid-Notts CCGS in 18/19, however this project will be fully embedded by winter 19/20, with evaluation metrics in place to evidence the national ambition of a reduced LoS after admission.
- NECS Care Home Bed Tracker was implemented after winter 18/19, is now fully live in mid-Nottinghamshire and is embedded within SFHFT. This tool is designed to offer a 'shop window' service to care homes when updated regularly and supports DToCs and LoS reduction by supporting families and carers through patients choice decisions. Sign up from Care Homes is continuing to increase with over 70% of homes in Mid Nottinghamshire engaged. Homes are now updating the system on at least a weekly basis and the tracker is now the SFHFT discharge teams' main method of identifying Care Home availability. Phase 2 plans to roll out the system wider including other hospital and continuing healthcare teams. Discussions are currently taking place around mechanisms to monitor the success of the scheme which will include measures such as a reduction in DTOCs and LOS.
- Significant 7 is a scheme which supports homes to monitor 7 observation elements of residents, record these holistically and identify early warning signs of deterioration, which may result in an emergency or acute episode of care if not addressed early enough. Crucially, conversations are taking place with community partners to offer an alternative referral route for residents who are identified as having a worsening condition, to avoid an increase in front door activity. This is as a result of learning the lesson from other areas that have identified increased attendances as an unintended consequence of rolling out the tool.
- Re-alignment of GP Practices to care homes to ensure a consistent offer and better patient experience is under way, with 3 of the 6 PCN areas currently aligned.
- Care Home Contracts were amended in 18/19 to include mandated reporting on the numbers of staff and resident flu vaccinations. Uptake rates were monitored by the A&E Delivery Board and Make Every Contact Count conversations took place amongst health partners to myth bust and promote the benefits of vaccination. In 19/20 PHE funding is enabling training to take place with the 10 homes identified in mid-Notts to require support around increasing flu vaccination rates.
- Rapid flu testing by SFHFT on care home swabs for flu last year enabled outbreaks to be identified or dismissed at pace, resulting in shorter care home closures and reduced delays in returning care home patients back to their usual place of residence. It is hoped that this service offer will continue in winter 19/20.
- The Proactive Care Homes Team continues to work with care homes which have the highest non-elective attendances (NELS), with additional homes having recently been

taken into the portfolio. This team are Significant 7 trained to achieve a MECC approach to the train the trainer scheme.

- Care homes across Nottinghamshire continue to have access to the 111 *6 service which provides access directly to a clinician, rather than a non-clinical call handler.

Compliance with the BGS Guide on Care Home Medicine -

As in previous years, all staff from the Mid-Nottinghamshire Healthcare system who are responsible for supporting Care Homes (Meds Management, Care Homes Leads, Community Providers, GPs) are strategically working to the NICE Guidance standards for Medicines in Care Homes and the Royal Pharmaceutical Guidance. The CCG policy for Care Homes Medicines references these sources in-line with CQC recommendations.

Nottinghamshire County Council are the Lead Commissioner for Care Homes, and the contract consistently requires substantial compliance and quality monitoring/reporting around the utilisation, storage, and administering of medicines within a Care Home setting.

111 –

DHU's resilience as an organisation and performance against national standards improved in winter 18/19, following a particularly challenging period in 17/18and the organisation has advised that there are no concerns around winter 19/20.

Derbyshire Health United (DHU 111) can book directly into PC24 through Adastra and to PC24 working with GP extended hours services to allow DHU 111 direct booking into both NEMS out of hours GP (PC24 and NEMS GP). Direct booking into appointment slots in the Newark Urgent Care Centre is also already in place. Work is currently taking place to enable 111 to book direct into Primary Care extended hours on a PCN basis and this will go live at the end of summer 2019.

DHU already deliver the Cat 3 re-triage pathway, whereby any Category 3 ambulance disposition is re-triaged and approximately 80% of conveyances are avoided using this method. There are a number of national Pathways changes since winter 18/19 which will

EMAS –

Non-conveyance

EMAS have access to pathways which offer an alternative to conveyance via Call for Care Community Pathfinder and the GP 10 minute call back protocol. The CCGs articulated their ambition of safely reducing type 1 ambulance conveyances in 18/19 via the local STP CQUIN for the Nottinghamshire division.

Whilst this project has proved fruitful in some areas, it is widely accepted that any reductions in conveyances have contributed to the stemming of activity growth, as opposed to reducing conveyances below the indicative activity and affordability plan baseline position.

This should be addressed in 19/20 with the introduction of a national non-conveyance CQUIN which will run alongside the local ICS CQUIN of the same ambition, and both will be supported by the contract mechanism which will see a proportion of the 19/20 contract value payment being dependent upon the reduction in conveyances (details still to be worked through). Moving forwards these conversations will form part of the 19/20 contract management meeting discussions to ensure a single strategic direction of travel.

The system ambition is to reduce the number of patients conveyed to Type 1 and Type 2 ED by ambulance, by at least 2% against forecast plan by April 2020. 17/18 target was 1.5% and achievement at December 18 was 2.4%. For Nottinghamshire this trajectory equates to a reduction in conveyance rate of 1% by Q3 and 1.5% by Q4. As the provider, EMAS are developing an associated action plan. In addition, Nottinghamshire have agreed a local CQUIN focusing on increasing use of demand management pathways to reduce conveyance.

To achieve this, the system will:

- Increase use of community pathfinder (paramedic clinical navigation system) by 12% against 17/18 baseline by April 2020
- Increase the % of care home calls directed to a clinical advisor from 111 from 22% to 50% by April 2020
- Implement a non-injured falls pathway by September 2020 to reduce ambulance dispatch to non-injured fallers (and therefore conveyance). In line with the Mid Nottinghamshire pathway outcomes, it is expected that 95% of referrals from EMAS will be managed though the non-injured falls pathway.
- Roll out access to Service Finder (next generation Directory of Services) by April 2020 to EMAS clinical triage teams and paramedics to support clinical navigation of patients to the correct service and enable an alternative to ambulance dispatch.
- The 19/20 UEC deliverables for ambulance digital developments will be delivered through national CQUIN 10. EMAS have advised that they are unable to deliver the requirements as set out in the national CQUIN document. On this basis, commissioners have agreed to receive an alternative proposal which sets out how EMAS will deliver the planned outcomes of the national CQUIN but in a different way. Regulators have agreed to a local variation to the national CQUIN on this basis. EMAS are responsible for formulating a proposal document which sets out the 19/20 plan for this CQUIN delivery and at the time of writing, this is due imminently. There is a timeline ambition to have this document agreed & CV'd into the EMAS 19/20 NHS Standard Contract by 30 July 2019. Further details will be available at this point.

Non-Conveyance Project Manager –

The 19/20 work plan for reducing conveyances includes the appointment of a dedicated Project Manager who will drive the work stream forward on behalf of the Nottinghamshire ICS. The post-holder, in a 12 month term will be employed by EMAS, but deliver non-conveyance service improvements and reductions on behalf of the two delivery systems. It is envisaged that this role, which is crucial to the success of the workstream will work closely with a number of organisations across the Nottinghamshire urgent care system and deliver transformational change.

There is an expectation that the post holder will spend time working with the Urgent and Emergency Care System to understand the wider system and how best to contribute to the transformation of Urgent and Emergency Care, this will require the individual to work with a range internal and external stakeholders.

Handovers -

Ambulance handovers have been a standing agenda item for the A&E Delivery Board during 18/19 and in 19/20 will form part of the boards' work plans. Whilst an SFHFT action plan to reduce pre-handover delays has been signed up to by EMAS, commissioners are keen that this evolves into a true joint organisational action plan which includes the ambulance provider actions required to address post-handover delays to deliver the ambition of handovers within 30 minutes.

It is acknowledged that SFHFT have an NHSI agreed trajectory in place supported by a set of key actions and assumptions. This has meant that handovers at SFHFT have significantly improved in recent months, and SFHFT are currently prioritizing a 10% tolerance to pre-handovers above 15 minutes.

Performance -

EMAS' performance in the 17/18 and 18/19 winter periods was below target for the ARP standards across the regional contract. As a result patients experienced long waits with risk of harm a source of concern for commissioners. Following contract negotiations in 18/19, investment has been made in additional crews and resources, with EMAS undertaking its biggest ever recruitment drive. EMAS have committed to delivering national standard performance at a county level and during 18/19 some Nottinghamshire CCGs had started to receive national performance at a CCG level. At the time of writing, performance has significantly improved on previous years and whilst there is work to be done to understand the conveyance rate of impact of the additional resources, the risk of poorer outcomes from long patient waits is a vastly reduced risk for the winter 19/20 period.

Integrated Rapid Response Service (IRRS) –

The overall ambition of the IRRS model is designed to prevent admissions by bolstering alternative services available once the patient has reached the front door of A&E, for example Call for Care. To date a design work shop has been attended by over 40 wider system stakeholders and an operating model has been produced. A key focus of the group is to understand what can be implemented to support the front door and wider system ahead of the winter period and it is envisaged that this solution will be built upon the successes of the previous Pull Collaborative function which supported patients being turned around at the front door where clinically safe and appropriate to do so.

In the longer term, the multi-organisational front door IRRS model will form a key interdependency with the new Integrated Urgent Care (IUC) specification, which beyond winter will deliver a local Clinical Assessment Service (CAS) to form a holistic admissions avoidance pathway.

The 19/20 winter plan will be updated when further granular detail becomes available as to the expected deliverables and outputs which will specifically mitigate winter pressures.

Integrated Urgent Care

Implementation of the nationally mandated Integrated Urgent Care (IUC) pathway will occur across Nottinghamshire, aiming to provide care closer to people's homes and help tackle the rising pressures on all urgent care services (primary and secondary). This will be delivered by procuring a clinical assessment service available to 111 to ensure patients are directed to the right service first time. This model will also support EMAS to hear and treat, see and treat and reduce conveyance rates to hospital. There are currently two mobilisation options being considered by commissioners and key stakeholders; one of these will deliver beneficial changes to the system during winter 19/20 and this plan will be updated with further details once the outcome and next steps have been confirmed

Call for Care

Call for Care (CfC) is a single point of access and navigation hub for Mid Notts Adult Community services (physical healthcare) which includes Urgent Response (CURRT), End of Life together and Community Nursing services.

CfC Option 1 (Urgent response) provides care navigation for the entire system from a hospital avoidance perspective. Health and Social care professionals in primary care, EMAS crews and EMAS Clinical Assessment Triage, lifeline providers and SFHT can access a 2 hour face to face assessment to safety net people who have sub-acute health needs, where a hospital attendance would have previously been the only viable option. CURRT can provide ACP led care for patients with sub-acute health needs and intensive rehabilitation for those who have deconditioned functionally.

CfC responds to an average of 100 patients per week and this looks likely to increase as the Integrated Rapid Response service develops. CfC is the golden thread which runs through healthcare services in mid-Notts and aids the urgent care system from an admissions avoidance, flow and discharge perspective. The provider joins the weekly/regular system calls, attends flow meetings and contributes to system OPEL reporting, while sharing transparent capacity data.

End of Life Care collaboration.

End of Life Care Together was developed following a 2 year evaluation where services for end of life care were redesigned jointly following collaboration between partners, including Hospices, Notts Healthcare Foundation Trust, Primary Integrated Care Services, Sherwood Forest Hospitals Foundation Trust and Cruse Bereavement.

The service was built on a capacity and demand model with resources allocated dependent on need. Integral to the pathway is the Electronic Palliative Care Coordination Systems EPaCCS, a single point of access which identifies and registers patients in the community on end of life care. Whilst this is currently only available in the community in mid-Notts to view, extensive work is underway to ensure wider system partners can see this information moving forwards.

The pathway helps to prevent A&E attendances by advocating early identification of those patients with end of life needs in order that advance care planning can be undertaken. Patient leaflets have been produced to provide further information. Complementary to the pathway the ReSPECT form, an advanced care plan provide an opportunity to share future care needs.

Referrals are made through a single point of access (SPA) which is supported by clinical triage to assess patient needs with two separate numbers available, but these would be answered by the same service. The SFHFT A&E team have engaged with the service by introducing new protocols allowing EPaCCS to be triaged by a consultant.

2096 patients are currently registered on EPaCCS and there is an ambition that this will increase to 3000 by April 2020. According to available data, 80% of patients have passed away in their preferred place of death.

It is acknowledged that some patients are still referred too late and work is taking place to address this. This includes encouraging care homes to refer all patients in care homes and those who are moderately frail to have advanced care plans in place. Resources will be put in place collaboratively to improve access and navigation and the wider health and social care community will be trained to identify end of life care needs.

Front Door – Admissions Avoidance

Front Door -

ED-led streaming at the front door of SFHFT provides an effective and robust mechanism to protect against 4 hour breaches. This process is being supported by a focus within the department of assessing all patients within 30 minutes of attendance, enabling diagnostics/tests to be undertaken earlier, and clinical decision making to be completed sooner, and more conclusively. This in-turn will positively impact upon admissions & the subsequent flow of patients throughout the hospital. GP referrals into Specialties are currently being picked up by main front door protocols.

Ambulatory Care –

The availability and expansion of the Ambulatory Emergency Care Unit (AECU), and expanded ambulatory care pathways allows for the occurrence of patients who need further specialist test to be undertaken without admission, or opportunity to breach the 4 hour ED standard. Current front door protocols allow for certain patients to be streamed straight into AECU where appropriate in addition to the additional ambulatory care pathways, NEMS have opened a DVT pathway which will absorb a proportion of those patients requiring diagnostics & further testing and the protocols allow for patients to be exempt from breaching the 4 hour target where appropriate.

Clinical input from medicine and surgical specialties is provided under the current process of clinicians coming to the ward within 30 minutes of patient need being identified. This will both allow the Specialty consultants to better utilise their time in not having to move from one area of the hospital to another, and will allow for better flow within the ED. Specialty Hot Phones are in place where GPs can contact Specialty Consultants direct for advice on potential elective or non-elective referrals, or more general to feed into care plans which will ensure the ongoing management of patients within the community and primary care. Consultant Connect, a similar intervention is also available for other specialty disciplines. These services cover geriatrics and respiratory, which have been identified as the two main conditions where vulnerable cohorts of patients are at risk of admissions.

Available intelligence has indicated that the ED-led front door streaming processes continued to work effectively over the winter 18/19 period, with streaming protocols being maintained during busy periods, and the levels of admissions indicating successful admissions avoidance pathways are in place. The continuation of the Children's Assessment Unit (CAU) will continue to drive this activity in 19/20. A key risk for winter 19/20 is ongoing increased demand with front door attendances up by approximately 10%. The outputs of the system-wide Drivers of Demand analysis work will be crucial to implementing mitigating actions to reduce the risk of the unprecedented demand experienced by urgent care services over the last 6 months.

NEMS at PC24 -

NEMS deliver the co-located Primary Care service at the front door of A&E. They have been experiencing an increased number of breaches of the 4 hour standard in recent times and rapid deep dive work is taking place to put in remedial steps to resolve this situation ahead of winter. A number of breaches from PC24 have resulted from waits for diagnostics relating to the ambulatory care pathways which are in place as attendance avoidance tactics.

PC24 breaches are reported by exception to the CCG ECN Manager in the form of an RCA. Conversations are taking place to understand how streaming to Primary Care can be increased, enhanced and developed as data shows that PC24 attendances have not increased at the same rate as A&E attendances.

Wider initiatives delivered by NEMS which will continue during winter 19/20 include the Community Pathfinder service, which offers a clinical advice and support service for EMAS, designed to reduce conveyances to acute hospitals across Nottinghamshire. In addition, the successful ED Illness disposition pathway will continue. This service takes referrals from the 111 service when pathways produces an 'ED Illness – attend ED' disposition. NEMS re-triage the call and in 80% of cases avoid an attendance by either giving self-care advice or signposting to alternative services.

High Intensity Service Users (HISU) -

The SFHT HISU Service identifies the top 200 patients with 10 or more A&E attendances and has a priority focus on mental health and alcohol dependency related activity. Patients are identified via SFHT A&E data. HISU patients and their carers are supported through an integrated Multi-Disciplinary Team (MDT) process.

The service is delivered by two HISU Nurses located within A&E, with support from an A&E Consultant. Monthly HISU Integrated MDT meetings will take place in the acute trust and also within GP Practices, as appropriate. The Nurses have access to SystmOne and will enter patient place care plans directly onto SystmOne to ensure that GPs are aware of the plans in place. Wider A&E staff are also made aware of the HISU Care Plan to enable them to appropriately address attendances.

The acute HISU Nurses liaise with counterparts in other system partner organisations (for example, EMAS and 111) to ensure that approaches and plans are aligned to provide a co-ordinated response and joined up care offer.

Rapid Response Liaison Psychiatry Service (RRLP) –

This service, operated by Nottinghamshire Healthcare Trust (NHCT) offers a front door assessment service, designed to provide an early identification and proactive referral pathway for patients with a variety of mental health needs who present to the front door of SFHFT. The service work collaboratively with the HISU Nurses and are working to the ambitions of the Core24 standards. The service have identified that service demand does not fluctuate throughout the year and that they don't experience winter and Christmas period influxes. On-

call arrangements are in place for the escalation of issues during weekends and these details can be found in the Surge & Escalation Policy.

Mental Heath 12 hour breach Route Cause Analysis reviews –

In most cases a 12 A&E breach occurs at SFHFT because the patient is awaiting a mental health bed. Whilst NHCT are working on transformation plans which will improve bed availability and processes, a joint mental health breach route cause analysis meeting now takes place on a quarterly basis. These meetings review both the SFHFT and NHCT routs cause analysis documents, enabling themes and trends of breaches to be identified and shared learning conversations to take place.

Frailty -

Plans are underway to enhance the existing robust frailty pathway available at the front door, which will strengthen admissions avoidance practices & enhance the outcomes of patients beyond front door services. This is part of the UEC deliverables for 19/20 in the A&E DB work plan. Part of this work is in conjunction with the National Acute Frailty Network and steps are being undertaken to understand how other frontline services and PC24 can and are holistically addressing frailty as a service offering.

Flow

The Mid-Notts A&E Delivery Board acknowledges that patient flow impacts every touchpoint of our local healthcare system from GP attendances, telephone calls to 111 & EMAS, through to A&E attendances and demand on community providers who offer admissions avoidance alternatives, and step down facilities. As such patient flow is a system priority, and individual provider plans underpin this system process. Flow has been discussed regularly at A&E DB meetings and this will continue throughout winter 19/20 to ensure that plans are working effectively. This will be monitored on a daily basis from acute trust & community provider bed states and weekly data around LoS, DTOCs and occupancy information.

From a business as usual perspective the acute trust has previously implemented the SAFER bundles piece of work and is continuing to deliver the Red to Green initiative on ward bases. The ambition is for the HFID discharge hub to facilitate and expedite discharges which have been identified as complex, and work closely with CfC in relation to community resource availability and management.

Outcomes for patients will be further enhanced by the capacity of the START Re-ablement and Home First Response home care service, which will enable the earlier safe discharge of patients as soon as they are medically optimised to leave hospital.

Nerve Centre -

SFHFT are utilising the NerveCentre bed management tool as part of business as usual and there is further scope for this to be utilised to greater effect. However, as the only provider using the application across the system, it is hoped that the outputs of the Capacity and Flow workshop will assist with delivery of a system-wide solution, acknowledging that the starting point is existing good and shared practice across the patch.

In place of a live demand & capacity function across the localities the mid-Notts system is utilising shared dashboards, bed states and intelligence from system calls to inform flow discussions and negotiations. The Home First Integrated Discharge work stream has the ambition of providing a solution to any cross-organisational boundaries which may impact on flow with the development of 8 detailed pathways for each component of the model ensuring that patients are in the right pathway at the right time. This work is being supported by the advance planning within the OPEL action cards for 19/20.

Hospital Discharge -

Length of Stay (LoS) and Delayed Transfers of Care (DToCs)

Both national targets are indicators on the 19/20 A&E DB work plan. SFHFT have a combined LoS and DToC reduction action plan, which reflects the commonalities and interdependencies between the two patient groups. The current focus for LoS is on the reduction for patients with a stay of over 21 days which is delivering a marked reduction and will continue to work toward the standard required of a 40% reduction in long stay patients from the March 18 baseline by March 2020. The NHSI target for >21 days is 70 patients and in June 2019 SFHFT achieved this level. July fluctuated between 70 and 80 days, and it should be noted that these figures include the community bed bases with appropriate longer lengths of stay.

- SFHFT are working to deliver the national reduction in LoS bed days, in-line with national targets and timeframes. To ensure that this piece of work is managed strategically, both DToCs and LoS are indicators within the 19/20 mid-Nottinghamshire A&E Delivery Board work plan and progress will be monitored on a monthly basis.
- A recent version of the plan has also been included in the SFHFT 19/20 NHS Standard Contract as part of the Service Development & Improvement (SDIP) to ensure strategic alignment in objectives.

Actions from the plan include:

- Long Stay Wednesday – a national initiative designed to expedite patients with a hospital stay of 21 days and over, unblocks barriers to discharge and promotes the accountability of ward staff in the discharge process.

- SFHFT hold a weekly over 21 day meeting led by Medicine DGM, Medicine Clinical Lead and Head of Nursing where all stranded patients are reviewed. Information is presented from Matrons, IDAT members, Therapists and Medics. This meeting is attended by partner organisations as well. From this meeting a clinical peer review is conducted on the wards where required.
- A weekly executive forum where the Medicine DGM and Head of Nursing present a summary position to COO and any updates on complex patients where escalations are in progress. From here the COO may then discuss cases with partner executives for response/ action where required.
- An over 21 day DPTL is in development and this will be shadow monitored with the implementation date to be confirmed
- The revised SFHFT Discharge Policy is in the sign off stage with launch and training taking place during July 2019.Daily escalation to both Medicine DGM and Head of Nursing occur from the HFID Hub and actioned.
- Internal improvement actions, for example a criteria-led discharge pilot.

A LoS working group meets weekly to address internal issues with a monthly meeting with partner agencies on wider system related requirements with an action plan and risk log supporting this meeting.

Home First Integrated Discharge (HFID) Workstream –

A key deliverable on the LoS/DToC action plan is the delivery of the Alliance Transformation Board supported HFID programme by December 2019. This project, currently in phase one, will further streamline and improve advanced discharge planning processes and timelines from a Home First – 'why not home, why not today?' ethos and discharge to assess (D2A) model.

Fundamental to this project is the HFID discharge hub; the hub underpins the HFID model with the following aims and objectives of the HFID model

- A daily system MDT meeting which identifies the appropriate discharge pathways for medically optimised and complex patients.
- A trusted decision making and pull approach to ensure patients are supported home first or as soon as medically fit for discharge
- The hub ensures that the admissions criteria principles for community bed stock are appropriately utilised,
- A dedicated system lead of the hub that can hold system parties to account for the delivery of the agreed principles within the Partnership Operating Model developed in collaboration. Currently this resource is provided by the CCG

- The hub will be supported by dedicated administration to track, monitor and manage patients being managed by the hub.

Phase 2 implementation of the model has already begun ahead of the August 2019 timeline will aim to re-configure the community bed base within the SFHFT bed stock.

A key KPI for delivery of this is the acute discharge pathway of cohorts of patients who have previously been proven to impact upon LoS, e.g. Non-weight bearing, rehab and DST patients.

The system-wide escalation meeting forms part of the governance of the HFID hub, and provides a route to Exec level facilitation where patients who have been identified for a HFID pathway have not been discharged within 24 hours.

The outputs of the hub will feed into the urgent care network system resilience teleconferences, and both LoS and DToC levels have been proposed as indicators within the SFHFT OPEL reporting framework to ensure focus on key challenges to hospital and system flow.

A key interdependency of the HFID project and another action on the LoS action plan is the revision of the SFHFT Discharge Policy which underpins operational D2A processes and encourages staff to discuss discharge upon admission, while enabling and empowering actions where discharges are delayed due to patient choice.

Social Care

Social Care colleagues have been attending the HFID discharge hub to assist with expedited discharges of patients on agreed pathways out of the acute. It is anticipated that Social Care staff will continue to work additional hours in the evening and at weekends on a voluntary basis in recognition of the need to meet with families who can't visit relatives during the day time. There is ongoing work taking place in respect of patients who refuse interim care, or are self-funders in terms of the joint key messages that are given to these patients and when, to contribute to a timely discharge and flow from the acute. Joint meetings are taking place with families, Social Care and IDAT team members, and this will be further supported by the delivery of messages which set patients expectations from the point of admission.

Flu Plans –

The Notts CC flu plan is inclusive of care home staff and the target is for 51% vaccination rates in 19/20, an increase from 50% in 18/19 when 41% of all Notts County Council staff were vaccinated. A comprehensive electronic flu voucher system has been implemented for 19/20 and a programme of work place vaccine sessions is in place.

BCF Funding

BCF funding and associated schemes from 18/19 have been carried over into full year effect for 19/20 for both core BCF funding and the winter pressures grant spend which saw a £3.5m investment in Nottinghamshire in 18/19. It is hoped that this will offer a more robust timeline on which to implement additional supportive services and schemes which build upon the successes of 18/19.

Social Care IT Transformation –

Several technological developments between Social care and system partners will improve system and processes for winter 19/20. For example,

- The Social Care Viewer which allows Acute Trust staff in ED and discharge coordinators to view social care information 24/7 which has reduced the number of admissions,
- Automated Assessment Notices from Health to Social Care - saving time in the hospital discharge workflow process,
- The Nottinghamshire Health and Care Portal which shares GP, Acute and Mental Health data with social care staff to support better decision making
- Providing social care data into GPRCC – the system allows care coordinators to review and action care gaps for key cohorts of patients with chronic diseases or who are at risk of admission.

Placement without prejudice –

The Mid-Notts CCGs and wider system partners continue to be fully committed to the protocol of placement without prejudice. We acknowledge that where this is not in place, this presents delays to the process of discharging patients from the acute into either community provision or back home with wrap around care. We appreciate that a risk of such delays could arise from disputes between Health and Social Care over responsibility for payment, and so all efforts are made to ensure that this is not the case. For 19/20 the Home First Integrated Discharge (HFID) Workstream has alleviated some of these issues, as community beds have been identified as the main pathway for some of the patients who fit this criteria, and for all other cases there is an accepted approach which is reflected within the relevant protocols (e.g. CHC, D2A, etc.) that the discharge of the patient from the acute is the immediate priority, and funding decisions will not be a barrier to the delivery of this ambition. The full implementation of the HFID pathway during winter 19/20 will further support and enable the ambition of the Mid-Notts system.

Non-Emergency Patient Transport (NEPTS) –

Patient transport is a crucial element of successful and timely discharge processes during winter. Regional contracts and system interdependencies are complex for NEPTS and the

current provision has experienced long-standing challenges and difficulties in delivering a responsive service. A NEPTS working group chaired by SFHFT is in place with improvement actions for both the current provider - Arriva and SFHFT in terms of processes.

After a recent procurement, a new provider will commence service delivery in December 2019. Whilst going live with a new service in winter brings an element of risk, Commissioners have put mitigating steps in place to minimise this risk. Assurance has been gained on the stability and capability of the new provider from the competitive procurement process that was undertaken, and the provider currently runs successful services in an area with a similar demographic size to Notts. The CCGs have employed a Mobilisation Manager who will oversee the first 2 months of the new service and will be available to resolve and troubleshoot any potential issues. This Manager has been invited to attend future NEPTS meetings as the current plans for improvements will still be relevant and beneficial under the new contract.

Business Continuity plans, OPEL thresholds, triggers and actions have been requested from the new provider, and the CCG Urgent Care Team will work with the provider in advance of the go live date to ensure that there is little system impact from the new service, and to discuss system expectations for example, joining the system call and local key contacts. There are no concerns around the change of provider, given that mobilisation meetings between Arriva and the new provider are positive, proactive and productive.

Wider considerations

End to end call reviews –

End to end call reviews take place on a monthly basis and are attended by representatives from Commissioners, Primary Care, EMAS, DHU111, Healthwatch, NEMS, acute trusts and community partners. A different call theme is chosen each month (e.g. paediatrics, end of life) and attendees listen to each step in the patient journey from the initial call to 111, through to NEMS, EMAS and where applicable, an update from the relevant acute trust. Whereas previously the aim of this meeting has been to identify specific areas of improvement for DHU111, the revised focus for the 19/20 period is a system-wide lens on quality, pathways and patient experience. Recent call reviews have identified where information on the Directory of Services (DoS) has been absent for the new mid-Notts End of Life pathway, the results of which were an ICS-wide comms and engagement piece on the end of life service for existing pathway patients and a signposting addition will be added to the DoS for these patients. The call reviews are invaluable for allowing a timely review of current patient pathways and enable remedial actions to be undertaken rapidly for maximum effect.

Bad Weather Operational Plans and Service Provision -

Individual organisational winter and/or business continuity plans will contain specific plans around business continuity, bad weather readiness and operational details around how both staff and patients will be cared for during a bad weather period. Organisations with bedded

facilities will prepare for the eventuality that both patients and staff are unable to get into or leave the facility, in terms of both food and comfort. Social Media groups will be used in the eventuality that additional staff are needed at certain times, and most organisations have access to a pool of 4x4 vehicles, including Arriva, the PTS provider. The CCG urgent care team can provide a central function for operationalising shared resources across organisations where required.

It is generally accepted that urgent care services are quiet with low attendances during periods of bad weather, but that demand increases significantly once the bad weather has cleared. The desk top test of the winter plan will understand how this can be proactively addressed and overcome in advance of these occurrences.

Community services continue to be busy during bad weather periods, as ensuring that patient are cared for in their own homes is imperative to reducing avoidable urgent care activity, and day to day business as usual operations will dovetail into business continuity measures to ensure that services continue to be delivered.

The CCG will issue weather warning details as part of system comms and this intelligence will be cross-referenced with forecasted demand activity to ensure that the system response to periods of bad weather is as proactive and sophisticated as possible.

Conclusion –

In the spirit of continual improvement, the ambition of this document is to build upon the successes of the safe and timely service provision that was delivered and maintained by the mid-Nottinghamshire urgent care system during winter 18/19.

The plan articulates how the mid-Nottinghamshire ICP will retain its recognition of being a successful and resilient system through the trusted collaboration of system partners and the evolving, mature manner in which plans are shifting from reactive responses to proactive planning.

Lessons have been learned from the winter 18/19 period, including deep dive analysis into particularly challenging peaks in demand. The plan will continue to evolve as a live document which will respond to the challenges and successes of the season, in-season, following a PDSA review style which will triangulate intelligence from data analysis, system resilience teleconferences and A&E Delivery Board meeting outputs.

Appendices

Provider	Flu Plan	Winter Plan
SFHFT	Flu Plan SFHFT	
NEMS		NEMs Winter Plan
EMAS	Notts Flu Plan 2019.docx	EMAS Hospital Predictions
111		
Social Care	A&E Delivery Board Briefing July 2019.pdf	
Local Partnerships	download.pdf	
Arriva		ATSL Winter Resilience Plan 2019 2
A&E Delivery Board workplan	A&EDB Workplan August 2019.xlsx	
OPEL calculation Matrix	MN System OPEL Calculation.xlsx	
19/20 Surge & Escalation Plan	1920 Surge & Escalation Plan	
18/19 winter de-brief		

ENC. F1

Meeting:	ICS Board
Report Title:	Update from the Nottingham City Integrated Care Partnership
Date of meeting:	Wednesday 9 October 2019
Agenda Item Number:	8
Work-stream SRO:	Ian Curryer
Report Author:	Ian Curryer
Attachments/Appendices:	Annex 1 – high level programme plan

Report Summary:

To update on Integrated Care Provider progress over the last month.

Action:

☒ To receive
☐ To approve the recommendations

Recommendations:

1.	The Board is asked to note the Nottingham City ICP work to date.

Key implications considered in the report:

Financial	☐	
Value for Money	☐	
Risk	☐	
Legal	☐	
Workforce	☐	
Citizen engagement	☐	
Clinical engagement	☐	
Equality impact assessment	☐	

Engagement to date:

Board	Partnership Forum	Finance Directors Group	Planning Group	Workstream Network
☐	☐	☐	☐	☐
Performance Oversight Group	**Clinical Reference Group**	**Mid Nottingham-shire ICP**	**Nottingham City ICP**	**South Nottingham-shire ICP**
☐	☐	☐	☒	☐

Contribution to delivering the ICS high level ambitions of:

Health and Wellbeing	☐
Care and Quality	☐
Finance and Efficiency	☐
Culture	☐

Is the paper confidential?

☐ Yes
☒ No

Note: Upon request for the release of a paper deemed confidential, under Section 36 of the Freedom of Information Act 2000, parts or all of the paper will be considered for release.

NOTTINGHAM CITY INTEGRATED CARE PROVIDER UPDATE

9 OCTOBER 2019

1. The ICP Board has pulled its areas of priority together into a high level programme plan, which is included in the Annex. The plan is motivated from a point of view that it is not about overseeing everything in the City, but about focusing our efforts together on the things that will enable a change to population health management. Change Management is therefore emphasised within the programme and we have considered the governance in this context too. The ICP group requested that each representative take this back to their own organisations within the next month. The five high level programme priorities are proposed as:

    - "Grip the City and confront the Brutal facts" – financial and performance grip on the city as a single view of the ICP
    - "Manage Now and sharpen our prioritisation and focus" - Leadership of the City Health and Care development activities
    - "Set the rules of engagement and decision making" – Establish great governance at the City and local PCN level
    - "Get behind the vision" – focus on Change Management relentlessly
    - "Build the team and lead the future" – identify roadmap for full population management.

2. The planning for the ICP Launch Event on 7 November continues. As this event is aimed at frontline staff, the ICP want to make this as accessible as possible and a rolling programme will be available so that staff can drop in. A wide range of "stalls" will be provided at the event which will enable the tangible aspects of the ICP to be brought to life for attendees.

3. The Governance proposal is now complete and it is proposed that a group of non-executive representatives will be asked to support the City ICP in the form of a Board. Initially this will be set up as a Forum rather than fully blown Board, and the objectives will be to focus on the relationships to support change management, on the 12 months support to get the ICP up and running and on developing the maturity path for the ICP.

4. The City ICP Development group will now be stood down and replaced with the City ICP Executive Management Team (EMT), chaired by Ian Curryer. This EMT will take forwards the Programme Plan. A Forward Plan for the EMT is now in place aligned to the Programme Plan.

5. New Social Prescriber posts have proved very popular posts in City - 90 applications received, 22 interviewed. All eight Social Prescriber positions filled along with a part time supervisor role. Social Prescribers will be employed by NCGPA on behalf of the PCNs. Comprehensive training programme agreed and locality team supporting Nottingham City GP Alliance on referral forms and System1 templates.

6. The Programme Director for the City ICP will take up post on 4 November. Rich Brady joins Nottingham City ICP with over ten years' experience working across the NHS, regulation, local government and the voluntary sector. Rich has coordinated and led national programmes of work to support integrated delivery of health and care services across the country, together in his current role as an adviser in the Local Government Association's Care and Health Improvement Programme and as project manager and policy lead for the Care Quality Commission's Local System Review Programme. Prior to joining the Care Quality Commission, Rich worked as a policy lead for voluntary sector organisations including The British Red Cross, Scope and Barnardo's. He began his career as a care worker in Bristol City Council's Children's Services.

7. The ICP lead has met with EMAS Chief Executive, Richard Henderson, following the request by Richard to explore links with EMAS in relation to developing much closer working between paramedics and PCNs following the changes made in EMAS. EMAS will now be part of the City ICP on a routine basis in order to take these forwards locally in the City.

8. The City ICP lead and City Interim Medical Director were asked to update the City Health and Wellbeing Board (HWBB), which occurred on 25 September. The HWBB will also now routinely receive updates on the City ICP.

9. Some members of the ICP group have continued to participate in the EMLA Living Systems Leaders programme and are now considering how to extend the reach of the systems leadership experience within the City.

10. Homecare proposals have been taken forwards by the Transforming Homecare Group and endorsed fully by the ICP Development group. Further business cases will be reviewed in 6 weeks' time.

11. Further to the proposals agreed to take forwards work on how Housing will relate to the PCNs and the ICP, the work between the City Council and Nottingham City Homes is now being extended to take on that work.

Ian Curryer
Nottingham City ICP Lead
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Annex 1

Nottingham City Integrated Care Provider (ICP)

2019-2020 - *High level programme plan*

"You can accomplish anything in life, provided that you do not mind who gets the credit". Harry S. Truman

Programme Priority	Key Activities	Rationale and Comments
"Grip the City and confront the brutal facts" - Financial and Performance grip on City as single view of ICP	• Risk management • City Financial envelope and clarification of degrees of freedom on budgets • Monitoring of agreed financial targets across organisations and cost management programmes • Performance management of outcomes for the city • PCN level financial and performance management	• The ICP Board and EMT require a firm grip on all the information regarding finances of the city and the performance of the city and therefore it is essential that a shared single view of the city is created. • The Shared single view will be an appropriate level and not an aggregation of all existing information, but framed to be actionable at ICP level or actionable at PCN level
"Manage Now and up the focus" - Leadership of the City Health and Care development activities	• Verification of all activities underway and confirmation of city priorities – ensure we are focusing on only the elements that will make the difference, and stop the others • Project management/ownership of 7 priority areas agreed for the City • Re-energise the Greater Nottingham Transformation Board, establishing role in partnership delivery of joint improvement programmes • Redefine the Interface between South Notts and City ICP for the purpose of achieving standardisation where appropriate • Contribution to key ICS wide work priorities • Launch of the ICP with workforce in November 2019 • Integration of key partners such as Housing, EMAS, VCS as core members	• There is no single visibility of all the activities underway to improve health and social care within the City, and it is commonplace that initiatives are agreed outside of the City ICP EMT. While that EMT is not yet a formal mechanism for decision making, it is essential that we undertake a verification process of the existing activities to validate or cease activities and establish a simple process for prioritising resources and new activities • Ensure the "golden thread" from ICS to ICP to PCN is strong in regard to immediate priorities and that support the Greater Nottingham Transformation group to ensure immediate urgent and emergency care across the City and South Notts is a priority
"Set the decision making rules" - Establish great governance at the City and local PCN level	• Set up ICP Board for initial meeting in October 2019 • EMT formation with core principles of operation such as standardisation, population based working, clear decision making rules • Alignment of Core team with ICP Programme lead post in November 2019 • Agree vision for City ICP	• The identity of the ICP as a core partnership for the City needs to take place and to launch effectively requires a new and meaningful Board to take control of the City ICP agenda, supported by a very strong Executive Management function that is able to take decisions at City level • PCN decision making is at the core of the ICP. It's necessary to build mechanisms to standardise where possible and support PCNs to operate at the most effective economies of scale
"Get behind the vision" – Focus on Quality Improvement and Change Management relentlessly	• Stakeholder management and "level 5" leadership (Good to Great reference) • Disciplined approach to quality improvement (QISR) and change management developed • Reposition entire workforce to population based health and care	• The primary activity for the first year is change management and quality improvement • Organisations that are within the ICP need to provide consistent leadership of their own organisations in support of the repositioning of the City Health and Care system towards population health management. Juggling of organisational and system priorities is essential
"Build the team and the future" – Identify roadmap for full population health management	• Assess maturity of City PCNs and support implementation of development plans to achieve full maturity and delivery of population health management • Understand the requirements of the ICP in relation to the ICS led Population Health Work Programme and maximise the opportunities to implement. • "get the right people on the bus" - Create necessary integration type functions to support the system • Identify and build the critical technologies for our future • Assess ICP system level workforce requirements and plan for migration of responsibilities to system oriented roles • Workforce development and recruitment – Linked to ICS workforce programme	• The City ICP is not a legal entity, however it does require staff to be aligned to the City ICP and work increasingly at population health level rather than silo'd organisational level. • Building on the insight from external work over the last 3 years we must identify the priority functions to develop and move forwards fast

ENC F2

Meeting:	ICS Board
Report Title:	South Nottinghamshire Integrated Care Provider Update
Date of meeting:	Wednesday 9 October 2019
Agenda Item Number:	8
Work-stream SRO:	John Brewin
Report Author:	John Brewin
Attachments/Appendices:	None

Report Summary:

To update on South Nottinghamshire Integrated Care Provider progress over the last month.

Action:

☒ To receive
☐ To approve the recommendations

Recommendations:

1.	The Board is asked to NOTE the South Nottinghamshire ICP work to date.

Key implications considered in the report:

Financial	☒	
Value for Money	☒	
Risk	☒	
Legal	☐	
Workforce	☒	
Citizen engagement	☒	
Clinical engagement	☒	
Equality impact assessment	☒	

Engagement to date:

Board	Partnership Forum	Finance Directors Group	Planning Group	Workstream Network
☐	☐	☐	☐	☐
Performance Oversight Group	**Clinical Reference Group**	**Mid Nottingham-shire ICP**	**Nottingham City ICP**	**South Nottingham-shire ICP**
☐	☐	☒	☒	☒

Contribution to delivering the ICS high level ambitions of:

Health and Wellbeing	☒
Care and Quality	☒
Finance and Efficiency	☒
Culture	☒

Is the paper confidential?

☐ Yes
☒ No

Integrated Care System
Nottingham & Nottinghamshire

Nottingham City Council | Nottinghamshire County Council | NHS

Note: Upon request for the release of a paper deemed confidential, under Section 36 of the Freedom of Information Act 2000, parts or all of the paper will be considered for release.

Update from South Nottinghamshire Integrated Care Provider
9 October 2019

Background

1. This paper summarises the key discussions that have taken place at the ICP Development Group meeting on 6th September and the ICP Planning Group on 11th September.

Understanding population need at Primary Care Network (PCN) level

2. Mike O'Neal presented the latest version of the eHealthScope dashboard which is evolving to include PCN level information. The group agreed that the granularity of the data will support the ICP in developing its key priorities and understanding where the focus on delivery is required.

3. Jonathan Gribbin, Director of Public Health at Nottinghamshire County Council, presented a PCN Health and Care profile pack that has been developed by the Public Health Intelligence Team. The aim of the profiles is to summarise key indicators of health status, needs, and health and care provision for each PCN population.

4. Members of the group agreed to further review the Health and Care profile pack to support the on-going development of information contained within the report to support development of a final version in the autumn.

Community Development Role

5. A proposal was supported for a role to work across South Nottinghamshire to support the community development element of the social prescribing model.

6. It was recognised that investing in community development, specifically in supporting strong and sustainable community groups, is central to ensuring the success of social prescribing.

7. The proposal was supported by the ICP and has been submitted to the Programme Manager of the Universal Personalised Care Programme to request that funds are released.

8. It was agreed that the role will be hosted by Gedling Borough Council on behalf of South Nottinghamshire.

NHS Long Term Plan and developing the ICP

9. The ICP planning group met for the first time on 11th September and agreed it will have a focus on ensuring there is appropriate ICP input into the planning process, as well as supporting the overall development of the ICP.

10. Members of the group have attended the NHS Long Term Plan workshops, and supported the production of the draft plan.

11. The group agreed to meet monthly, and develop an action plan for the mobilisation of the ICP.

ICS Memorandum of Understanding

12. The ICP confirmed its support for the ICS Memorandum of Understanding and a letter has been sent to the ICS Chair to confirm this.

John Brewin
South Nottinghamshire ICP Lead
john.brewin@nottshc.nhs.uk
26 September 2019

ENC. F3

Meeting:	ICS Board
Report Title:	Mid-Nottinghamshire ICP Board Update – September 2019
Date of meeting:	Wednesday 9 October 2019
Agenda Item Number:	8
Work-stream SRO:	Richard Mitchell
Report Author:	Kerry Beadling-Barron, Director of Communications and Engagement at Mid-Nottinghamshire ICP
Attachments/Appendices:	None

Report Summary:

The report is the latest in the monthly summaries of the key discussions and decisions taken at the latest Mid-Nottinghamshire ICP Board which met on 9 September 2019.

In particular ICP Chair Rachel Munton was pleased to welcome seven members of the public to the Board's first meeting in public. The members of the public were all given the opportunity to comment and ask questions at the start and end of the meeting and were thanked for their contributions. It was also the first time the meeting had been held in a community setting - The Summit Centre in Kirkby in Ashfield. As part of the Board's approach to transparency and engagement, papers went online beforehand on the ICP website here and were advertised on the ICP twitter account (@careinMidNotts).

Action:

☒ To receive
☐ To approve the recommendations

Recommendations:

1.	To note the report.

Key implications considered in the report:

Financial	☐	
Value for Money	☐	
Risk	☐	
Legal	☐	
Workforce	☐	
Citizen engagement	☒	Meeting in public and in community venues enhances the opportunity for citizen engagement.
Clinical engagement	☒	The presentation on Winter Respiratory Admissions Prevention demonstrates the PCN clinical engagement on winter and flu planning.
Equality impact assessment	☐	

Engagement to date:				
Board	Partnership Forum	Finance Directors Group	Planning Group	Workstream Network
☐	☐	☐	☐	☐
Performance Oversight Group	Clinical Reference Group	Mid Nottingham-shire ICP	Nottingham City ICP	South Nottingham-shire ICP
☐	☐	☒	☐	☐

Contribution to delivering the ICS high level ambitions of:	
Health and Wellbeing	☒
Care and Quality	☐
Finance and Efficiency	☐
Culture	☐

Is the paper confidential?

☐ Yes
☒ No

Note: Upon request for the release of a paper deemed confidential, under Section 36 of the Freedom of Information Act 2000, parts or all of the paper will be considered for release.

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Mid-Nottinghamshire Integrated Care Partnership

Mid-Nottinghamshire ICP Board Update – September 2019

Below is a summary of the key discussions and decisions taken at the latest Mid-Nottinghamshire ICP Board which met on 9th September 2019.

Meeting in Public

1. ICP Chair Rachel Munton was pleased to welcome seven members of the public to the Board's first meeting in public. The members of the public were all given the opportunity to comment and ask questions at the start and end of the meeting and were thanked for their contributions. It was also the first time the meeting had been held in a community setting - The Summit Centre in Kirkby in Ashfield. As part of the Board's approach to transparency and engagement, papers went online beforehand on the ICP website here and were advertised on the ICP twitter account (@careinMidNotts).

Partnership Agreement, Terms of Reference and Governance Diagram

2. Peter Wozencroft (Director of Care Integration, Mid-Nottinghamshire ICP) presented the ICP Board Terms of Reference. The Chair explained that these would be reviewed continually to ensure read across to other relevant documents. The Board would be asked to review the Terms of Reference initially on a six-monthly basis with the aim to move to annually. The Board approved them on that basis.

3. Mr Wozencroft agreed to update and bring together the ICP governance chart and Schedule 7 of the ICP Agreement to form a revised accountability framework for the ICP and circulate the revised framework to members for virtual approval by the end of September 2019.

4. He also presented the draft interim Partnership Agreement which had been adapted from the Alliance Agreement, which a number of partners were already signed up to. Members supported the proposal to work towards formalising the partnership approach by developing and signing up to a formal partnership agreement. The interim ICP agreement itself required further work and possibly some legal advice.

Neighbourhood approach presentation

5. Matt Finch (Director - Communities and Environment, Newark and Sherwood District Council), David Evans (Head of Communities and Wellbeing, Mansfield District Council), Theresa Hodgkinson (Assistant Director – Place and Wellbeing Ashfield District Council) and David Ainsworth (Locality Director, Mid-Nottinghamshire CCGs) presented the District Councils' Approach to Neighbourhoods highlighting:

- The wider determinants of health which included: poor access to services, housing standards, high levels of unemployment, low levels of income and high levels of crime and anti-social behaviour;
- The strategic objectives and key themes across the patch from District Health and Wellbeing Plans which included to give every child the best start in life and to maximise opportunities to develop healthy places;
- The priority neighbourhoods across Mansfield, Ashfield, Newark and Sherwood and the methodology that had been used to identify and then prioritise these;
- Some of the common themes across the priority neighbourhoods such as low income, long-term unemployment and high crime rates;
- The increased opportunities to support the priority neighbourhoods through the development of PCNs.

6. A further discussion will take place at the November meeting to explore how partners will collectively address the neighbourhood focus across Mid-Nottinghamshire.

GP Provider Alignment; Winter Respiratory Admissions Prevention

7. Dr Gavin Lunn (Clinical Chair, Mansfield and Ashfield CCG) presented on Winter Respiratory Admission Prevention noting:

    - The reasons for focussing on respiratory which included: high disease prevalence and respiratory being a leading cause of ED attendance and admission over winter;
    - An outline of Wellbeing and Respiratory Management highlighting the importance of targeting at-risk groups and optimising vaccine update;
    - Next steps included GP provider meetings with hospital respiratory clinicians, liaison and alignment with wider system partners.

8. After a discussion members agreed that this initiative would align to a place based approach and could address a number of issues for priority neighbourhoods, as above.

Thanks Given

9. This was the last meeting for Rob Mitchell who is moving on from his role of Chief Executive of Ashfield District Council to become Chief Executive of Charnwood Borough Council in Leicestershire. He was congratulated on his new role and thanked by ICP Chair Rachel Munton on behalf of the Board for his passion and enthusiasm for the ICP.

10. The next ICP meeting will take place on November 18 following an urgent matters only meeting on 7 October meeting to allow members to attend the Wigan Deal conference. The November meeting will again take place in a Mid-Nottinghamshire community venue, this time at Civic Quarter, Civic Centre, Chesterfield Road South, Mansfield and papers will be available on the ICP website prior to this.

ENC. G1

Meeting:	ICS Board
Report Title:	October 2019 Integrated Performance Report
Date of meeting:	10th October 2019
Agenda Item Number:	9
Work-stream SRO:	Andy Haynes
Report Author:	Sarah Bray
Attachments/Appendices:	Enc. G2. Integrated Performance Summary

Report Summary:

This report supports the ICS Board in discharging the objective of the ICS to take collective responsibility for financial and operational performance as well as quality of care (including patient/user experience). Key risks and actions are highlighted to drive focus and strategic direction from across the system to address key system performance issues.

Current key risk areas are outlined below, with a summary of key performance enclosed.

Main areas of current risk:

- Urgent Care System delivery – significant pressures continue
- Cancer Performance – low performance continues (mid 70%)
- Financial Sustainability
- Mental Health – OAPs (National outlier, however no longer in bottom 10)

Emerging & Continuing Risks:

- Planned Care – *diagnostics performance and waiting list increases.*
- Quality - performance across Maternity and risks within the Transforming Care Programme.
- Activity – 'other referrals' and elective day-case are over planned levels. Non-electives are under planned levels due to Same Day Emergency Care not being reported as expected. Demand has continued to increase in line with unmitigated growth trends.

Service Delivery Area	2019/20 ICS Performance		
	No. KPIs	% Not Achieved	% Achieved
Mental Health	10	40%	60%
Urgent & Emergency Care	11	73%	27%
Planned Care	5	50%	50%
Cancer	8	50%	50%
Nursing & Quality	5	40%	60%
Finance	8	50%	50%
Workforce	12	tbc	tbc
Overall Performance Delivery	47	52%	48%

Nottingham and Nottinghamshire ICS - Performance Overview - as at 2nd October 2019

Assurance Frameworks

An overview of the current standards of provider and commissioner assessments has been provided for information.

September 2019	IA	RI	GO	OU	NR	Total
CQC- Provider Trusts	0	1	3	1	0	5
CQC- GP	2	6	99	20	5	132
CQC-Nursing Homes	6	31	49	6	2	94

Provider List	CQC Rating
Nottingham University Hospitals	Good
Sherwood Forest Hospitals	Good
Notts Healthcare NHS FT	Requires improvement
CityCare	Outstanding
East Midlands Ambulance Service	Good

All 6 CCGs were assessed as 'Good' for 2018/19. Support is provided for all organisations which are assessed as Inadequate or Requires Improvement.

Regulatory Assurance Escalation Areas

As a system there are several areas where additional assurance and support processes are in place with the Regulators, to support improvements:

- Greater Nottingham Urgent Care
- Mental Health – Out of Area Placements / Intensive Support Team (IST) support for CYP being discussed
- Maternity – additional support offer being developed
- Finance – additional review meetings jointly chaired by NHSEI and ICS Finance Director

There is increasing focus upon Cancer across the region, due to the deterioration of the positions. Recovery plans have been provided to the regulator.

Action:		
☒ To receive ☐ To approve the recommendations		
Recommendations:		
1.	That the board note the contents of the report	
Key implications considered in the report:		
Financial	☒	Delivery against forecast and year to date
Value for Money	☐	
Risk	☒	Service delivery and performance risks
Legal	☐	
Workforce	☒	Delivery against workforce plans
Citizen engagement	☐	
Clinical engagement	☐	
Equality impact assessment	☐	

Engagement to date:				
Board	Partnership Forum	Finance Directors Group	Planning Group	Workstream Network
☐	☐	☒	☐	☐

Performance Oversight Group	Clinical Reference Group	Mid Nottingham-shire ICP	Nottingham City ICP	South Nottingham-shire ICP
☒	☐	☐	☐	☐

Contribution to delivering the ICS high level ambitions of:	
Health and Wellbeing	☒
Care and Quality	☒
Finance and Efficiency	☒
Culture	☒

Is the paper confidential?

☐ Yes
☒ No

Note: Upon request for the release of a paper deemed confidential, under Section 36 of the Freedom of Information Act 2000, parts or all of the paper will be considered for release.

Integrated Performance Overview

2 October 2019

Red Risks to System Delivery		
RAG	***Performance Issues***	***Actions to Address***
A: Mental Health	***Performance*** concerns relating to: CYP Access & data capture issues ongoing relating to Kooth, being supported nationally. EIP Concordant compliance & Data – Level 2 assessment May 2019. Further improvements potentially at risk due to CBTp training issues ***5YFV Transformation Areas*** issues: Out of Area Inappropriate placements – remain national outlier on volumes of placements, however the position has improved from 3rd highest in the country to 11th during Q1. Revised trajectories were agreed for 2019/20, system has achieved Q1. National clinical support and regulatory deep dive overview is in place. IPS – Service not currently delivered across the ICS. Wave 2 funding has been received to progress the service across the ICS . Physical Health Checks are currently not progressing in line with requirements, the system is reviewing alternative service models.	A number of performance and 5YFV transformation area concerns remain for Nottinghamshire. As a result the system has Service Improvement plans for IAPT, EIP, CYP, Out of Area Placements (including Liaison & Crisis) and Physical Health Checks which include phased performance improvements to deliver requirements planned for 2019/20. ICS Executive Mental Health monthly oversight remains in place to progress the actions required through the service improvement plans. Discussions are ongoing with Health Education England to progress potential barriers to success, including CBTp and IAPT training programmes. Funding requests have been approved for IPS, Crisis & Liaison transformation, Perinatal and CYP School Trailblazer (Nottingham City expansion, and Mansfield & Ashfield)
B: Urgent Care	ICS A&E performance remains below target at 89.2% however this now only includes SFHT. NUH are trialling the new UEC metrics until April 2020. Pressures remain across the service. There were 2 twelve hour ED waits, one at each trust. Both related to waiting for local inpatient beds. Urgent care attendances and admissions continue on the growth trajectory seen during 2018/19 (3.4% A&E, 8.9% NEL), however are under the ICS plan (-2.6% A&E, -5.9% NEL). There are differential positions within the ICP areas and between providers & commissioners, with Mid-Notts being over plan (SFHT & CCGs), whilst Greater Notts are under plan, but are over year-on-year. The trusts have experienced greater growth than the CCGs indicating increased volumes from out of Nottinghamshire. EMAS has struggled to achieve category 2, due to increased volumes. Performance is	NUH remains in regional escalation for urgent care performance as service difficulties continue. Significant volume increases have continued. Actions to address acute and community bed capacity gaps and front door /ambulatory service redesign continue to be implemented. Weekly executive calls continue to be in place to respond to the pressures across the system. ECIST support is being provided and the Trust are participating in the Same Day Emergency Care accelerator programme. Due to continuing activity increases, the ICS has undertaken an activity driver deep dive into urgent care activity, which has completed analytical analysis and clinical challenge and review. Actions include reviews with 111 and EMAS on conveyancing and triage protocols, as well as audits on the increased volumes of A&E attendances with no subsequent interventions (40% increase Nottm City Type 1 Attendances), and audits on ambulatory care activity. An audit of NUH A&E attendances has been undertaken during September, which will be reviewed by the A&E Board.

	more positive across Nottinghamshire, than EMAS as a whole.	
D:Cancer	Cancer 62 performance has remained at a low level for July 2019, 73.16%. (SFHT 79.58% / NUH 67.98%, Circle 74.58%). Performance is expected to have improved slightly for August at between 77-79%. 62 day and 104 day backlogs have continued to increase august and September.	The trusts expected performance for Sep 19 to Oct 19 is 71-75%, which is maintaining current low levels of performance. The trusts continue to work through the increased demand, and capacity constraints from revised pathways and workforce issues. Alternative capacity is being sourced, through workforce, alternative providers and additional equipment / clinical capacity. Recovery plans have been provided, however, recovery is not now expected to be achieved before the end Q3 2019/20.
G: Financial Sustainability	There is no reporting of the City Council due to information not being received. The NHS and Local Authority system has not delivered against the system financial plan for August 2019 due to continuing pressures (activity/demand, staffing pressures and non delivery of savings & efficiency programmes). The NHS has not delivered on the system control total for August 2019 and therefore reporting a shortfall at Month 5 against the System Provider Sustainability Funding though forecast to receive all available by the end of the financial year.	The system is forecasting to deliver against the financial plan and system control total by year-end. However, this is a very challenging position with key risks the under delivery of savings/efficiency programme and activity pressures across the system. The ICS Financial Sustainability Group are monitoring the year-to-date and forecast position and identifying where further actions are necessary. The system has had a joint assurance review by ICS FD and NHSEI during September to discuss plans and will be undertaking a follow-up meeting during October.
Amber Risks to System Delivery		
C: Planned Care	RTT has not achieved at ICS 91.1% July 2019. (SFHT 88.89% / NUH 92.52%). Increasing number of specialties failing the standard (7 in April to 10 in July) Waiting lists have increased further to 8% over March 2019 levels, and 6.8% over June trajectory. There has been an increase in 'Other Referrals' by consultants and A&E departments, which is being investigated. Diagnostics impacted by NUH MRI Outpatient due to scanner and staffing issues. Children's wheelchair waits have continued to achieve at Q1 19/20 98.6%.	The ICS has expanded the Drivers of Demand review to include planned care activity. This will be reviewed October 2019. SFHFT and the CCG are monitoring recovery plans at speciality levels, which include staffing and additional capacity, intending on for recovery from September 2019. Actions include staged implementation of Medefer Virtual Hospital Model, June-August. NUH have investigated causal factors of growth in specific specialties during August. NUH Diagnostics is expected to be resolved for September, as additional capacity has been sourced from the independent sector and an interim scanner has been located.
E. Nursing & Quality	Transforming Care achieved August 19 trajectory -4 under planned levels. CHC: ICS achieved both QP standards for August 19. LeDeR – There has been an increase in the number of completed reviews to 48% (69) July this is behind trajectory. 74 reviews are remaining.	TCP remains in regional escalation. Recovery plans are in place, focus on admission avoidance, with refreshed targets having been agreed for 2019/20. CHC performance has reduced, CCGs and Local Authorities are identifying immediate actions to be taken. Virtual MDTs to be progressed. LeDeR – Improvement trajectory is in place supported by NHSEI. ICS is on track to clear the backlog by the

	Maternity did not achieve the continuity of carer 20% requirement, achieving 5.1% August 19. The ICS is assessed by NHSE as 'Requiring Some Support' because of delayed implementation of Savings Babies Lives Care Bundle, CoC and higher than average rates of Smoking at the Time of Delivery.	end of Q2, as additional review capacity has been sourced, and achieve national standard by Nov 2019. Maternity recovery plan is in place, revised trajectories are expected for June 2019, to progress towards the 35% requirement from March 2020, expect achievement Q1 20/21. Pilots commenced march, April, July and September, with proposals for dedicated resource within each provider to lead the implementation. NUH: 1 pilot in place commenced July with 195 women joining the pathway. A bespoke support offer is currently being co-produced with the National and Regional NHSEI teams.
H. Workforce	Delivery of primary care workforce plans is a raising concern.	Primary Care and delivery of increased workforce is at risk of delivery against the planned trajectory, due to overseas recruitment not being as successful as planned. Contingencies including reviewing skill mix and further retention are being developed.

Integration of services, improving health of the population

While healthy life expectancy has increased both nationally and locally over recent years, Nottingham and Nottinghamshire remain below both national and core city averages. Additionally, there is a significant downward trend in female healthy life expectancy across the previous four rolling averages.

The ICS performed well against the Personalisation agenda, and achieved all targets.

Activity Data (number of people)	2017/18	Target 2018/19	Actual 2018/19	2019/20 Target
Person				
Personalised Care and Support Plans	3709	10840	18519	16680
Personal Health Budgets & Integrated Personal Budgets	1743	2060	2320	2900
Community				
Self-Management Support or Health Coaching	493	10840	17652	31615
Community Based Approaches	3352			

Strengthened Leadership

ICS Governance arrangements are continuing to be strengthened, with on-going work programmes related to management of risk, organisational and system arrangements, and workstream oversight. This includes development of the ICS Outcomes Framework. A governance review is to be undertaken during Q2 2019/20.

The performance report will continue to be developed during 2019/20 to reflect the emerging governance of the ICS and ICPs and the establishment of the ICS Outcomes Framework.

CCG joint management arrangements are progressing, awaiting the approval to proceed with the merger from the National Statutory Committee during October.

Recommendations

The Board are asked to note the Integrated Performance Report and:

a. Key risk areas:
   - Urgent Care System delivery
   - Mental Health OAPs
   - Financial Sustainability
   - Cancer Services Delivery

b. Areas of Emerging Risks:
   - Local Maternity & Neonatal Services Transformation
   - Planned Care – continual rising waiting lists

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2 October 2019
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October 2019

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Nottingham City Council
Nottinghamshire County Council
NHS

ICS Board 9 October 2019
Item 9, Enc G2

	Key Performance Indicator	19/20 ICS Basis	National 19/20 Required Performance	19/20 Reporting Period	2019/20 ICS Performance				Exception Narrative
					Latest Period	National Month RAG	Month Delivery Trend	Forecast Delivery Risk	
A. Mental Health Deliver the MHFV, with a focus on Children and Young Peoples services (CYP), reductions in Out of Area Placements, improved access to mental health services (EIP / IAPT / Crisis and Liaison services)	CYP Access Rate	CCG	34%	Q1 19/20	20.1%	R	↑	R	**IAPT** – ICS performance was 5.44%; M&A CCG did not achieve the target (4.74%). Greater Notts performance impacted by addressing waiting lists, expect to achieve standards from Q2. Mid Notts transfer of waiting lists has been addressed, targeted action at M&A. Expect to achieve all targets from Q3. **EIP** – ICS achieved 80.4 % in July 19, all CCGs achieved standard. Actions ongoing to improve service delivery against NICE standards. **OAPs** – Continuing reduction in number of inappropriate OBDs. In Q1 19/20, 2,435 v 3,432 plan. Reported OBDS were 861 in July 19 and reduced to 812 in Aug 19. Increase in July due to demand for PICU beds and higher numbers of admissions to spot purchased beds. **CYP** – The specialist eating disorder service is now configured to meet the waiting time standard. Service review has commenced to identify areas of improvement and alternative service provision. NHSI IST has been approached to provide review and support into the service for areas of further improvement.
	CYP Eating Disorders Urgent 1st <1 weeks	CCG	95%	Q1 19/20	75.0%	R	↑	G	
	CYP Eating Disorders Routine 1st <4 weeks	CCG	95%	Q1 19/20	79.6%	R	↓	G	
	IAPT Access - 22% (4.94% Q1% min, to 5.5% Q4) 2/3 of increase in IAPT-LTC	CCG	4.94%	Jun-19	5.44%	G	↑	G	
	IAPT Waiting Times - 6 weeks (Rolling Quarter)	CCG	75%	Jun-19	71.1%	R	↓	G	
	IAPT Waiting Times - 18 weeks (Rolling Quarter)	CCG	95%	Jun-19	98.7%	G	↓	G	
	IAPT Recovery Standards (Rolling Quarter)	CCG	50%	Jun-19	52.5%	G	↓	G	
	EIP NICE Concordant Care within 2 Weeks	CCG	56%	Jul-19	80.4%	G	↑	G	
	Inappropriate Out of Area Placements (bed days) Q1 3432, Q2 2024, Q3 1748, Q4 1440	CCG	3432	Jun-19	2435	G	↓	A	
	Maintain Dementia diagnosis rate at 2/3 of prevalence	CCG	66.7%	Jul-19	76.7%	G	↑	G	
B. Urgent & Emergency Care Improved A&E performance in 2018/19, reduce DTOCs and stranded patients, underpinned by realistic activity plans. Implementation of NHS 111 Online & Urgent Treatment Centres.	Aggregate performance of 4 Hour A&E Standard (SFHT performance only as NUH trialing new metrics)	Provider	95%	Aug-19	89.2%	R	↑	R	**Activity** - Pressure continues with attendances and admissions up year on year, especially NE 0 day LOS. Although the activity across the ICS is below plan. **A&E** - NUH ED are part of the new NHSE reporting pilot and will no longer be reporting against the 4 hour target. SFHFT failed to achieve national standard and planned trajectory performance with 89.92% for August 2019. **12 Hour Wait** - NUH patients - 1 x lack of inpatient bed locally. SFHFT - 1 x lack of inpatient bed locally **DTOCs** - NUH achieved with 3.05% for July. SFHFT failed to achieved target in July with 5.37% **Long Stay** - failing to deliver reductions in patients in hospital for +21 days **Ambulance** – The ICS non conveyance group are reviewing ambulance activity with targets having now been agreed with EMAS.
	12 Hour Breaches	Provider	0	Aug-19	2	R	↓	R	
	NHS 111 50% population receiving clinical input	Provider	50%	Aug-19	54.5%	G	↓	G	
	Ambulance (mean) response time Category 1 Incidents (Notts Only)	Provider	00:07:00	Aug-19	00:06:29	G	↓	G	
	Ambulance (mean) response time Category 2 Incidents (Notts Only)	Provider	00:18:00	Aug-19	00:24:53	R	↓	R	
	Manage Optimal Length of Stay - reduction in >21 days	Provider	279	Aug-19	318	R	↓	A	
	Reduce DTOCs across health and social care- NUH	Provider	3.5%	Jul-19	3.05%	G	↓	G	
	Reduce DTOCs across health and social care- SHFT	Provider	3.5%	Jul-19	5.37%	R	↑	A	
	A&E Attendances - Variance to Plan	CCG	±2% of plan	Jul-19	-2.60%	R	↓	R	
	NEL - Variance to Plan	CCG	±2% of plan	Jul-19	-5.90%	R	↑	R	
	NEL Short Stay - Variance to Plan	CCG	±2% of plan	Jul-19	-13.30%	R	↑	R	
C. Planned Care	RTT Incomplete 92% Standard	Provider	92%	Jul-19	91.0%	R	↓	A	**RTT** – ICS failed the July target, achieving 91.01%. This is the 23rd consecutive month that SFH has failed the RTT 92% standard bottom-line. Performance has slightly declined from 89.37% in June to 88.89% in July **Waiting list** – NUH +9.6% and SFHT +10.8% over trajectory. Treatment Centre waiting lists are not in the current figures (11,000 expected). **52 Week Waits** - 0 breaches for July 19. **Diagnostics** - The ICS failed to meet the standard for the fourth month in a row due to issues at NUH. The trust experienced a further scanner breakdown in August 2019, as well as a staff sickness issues. Recovery by end September. **Wheelchairs** – performance has been maintained for Q1 19/20. **Referrals** - Greater Nottingham CCGs have seen a 2.2% variance to plan in Total Referrals for Month 4 year to date. Year on year increases have been seen in Cardiology, ENT, Neurology, Rheumatology and Dermatology.
	RTT Waiting List - March 2020 incomplete pathway < March 2019	Provider	56,751	Jul-19	54,700	R	↓	R	
	+52 Week Waits - to be halved by March 2019, and eliminated where possible	Provider	2	Jul-19	0	G	↓	G	
	Diagnostics +6 weeks	Provider	0.9%	Jul-19	2.17%	R	↑	G	
	Children's Wheelchair Waits < 18 Weeks	CCG	92%	Q1 19/20	98.60%	G	↓	G	
	E-Referrals increased coverage 100%	CCG	100%	Jun-19	96%	R	↓	G	
	GP Referrals - Variance to Plan	CCG	±2% of plan	Jul-19	1.00%	G	↓	G	
	Other Referrals - Variance to Plan	CCG	±2% of plan	Jul-19	4.70%	R	↑	A	
	Total Referrals - Variance to Plan	CCG	±2% of plan	Jul-19	2.20%	R	↓	A	
	Outpatient 1st - Variance to Plan	CCG	±2% of plan	Jul-19	-1.90%	G	↓	G	
	Outpatient F/U - Variance to Plan	CCG	±2% of plan	Jul-19	1.40%	G	↓	G	
	Total Elective - Variance to Plan	CCG	±2% of plan	Jul-19	0.50%	G	↓	G	

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					Latest Period	National Month RAG	Month Delivery Trend	Forecast Delivery Risk	
D. Cancer Delivery of all eight waiting time standards, implementation of nationally agreed radiotherapy specifications and diagnostic pathways, progress risk stratified scanning and follow-up pathway	Cancer 2 weeks - Suspected Cancer referrals	Provider	93.0%	Jul-19	94.2%				**July Performance** - 73.16%. NUH – 67.98%, SFHT - 79.72%, Circle – 74.58%. **NUH** - Breeches increased to 52.5. Main contributors Urology,H&N, Lung, LGI, UGI. Treatment numbers increased to 178 July. (June 151.5). 62 day backlog decreased to 125 (as of 9.9.19). Number of pts over 104 days increased to 36; due to complexity, choice and late tertiary. LGI driving increase at 18, however clinical review showing most are low risk **SFHFT** - 79.72% in July 19 (68.1% in June). Breaches across all sites with causes being treatment, outpatient clinic capacity and pt choice. Breaches 25.5 (26.5 in June). 9 breaches in Urology accounts for 28% of all breaches. Others include–lung, H&N, UGI. Number of pts who exceeded 62 days in backlog remains high at around 65. Recovery plans have been provided by both trusts, which include use of independent sector and staffing increases, however, recovery is not expected before the end of Q3.
	Cancer 2 weeks - Breast Symptomatic Referrals	Provider	93.0%	Jul-19	98.1%				
	Cancer 31 Days - First Definitive Treatment	Provider	96.0%	Jul-19	92.9%				
	Cancer 31 Days - Subsequent Treatment - Surgery	Provider	94.0%	Jul-19	78.7%				
	Cancer 31 Days - Subsequent Treatment - Anti Can	Provider	98.0%	Jul-19	100.0%				
	Cancer 31 Days - Subsequent Treatment - Radiothy	Provider	94.0%	Jul-19	100.0%				
	Cancer 62 Days - First Definitive Treatment - GP Referral	Provider	85.0%	Jul-19	73.2%				
	Cancer 62 Days - Treatment from Screening Referral	Provider	90.0%	Jul-19	75.9%				
	Cancer 62 Days - Treatment from Consultant Upgrade	Provider		Jul-19	89.9%				
E. Nursing & Quality									**LeDeR**: Improvements continue. Increase in number of completed reviews, from 41% (55) to 48% (69). Of remaining 74 reviews, 47% have been allocated to reviewers. 8 reviews are awaiting formal reports prior to allocation to a reviewer: 6 CDOP (child death overview panel) and 2 HMP (deaths in custody) cases. **CHC:** ICS achieved both Quality Premium Standards. **Maternity**: LMNS not achieving national or local trajectory for CoC with cumulative YTD position of 6.04%. Nottm and Notts LMNS assessed by NHSE/I as 'Requiring Some Support' as result of delayed progress in implementing Saving Babies Lives Care Bundle, CoC ambition, and higher than national average rates of SATOD. Bespoke support offer currently being coproduced with National and Regional Teams.
Transforming Care Continued reduction of inappropriate hospitalisation of people with Learning Disabilities	Reductions in patients against Local planning trajectories - Total for Nottinghamshire	CCG	47	Aug-19	43				
	Learning Disability Mortality Reviews (LeDeR) 85% Mar 2020	CCG	53%	Jul-19	48%				
Continuing Health Care	Fewer than 15% of Continuing Health Care Full Assessments undertaken in acute setting	CCG	<15%	Aug-19	5%				
	More than 80% eligibility decisions undertaken within 28 days from receipt of checklist	CCG	80%	Aug-19	91%				
Maternity Deliver improvements in safety for maternity services, and improve personal and mental health	Continuity of Carer	Provider	20%	Jul-19	5.10%				
Quality Measures	Mixed Sex Breaches		0	Aug-19	TBC				CQC inspection at SFHT in April has improved overall rating to good. HCAI (Hospital Aquired Infections) have action plans to address the increased rates
	MSSA Breaches	Provider	No Target	Aug-19	0				
	MRSA	Provider	0	Jul-19	0				
	C-Difficile	Provider	22	Jul-19	26				
	E Coli	Provider	No Target	Jul-19	82				
F. Prevention & Public Health			To be developed and populated by public health and social care						Nottingham and Nottinghamshire remain below both national and core city averages. Additionally, there is a significant downward trend in female healthy life expectancy across the previous four rolling averages

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G. Finance & Efficiency ***Note: Nottingham City Council information not provided and therefore is not included in finance & efficiency reports***	**Overall Revenue Financial Position** (excluding Provider Sustainability Funding, Marginal Rate Emergency Threshold and Financial Recovery Fund)	ICS - Health & Social Care	Nil variance to the system financial plan of £65.7m in year deficit	Aug-19	-£3.0	🔴	↓	🔴	Year-to-date deficit higher than planned due to Local Authority pressures as a result of social worker staffing pressures and growth pressures on external residential placements, commissioner pressures arising for acute activity & non-delivery of QIPP and provider pressures arising from non-delivery of CIP. FORECAST - NHS forecast to deliver against £65.7m in-year deficit (control total £67.7m deficit) with the Local Authority forecasting a £4m over-spend. This is a very
	Overall Revenue Financial Position (including Provider Sustainability Funding, Marginal Rate Emergency Threshold and Financial Recovery Fund)	ICS - Health & Social Care	Nil variance to the system financial plan of £8.3m in year deficit		-£3.7	🔴	↓	🔴	Year-to-date deficit higher than planned due to the pressures above & shortfall at M5 on PSF system monies due to the YTD financial position. FORECAST - to deliver £8.3m in-year deficit. This is a very challenging position with key risks the delivery of savings/efficiency programmes and activity pressures across the system. This could impact on the receipt on provider sustainability funding in year.
	NHS Revenue System Control Total (excluding Provider Sustainability Funding, Marginal Rate Emergency Threshold and Financial Recovery Fund)	NHS	Deficit does not exceed System Control Total of £67.7m in year deficit		-£1.4	🔴	↓	🔴	Year-to-date the NHS system was off plan due to acute activity pressures and non-delivery of savings. FORECAST - to deliver £65.7m in-year deficit (control total £67.7m deficit). This is a very challenging position with key risks the delivery of savings/efficiency programmes and activity pressures across the system.
	System Capital Control Limit	NHS	Spend does not exceed system capital control limit of £70.5m		£0.0	🟢	→	🟢	All provider organisations are within the System Capital Control Limit year-to-date plan. YTD spend is £18.5m. FORECAST - to deliver.
	Savings & Efficiency Programme	ICS - Health & Social Care	Nil variance to plan - £159.7m (4.9%)		£1.6	🟢	↓	🔴	Delivered £44.8m of savings year-to-date, under delivery across the NHS offset by over-achievement of Local Authority savings plans. FORECAST - NHS organisations are forecasting £127.9m (£145m plan) & Local Authority £17.7m (£14.9m plan)
	Provider Sustainability Funding (PSF)	NHS	Nil variance to available PSF of £27.5m		-£0.7	🔴	→	🟡	The system is reporting to be off plan at Month 5 & therefore a shortfall on PSF System monies. FORECAST - All provider organisations are forecasting to receive full provider
	Mental Health Investment Standard (MHIS)	NHS	MH spend (exc LD & Dementia) is at least £165.1m		£0.2	🟢	↑	🟢	MHIS is forecast to be above target at the end of August 2019.
	Agency Ceiling	NHS	Agency Spend is within the ceiling limit of £45.4m		£0.0	🟢	→	🟢	All provider organisations are within the agency spend ceiling year-to-date. FORECAST - to deliver, low risk.

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					Latest Period	National Month RAG	Month Delivery Trend	Forecast Delivery Risk	
H. Workforce	Substantive WTEs	ICS (NHS)	25748.26	Aug-19	187.00				Excludes Primary and Social Care and Nottingham City Care
	Agency/Bank WTEs		1608.28		-226.74				Excludes NUH actual data as not included in NHSi return
	Working in A&E WTEs		438.24		-256.69				Taken from NHSi monthly returns excludes NUH planned figures
	Transformational Roles WTEs		TBC	Aug-19	n/a				Plan & Actual exclude primary and social care. Data accurate for 2018-2019 above plan by 56 apprentices.
	Apprenticeships WTEs		TBC		n/a				
	Vacancy Rates		10.0%	Aug-19	10.00%				.
	12m Rolling Sickness Absence Rate %		3.0%		3.00%				
	12m Rolling Staff Turnover %		10.0%		10.00%				
	Primary Care Workforce - GPs		554.19	Jun-19	539				Data taken from NHS General Practice Workforce Statistics - June 2019
	Primary Care Workforce - Nurse				312				Data taken from NHS General Practice Workforce Statistics - June 2019
	Primary Care Workforce - Non-Clinical		1273.13		1286				Data taken from NHS General Practice Workforce Statistics - June 2019
	Primary Care Workforce - Direct Patient Care				219				Data taken from NHS General Practice Workforce Statistics - June 2019
	Primary Care Workforce - Clinical		532.00	Apr-19	491.11				Data taken from Primary Care Census - March 2019