Item 057 - Appendix 2

Joined Up Care Derbyshire

JUCD Seasonal Plan 2025/26 Summary

NHS

The Derbyshire VCSE sector Alliance

Derby City Council

DERBYSHIRE County Council

EXECUTIVE SUMMARY

- The JUCD Seasonal Plan (Winter) aims to ensure that the health and care system is well-prepared to manage increased demand throughout the year with adequate capacity and mitigations throughout periods of high demand this winter.
- The Seasonal Plan is supported by a Demand and Capacity modelling tool that has been completed by all organisations; mitigation plans are in place to address any shortfall over winter.
- The Plan details oversight and escalation processes to ensure a collective and dynamic management of risk is in place throughout the winter period.
- High demand is expected; system escalation processes and responses must be effective to support the operating environment this winter:
    - Individual organisations have reviewed internal triggers and actions.
    - The system has a system escalation plan which has thresholds and triggers along with arrangement for command and control during heightened pressure.
    - Demand, and the delivery of plans will be tracked and monitored weekly through the system Weekly Winter Monitoring Group (chaired by the nominated System Winter Director) to ensure system partners have a shared understanding and awareness; and enabling the system to respond dynamically to emerging risk and changes.
- The system Seasonal Plan is under continual review and will be updated to reflect system plans as they continue to develop or should new pressures emerge.

APPROACH & PURPOSE

- An effective system seasonal plan will support the system being safe over winter and that there is a shared understanding of demand and arrangements relating to capacity, surge and escalation.
- The system Demand and Capacity Modelling Tool provides a clear view of the forecasted demand and capacity. We will monitor delivery by reviewing planned vs actual outcomes via the weekly winter monitoring group with support from BI.
- Partners and providers from across Derby and Derbyshire ICS have worked collaboratively to coproduce a system seasonal plan to ensure the system is prepared for the heightened demands throughout the year.
- Local approach summary:
    - Winter wash up - review of effectiveness of plans for 24/25 to inform arrangements for 25/26
    - Winter key lines of enquiry (KLOE) completed and submitted to NHSE
    - Wider engagement – targeted engagement across the JUCD footprint
    - Weekly Winter Monitoring Group – will be stood back up between October 2025 – April 2026
    - Effective System Control Centre and Central Navigation Hub, enhanced by adding a Winter Room facility
- Initial winter plan submission to NHSE on 01 August 2025.

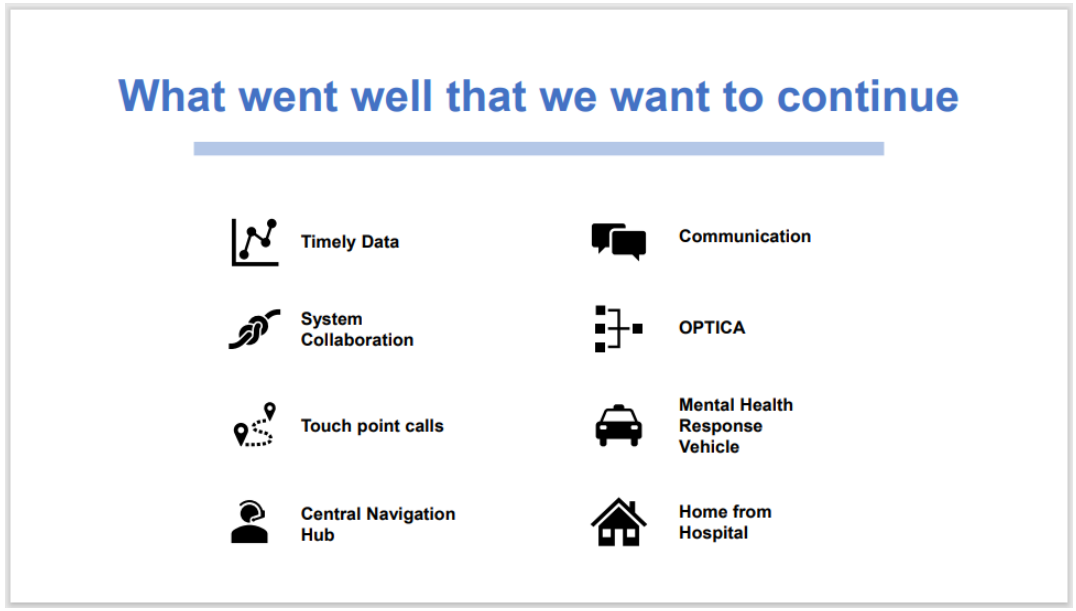
ROLES AND RESPONSIBILITIES

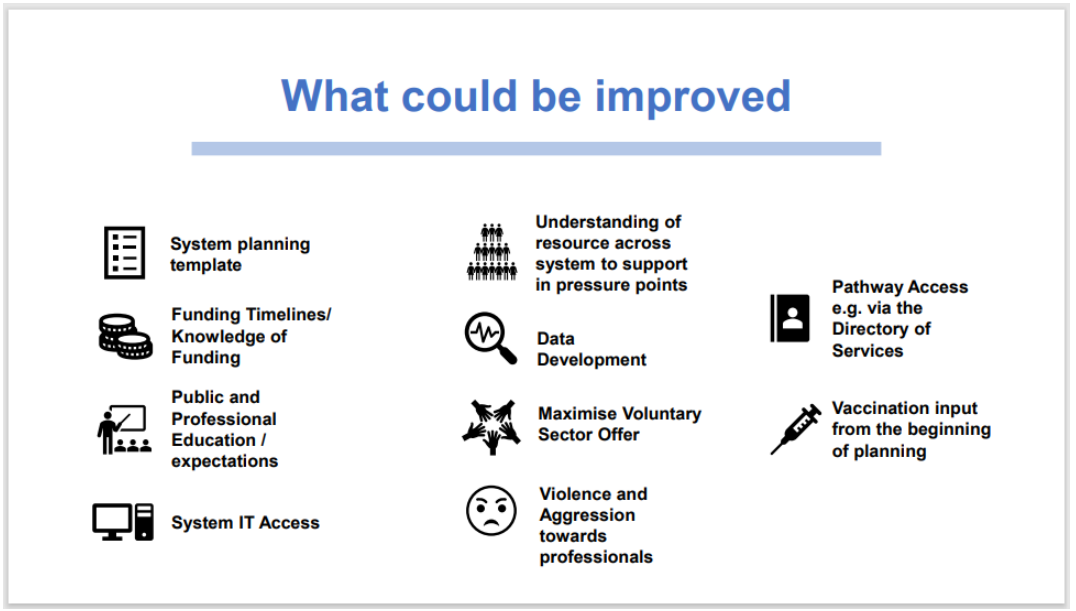
Integrated Care Board (ICB)	• The ICB coordinate efforts across healthcare providers to manage winter pressures, maintain oversight through the System Co-ordination Centre (SCC), develop a comprehensive winter plan, and report to NHS England (NHSE).
Hospital	• Hospitals need to ensure adequate staffing, maximise bed capacity, and implement strict infection control measures.
Primary Care and Community Health	• Primary care should manage non-urgent cases, promote vaccinations, and educate the public on health during winter. • Community health services must support patients at home, ensure timely discharges, and provide rehabilitation services.
Ambulance Services	• Ensure rapid response times and effective triage to manage emergency cases efficiently. • Support patient flow by the provision of effective patient transport services
Local Authority	• Local authorities are responsible for coordinating with Integrated Care Systems (ICSs) to manage winter pressures, providing social care support to facilitate hospital discharges, and ensuring community services are available for vulnerable populations.
Public Health	• Public health focuses on leading vaccination campaigns for flu and COVID-19, conducting health education campaigns to inform the public on staying healthy during winter, and implementing infection control measures in community settings.

2024/2025 – LESSONS LEARNED

On the 2nd April 2025 Joined Up Care Derbyshire held a Winter Wash Up Event at The Post Mill Centre in South Normanton bringing together all system partners and providers to review and reflect on Winter 2024 and begin planning for Winter 2025.

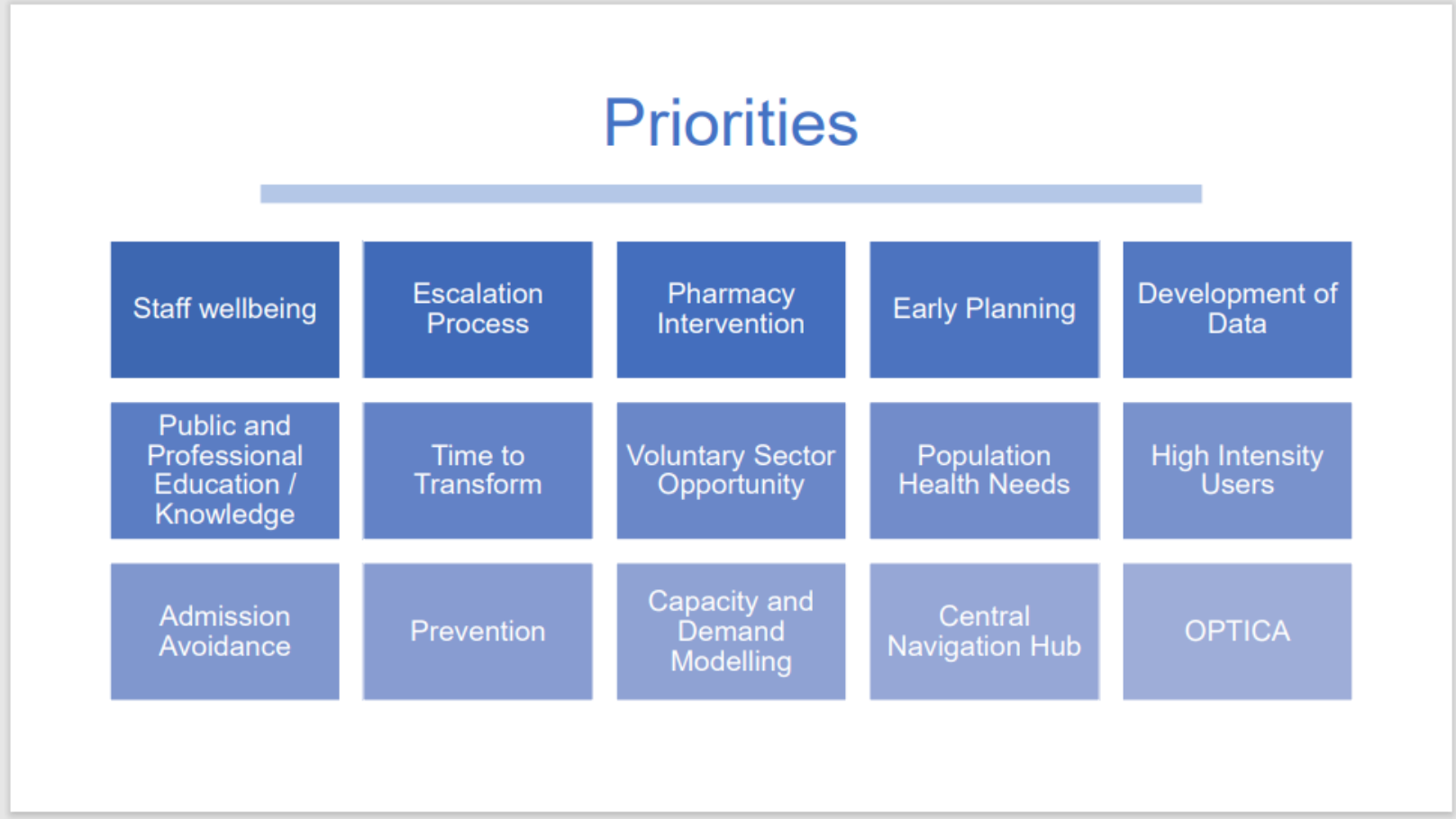
The session was interactive, attendees were involved and engaged in collaboratively working to understand how effective plans for winter 2024/25 had been, what worked well, and where there were opportunities for improvement in winter 2025/26.





2025/2026 – AGREED PRIORITIES

A collective set of priorities were agreed at the end of the session and all providers were asked to ensure their internal winter plans aligned to the priorities agreed.



WINTER LETTER SUMMARY

- The NHS England winter letter for 2025/26 emphasises the need for:
  - A quantative demand and capacity excel document that is monitored throughout the winter period.
  - Vaccination uptake information and monitoring
  - Implementation and management of infection prevention control measures to protect service capacity.
  - Workforce resilience and availability across the whole system

- Integrated Care Systems (ICSs) are tasked with leading these objectives, maintaining oversight through the System Co-ordination Centre (SCC), and ensuring a comprehensive winter plan is in place to support the entire healthcare system.

- The following three slides detail the priorities set out, the interdependencies between the UEC recovery plan, the NHSE winter letter and what is embedded within our system plan and KLOE submission.

Benchmarking Derby and Derbyshire against current guidance, requirements and existing UEC plans and the Winter letter

IN-FLOW

NHS UEC Plan 2025/26

- Acute trusts to establish a defined improvement trajectory towards achieving the 15-minute hospital handover target.
- Ambulance trusts to operate a call before convey principle and enable "see and treat", supported by additional clinicians in emergency operating centres and single point of access.
- Ambulance trusts to expand overnight support for 999 call handlers and clinicians to provide urgent in-home care for clinically assessed patients, with follow-up services available the next day.
- Ambulance trusts to reduce the rates of 'hear and treat' and 'see and treat'

NHSE Winter letter

Systems must develop robust demand & capacity modelling, including but not limited to:

Demand forecasts:

- Admissions vs Discharges (daily and weekly net position) across all bed bases.

Capacity forecasts:

- Weekly operating plan (October to March)
- Forecast admissions and discharges

Ambulance activity:

- 999 calls
- Hear & Treat (% and volume)
- See & Treat (% and volume)
- See & Convey (% and volume)

JUCD System Seasonal Plan

- The demand and capacity modelling tool captures system activity forecasts and through the weekly winter monitoring group planned vs actuals will be monitored and reported on.
- EMAS analyses A&E activity data from the past two years to identify potential peaks and forecast surges. This includes considering hospital predictions and internal forecasting to provide a comprehensive view of expected activity.
- EMAS take proactive steps such as increasing the opportunity to send non-urgent cases to alternative care providers, conducting horizon scanning for potential threats, and enhancing staffing during peak periods like Christmas and New Year.
- EMAS actively manages roster gaps, time off in lieu (TOIL), and annual leave policies to minimize disruption.
- Measures are in place to support staff wellbeing, including access to support services, hot drinks, proactive recognition, regular sickness review meetings, and a robust flu vaccination campaign to maintain health and morale during peak winter pressures.

Benchmarking Derby and Derbyshire against current guidance, requirements and existing UEC plans and the Winter letter

FLOW

NHS UEC Plan 2025/26

System Plans should include:

- Delivery approach to strengthening the childhood vaccination offer.
- Delivery approach to the year-round RSV vaccination programme for older adults and pregnant women, ensuring all those in the older adult catch up cohort (75 to 79) have been offered a vaccination by 31 August 2025.
- Stretching plan for flu vaccine uptake by NHS staff with a target percentage increase on last year's uptake.
- Winter virus resilience plans against the infection protection and control (IPC) mechanisms available both in and out of hospital, including appropriate policies and procedures, appropriate co-horting spaces and exploring the direct admission of flu patients into community bedded capacity.
- How systems intend to expand access to urgent care services at home and in the community, so patients don't need to attend hospitals unnecessarily.
- How local partners are working together to identify patients who are most vulnerable during the winter period and co-ordinate proactive care for these individuals.
- How their clinical model will be configured and adapted to make sure that the most appropriate clinician is consistently available to provide continuity of care, proactively identify deteriorating conditions, support rapid assessments and join up more effectively with primary and community teams.
- How local mental health providers can evidence that, when mental health patients are admitted to an inpatient setting, their stay will be as short as possible. This should include producing their own % reduction target of re-admissions for their highest intensity users, how the number of patients in out-of-areas placements will be reduced, and how to reduce the number of patients who need a mental health admission waiting over 24 hours

Systems:

- Some systems to test the use of health visitors to administer childhood flu vaccinations and other routine immunisations for eligible children.
- Implement the "Release to Rescue" standard without exception, including in the winter months.

NHS Trusts:

- Demonstrate plans to improve vaccination rates in health and care workers.
- Have an accessible occupational health vaccination offer to staff throughout the entire flu campaign window, including onsite bookable and walk-in appointments.
- To achieve the target of more children being seen within 4 hours, deliver effective utilisation of UTCs, children and young people's specific services and standards.
- Demonstrate effective use of capacity across the full system by reviewing bed usage, returning people to home-based care where possible, and providing surge capacity alongside IPC co-horting where it is effective and appropriate to do so.

Benchmarking Derby and Derbyshire against current guidance, requirements and existing UEC plans and the Winter letter

FLOW
NHSE Winter letter

Vaccination and IPC

Preparedness Forecasted data is required for:

- Weekly flu workforce vaccination rates
- Weekly flu eligible cohorts (specifically children, adults 18-64 with at risk condition and those 65 + over) vaccination uptake
- Total population coverage by scenario week

IPC Impact Forecasting:

- Weekly projection of beds closed due to infection
- Average IPC-related LoS extension
- Forecast workforce disruption (absence due to outbreaks

Systems must be able to:

- Demonstrate how they will manage and contain outbreaks, including IPC surge capacity, workforce resilience, and minimising service disruption. Plans should reflect the learning from the extended flu season last winter, including the handling of RSV and Norovirus pressures.
- System vaccination uptake plans, once tested with regional vaccination colleagues, are to be submitted as part of the system winter plan by 1st August.
- Have detailed trajectories and delivery models for workforce vaccination and uptake among eligible flu cohorts (specifically children, adults aged 18-64 with an at-risk condition and those aged 65 and over).

Workforce resilience and availability
Submit:

- Weekly forecast of staffing levels by sector
- Absence modelling (flu, COVID, industrial action)
- Surge staffing capability by scenario
- Expected deployment of bank/agency by week.

Scenario based planning must include:

- Baseline – typical winter activity
- Surge – flu/covid/RSV-driven pressure
- Super Surge – combined pressure from respiratory illness, workforce gaps, and IPC outbreaks

Systems must define their:

- Escalation triggers and thresholds
- Capacity stretch (how far and how fast beds/staff can scale)
- Sector-specific impact by scenario (e.g. MH, CYP, acute)

Benchmarking Derby and Derbyshire against current guidance, requirements and existing UEC plans and the Winter letter

FLOW
JUCD System Seasonal Plan
• The demand and capacity modelling tool captures system activity forecasts, and through the weekly winter monitoring group planned vs actuals will be monitored and reported on. • Each provider has confirmed they are reviewing their offer and will look to provide accessible vaccinations via onsite services which are bookable and available via walk in, there are however still internal discussions within Trusts regarding how this can be offered throughout the full campaign to provide a 100% offer. • Regarding the offer of vaccination for inpatients, there is still some clarity required from NHSE regarding the extensiveness of this requirement with a webinar due in the coming weeks. It has been stated that it is optional for Trusts to provide this. • There is a comprehensive vaccinations programme plan across the NHS and public health. • All providers have arrangements in place to ensure 7-day cover during winter and periods of high infection prevention and control (IPC) demand, using a combination of in-hours internal support and out-of-hours on-call systems. • Acute Trusts have point of care testing in place for winter. • Our Community Trusts test through a PCR test which is then submitted to the acute trust labs. • Provider human resource directors will work in collaboration to understand the workforce required, explore solutions and availability of current workforce to determine any gaps. • Providers have plans in place to deliver additional capacity utilising their available workforce through skill mix, redeployment and additional hours. They will continue to assess and review their workforce models and additional capacity required, utilising a range of roles and adopting flexible workforce models which respond to demand accordingly. • The Derby and Derbyshire system offer a system wide health and wellbeing activity timetable, which includes mental and emotional Health, MSK / physical health and health Inequalities to support health, wellbeing and workforce retention. • There are escalation triggers and thresholds embedded within the system plan with provider plans outlining internal processes. • Work is ongoing across the system to ensure that BCF capacity plans include appropriate capacity for surges over winter, both for step-up and step-down care. • BCF funded schemes to support discharge including work with VCSE on transport and settle scheme, dementia palliative care service and a programme of discharge work including P2 transformation.

Benchmarking Derby and Derbyshire against current guidance, requirements and existing UEC plans and the Winter letter

OUT-FLOW

NHS UEC Plan 2025/26

System plans should include:

- How NHS providers and local authorities (through health and wellbeing boards) will improve discharge and admissions avoidance.
- Acute trusts to set stretching local performance targets for daily pathway 0 discharges and profile them through the week.
- Acute trusts and local authorities to set local performance targets for pathway 1, 2 and 3 patients.

NHSE Winter letter

Demand forecasts:

- Admissions vs Discharges (daily and weekly net position) across all bed bases.

Capacity forecasts:

- Weekly operating plan (October to March)
- Forecast admissions and discharges

JUCD System Seasonal Plan

- The demand and capacity modelling tool captures system activity forecasts and through the weekly winter monitoring group planned vs actuals will be monitored and reported on.
- Improving complex discharge pathways and processes & increasing the volume and effectiveness Pathway 1 reablement interventions.
- The operational improvements are expected to impact this winter and are involving a wide range of system partners in designing and implementing interventions under a structured programme approach.
- The system has a focus on strength-based conversations using standardised referral form and have much focus on establishing our Care Transfer Hub.
- The system has agreed discharge improvement strategy metrics, these cover P1, P2 and P3. We are working collaboratively to improve how we monitor our pathway performance at present – ensuring we know comprehensively how the pathways are working for patients and how effective our improvement work is.
- To support this and to support operational decision making we are embedding OPTICA at both our acute sites, good progress is being made here.

CAPACITY AND DEMAND

POSITION STATEMENT – FULL SYSTEM

Provision/Provider		RAG (Capacity)
Chesterfield Royal Hospital	• Chesterfield Royal Hospital has a core bed base of 527 beds, which incrementally increases to 554 beds between January and March 2026 to accommodate rising demand. From March through April, bed capacity is gradually scaled back to the baseline of 527. The baseline capacity includes built-in contingencies for both surge capacity (10 additional beds) and super surge measures (activation of an extra ward) to help manage fluctuations in demand, particularly during periods of high pressure. • Improvement initiatives are in place across the trust to support demand management and flow.	Dependant on D2A capacity
University Hospitals Derby and Burton	• Royal Derby Hospital (RDH) has a core bed capacity of 912. It is currently operating with a medical bed deficit and is utilising outlying beds, providing up to 114 additional spaces during peak months, as well as escalation areas, including GDCU and TES Capacity 1 & 2, which offer up to 58 extra spaces during periods of high demand. • Queen's Hospital Burton (QHB) has a core bed capacity of 378. Between September 2025 and March 2026, QHB is projected to experience a medical bed deficit and will utilise outlying beds and escalation areas to provide up to 47 additional beds during peak demand periods. • UHDB predicts a winter bed deficit of 208 beds, with 38 at QHB and 170 at RDH, based on 95% occupancy at its peak in January. Planned mitigations/ actions are in place to address this .	The modelling is based on a 95% bed occupancy
Community Urgent Treatment Centres	• DCHS UTCs overall activity projection across all 4 units is a 2.7% increase on the 24/25 plan with variance across individual UTCs to reflect trends at a local level and in particular the resumption of business as usual at Ilkeston UTC following a period where business continuity arrangements were in place. • As ever, the actual demand at each of the UTC is subject to fluctuation in year because of increased acuity, complexity, clinical outbreaks and reduced capacity in other parts of the system. • DHU Derby UTC operates consistently above planned activity, with winter months demand increasing by over 30% in Oct –Mar 24/25. DHU have factored this increase into their 25/26 forecast. No workforce/capacity concerns have been flagged; therefore, the assessment is that there is sufficient capacity within the DUTC to meet the level of demand.	Whilst sufficient capacity outlined, it is dependent on recruitment/ workforce plans
Co-Located UTCs at DRH and CRH	• Plans indicate sufficient capacity to meet the demand this winter • Opportunity to increase activity and throughput into the co-located UTC. Work taking place with Acutes and DHU to support this.	Increase in utilisation required to support wider system pressures.
Same Day Emergency Care (SDEC)	• Plans for SDEC improvement within the acute providers are focussed on reducing variation in provision and implementing guidance, operating a variety of SDEC services for at least 12 hours per day, 7 days a week. • There is an ongoing workforce review, demand and capacity modelling is in progress and there is rapid access to diagnostics 7 days a week. • System partners are encouraged to maximise opportunities including direct referrals to SDEC from alternative pathways.	Improvement plans in place, demand and capacity modelling in progress
Virtual Ward Capacity	• Derby and Derbyshire ICB Virtual Ward Programme has been reviewed to assess its performance and alignment with current service capabilities. One of the key recommendations from this review is to reduce the technical capacity of virtual wards, based on delivery data from 2024/25. Specifically, the proposal is to adjust capacity from 145 to 112 beds, providing a more realistic reflection of what the system can sustainably deliver. Changes to take place from September 2025. • Community Transformation – There is work underway to deliver new step-up care model via the Local Navigation Hub network. • Improvements across existing virtual wards – continue to develop new pathways.	Increase in utilisation required to support wider system pressures.

POSITION STATEMENT – FULL SYSTEM

Provision/Provider		RAG (Capacity)
D2A Modelling	Demand for P1 and P2 Pathways: There is a need for Private, Voluntary, and Independent (PVI) sector services to meet winter demand, especially for Pathways 1 and 2. This includes spot purchasing of home care and residential/nursing placements. Discharge Delays: Delays in arranging discharge-to-assess (D2A) packages are not fully quantified, but they are expected to impact patient flow, particularly at Chesterfield Royal Hospital. Winter Escalation Role: A dedicated Winter Escalation post was established in 24/25 to oversee capacity, demand, and Pathway Operations Group (POG) meetings. This role supported operational oversight during winter and will transition to the new Care Transfer Hub managing discharges for JUCD residents for 25/26. Exact date of this transition to be confirmed. Monitoring and Governance: Winter performance is monitored and adjusted through weekly Strategic Discharge Group reports. Reporting feeds into system-wide coordination via the Pathway Data Group and a forecasting subgroup. These groups report to the Strategic Pathway Group, overseen by the Director of Integration and the Chief Operating Officer of Derbyshire Community Health Services, who is also the system executive lead for discharge. The Winter Monitoring Group will be cognisant of these reports as part of wider system monitoring.	While the collective position shows balance, there are different pressures in city/county which offset each other as part of the total position.
Mental Health	• DHcFT Winter Plan indicates sufficient capacity to meet the expected demand this winter, based on a projected demand increase of 4%. • In addition to the capacity outlined in the table above, Derbyshire Healthcare Foundation Trust (DHcFT) has 8 additional surge beds available across the two wards at the Radbourne Unit. These beds will be made available if required during any peak periods of demand during Winter.	MH bed challenges nationally. Requires system support with NCTR
Primary Care	• By using GP Access Data (GPAD) we know that the total appointments delivered April 2023 – March 2024 were 6951860 and for the same period, April 2024 – March 2025 the total is 7175523. This is a total increase of 3.22%. • Demand and capacity will continually be reviewed as part of business as usual within Practices – balancing demand for on the day and routine appointments against available capacity. Practices are balancing the fact that increased same day appointments will impact on Long Term Condition (LTC) management and support for people needing complex care. • There has been no additional funding provided for the delivery of ARI hubs currently. A paper is in development using latest national ARI data and insights from other systems to demonstrate how year-round ARI Hubs can deliver long-term savings and support strategic commissioning.	Unknown impact of Contractual Action
111 Capacity	• Whilst activity starts to increase from October onwards, the main peak of activity over the winter period is centred on the Christmas and New Year bank holiday periods. • DHU are anticipating that call volumes will exceed 1,700 calls per hour during periods of highest activity on 5 category 'A' days (see table below), and there are a further 3 days predicted where call volumes will exceed 1,400 calls per hour. • Plans indicate sufficient capacity to meet the demand this winter	
999 Capacity	• Plans indicate sufficient capacity to meet the demand this winter • The Trust considers Hospital Predictions, which includes the 'actual' conveying activity by ED and Derbyshire Division for the previous 2 years with highlighted busiest days for the 2 years and an 'Uplift' selector to allow to review the potential impact of increased activity. • Increasing the opportunity to send the majority of c3,4,5s to SPAs, UCRs etc via the ITK 24/7 and call before convey included in the plans to support us during winter. • Clear plans are in place regarding the no individual handovers exceeding 45 minutes at both CRH and RDH.	Significant fluctuations in C2 and handover performance

POSITION STATEMENT – FULL SYSTEM

Provision/Provider		RAG (Capacity)
Patient Transport Services (PTS)	• Fluctuating Demand: The number of planned journeys varies across the months with on the day bookings remaining high for both acute trusts. • Planned resource allocation remains constant at 60 units per month throughout the entire 12-month period, regardless of the projected fluctuations in demand. • Improvement work is on-going to increase pre-booking and improve processes and system working	Increasing the number of pre-booked journeys will support .
Community services, such as Urgent Community Response, Team up, Community Nursing	• Predominantly sufficient capacity to meet current demand, there are opportunity to increase referrals into Team up including into the Falls recovery service. • The initial phase of the Team-Up offer is delivery of an urgent (same / next day) community response. It provides a joined-up response to help people, with escalating urgent needs remain at home. There are four components of this urgent community response which are: At scale PCN Home visiting services, Rapid response nursing and therapy services – provided by Derbyshire Community Health Services, Adult social care Rapid Response services provided by local authorities and increasingly being integrated with NHS services and Falls prevention and falls recovery services – delivered via a variety of LA and NHS providers. • 15 Home Visiting Services across Derby & Derbyshire providing reactive and proactive care.	Clinical prioritisation in place to ensure urgent referrals seen.
Clinical Navigation Hub	• There is sufficient capacity within the CNH to meet current demand levels and forecast growth over winter. The CNH aim is right care, right place, first time for patients • Continued collaboration with EMAS to increase appropriate referrals.	

RISKS AND MITIGATIONS

Please note: This slide is a high-level summary of the risks/mitigations highlighted within individual plans.

KEY SYSTEM RISKS & MITIGATIONS

Risk Category	Risk Description	Impact	Mitigations (What is in place to prevent the risk from occurring?)
Workforce	Insufficient staffing levels due to sickness and burnout. Bank & agency usage Potential industrial action	• Increased sickness and burnout • Reduced capacity of services due to insufficient staffing o Fewer frontline staff can delay patient assessments, increase wait times, and reduce the availability of beds or services. o Impacts patient safety, especially in emergency and urgent care • Financial cost of additional temporary staffing o Increases operational costs significantly. o Can lead to continuity of care issues, as temporary staff may not be familiar with systems, patients, or protocols. • Reduced staff resilience/Increased pressure on remaining Staff: o Staff who remain in service may face excessive workloads, leading to further burnout, sickness absence, or resignation. o Risks to morale and quality of care. • Service Disruptions from Industrial Action: o Industrial action (e.g., strikes) can lead to cancellation or postponement of non-urgent services. o Can significantly affect elective recovery plans and increase winter pressures. • Failure to Meet Targets: o Risk of not achieving key performance indicators (KPIs) such as A&E 4-hour target, ambulance handover times, and elective recovery metrics.	• Strengthen workforce capacity through targeted recruitment campaigns, increased use of temporary staffing (bank and agency), and deployment of returners and students where appropriate. • Support staff wellbeing and resilience by offering comprehensive mental health support services, promoting flexible shift patterns, and ensuring effective management of annual leave to maintain rest and recovery. • Work collaboratively with system partners to develop and implement robust workforce contingency plans that protect essential services during peak winter demand and potential industrial action. • Promote high vaccination uptake among staff (e.g., flu and COVID-19) to reduce illness-related absences and protect both staff and patients. • Maintain awareness of staff health and wellbeing, with clear escalation routes and support mechanisms embedded at team and organisational levels, ensuring early intervention and sustained engagement throughout the winter period.
Capacity	Limited bed availability and resources to handle increased demand across all services Ambulance handover delays and delayed ambulance response times No additional funding for ARI hubs this winter, reduction in capacity/ offer from last year	• Increased reliance on non-standard care settings (e.g., virtual wards, walk-in centres), potentially increasing clinical risk and variation in patient outcomes. • Delays in ambulance response times and patient handovers at hospitals, risking patient deterioration in the community. • Inability to provide timely and appropriate care pathways, especially for vulnerable cohorts.	• Support patients to remain well at home through enhanced community care offers, proactive long-term condition management, and remote monitoring (e.g., virtual wards) • Maximise existing resources via effective discharge planning, reducing length of stay, and optimising patient flow across acute and community sectors.

Risk Category	Risk Description	Impact	Mitigations (What is in place to prevent the risk from occurring?)
Capacity		• Escalating system costs due to emergency escalation measures and use of out-of-area or private provision. • General Practice workforce constraints due to contractual action (e.g., safer working limits) may reduce appointment availability and lead to overflow into other system services. • Reduced respiratory pathway provision from the prior year (due to lack of ARI hub funding) may increase ED attendances and demand in urgent care settings.	• Enhance ambulance interface with streamlined handover protocols, rapid triage at EDs, and direct conveyance to alternative care settings where clinically appropriate. • Strengthen primary care resilience, including support for practices facing contractual action and increasing workforce flexibility through system-level pooling of resources. • Coordinate winter pressures response at ICS level, using system control centres (SCCs) to monitor demand, trigger escalation, and reallocate resources dynamically. • Embed flexible access to respiratory pathways within existing services to mitigate the loss of dedicated ARI hubs, ensuring early intervention and reducing acute presentations.
Demand	Increased demand across the UEC pathway	• System pressure across UEC pathway: Higher volumes of patients presenting through 999, 111, walk-in, and ED services, overwhelming service capacity. • Longer wait times: Prolonged triage and treatment times in EDs, increasing clinical risk, patient dissatisfaction, and potential for adverse outcomes. • Reduced flow and bottlenecks: Inability to move patients from ED to inpatient beds (due to bed occupancy), resulting in breaches of the 4-hour target and delays in ambulance handovers. • Primary care overstretch: Difficulty securing timely GP appointments drives more patients into urgent care settings unnecessarily. • Increased Hospital Admissions: Higher acuity patients more likely to require admission, compounding existing bed shortages. • Impact on staff: Increased pressure on frontline services exacerbates staff fatigue, sickness absence, and burnout. • Escalation of costs: Greater reliance on surge capacity, out-of-area beds, and overtime staffing, leading to higher operational expenditure.	• Demand management & communications: Implement targeted communication campaigns to direct patients to appropriate services (e.g., NHS 111, pharmacies, UTCs), reducing unnecessary ED attendances. • Optimised use of alternative care pathways: Expand utilisation of CAS, SDEC, UCR, Virtual Wards, UTCs, and Community Nursing Hubs to manage patients safely outside of acute settings. • Primary & community care resilience: Increase same-day access in general practice, extended hours via Enhanced Access, and use of ARRS roles and Pharmacy First to absorb lower acuity demand. • System flow & discharge optimisation: Maximise discharge-to-assess (D2A) and Home First models; coordinate discharges to maintain acute bed availability. • Emergency department capacity & front-door models: • Embed rapid triage, acute frailty services, and clinical decision units to prevent avoidable admissions and improve patient streaming. • High acuity patient management in the community:
	Increased acuity		
	Increased demand for primary care services		

Risk Category	Risk Description	Impact	Mitigations (What is in place to prevent the risk from occurring?)
Demand	Overcrowding in emergency departments	• High acuity patient management in the community: Expand virtual ward coverage and remote monitoring for complex patients; work closely with ambulance and community teams to reduce ED conveyance. • Real-time system oversight & coordination: Use the System Coordination Centre for live demand monitoring, escalation management, and mutual aid deployment across providers. • Surge planning & workforce flexibility: Align capacity and surge plans across the system with dynamic resource allocation to respond to peak pressures.	
Infection Prevention and Control	COVID, Influenza, Respiratory Syncytial Virus (RSV), Norovirus, and MPOX within care settings. There is an increased risk of whooping cough (pertussis) due to a rise in cases observed earlier this year	• Increased incidence of healthcare-associated infections (HAIs): The circulation of multiple respiratory and gastrointestinal pathogens, including COVID-19, Influenza, RSV, Norovirus, MPOX, and pertussis, significantly raises the likelihood of hospital-acquired infections. This can lead to worsened patient outcomes, prolonged hospital stays, and increased morbidity and mortality, particularly among vulnerable populations. • Greater demand on cleaning and decontamination resources: The need for enhanced environmental cleaning and disinfection protocols intensifies to reduce the transmission of infectious agents. This requires additional staff time, specialised cleaning products, and potentially increased financial expenditure. • Delays in care pathways and treatment progression: Infection outbreaks and necessary isolation precautions may cause interruptions or delays in planned care, diagnostics, or procedures, negatively impacting patient flow and recovery times. •Elevated Demand for Isolation Facilities and Side Rooms: The increased need to cohort or isolate infectious patients creates pressure on limited side room availability, potentially leading to operational challenges in accommodating patients safely.	• Promotion and facilitation of vaccination uptake: Actively encourage and support COVID-19, Influenza, pertussis, and other relevant vaccinations for both the general public and healthcare workforce to reduce susceptibility and transmission risk. • Consistent reinforcement of hand hygiene and respiratory etiquette: Deliver ongoing education and visible reminders on the importance of regular handwashing, use of hand sanitisers, respiratory hygiene, and cough etiquette to minimise spread. • Continuous monitoring and surveillance of IPC risks: Implement robust surveillance systems to promptly detect, report, and respond to infection outbreaks and emerging IPC threats, including pertussis. • Regular, comprehensive staff training and competency assessment: Provide frequent, up-to-date IPC training sessions, including proper use of personal protective equipment (PPE), environmental cleaning procedures, and isolation protocols, ensuring staff competency and compliance. • Rapid activation of isolation and cohorting protocols: swiftly implement isolation measures for suspected or confirmed cases to prevent cross-transmission within care settings, supported by clear guidelines and access to appropriate facilities.

Risk Category	Risk Description	Impact	Mitigations (What is in place to prevent the risk from occurring?)
Infection Prevention and Control	COVID, Influenza, Respiratory Syncytial Virus (RSV), Norovirus, and MPOX within care settings. There is an increased risk of whooping cough (pertussis) due to a rise in cases observed earlier this year	•Higher rates of staff absence due to illness: transmission of these infectious agents among healthcare workers leads to increased sickness absence, which can exacerbate staffing shortages, impact service delivery, and increase workload for remaining staff. Increased demand on specialist services and resources: Respiratory and infectious disease services, laboratory diagnostics, and infection control teams face higher workloads to manage outbreaks, monitor infection trends, and provide specialised care.	• Ensure adequate supply and correct use of PPE: Maintain sufficient stocks of appropriate PPE and emphasise correct usage through training and supervision to protect both staff and patients. • Enhanced environmental cleaning and disinfection regimens: Conduct frequent and thorough cleaning, including deep cleaning of high-touch areas, using effective disinfectants to reduce environmental contamination. • Education and support to foster policy adherence: promote a culture of safety by providing ongoing education, guidance, and leadership support to ensure consistent adherence to IPC policies across all healthcare and care settings.
NHS Reform	There is an increased risk due to the NHS reform and cost reductions programme across the system that the direction of seasonal planning may change dependant on direction from Midlands/ Region NHSE including: • Organisational disruption and transitional challenges: The restructuring of NHSE national and regional teams alongside the establishment and evolution of ICBs may cause temporary confusion, delays, or gaps in leadership, decision-making, and communication pathways during a critical winter period. • Reduced clarity in roles and responsibilities: changes in governance and operational roles might lead to uncertainty among staff and partner organisations about accountability for key functions	• Reduced operational efficiency and responsiveness: Transitional uncertainties and adjustments may result in slower decision-making and reduced agility in responding to escalating winter pressures or emerging infection outbreaks. • Increased risk of service bottlenecks and patient flow disruptions: Disjointed coordination could lead to delayed discharges, increased waiting times, and overcrowding in emergency departments and inpatient wards. • Potential gaps in infection prevention & control (ipc) and quality oversight: Changes in regional IPC teams' structures might affect consistency in infection monitoring, outbreak control, and support to frontline teams during peak infection seasons.	•Clear communication and role definition: Establish and disseminate clear guidance outlining roles, responsibilities, and escalation pathways within NHSE teams and ICBs to ensure clarity and reduce confusion during winter operations. •Robust transitional planning and support: Develop detailed transition plans that include contingencies to maintain continuity of leadership, governance, and operational functions throughout the winter period. •Strengthened collaboration and partnership working: promote joint working arrangements between ICB's providers, local authorities, and NHSE regional teams to ensure integrated service delivery and shared winter preparedness.

Risk Category	Risk Description	Impact	Mitigations (What is in place to prevent the risk from occurring?)
NHS Reform	• Reduced clarity in roles and responsibilities: changes in governance and operational roles might lead to uncertainty among staff and partner organisations about accountability for key functions such as surge management, resource allocation, and IPC oversight. • Potential fragmentation of services: integration and coordination challenges between newly formed ICBs and existing providers could affect seamless patient pathways, impacting the flow of patients across primary, secondary, community, and social care during peak demand. • Resource constraints and workforce pressure: Transition-related workload, combined with winter pressures and ongoing workforce shortages, may exacerbate stress on frontline staff and managers, potentially reducing capacity for service delivery and planning. • Delays in implementation of winter plans: changes in leadership and structural reorganisation might slow down the development, approval, and execution of robust winter plans, hindering preparedness and responsiveness to seasonal demand spikes. • Data and information sharing challenges: New systems and partnerships may face interoperability issues or inconsistent data flows, complicating surveillance, demand forecasting, and real-time operational decision-making.	• Challenges in cross-organisational collaboration: New governance frameworks may initially impede effective partnership working between NHS organisations, local authorities, and other stakeholders critical to delivering integrated care during winter. • Impact on staff morale and retention: The added uncertainty and change fatigue associated with reforms during a demanding winter period could contribute to lower morale, increased burnout, and higher staff turnover.	•Focus on workforce support and wellbeing: Implement targeted initiatives to support staff wellbeing, manage workload pressures, and retain key personnel during the reform transition and winter surge. •Maintain and enhance data sharing capabilities: Prioritise the integration and interoperability of data systems to support timely, accurate surveillance, demand forecasting, and operational decision-making. •Regular monitoring and review of winter plans: Ensure ongoing oversight and adaptive management of winter plans to quickly identify and resolve emerging challenges linked to reform impacts. •Targeted training and development: Provide training sessions to familiarise staff and leadership with new structures, systems, and processes to enable smooth operational delivery and adherence to IPC and quality standards.

All risks will be monitored at the system weekly winter monitoring group.

Further MITIGATION

N.B. The table below is a summary and does not detail all mitigation planned.

In flow	Flow	Outflow
• Co-located UTC at Acutes • 36 dementia beds South & 30 functional beds South and North County – change in beds 12, can be flexed to 14 beds created at stand-alone Bluebell ward to serve North patients. • QHB – maximising UTC performance and efficiency • QHB – maximising multi-speciality SDEC opportunities inc. frailty and move to acute medicine led medical take • RDH – maximising medical and frailty SDEC opportunities to avoid admission and divert attendances from ED	• Mental Health Response Vehicle 7 days a week – 4pm to 1am. • Vaccination Programme Delivery • Voluntary Sector Access • SHREWD • Community Diagnostic Centres • Dedicated section 136 staffing model. • Increased flow function for DHcFT via discharge funding, supporting flow and discharge functions through acute and community services • To include PICU provision in Derbyshire – Beds opened in July 2025. • LD intensive support team • Community LD / Crisis Services • Robust communications plan across system as well as provider communication plans • QHB & RDH – maximising the available bed base through good management of internal and external delays and concise and consistent reporting • RDH – review model for medical admissions to maximise safety, flow and effectiveness • Cancer – Oncology and Haematology - Cancer Triage Assessment Unit extended opening until 9pm. Proposal to staff 2x super surge beds on 303 to support bed base • UTC - A new staffing model has been implemented with ongoing training and recruitment in progress. By winter 2025/26, new shift patterns will have taken effect which is expected to further strengthen resilience. • Reducing sickness absence is a key priority in the Trust's 2025/26 operational plan, with a comprehensive action plan in progress. • Trial of CSW from discharge lounge as transfer team	• Home from Hospital Coordinator increase hours/WTE. • Weekend Cover for Discharge Coordinators • DCHS OPMH bed capacity will be set at 18 with ability to flex to 19 as required and where staffing allows. • DCC/ DCHS Sprint work to continue to increase flow through P2 bedded settings. • Perth House – trialing reduced beds flexibility: 15 beds at ability to manage increased needs based on acute demand. • MADE Events across all organisations • Voluntary Sector Access • OPTICA • P2B - 80 beds plus 4 surge beds, and plus 4 more through reverse boarding • OPMH – 18 plus 1 surge bed • Support discharge lounge TTO dispensing and support with full time pharmacy assistant cover • Care Transfer Hubs Phase 1

SERVICES IN PLACE TO SUPPORT THE URGENT AND EMERGENCY CARE PATHWAY

SERVICES IN PLACE TO SUPPORT THE UEC PATHWAY

See Key	Service	Description
I	Urgent Treatment Centres (UTC)	Urgent Treatment Centres deal with many of the most common ailments people sometimes attend A&E for. There are 4 community base UTCs, and 2 co-located UTCs at both sites.
I	NHS 111	NHS 111 services aim to ensure that patients get the right advice and treatment they need in the most appropriate care setting.
I	GP In hours	On the day appointment capacity will support the management of urgent primary care needs of patients this winter.
I	GP OOH	Delivers a versatile and responsive service to meet the urgent primary care needs of patients.
I	EMAS 999	Provide emergency ambulance response services, patients are referred to the most appropriate services.
I F	Mental Health Liaison	Liaison mental health services support people in crisis in all areas of the hospital including the Emergency Department.
I	MH CRISIS Support	Home based intensive support will help reduce both the number and length of hospital admissions and ease the pressure on inpatient units.
I	Mental Health Response Vehicle	A joint EMAS Paramedic and Mental Health Nurse See and Treat Model is in operation daily from 4pm-1am. It aims to reduce the dispatch of an ambulance for mental health related calls, reducing mental health attendance at ED and supporting purposeful admissions.
I	Mental Health NHS111 option	NHS 111 mental health option provides immediate access to mental health support, helping to prevent crises and reduce the need for emergency services.
I O	Team up	The Team Up Urgent Community Response service offers crisis care within two hours and reablement care within two days of referral. It includes home visiting services by health and care professionals, rapid response nursing and therapy services and expanded falls prevention and recovery services across the city and county.
I O	Pharmacy first	Pharmacy First enables patients to be referred into community pharmacy for a minor illness or an urgent repeat medicine supply.
I O	Urgent Community Response (UCR)	Providing urgent responsive community nursing care to the housebound in and out of hours, so patients are being managed effectively in the community in a timely manner, supporting end of life patients, recent discharge patients and to prevent admission.
I	Central Navigation Hub (CNH)	Central Navigation Hub navigates patients, directing them to the right services in a timely way.
I	Vaccination Programme	This programme encourages the uptake of vaccinations including those for COVID, Flu and RSV.
I O	Time limited bed based & homecare support	A range of Health and Social Care services including 24hr community bedded care and homebased reablement support.
I O	Virtual Wards	Provision of hospital-level care at home, reducing the demand for acute bedded services.
I O	End of Life Care	Provision of specialist, palliative and end of life care and support for adults and children with life limiting illness.
I F	Acute Trusts	Including (but not limited to) Emergency Department, Assessment Units, Inpatient and Critical Care provision.
I F	Same Day Emergency Care	Same Day Emergency Care and enhanced front door frailty services provide consultant led assessment and care plan. Patients are referred to the most appropriate place of care, hospital admissions are avoided where possible.

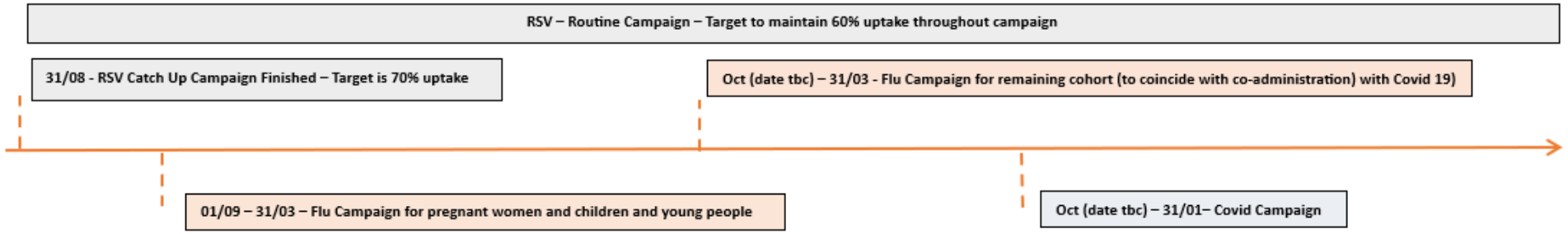
Key and Descriptions:	
I	Inflow
F	Flow
O	Outflow

PREVENTION

VACCINATION PROGRAMME

15. Vaccination Programme and Timeline

Below outlines the timeline for the system vaccination programme, delivery of this will be monitored weekly



RSV (Year-round RSV vaccination programme for older adults and pregnant women (for infant protection)):

RSV vaccination provides multi-year protection, so those vaccinated now will have protection this coming winter. The UK Health Security Agency continues to analyse and evaluate these new programmes, with early assessment of the RSV vaccination programme in older adults showing it led to a 30% reduction in the confirmed RSV hospital admission rate among eligible 75 to 79-year-olds.

- ensuring all those in the older adult catch-up cohort (aged 75 to 79) have been offered a vaccination by 31 August 2025. The aim is to achieve 70% for the catch-up cohorts and 60% in the routine cohort during 2025/26.

Flu season 2025/26 will be a phased delivery:

Flu Campaign for pregnant women and children and young people

From 1 September 2025:

- pregnant women
- all children aged 2 or 3 years on 31 August 2025
- primary school aged children (from Reception to Year 6)
- secondary school aged children (from Year 7 to Year 11)
- all children in clinical risk groups aged from 6 months to less than 18 year

Flu Campaign for remaining cohort (to coincide with co-administration)

From October 2025, exact start date to be confirmed by NHS England in due course:

- those aged 65 years and over
- those aged 18 years to under 65 years in clinical risk groups (as defined by the Green Book, Influenza chapter 19)
- those in long-stay residential care homes
- carers in receipt of carer's allowance, or those who are the main carer of an elderly or disabled person
- close contacts of immunocompromised individuals
- frontline workers in a social care setting without an employer led occupational health scheme including those working for a registered residential care or nursing home, registered domiciliary care providers, voluntary managed hospice providers and those that are employed by those who receive direct payments (personal budgets) or Personal Health budgets, such as Personal Assistants

Covid Campaign:

- adults aged 75 years and over
- residents in a care home for older adults
- individuals aged 6 months and over who are immunosuppressed (as defined in the 'immunosuppression' sections of tables 3 or 4 in the COVID-19 chapter of the Green Book)

INFECTION PREVENTION CONTROL

- Regular meetings taking place to review IPC processes in organisations
    - IPC teams proactively supporting de-isolation of patients and monitor for escalation for cohort bays
- Regional IPC input and support available as and when required.
- Organisations have reviewed their internal IPC plans and are aligned with the National IPC manual.
- All organisations are committed to enhancing their Vaccination Programmes to ensure staff are well-protected and prepared for the winter season
- Individual providers have confirmed they have plans in place for managing Measles, Mpox, Covid, Norovirus, Flu and other infectious diseases.
    - Emergent disease and IPC working groups stood up, dynamically reviewing information, risks and plans accordingly.
- Outbreak response plans and operational continuity during infection surges agreement, framework and procedure embedded within the system seasonal plan.
- UKHSA syndromic surveillance data is disseminated through EPRR channels, with all providers receiving this information promptly. This supports their effective management of outbreaks and infectious diseases across the system.
- Expert decision making in place to enable flow and prevent blocks due to IPC.
- Education programmes across all settings to support best practice and reduce rates of infection.
- Achievements of wider partnership and continued system work for 2025/26 – *please refer to section 16 for further information.*
- IPC updates will be shared at the weekly system winter monitoring group.

SYSTEM ESCALATION & MONITORING

SYSTEM COORDINATION CENTRE (SCC)

- Daily management of operational pressures as part of established BAU.
- A physical room at Scarsdale is in operation throughout the year for seasonal pressures.
  - Support focused resilience and risk understanding and mitigation response.
  - Operations Room has year-round availability to the SCC team.
- Senior Operational Cover to be provided 08:00 – 18:00, 7/7, with supported out of hours by the on-call teams.
  - Clear access to Senior Clinical Leadership to support with risk management and escalations.
- Operational oversight and understanding of the system position through the daily system call and Provider bed/capacity meetings.
- Live position visible via SHREWD, EMAS Screens, NACC.
- Winter room shared space, enhancing response to EPRR/business continuity incidents and closer working between EPRR and UEC Teams.
- Clear escalation process into the SCC across the system.
- SCC management of single point of contact (SPC) inbox into the ICB.
- Coordination of mutual aid beyond DDICB as part of escalation.

SYSTEM ESCALATION, MONITORING AND OVERSIGHT

BUSINESS AS USUAL

- Senior Operational Management Cover from 8am – 6pm 7/7
- Team supporting with operational oversight and management, providing updates to regional colleagues, as necessary.
  - Monitoring of ambulance handovers including individual 45 minute handover breaches
  - Mutual aid requests within ICS
  - Repatriations
  - Mental Health Escalations
  - Ensuring Alternative Pathways are pursued
- Daily System Calls and routine updates
- OPEL framework and guidance received and embedded for: Acutes, MH, 111, Community and Primary Care.
- Automated data flow

WINTER (November – March)

- 'Winter Room' – local ops centre established at Scarsdale
- Winter Director identified
- Escalation Process and Trigger review
- Weekly Winter Monitoring Group
- 45minute Ambulance Handover initiative
- Quality led NHS visits to sites, supportive peer and not assurance
- Daily system calls extended to include weekends

HEIGHTENED PRESSURE AND ESCALATION MANAGEMENT

- Clear escalation triggers and scores determining which process to follow
- Agreed meeting cadence initiated
- Senior Leadership involvement
- Dynamic risk assessments
- Mutual aid beyond DDICB
- Regional Support
- Unlocking blockers to provide additional resource

COMMUNICATIONS PLAN

Objective
To deliver proactive and reactive communications to help residents stay well, access the right services, and reduce pressure on urgent and emergency care.

Key Activities

ICB Activity

- **Covid, Flu, and RSV Vaccinations:** Promote vaccinations to protect vulnerable individuals, reduce hospital admissions, and ease NHS pressures. Budget: £60,000.
- **Community Pharmacy Blood Pressure Checks:** Increase blood pressure checks to prevent serious complications.
- **Central Navigation Hub:** Increase awareness and confidence in its use to support faster, safer triage and reduce unnecessary ED and GP attendances.

DCHS Activity

- **Urgent Treatment Centres:** Increase awareness of UTCs to ease pressure on ED.

DHU Activity

- **Pharmacy First:** Reinforce messaging and provide vaccination advice.

EMAS Activity

- **Life on the Line Campaign:** Reinforce when to call 999 and encourage use of NHS 111 for non-urgent medical advice.

Joint Activity

- **Think Which Service:** Help people choose the most appropriate NHS service to reduce unnecessary demand on A&E and GP practices.
- **Patient Transport Service:** Raise awareness of alternative transport services to reduce demand on EMAS PTS.

Pressures Protocol: Framework for scaling up communications during periods of elevated demand to maintain public confidence and direct people to appropriate services.