NHS
Nottingham
University Hospitals
NHS Trust

Winter Plan

We Listen
We Care

2022/23

Contents

1. Executive summary

- There is uncertainty in winter 2022/23 as a result of the continued impact of the pandemic and learnings from the Southern Hemisphere relating to influenza. As a result, an agile approach will need to be adopted to respond to a potentially rapidly changing environment.
- Adult base ward bed modelling for the remaining months of 2022/23 show a mitigated position against the nominal state and a peak bed deficit in Jan-23 of 18 beds against the challenging winter scenario. It is important to note that residual, forecast bed position is based on the successful delivery of the mitigating actions to the intended level of impact. Given the uncertainty and changes in non-elective demand, hospital length of stay and Covid-19 and influenza epidemiology; the modelling may not be as informative as in pre-Covid-19 years.
- The pressure from the modelled medically safe patient cohort provides significant scope for improvement. System plans are in place to significantly reduce the number of medically safe patients in hospital; it is of utmost importance that these schemes deliver.
- Internal actions are in place to: (1) reduce demand on our services; (2) have the highest number of hospital beds open and enhance our bed configuration; (3) enhance our processes and improve patient flow; and (4) make strategic enhancements in staffing.
- Specific Christmas and New Year plans will be created in November and embedded in this plan.
- Escalation triggers for the Trust are monitored throughout the day (365 days a year), with corresponding actions cards in place to support de-escalation. A full capacity protocol is in place.
- 24/7 rotas are in place for site management Duty Matrons and clinical staff for all 24/7 services. On-call senior staff are in place throughout the year 24/7 (gold on-call and two silver on-call at all times).
- Key risks have been documented with work continuing on mitigations.

2. Context

Nottingham University Hospitals NHS Trust (NUH) strives to deliver accessible, high quality services throughout the year. Winter is one of the nationally recognised pressure points where additional planning is required in order to maintain resilient services.

The aim of the NUH winter plan is to ensure NUH capacity, processes and systems are fit for purpose and resilient to meet the anticipated level of demand throughout winter and maintain and optimise patient safety. Our vision is to deliver a caring, safe and productive winter.

The NUH winter plan is underpinned by the following principles:

- Health and care partners across the Integrated Care System (ICS) will work together to offer appropriates services to our population in the right place at the right time
- Appropriate services are available for patients requiring care in the acute setting
- Patient safety is optimised and quality of care is maintained. Patients are not exposed to unnecessary clinical risk (including Covid-19, influenza and norovirus)
- The health and wellbeing of staff is maintained
- Any adverse impact on elective activity and associated patient experience, income and performance is minimised. Cancer and clinically urgent activity is preserved
- An agile approach is adopted with plans in place to respond to a potentially rapidly changing environment as a result of the Covid-19 pandemic and influenza.

This plan is to be read in conjunction with and is supported by the following documents:

- Nottinghamshire ICS System-wide Winter Plan 2022/23 – recognising the need for a whole-system accountability and responsibility framework that span health and social care to effectively manage patient safety.
- NHS England Cold Weather Plan.
- Management of Adult and Children Patient Flow Policy (includes escalation triggers and actions) (CL/CGP/087).
- Trust Emergency Preparedness, Resilience and Response (EPRR) policy (GG/CM/050).
- Major incident plan (GG/CM/052 Parts A, B & C).
- Business continuity planning policy (GG/CM/054).
- Discharge Policy for Greater Nottingham (CL/CGP/096).
- All usual clinical and operational policies which remain active throughout winter.
- National 'next steps in increasing capacity and operational resilience in urgent and emergency care ahead of winter' letter.
- National 'going further on our winter resilience plans' letter.

This document is structured as follows:

- **Anticipate and assess** issues in maintaining resilient services
- **Prevent** the likelihood of occurrence and effects of any such issues
- **Prepare** by having appropriate mitigating actions, plans and management structures in place
- **Respond and recover** by enacting plans and contingencies as required.

The embedded slide pack below is a summary document of 2022/23 winter planning (including some reflections on winter 2021/22) that was considered by our Operational Leadership Team on 5 Sep-22*
*NM slide pack attached as appendix to report.

This winter follows an unprecedented 30 months with the Covid-19 pandemic. There have been staffing pressures throughout the system which has been limiting some services and derogating staffing levels in others. Although a wellbeing offer is in place at both Trust and system-level, our workforce is entering the winter period tired and in some areas fragile.

The table below provide context on some key indicator changes we have seen when comparing the month of September with previous years.

Indicator	Change between Sep-21 and Sep-22	Change between Sep-19 and Sep-22
Emergency Department attends	Reduced by 11% (61 patients per day)	Reduced by 7% (40 patients per day)
Average discharge length of stay	Increased by 12% (0.7 days)	Increased by 8% (0.4 days)
Average number of General and Acute beds open	Increased by 89 beds to 1,542	Increased by 32 beds
Average number of medically safe for transfer patients requiring a supported discharge	Increased by 46% (increase of 54 patients waiting)	Increased by 27% (increase of 37 patients waiting)

3. Anticipate and assess

3.1 Reflecting on winter 2021/22

Winter 2021/22 was once again dominated by Covid-19 with surging demand pre-Christmas as the Omicron wave peaked in early Jan-22. Community infection levels were high and with no national lockdowns; demand on many hospital services remained high. However, the demand on critical care due to Covid-19 was significantly lower than the previous winter period with many patients being in hospital 'with Covid-19' as opposed to being in hospital 'due to Covid-19'.

Pathway segregation remained in place across our hospitals all winter which adversely impacted on patient and staff flows between areas. Staff sickness levels were high in line with high prevalence of Covid-19 in the community; this placed significant pressure on an already tired workforce.

In many regards the pressures from winter did not ease with the change in seasons in 2022. We have continued to have significant delays in admitting patients with long 'fit for ward' times and an associated extended mean time in our Emergency Department (ED). The number of patients in our hospitals whilst medically safe to leave was high over the winter period and grew further during the summer (at odds with usual seasonal trends) placing significant pressure on effective patient flow through our bed base.

Over the winter period of 2021/22 elective activity was curtailed as bed capacity was required to support non-elective demand (including Covid-19 and medically safe patients). Theatre availability has also been constrained throughout 2022 due to staffing pressures; this has adversely impacted on the volume of elective surgical activity as we have been working hard to recovery and restore our elective programme.

3.2 Modelling winter demand - bed model

On an annual basis, detailed modelling is undertaken in order to forecast capacity required in terms of our acute adult base-ward bed capacity. This is our largest cohort of beds and recognised as being the most challenged in terms of provision of effective patient flow. In terms of demand and capacity planning, the bed model is considered an important driver to inform operational plans as bed pressures are often a key driver to: (1) patient delays; or (2) restrict the volume of patients that we are able to treat resulting in increased elective backlogs and increased risk of delay-related harm across all our pathways. There are a variety of risks recorded on Datix with a number considered as significant risks scoring 20 and above.

Bed modelling in the context of annual planning has a long history. The core modelling approach remains largely unchanged, although it has been refined continuously over time. The key focus remains on the adult general and acute base-wards with a percentile-based modelling approach calculating demand projections at specialty group level. The key modelling parameters include: the planning percentile (typically 85th i.e. the forth busiest day in the month); a target bed occupancy rate; medically safe bed occupancy levels and capacity assumptions and mitigations (the mitigations include physical capacity alongside efficiency savings). The inputs relating to historical bed occupancy, demand modelling assumptions and capacity assumptions are used to produce bed demand projections and resulting views of any residual 'bed gaps'.

A variety of planning scenarios have been modelled including one to align to the national planning guidance. The scenario in alignment with planning guidance (low Covid-19 demand, pre-pandemic levels of non-elective demand, 104% elective demand, pre-pandemic length of stay and reduced levels of discharge delays) created a relatively balanced bed position. However, the planning guidance assumptions and the operational reality of the year-to-date position at the end of the first quarter of 22/23 were very different. Broadly speaking the key changes can be summarised as:

- Covid-19 demand continued to present 'waves' with significant numbers of positive patients. Recent trends are that the majority of patients are in hospital 'with' Covid-19, rather than 'due to Covid-19'. The Covid-19 status of patients does impact on patient placement, length of stay and also the ability to discharge the patient in a timely manner (particularly if transferring into a community service). Covid-19 prevalence not only impacts on hospital capacity from a patient perspective, it also places constraints on our workforce affecting our ability to maintain our services at the level we would wish (for example: offer the planned number of theatre sessions).
- One day plus non-elective demand has remained below pre-pandemic levels. This, in part, is likely to be due to increased levels of Same Day Emergency Care (SDEC) activity and other system demand avoidance schemes/initiatives.
- Length of stay for patients on our base wards has remained above pre-pandemic levels. This partly will be due to increased SDEC; however, will more fundamentally link to ongoing Covid-19 demands and the following point.
- The number of patients medically safe and awaiting a pathway 1, 2 or 3 discharge (formerly known as a 'supported' discharge) have been exceptionally high and have not followed usual seasonal trends (reduced levels in the summer period).

The net result of the above factors has been significant hospital flow challenges (adversely impacting on a number of our performance metrics) and difficulties to increase elective activity at the pace we would have wished and in alignment with our operational plan.

Due to the variance in our lived reality, we created further scenarios. Our 'nominal' state was further refreshed at the end of quarter one based on our year-to-date experience. The key parameters/ assumptions included:

- Non-elective demand: 94% (based on Jun-22) at 85th percentile (includes influenza demand as per 2019/20)
- Elective demand: 104% (based on activity plan)
- Length of stay: Based on 21/22 H2 out-turn
- Medically safe: Uplifted levels based on elevated numbers seen in first six months of 2022
- Bed occupancy target: 90%
- Core bed base: 1,283 adult G&A beds with 2.95% closed bed factor applied
- Variable capacity: Peak total of 98 beds in Jan-23 to Mar-23
- Efficiencies: Peak total of the equivalent of 132 beds.

In additional to the above 'nominal' state, a 'challenging winter' scenario was created at system level. The challenging winter scenario added additional demand pressure due to Covid-19 and influenza alongside additional capacity constraints due to a likely increase in bed closures/pathway segregation due to infection. In developing the 'challenging winter' scenario evidence from Australia was used, based on their influenza experiences, together with University College London forecasts around future Covid-19 waves.

The latest Trust-wide view of the adult base ward bed model outputs is shown in section five below.

3.3 Modelling winter demand - bank holiday pressure points

In order to understand specific pressure points throughout the year (i.e. bank holidays), analysis is undertaken considering historical data normalised around the New Year bank holiday (day zero).

For the Christmas and New Year period, Emergency Department (ED) attends and admissions, emergency admissions (all routes) and discharges have been considered for the two weeks running up to Christmas and the two weeks following New Year. The outputs can be found in the embedded Excel files below.


Christmas New Year Emergency Trends.xls


Christmas Holiday Analysis 2019-21.xlsx

Key messages include:

- Ambulance arrivals tend to remain at stable levels during Christmas. 2019 and 2020 saw reductions in arrivals after the end of the Christmas holiday period.
- Daily average ED attendances on average drop by circa 45 patients per day during the Christmas holiday. They tend to remain at a lower level in the two weeks after the Christmas period.
- Daily average non-elective admissions and discharges on average drop by circa 20 patients over the Christmas period, with net outflow (more discharges than admissions) in the first week and net inflow (more admissions than discharges) in the second week of the holiday period.
- Daily average elective admissions reduce by circa 40% during the Christmas period.
- Daily average supported discharges typically reduce during the second week of the Christmas period.
- Medically safe patient numbers typically accumulate across all pathways during the Christmas period.

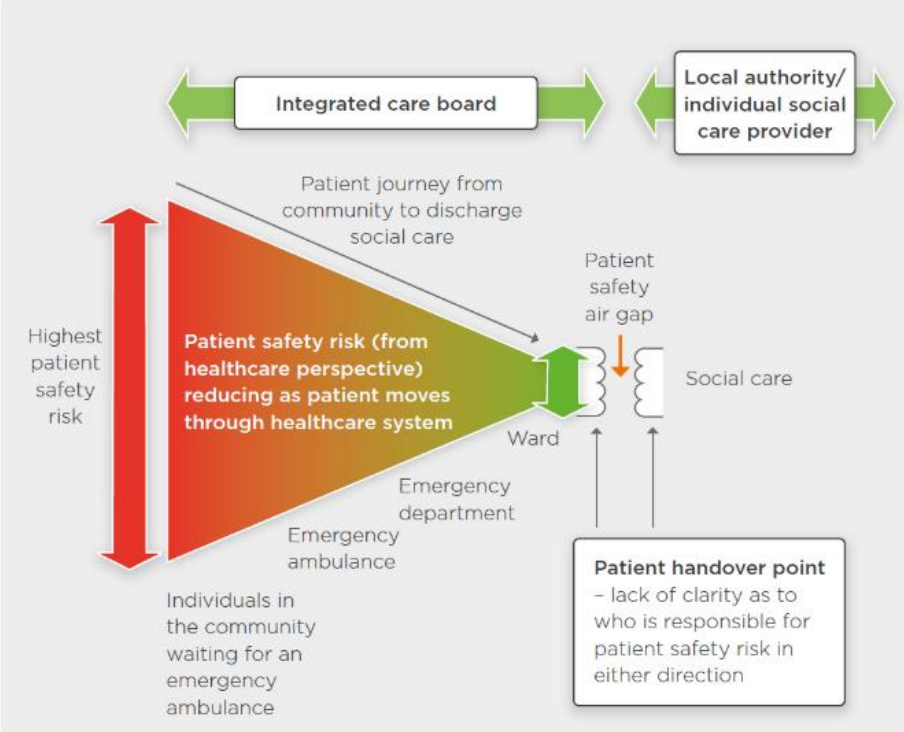
The embedded outputs are shared with divisional teams as part of the specific Christmas and New Year planning exercise that takes place in November each year. This exercise is completed in November once staff rotas are clearer (typically set 6-weeks in advance at all times) due to the relationship between service plans and staff rotas.

3.4 Risks

The Trust risks associated with capacity-related winter pressures can be summarised as:

IF	THEN	RESULTING IN
▪ Physical space is insufficient to meet demand. ▪ Unable to provide sufficient medical and nursing staff to meet demand. ▪ Unable to maintain a resilient workforce. ▪ Insufficient equipment to meet demand. ▪ Insufficient number of hospital beds to meet demand. ▪ Insufficient system capacity to maintain system flow and the timely transfer of medically safe patients. ▪ Experience a influenza pandemic or significant norovirus or CRE outbreaks. ▪ Experience any significant issues with the fabric of our buildings or other infrastructure (e.g. ICT).	May not deliver resilient services over winter.	▪ Adverse impact on patient safety. ▪ Inability to deliver appropriate services to our patients (particularly on elective pathways). ▪ Adversely impact on our reputation causing undesirable media coverage and a loss in confidence from the population we serve. ▪ Reduced staff morale, resilience and retention. ▪ Lack of compliance with national standards causing undesirable regulatory action.

The diagram below is extracted from a Nov-22 Healthcare Safety Investigation Branch interim bulletin titled ‘harm caused by delay in transferring patients to the right place of care’; it provides a simplified diagram of risk to patient safety as a patient is moved through the healthcare system to social care.



Key controls and areas of mitigation include:

- Deliver the actions detailed in this winter plan and our ICS system winter plan.
- Maintain a healthy workforce to maximise the ability of the acute to be able to respond to urgent and emergency care pressures (including encouraging the uptake of the flu and Covid-19 vaccines and promotion of existing health and wellbeing offer).
- Flexible use of staff to cover areas experiencing shortages with the use of bank, agency and locum staff where necessary and offering overtime.
- Timely completion of maintenance to keep estate in good condition.
- Enact the management of patient flow policy, full capacity protocol and surge plans as required including continuing to off-load ambulances as promptly as possible; even when this results in crowding in our Emergency Department recognising the patient safety risks detailed above.

4. Prevent

4.1 Preventing and managing infection

The Trust has in place a series of guidance and policies that are followed throughout the year to avoid, manage and contain infections including any cases of diarrhoea and vomiting (D&V), influenza and norovirus. These include:

- Infection preventions and control policy (CL/CGP/031)
- Outbreak of infection policy (CL/CGP/014)
- Viral gastroenteritis policy (CL/CGP/032)
- Isolation policy (CL/CGP/033)
- Respiratory viruses policy (CL/CGP/058)
- Pandemic influenza policy and procedure (GG/CM/020)

Planning for the annual influenza fighter campaign is underway with a nurse in place leading the vaccination process across the Trust. Peer vaccinators are identified with training underway in Sep-22. Influenza vaccines are expected to be delivered early Oct-22 at which point clinics will commence. In liaison with community partners we also plan to opportunistically vaccinate eligible unvaccinated patients attending our outpatient clinics. There is a 90% frontline staff vaccination CQUIN target in place for 2022/23. The influenza vaccine programme is operating alongside the Covid-19 immunisation programme which commenced in Sep-22 with staff uptake closely monitored and all staff encouraged to get vaccinated. Encouraging high staff uptake in both vaccine programmes is important to protect each other, our patients and support a resilient workforce over the winter period. As of 4-Nov the staff vaccination rates were 23% for influenza and 26% for the Covid-19 booster.

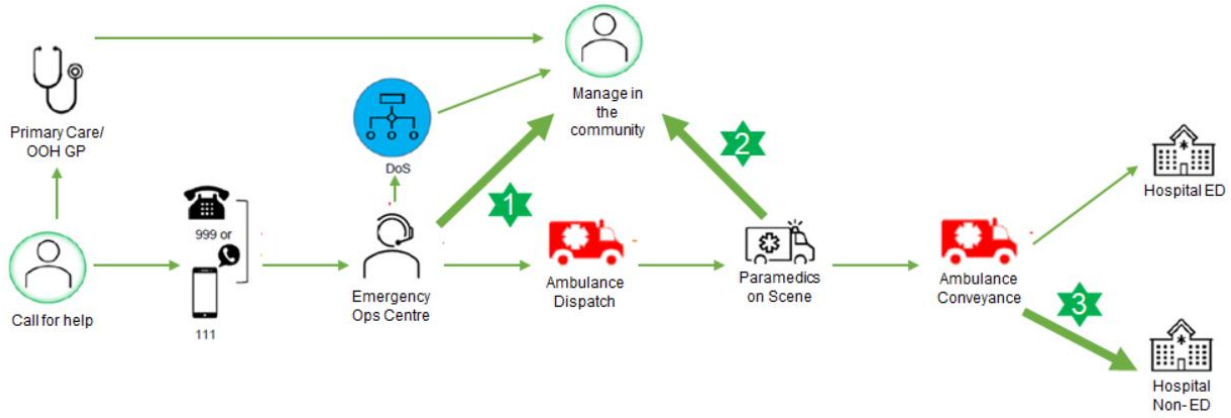
4.2 Communications

The system winter communications plan sets out the approach to delivering proactive and reactive communications across the NHS Nottingham and Nottinghamshire ICB to support the ICS wide plan for winter resilience in 2022/23. As with previous years, the focus locally continues to be on adult and staff flu and Covid-19 vaccination campaigns, the childhood flu campaign and supporting people to get the help they need at the right time, in the right place. In addition, this year, there is a focus on 111, discharge and virtual wards.

The Trust will continue to work with system partners to deploy a consistent message. For further details on system communication, please see the system winter plan.

4.3 Demand avoidance

The system-led changes and investment to reduce demand on the acute setting can be summarised in the visual below:



The priority system admission avoidance areas are:

1. Two hour urgent community response.
2. Promotion or existing alternative pathways, access to GPs and training and education.
3. Access to Same Day Emergency Care (SDEC) services and specialty triage lines. In recent years, NUH has invested heavily to increase the SDEC offer across our clinical services.
4. Additional capacity in the acute community Integrated Respiratory Service (IRS).

In addition there are system activities which identify vulnerable people at risk of hospitalisation and help people to stay well; initiatives include annual health checks; personalised care plans and social prescribing.

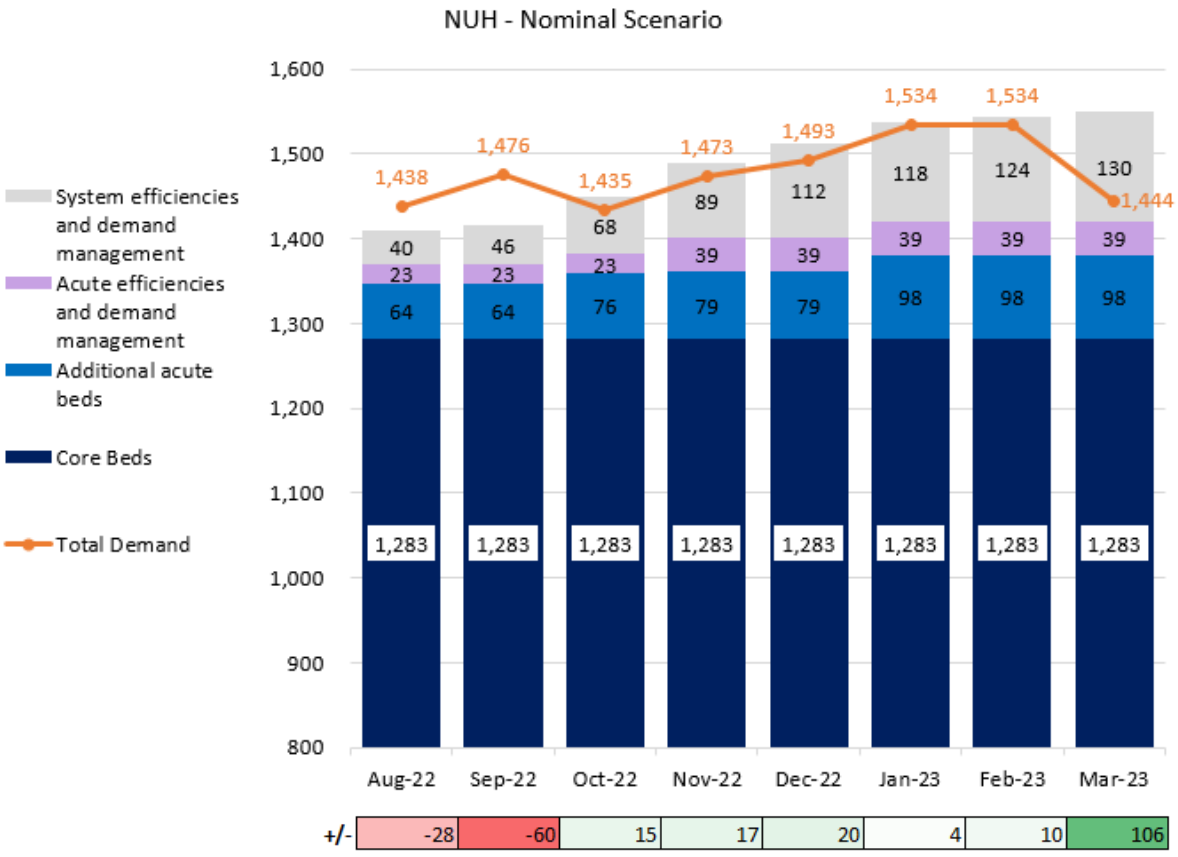
5. Prepare

5.1. Hospital capacity - mitigations for predicted bed deficit

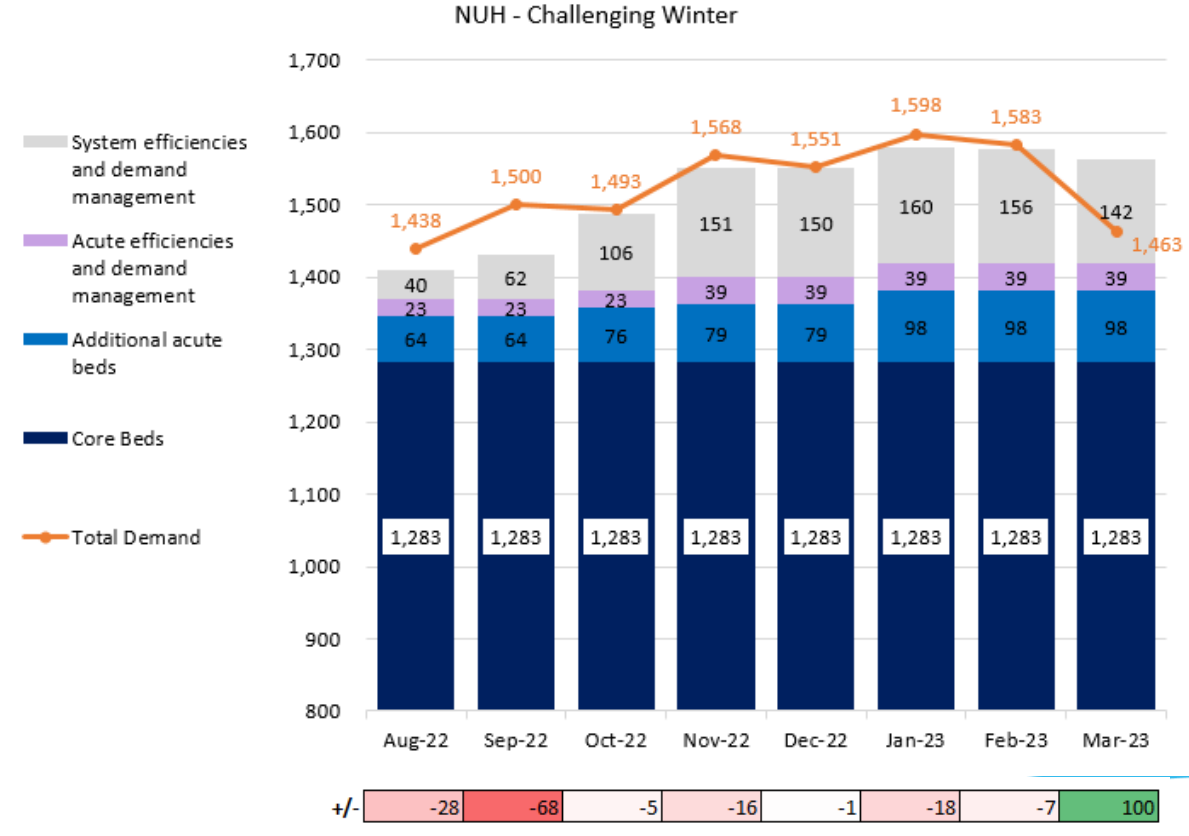
The Trust has kept open year-round in 2022/23 many of the beds that would usually be opened on a seasonal basis to support elective recovery and deal with times of heightened non-elective (including Covid-19) demand. As a result there is very limited additional capacity that can be opened over the winter period. The increases in acute bedded capacity since the summer period primarily relate to the opening of Berman 2 ward (brought forward due to Critical Incident in Sep-22), the opening of three additional beds on our Cystic Fibrosis Unit and the opening of the new modular ward (Jubilee unit) in Jan-23.

Efficiency and system mitigations have been applied to our model; further details are included on the following pages and in appendix A.

As the graph below presents the position against the 'nominal' scenario going forwards is a mitigated position on the basis of the successful delivery of all schemes to the intended level of impact. The Mar-23 position in both scenarios is underestimating the likely demand due to the baseline period being Mar-20 (the start of the Covid-19 pandemic).

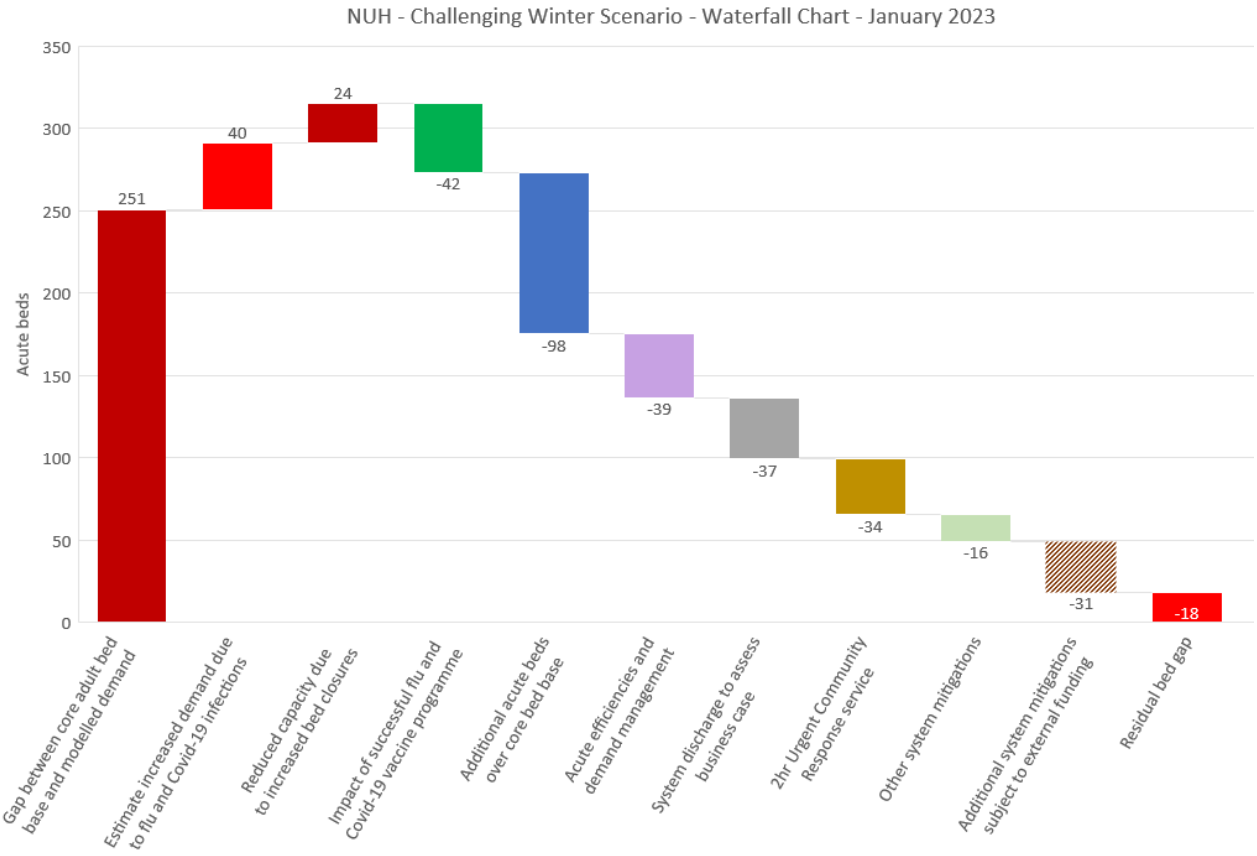


The graph below considers the forecast adult base ward bed position against the 'challenging winter' scenario. Within this scenario additional mitigations are included relating to the successful delivery of the Covid-19 and influenza vaccination programmes. In this scenario the peak residual bed gap going forwards is 18 beds in Jan-23 (again based on successful delivery of all schemes to the intended level of impact).



Please note: Both mitigation charts above include 31 beds of system mitigations from mid-Nov-22 that are subject to social care winter funding.

A waterfall chart is included below for the forecast 'challenging winter' Jan-23 position (the month with the largest residual bed gap going forwards).



Appendix A provides a breakdown of the schemes that form part of the above bridge chart.

Whilst some of the mitigations are easy to evidence once implemented e.g. opening additional beds; others are more challenging to evidence and quantify the impact. As such, there might be areas where the assurance level in terms of delivery is less clearly understood.

Within NUH we have further mitigating actions agreed and either in place or being delivered to support an improved position that it is difficult to quantify the bedded impact (or that deliver alternative benefits). The key actions have been grouped in themes and are summarised as follows:

Reduce demand on our services

- Maximising Same Day Emergency Care (SDEC) services with focus on increased use of our SDEC service in our Cancer and Associated Services (CAS) division and delivering paediatric SDEC. Gastroenterology SDEC has also commenced in two beds on ward C24 that cannot be used for inpatient care due to evacuation routes.
- Creation of a QMC admissions and discharge unit following the merger of QMC Daycase Unit, QMC Discharge Lounge and the Elective Admissions Lounge admissions and discharge areas to create an integrated service offer and sustainable workforce. This is being delivered in a phased manner and we plan pre-winter to increase the number of patients returning to the unit post-surgery to release inpatient beds. It has not yet been possible to quantify the potential bed impact for this scheme yet.

Enhance our bed configuration

- Berman 2 (12 beds) opened as a 'fit for home' unit. This unit opened early in Sep-22 during the Critical Incident.
- Jubilee Unit (20 beds) opening as a new elective ward in Jan-23 to support the transfer of elective activity from QMC to City to enable reconfiguration and expansion of Gastroenterology and Emergency General Surgery at QMC.
- Reconfigure Surgery Division Bed Capacity, utilising the opportunity presented by the Elective Colorectal/HPB move to City to create additional bed capacity for Gastroenterology at QMC.
- Increase surge capacity across our children's wards D33 and E37 from Dec-22.
- Expansion of Elective Admissions Lounge/Theatres Admission Lounge capacity at City to enable increase volume and specialty mix of patients to utilise this Daycase pathway, reducing use of inpatient beds by daycase patients.
- Maximum utilisation and flexible use of the Short Stay Unit (SSU) in the Treatment Centre.
- Improve ability to use any Linden Lodge capacity if there are no patients waiting elsewhere in the hospital for rehabilitation.
- De-medicalisation of a Healthcare of Older People (HCOP) ward to support specialty in-reach.
- Utilise ward A24 (Lyn Jarrett Unit) as a medically safe for transfer ward. This is dependent on securing sufficient staff and is presently high risk (so not yet reflected in our bed model).
- Create a four cubicle Trauma and Orthopaedic frailty unit at the end of ward F18 to provide additional capacity during the day shift in order to support early pull from ED (dependent on capital works).

Enhance our processes and improve patient flow

- Deliver symptomatic point of care testing in key arrival areas using the 4-plex Cepheid test (Covid-19, influenza A, influenza B and Respiratory Syncytial Virus) to support effective management of infected patients.
- Home care reablement trial provided by a third party for an initial 12-week period from Sep-22 to Dec-22 to bridge the gap before the system discharge to assess programme delivers impact. Scheme extended to the end of Mar-23.
- NUH care in the community scheme to start in a stage manner from Nov-22 as a 'provider collaborative' to provide up to twice daily packages of care to bridge the gap between the end of the patients hospital stay and the start of the social care commissioned package of care.
- Opening of the new expanded and developed paediatric ED estate from early Oct-22.
- Delivery of the NUH element of the ICS virtual ward business case. Potential being explored for further expansion into other specialties (see appendix A).
- Continued delivery of the microbiology 24/7 case approve and implemented in 2021/22.
- Continued delivery of our Enhanced Peri-Operative Care (EPOC) unit at QMC with the service expanding to an extra two patients per week from Oct-22. Deliver a City Hospital EPOC service with new processes in place for booking elective higher care beds from Nov-22.
- Work to increase utilisation of our Discharge Lounges across QMC and City Hospital with a proactive 'pull' of patients, maximising early moves and increasing use of the City Hospital discharge lounge for surgical specialties (for patient's post-operative care).
- Delivery of criteria-led discharge in our respiratory service.

Strategic enhancements in staffing

- Social prescribers in ED to ensure appropriate use of services and check and challenge.
- Work to establish a temporary transfer team for patient moves between our paediatric Emergency Department and the Childrens Assessment Unit (CAU).
- Pharmacist cover at City Hospital until 3pm at weekends.
- Additional morning phlebotomist at City Hospital to support the availability of earlier blood tests for blood dependent discharges.
- Enhance flow matron support and discharge co-ordinator capacity in our CAS division.

5.2. System medically safe for transfer mitigations

As mentioned above the system has committed to reducing the number of supported medically safe for transfer patients (MSFT) in hospital with a number of schemes identified, quantified and risk adjusted. Full details of these schemes are held by system partners with tracking taking place via the ICS.

The schemes identified for this winter have been identified in conjunction with all system partners, reviewed through multi agency discussion, considering the dual goals of positive impact on capacity and flow for the system, and being deliverable for this winter. The agreed list of proposals also went through an ICB assurance process with representation from ICB quality, finance, contracting and the urgent care teams to scrutinise the proposals and agree the schemes that offered the best return on investment for the system. The alternative to bed capacity – home based schemes were assessed as high priority.

These proposed schemes have been worked up by the SAIU using methodology from previous winter scheme models to produce a predicted impact on the bed gap, both at system and individual acute levels. Each scheme has the totality of the impact calculated, and then an assurance percentage applied to it to give the impact expected for this winter. For example if a scheme is only 60% assured, only 60% of its projected total impact would be taken into account as affecting the bed gap position.

The schemes can be summarised as follows:

Additional home care & fast track capacity

- Sciensus pathway 1 capacity.
- Homecare block (City and County Local Authorities).
- Utilisation of smaller homecare providers.
- Third sector support including the use by community providers of the British Red Cross.

Maintain spot purchased community beds

- Circa 140 interim beds, many of which have been in place since last winter, at a system cost pressure.

Community virtual wards

- Nottinghamshire Healthcare and CityCare service will deliver a community led offer which will deliver a consistent approach to virtual ward across the Nottinghamshire system. The priority of the service will be frailty and respiratory patients, although this clinical offer will not be confined at the expense of other conditions. The service will deliver a wraparound offer supporting other conditions and complexities which demand an intensive level of support and monitoring

All system schemes have been quantified, risk adjusted and, where appropriate, reflected in our bed model mitigations.

5.3. Elective activity over winter

As we enter the winter period we face staffing constraints that are impacting on our theatre offer. At the time of writing the theatre constraints are the rate limiting factor to the delivery of elective inpatient and daycase activity. It has been agreed that the theatre timetables for Dec-22 to Mar-23, once published, will be used to inform the volume of elective beds required to maximise the available theatre capacity. This volume of beds will then be protected to support the delivery of elective care over the winter period.

We will work towards maximising the use of the Treatment Centre theatres and beds over the winter period as a dedicated elective environment.

Elective activity would normally naturally reduce over the Christmas and New Year holiday period in line with patient choice – this is reflected in our bed modelling. This normally provides a degree of outlier capacity during one of the peak periods for non-elective demand.

5.4. Specific pressure points (Christmas and New Year)

Divisional Christmas and New Year staffing and service plans will be collated in November to align with staffing rotas. A cross-divisional review session will be completed. The Christmas and New Year plans will span from Monday 19 December 2022 to Sunday 8 January 2022. A copy of the plan will be embedded below in Dec-22.

The Christmas and New Year plan master version will be held by the site management team.

6. Respond and recover

All plans will be enacted in order to respond to winter demand and maintain and optimise patient safety.

6.1. Escalation triggers and actions

The Trust has in place escalation triggers that are routinely monitored by the site management team. Corresponding escalation actions detailed in the Trust Management of Adult and Children Patient Flow Policy (CL/CGP/087) are followed in order to respond to issues affecting our ability to maintain resilient services and de-escalate the position. The Trust Management of Adult and Children Patient Flow Policy has been reviewed in 2021 prior to entering the winter period.

The hospital has a full capacity protocol that will be followed during times of peak pressure when patient flow is compromised. The full capacity protocol includes actions such as going 'one-over' on suitable wards where there is an identified discharge.

The use of the escalation triggers and actions and full capacity protocol are business as usual activities.

6.2. Business continuity plans

Business continuity plans are in place across key Trust services. They will be enacted as needed during winter (in the same way they would be at any other time of the year) and kept in place until normal services can resume.

6.3. Governance

The normal Gold and Silver on-call rotas continue 24 hours a day throughout the year. The rota for staff on-call can be found here on the Trust intranet. Details of on-call staff together with the site management team Duty Matrons are included in the specific Christmas and New Year plans referred to above.

The executive operational lead for winter for the Trust is Lisa Kelly, Chief Operating Officer.

A system control centre will be in place seven day a week throughout winter. The centre has had a 'soft' launch in early Nov-22 and will be refined with discussions with acute Trusts to ensure processes are aligned.

6.4. System documents

The local ICS has in place system-level winter plan (that this plan should be considered in conjunction with) alongside system-wide OPEL framework and escalation processes.

7. Appendices

7.1. Appendix A: Bed mitigation scheme breakdown

Theme	Scheme	Impact	Timescale	Delivery Status
Additional acute bed capacity over core bed base				
	Daybrook	3 additional beds	Year-round	In place
	Harvey 2	4 additional beds	Year-round	In place
	Loxley	4 additional beds	Year-round	In place
	Southwell	5 additional beds	Year-round	In place
	Winifred 2	4 additional beds	Year-round	In place
	C4	6 additional beds	Year-round	In place
	Nightingale 2	12 beds	May-22 onwards	In place
	D55	12 beds	May-22 onwards	In place
	Berman 1	16 beds	Jun-22 onwards	In place
	Berman 2	12 beds	Nov-22 onwards	In place
	Cystic Fibrosis Unit	3 additional beds	Nov-22 onwards	In place
	Jubilee Unit (Modular ward)	20 beds	Jan-23 onwards	Build underway
	Lyn Jarrett Unit (20 beds) (as a medically safe ward)	0 beds	Not currently in model. Subject to staff availability.	
Sub-total		**Peak of 101 beds.** **Adjusted to 98 beds to include a 3% closed bed factor**		
Internal Trust efficiencies				
	CHS home care trial	3 beds worth of savings	Sep-22 to Mar-23	In place
	Provider collaborative	15 beds of savings	Nov-22	Commenced in Nov-22
	Microbiology 24 hour (carried forward scheme from 21/22)	7 beds of savings	Year-round	In place
	Virtual wards (VW) ○ Circulatory heart failure (in place for over 1-year) ○ Digestive (Aug-22) ○ Max Fac (Nov-22) ○ Neurosurgery (Nov-22) ○ Vascular (Dec-22)	13 beds of savings	Oct-22 onwards	Impact currently averaging 3 beds in Oct-22 for circulatory and digestive. Activities ramping up.
	Gastroenterology SDEC	1 bed saving	Nov-22	Commenced in Nov-22
Sub-total		**Peak of 39 beds.**		

Theme	Scheme	Impact	Timescale	Delivery Status
Discharge to Assess (D2A) business case		**Peak of 49 beds of savings (37 in Jan-23)**	Impact ramping up throughout the winter period	Variable, some over and some under. Schemes ramp up over winter.
2 hour urgent community response service		**34 beds of savings**	Year-round with set up in Oct-22	In place and over delivering against activity plan.
Other system mitigations				
	CityCare additional beds at Connect Heritage	14 beds	Nov-22 onwards	In place
	Virtual wards ran by Nottinghamshire Healthcare Trust	2 beds of savings	Nov-22 onwards	Commenced in Nov-22
Sub-total		**16 beds/savings**		
Additional system mitigations subject to social care winter funding				
	County local authority homecare block (up to 105 additional packages of care per week)	14 beds of savings	Subject to external funding.	
	Respiratory, cardiac and palliative in-reach	9 beds of savings		
	Additional capacity in IRS.	2 beds of savings		
	Block home care extension (400 hours of additional homecare)	3 beds of savings		
	Other schemes (including Asthma Biologics and IDT care home nurse)	3 beds of savings		
Sub-total		**31 beds of savings**		
Grand total		**266 (251 in Jan-22)**		