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# Draft Winter Plan

**2023-2024**

# Our aims

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- Ensure Homefirst remains the default and preferred option across all partners
- Enhance support to those who are the most vulnerable and with the most challenging needs (including those with mental ill-health, the homeless, and those with drug and alcohol issues)
- Deliver a place-based response to winter by working closely with partners
- Reduce conveyancing to hospital and ambulance handover delays
- Expedite flow and discharge from the acute setting

# Learning from last year

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- Learning from the successes of last year, we have built on the strength of our partnership working
- This has included a full evaluation of schemes that were implemented in the previous winter to inform decision-making
- Schemes that proven successful in the previous year have been prioritised for implementation for 23/24 through ASCDF

# Working in Partnership and Governance

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- The Place-based Winter Plan continues to be overseen by the Urgent and Emergency Care Strategic Working Group
- This meeting is chaired by the Chief Operating Officer of the Royal Wolverhampton NHS Trust (RWT) and membership includes the Managing Director for Wolverhampton (ICB) and the Head of Adult Social Care and Health Partnerships (City of Wolverhampton Council)
- Support has been identified from within OneWolverhampton to support the monitoring and delivery of the Wolverhampton Winter Plan using a project management approach

# OneWolverhampton UEC Priorities

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- **Helping people with urgent needs access the right care, first time**
  - Ensuring Care Coordination becomes the first option for WMAS, GPs and Care Homes when navigating same-day needs for individuals
  - Delivering a range of community services that meet same-day urgent needs as an alternative to hospital
- **Ensuring a timely experience when accessing ED**
  - Maximising the use of same-day emergency care (SDEC) and Urgent Treatment Centres
- **Ensuring effective discharge from hospital (push)**
  - Improving discharge processes by ensuring planning for discharge starts at admission
  - Scaling up social care services with a focus on domiciliary care
- **Delivering an integrated approach to demand and capacity planning**
  - Reviewing impact of previous initiatives to ensure effectiveness and value for money of commissioned services
  - Gaining a holistic understanding of needs and services across the city
- **Expanding new services in the community that provide alternatives to bed-based care**
  - Support the expansion of Virtual Ward services to ensure the right number of beds is available to support Wolverhampton's needs

# Current position

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- The modelling predicts a worst-case deficit of between 37 and 53 general and acute beds, which will peak in January 2024. This is without any mitigation or additional capacity.
- The following assumptions have been made with the modelling:
  - This modelling is based on August 22 to March 23 actuals
  - 3.5% growth across the Trust
  - Elective and Cancer activity continues throughout the winter
  - Forecast rate of beds that could not be available for use due to infection prevention (Covid, Norovirus, Flu)
  - Modelling dependent on occupancy rates between 92% and 95%
- The schemes detailed here work to address this deficit and the position will be updated as schemes are mobilised
- There are no plans to mobilise additional general and acute beds at present due to estates and workforce capacity challenges
- While these proposals relate to Wolverhampton residents and are not inclusive of wider local authorities, we will endeavour to work collectively to support the flow of patients across local government boundaries

# Funding available

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- Wolverhampton Place was allocated £3,453,504 from the Adult Social Care Discharge Fund for 2023/24. This was allocated as follows:
  - £2,069,492 for the City of Wolverhampton Council (CWC)
  - £1,384,012 for the Integrated Care Board (ICB) Wolverhampton Place

- This funding is used to support:
  - Increasing Social Care capacity; providing more care packages to more people, in ways that have the greatest possible impact in reducing delayed discharge from hospitals
  - Ensuring local partners can plan services sufficiently far in advance and for providers to develop long-term workforce capacity plans
  - Being used in ways that build on learning from evaluation of the impact of previous discharge funding
  - Allowing Local Authorities, the NHS and the Social Care sector to streamline discharge, assessment and placement processes and help to free up greater Social Worker time and capacity

# Funding approach

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- A multi-agency task and finish group has been established to determine priority areas for spend – including areas prioritised from last year
- Membership was drawn from the ICB; City of Wolverhampton Council (CWC); OneWolverhampton; RWT; and Black Country Healthcare Trust
- Proposals were received from City of Wolverhampton Council; the Care Homes Team at the ICB; RWT; Compton Care; Black Country Healthcare; and Wolverhampton Voluntary and Community Action
- These were assessed against alignment with BCF or ASCDF metrics; duplication; ability to deliver in required timeframe; scalability; cost; sustainability; and clarity of metrics

# Agreed schemes – CWC Funded

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| Scheme / Initiative | Brief Description of Scheme / Initiative | Year 1 (23/24) |
|---|---|---|
| **Hospital Enhanced Social Work** | Additional social worker capacity to support timely assessment and discharge of patients to include out of area hospital discharges. | £440,375 |
| **Enhanced PST** | Additional brokerage staff capacity to support timely assessment and discharge of patients to include out of area hospital discharges. | £41,000 |
| **Home Assisted Reablement Programme** | Additional hours of HARP assistance provided for reablement to support discharge and make sure people identified as benefiting from reablement were able to be supported on the correct pathway. | £40,638 |
| **Additional OT Capacity** | Recruitment of additional OTs to support timely discharge for pathways 1-3. | £300,000 |
| **Bariatric Reablement Service** | Dedicated service to enable people that are identified as bariatric to access a bed based reablement service as part of their planned return home when it is identified that a home discharge is not possible. | £179,780 |
| **Pathway 1 Seasonal Reablement** | Contingency funding to support additional winter demand / capacity pressures for Pathway 1 seasonal reablement at home. | £125,000 |
| **Pathway 2 Seasonal Spot Beds** | Contingency funding to support additional winter demand / capacity pressures. | £400,000 |
| **BCHT Mental Health Social Worker** | A designated, locality-based, named, mental health social worker to oversee or undertake assessments of patients requiring adult social care support. | £50,473 |
| **Community Equipment Stores** | Contingency stock of equipment to ensure capacity can meet demand and minimise the chances of delays occurring because community equipment is not available | £52,500 |
| | **TOTAL** | £1,629,766 |

# Agreed schemes – ICB Funded

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| Scheme / Initiative | Brief Description of Scheme / Initiative | |
|---|---|---|
| **Pathway 3 Block Booked Contingency** | Funding to enable additional block-booked beds to be commissioned (e.g. complex beds) and / or to support increased costs in Care Homes above existing commissioned activity. | £100,000 |
| **BCHT Structured IP Day Support** | In-reach work on wards to help patients and staff identify support to achieve discharge and connection with outreach services. | £34,956 |
| **BCHT Additional Step-Down** | Accommodation and support for people MFFD and waiting for additional support packages, (24-hour ongoing support prior to discharge home or to onward package of support). | £50,000 |
| **BCHT Welfare Rights Workers** | Supporting patients with a successful discharge from a mental health ward (e.g. financial advice, information and solutions around benefit entitlement). | £55,000 |
| **RWT Enhancing Care Co-ordination** | Improving the digital and staffing infrastructure of Care-Co to enable increased and wider support for hospital discharge.. | £119,664 |
| **RWT Intermediate Care** | Supporting early facilitated discharge for patients waiting for start dates of social care funded packages of care, reducing deconditioning for patients and improving flow. | £650,000 |
| **RWT Virtual Wards** | Supporting the delivery of Virtual Wards in conjunction with Community Infrastructure funding. In line with the 2022/23 commitments made and the operating plan 22/23 and 23/24. | £221,519 |
| | **TOTAL** | £1,231,139 |

# Agreed Schemes – Funded in Partnership between CWC and ICB

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| Scheme / Initiative | Brief Description of Scheme / Initiative | Year 1 (23/24) |
|---|---|---|
| **Care Homes** | To provide increased support to Care Homes (e.g. education, training, networking opportunities), linking in to the OW Care Homes Workshop / Steering Group | £5,000 |
| **Delirium Patients** | Develop delirium pathways and test out different pathways out to establish future approach. | £50,000 |
| **Non-Weight Bearing Patients** | Trial / test out alternative placement arrangements for NWB patients to determine future ongoing approaches / arrangements. | £50,000 |
| **Community / Voluntary Sector** | Increase in social prescribing support capacity to meet additional demand. | £72,000 |
| | **(Split equally 50/50) TOTAL** | £177,500 |

# Reducing the bed gap

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| Initiative theme | Delivery Partner | Proposed impact on bed gap |
|---|---|---|
| Enhanced social care services (including additional social worker capacity, and ring-fenced mental health hospital social worker, and increased Personalised Support Team Hours) | CWC | Reduction in time to assessment reducing length of stay |
| Increased reablement services (including HARP, CICT, additional Community OT and bariatric) | CWC and RWT | Increasing reablement and intermediate care capacity to reduce length of stay |
| Contingency funding to enable reablement and/or additional beds across Pathways 1, 2 and 3 | ICB and CWC | Reduction in length of stay by reducing discharge delays |
| Additional equipment | RWT and CWC | Reduction in length of stay due to equipment delays |
| Investment in additional mental health services (including inpatient day support, step-down and welfare rights workers) | ICB | Reduction in length of stay |
| Enhancing Care Coordination, intermediate care and virtual wards | RWT | Reduction in length of stay through additional intermediate care capacity and VW capacity; reducing unnecessary admissions through appropriate care navigation |
| Targeted working with care homes to increase education and work on some of the more challenged pathways (delirium and non-weight bearing) reducing demand on other pathways | Partnership | Reducing unnecessary admissions and expediting discharge for patients awaiting delirium of NWB |
| Increase in social prescribing support – including dedicated member of staff in the discharge lounge | WVCA | This will include a holistic assessment to understand both barriers to discharge and supporting a reduction in readmission by taking a whole-person approach |
| A range of initiatives within RWT including specialty physician input in ED, development of an enhanced same-day discharge centre and mobilisation of a paediatric SDEC | RWT | Minimising unnecessary admissions through senior decision making and supporting the capacity of the discharge lounge to expedite discharge |

# Adult Social Care

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- **Enhancing the hospital Social Work team** to reduce the allocation of NCTR patients with one additional Social Work Manager; four additional Social Workers; and three Social Care Workers
- Additional capacity within the **Personalised Support Team** (PST) to support timely assessment and discharge
- An additional 50 hours of reablement per week offered through the **Home Assisted Reablement Programme** (HARP)
- Expanding the **Community Occupational Therapy Team** (COTT) to support the review of discharges patients
- Establishing a **dedicated bariatric reablement service**
- Piloting a test and learn C**ommunity TOC pathway** for health professionals to refer a person living at home and without an existing package of care to adult social care for community reablement for up to 4 weeks to avoid unnecessary admissions

# RWT Acute Services

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- A number of initiatives have continued from last winter, including:
  - The **Ambulance Receiving Centre (ARC)** providing an additional 17 ambulance offload spacing, increasing the total to 28
  - The **10 additional surge beds** have remained open
  - Utilisation of the **North Bristol 'push' model** continues and has developed into the RWT 'priority patient' model
- **No Criteria to Reside** (NCTR) patients are discussed three times per week – attended by partners across the City to support escalation
- A bespoke huddle tool is in use at the **twice-daily huddles** that escalates any blocks in patient flow
- Medical, surgical, frailty, and head and neck **SDECs** are in place – direct access remains in place from both WMAS and Care-Coordination

# RWT Acute Services

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- In addition to schemes that have continued, a number of new initiatives are being implemented:
  - Learning from the periods of industrial action, a **Specialty physician** role is being implemented at the front door to work alongside the existing medical complement. They will work in ED and SDEC to facilitate moves to virtual wards, HOT clinics and support admission avoidance.
  - A **Same-day Discharge Centre** is being established from the beginning of November to provide an enhanced discharge lounge where patients will receive the final elements of their care to support a return to the place they call home. This will include an increased MDT approach and will remain open until 22:00. Patients will be onboarded to the virtual ward from the Same-day Discharge Centre.
  - A **Paediatric SDEC** is planned to go-live in October to support an increase in same-day treatment and reduction in unnecessary admissions.

# RWT Community Services

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- RWT will be maintaining the capacity and scope of the **Virtual Ward** offering, allowing patients to receive the care they need in the place they call home, support expedited discharge and reduce unnecessary hospital admissions
- The Rapid Intervention Team (RIT) has extended operating hours to provide a **24/7 Urgent Community Response**
- The **Care-Coordination** offer is being enhanced through ASCDF to include pharmacy and social care support, as well as strengthened infrastructure to support greater call-handling capacity
- **Intermediate Care** is continuing to deliver an 08:00 – 20:00, 7-day service through the Rapid Access to Social Care (RASC) and Community Intermediate Care Team (CICT)

# RWT Children and Young People's Services

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- Mobilisation of **Paediatric SDEC** in October 2023 to support same-day treatment and reduce unnecessary admissions
- Delivery of a **paediatric virtual ward** to support expedited discharge and allow children to be cared for in the place they call home
- Deployment of a paediatric **respiratory clinical nurse specialist service** – this includes active care planning to reduce the risk of escalation for respiratory conditions; undertaking home visits; delivering Hot clinics; education to schools and nurseries; and supporting parents and carers with telephone queries
- Commissioned to operate **2 Level 2 acute** beds for Winter 23/24

# Primary Care

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- The development and implementation of a new Primary Care Framework for Primary Care; a local incentive based scheme to support continued improvement and development of Primary Care and build on the benefits of the national Quality Outcomes Framework Scheme (QOF). The Framework focuses on 6 key thematic areas:
  - **Increasing Primary Care access**; through initiatives such as capacity and demand modelling, additional appointments and effective care navigation
  - **Supporting the prevention agenda** on obesity, smoking, alcohol, cardiovascular disease and falls
  - **Supporting vulnerable cohorts** through identification, care planning and signposting of those with Severe Mental Health, Unpaid Carers and those people living with Dementia
  - **Supporting those people with a long-term condition**; such a diabetes and cardiovascular disease
  - **Earlier identification of people with cancer**; to include learning from National Cancer Diagnosis Audits and timely completion of Cancer Care Reviews
  - **Early identification, management, support, personalisation and advance care planning** for people in the last 12 months of life
- While this work will become business as usual and is not funded through winter monies, it is anticipated that these actions will support access to primary care and a reduction in escalations to secondary care and thus support the increased demand seen in the winter period

# Primary Care

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- Working with wider teams across the system to review the **Enhanced Health in Care Homes** approach to minimise avoidable conveyances to hospital;
- Pro-active care planning around **frailty**, in particular, identifying patients with mild frailty, over 65 years at risk of a fall and revisiting information around prevention, assessment, diagnosis and treatment of delirium;
- Maximising the use of **MDT Co-ordinators**;
- Expanding the **Healthy Ageing Co-ordinators** (HACs) roles in to ALL PCNs across Wolverhampton;
- Increasing referrals to the **Community Pharmacist Consultation Services (CPCS)** and other, alternative services;
- **Increasing access to routine appointments** and releasing clinical time through alternative delivery of the Covid-19 vaccination programme (e.g. community pharmacies) and additional roles and reimbursement scheme (ARRS) roles.

# Primary Care-led Acute Respiratory Infection (ARI) Hubs

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- An ARI hub is being commissioned during the winter months to provide access to **same-day urgent assessment** for both adults and children, preventing unnecessary hospital attendances and ambulance conveyances
- The service will operate Monday to Friday, between 13:00 and 20:00 with a minimum of **42 appointments provided per day**
- Appropriate estate has been identified and the service will be delivered from the Phoenix Centre
- The expected go-live date is the **4th of December** 2023

# Compton Care

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- Delivery of personalised care and support through the completion of **Advanced Care Plans and ReSPECT** documents to support unnecessary and unwated hospital admissions
- Compton's palliative and end of life care U**rgent Community Response** will be operational over the winter months, with a 4-hour daytime response and a 2 hour night-time response
- Palliative and end of life care **virtual ward** will be caring for complex patients in a step up/step down model
- Delivery of consultant-led, i**ntegrated MDT with RWT**

# Pharmacy

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- Pharmacies are being encouraged to sign-up to deliver **flu and covid vaccinations** to support primary care
- From December, pharmacies will be delivering the **common conditions service** for seven common conditions, including earache, sore throat, or UTI
- This means that patients will be able to **access medication without the need for a GP appointment**
- During the Christmas period, pharmacies across Wolverhampton will be participating in a rota to ensure there are **4-6 pharmacies open across the city during the Bank Holidays**

# Care Homes

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- **Place-based Care Homes** programme of work being established to include Quality Framework; reduce duplication; and a Care Academy
- **Personalised Care Plan** training continues to be rolled-out
- Compton Care supporting **Advance Care Plans and ReSPECT** to reduce unnecessary conveyances
- Place-based **CQC information-sharing** meetings are held by partners to share relevant information, concerns, and best practice
- **Frailty, recognising End of Life and Escalating Deterioration** (FREED) training is being offered to all bed-based services
- **Falls response pilot** in place which includes strength and balance classes and nutrition and dietetic support
- **24/7 UCR** model in place which is achieving the national target for response times
- Docobo continues to be rolled out to support **remote monitoring** – currently in place across 2,647 beds

# Infection Prevention and Control

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- From September, an infection prevention focus will be delivered across RWT based on winter preparedness, including education, communications and support with outbreaks in inpatient areas
- Vaccinations are on offer to all stuff – both Covid booster and flu
- The Public Health team commission RWT's Infection Prevention Team to support care homes with outbreak management, surveillance, education and audits
- Community infection and vaccination rates are routinely monitored by the system and within the Trust

# Supporting Staff

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- A wellbeing offer is in place for both RWT and CWC to provide support for physical, emotional, mental and financial wellbeing
- This includes access to a 24/7 counselling helpline for RWT staff as well as staff physiotherapy
- Both CWC and RWT have local Wellbeing Champions and Mental Health First Aiders available to support staff at challenging times

# Risks to delivery

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- These include:
  - Lack of funding to support preventative initiatives
    - This includes funding in previous years which supporting additional opening for GPs, including 7-day working and Bank Holidays and is not available in 23/24
  - Recruitment of appropriate workforce
    - Many schemes have continued at risk, now funded through ASCDF, which reduces risks around recruitment
    - When schemes require additional staffing, recruitment has started in the summer to ensure start dates prior to Winter
  - Workforce illness and absence – including potential Covid and Flu spikes
    - Covid and Flu vaccines are available to all RWT; and Flu vaccines available to CWC staff
    - RWT has set safe-staffing levels across wards to allow managers to cater for planned absence
    - Staffing is monitored and reviewed at multiple times daily to ensure front-line services are prioritised
  - Availability of residential care beds in the city
    - We have historically always had sufficient residential care capacity over the winter period in the city and have block-booked beds based on previous levels of demand

# Further opportunities

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- If additional funding were made available, priority would be given to:
  - Admission avoidance schemes
  - Exploring opportunities for enhanced extended access in primary to support 7-day and bank-holiday working
  - Further focus on known vulnerable cohorts
  - Greater focus on care homes to support individuals staying in the place they call home
  - Support services that have continued at risk
  - Greater engagement and financial support with the charity, voluntary and community sector to support known vulnerable groups
  - Further enhancing those services which delivered successfully in the previous year