Wolverhampton Health Economy

Winter Plan 2017/18

Covering the period of 1 Dec 2017 to 31 March 2018 (including Easter)

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1. WOLVERHAMPTON HEALTH ECONOMY

Wolverhampton Health Economy is committed to continual system and service improvement to ensure services for patients are accessible, safe and of a high quality. Planning for system resilience is key to ensuring that the services can continue to deliver these quality services at times of pressure.

System pressure is experienced all year round however the Winter period brings with it added risk factors such as Flu, Norovirus, poor weather conditions/colder temperatures, extended Bank Holidays.

This plan sets out how our local system plans to continue to deliver this and the additional steps we are taking to ensure the system remains stable and resilient throughout the extended winter period. W'ton AE Delivery Board is sighted on the WMAS Winter Plan and is assured that this plan will address the challenges faced by this health economy. Through local representatives, this plan has also been received and commented on via the lead commissioner (SWB CCG).

This plan is owned and monitored by the Wolverhampton AE Delivery Board who continue to review capacity and demand across the whole system. The AE Delivery Board consists of members from multiple stakeholders:

Organisation	Members
NHS Wolverhampton CCG	Chief Officer and/or
NHS Wolverhampton CCG	Director of Strategy and Transformation *
Royal Wolverhampton Trust	Chief Executive (Chair – Delegated to Medical Director) *
Royal Wolverhampton Trust	Medical Director
Royal Wolverhampton Trust	Chief Operating Officer (Vice Chair) *
West Midlands Ambulance Trust	Director of Clinical Commissioning and Service Development (deputising for CEO) *
Black Country Partnership NHS Foundation Trust	CEO *
Local Authority	Director of Adult Services *
NHS England	Operations Director *
NHS Improvement	Senior Delivery and Improvement Manager *
Staffordshire CCGs	Director of Operations *

The AE Delivery Board has oversight of the Better Care Programme and is cognisant of the work being delivered through this forum.

In addition, the CCG is mindful of the wider programmes of work across the Black Country and West Midlands. The West Midlands Ambulance Service is a key member of the AE Delivery Board and the local Urgent Care Centre is a member of the Integrated Urgent Care system. This affords the health economy the opportunity to work across organisational boundaries and ensure winter plans are aligned.

The AE Delivery Board closely monitor all the programmes of work detailed within this Winter Plan. Appendix 1 details the Programme Plan and progress towards implementation of many projects aimed at improving flow, reducing admissions and improving patient experience.

2. WIDER HEALTH AND SOCIAL CARE SYSTEM PREPARATION

2.1 Early Winter Planning

In order to plan appropriately for Winter 2017/18, the CCG and RCMT undertook at Winter Health economy debrief. This required all key stakeholders to participate in a round table discussion into the challenges faced by last Winter and actions moving forward into winter of 17/18. The event was well attended and all stakeholders participated. Key points of note were the Cyber Attack and the impact this had on NHS111 services with regards to patient demand but also on the operational ability of organisations/services across the area. Of particular benefit was the Trusted Assessor function which has been further developed throughout the year.

Key actions moving forward were:

- RCMT to progress the Mental Health Capacity Grid
- Local Authority to progress engagement with out of area (Staffordshire)
- RWT to look at how an increased number of patients can be transferred from ED to the UCC at point of triage
- CCG to pursue pathways for frail elderly in the community.

It was noted that the health economy felt they were in a robust position moving into the winter period of 17/18.

The urgent care centre has made rotas available early to ensure staff can book into shifts via the online booking system

2.2 Primary Care Provision

Practices across the city are working within their respective groups to provide a range of additional services that have been developed to assist us in continuous improvement in access to general practice. Many practices continue to open beyond core hours offering additional appointments to improve access to their practice, this will continue during the winter period. In addition practices are implementing different consultation types including telephone and online consultations with range of professionals such as General Practitioners, Advanced Nurse Practitioners & Clinical Pharmacists. Such provisions will be available during weekdays, weekends and bank holidays.

There are also a range of other enhanced services provided by many practices although not all in the city comprising of in-reach to care homes. Care homes with greatest need are being supported by the Primary In-reach Team(s) during core hours and by 111's *6 project during out of hours. There are currently 18 residential homes benefiting from this service and this will rise to 38 from September. The aim of the service is to ensure residents have access to timely medical advice and review so that they continue to reside in the RCH. The GPs will ensure that care plans exists for all residents, that it is regularly reviewed and that this forms the basis for the work of all the staff who provide support. This enhanced the level of care (GP or other clinician) helps to reduce avoidable hospital admissions.

Other enhanced services that will also be taking place include risk stratification, peer review (pro-active & reactive), end of life care planning, minor injuries and a number of basket services such as dressings, suture/clip removal, pessary changes, post-surgery checks to name but a few.

The purpose of all of these measures is to reduce the burden on A&E or out-patient secondary care appointments and provide shorter waiting times for treatment, interventions that are safe and clinically effective giving access to timely health interventions.

2.3 Integrated Urgent Care Development Plans

Wolverhampton CCG is part of the West Midlands commissioning collaborative for integrated urgent care (IUC). We are working within an alliance of providers who are delivering the components of IUC; NHS 111 call handling and triage, a clinical assessment service (CAS) and out of hours (OOH) services. Across the West Midlands there are a number of shared priorities, as set out below, which Wolverhampton patients will benefit from:

- Direct Booking from NHS 111 / IUC CAS into GP Surgery
- Access to the Patient Records via MIG
- IUC CAS Advanced Clinician Module

A new key priority area being added to this list is integration with West Midlands Ambulance Service NHS FT. This will facilitate access for crews & paramedic to a clinical desk 24/7 and ensure that lower acuity calls can be passed from 999 into the IUC service offer. Detailed delivery plans are being agreed at a West Midlands footprint.

Additional priority areas are also in the pipeline but may not be in place for this Winter period. These will aid integration between services and improve patient experience:

- Wider Prescribing from the IUC CAS
- Mental Health Crisis Resolution in the IUC CAS
- Direct Booking/Kiosks in ED
- IUC Dashboard
- Condensed ITK PEM Messages
- SMS Messages for Appointment Confirmation
- SMS Message for Self-Care Advice

Locally we are also moving forward with our own priority areas, these include:

- NHS111 Care Home *6 project – care homes call NHS111 *6 and will be put through to a GP at the 111 Clinical Hub. This is an alternative to calling 999 where appropriate. This is currently live in at least 15 care homes.

- NHS111 primary care pilot – when GP practices are at full capacity, they can 'switch off' their surgery on the Directory of Services and advise patients to call NHS111. If the patient requires a GP (see or speak to) within the following 24 hours, they are passed through to the UCC.

Both of these schemes aim to ensure the patient is managed by the right clinician in a timely manner and reduce unnecessary pressure on the ambulance service or ED.

2.4 WMAS

2.4.1 Ambulance Response Programme

WMAS were part of the pilot for the Ambulance Response Programme (ARP) and therefore all of the required changes in operational processes have already been fully implemented across the West Midlands.

WMAS have highlighted the following achievements following implementation of the ARP:

- Significant shift of focus, towards ensuring the correct capacity of Paramedic Emergency Ambulances are available to service the demand

  (Previously peak outputs each day - 215 Ambulances and 99 RRVs, Under ARP Phase2 – 310 Ambulances and 14 RRVs)

- Providing faster response to patients across all categories
- Ensuring priority patients such as Stroke cases get to hospital quicker
- Consistent delivery regardless of high demand periods
- 96% of resources now have a Paramedic on board and will 100% by Winter 2017
- RPI Reduced from 1.23 to 10.7 – saving nearly 100,000hours
- WMAS responding to +8% more demand (+69,000 incidents)
- WMAS utilising -4.5% less resource (-50,000 resources to scene)
- The number of patients transported to hospital has fallen from 62% to 60%
- Less Control / Dispatch staff required to handle a simpler model
- Wastage reduced by two-thirds in Paramedics on RRVs needing to travel with an Ambulance
- Total Fleet mileage reduced by 5%
- Total Fleet assets reduced, whilst the Emergency Ambulance Fleet has increased by +69
- Total number of Estate locations reduced 50% (+64)

Next steps for WMAS are set out below:

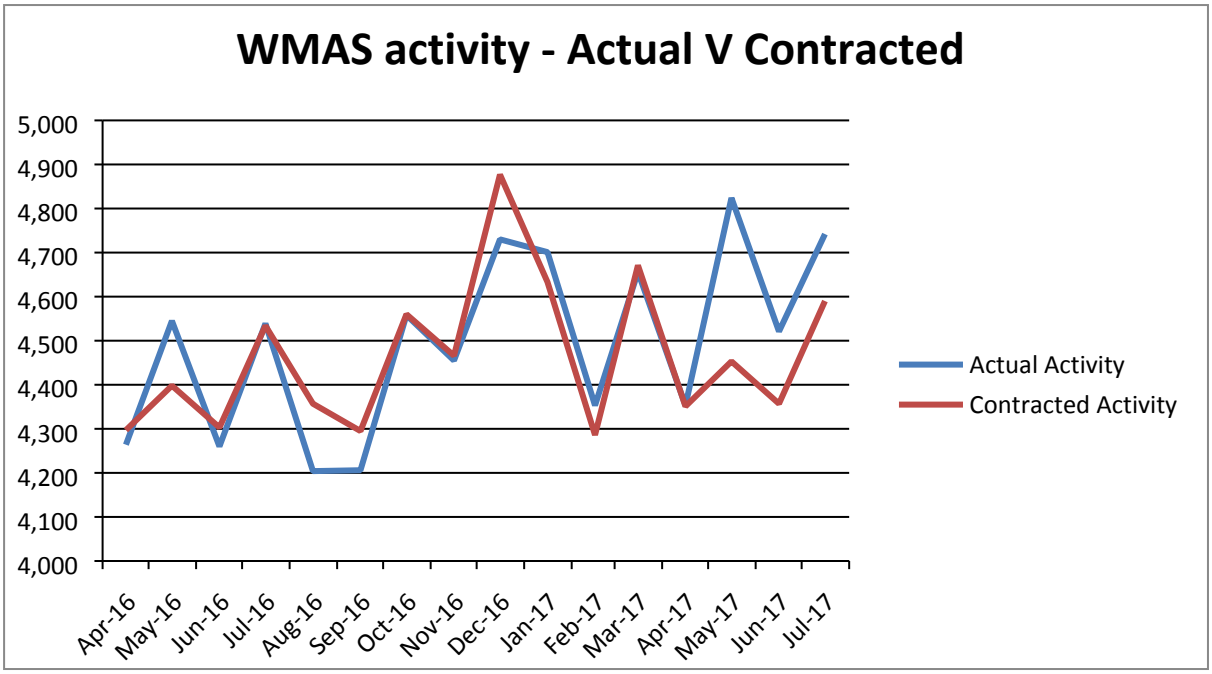
- Ensure 100% of all resources are Paramedic crewed (currently 96%), and ensure all patients are assessed and treated by a Paramedic, utilising only 1 resource
- RPI will be further reduced
  Improve (reduce) the time to Hospital for key patient groups (Stroke and Cardiac)
- Reduce the number of patients transported to hospital

- Further reduce the number of sites where resources respond from
- With further improvements to dispatch methods, it is intended that both fleet mileage and control staffing could be further reduced.

2.4.2 WMAS activity

The demand for ambulance services by Wolverhampton patients has shown an increase in the Q1 of 2017/18 resulting in activity of 3.89% above contract at July 2017 - outstripping the level of growth commissioned. See table 1 below.

Table 1 – Ambulance activity April 16 to date



This is not unique to Wolverhampton. Whilst this is challenging for Wolverhampton Health Economy, the percentage increase is lower than the current Black Country average. Commissioners are working to understand where this growth originates from. WMAS have addressed the system pressures with their winter plan which is attached at Appendix 2 for information.

We also note that winter resilience monies are made centrally available to WMAS and will work as part of the regional commissioning arrangements to understand how this will be committed.

Within the Wolverhampton areas, WMAS are struggling to hit the 75% target for Category 1 calls however Wolverhampton report 72.5% for July which was the highest in the Black

Country. In an attempt to understand and support WMAS, the AE Delivery Board is investing in additional HALOs to ensure minimal delays in handovers and turnarounds to facilitate crews being able to respond to the calls quickly.

See and Convey volume has seen a drop down to 60.4% (July 17) from 62.5% (Year to date – 2016/17). This has been partly down to the introduction of the Rapid Intervention Team in the community.

2.5 Support to Care Homes

- Geriatrician/ANP input into care homes
- Targeted intervention into care homes by the QNAs
- Assessing compliance with the BGS Guide on care home medicine
- Red bag scheme - 'hospital transfer pathway' to provide prompt and efficient transfer of clinical care, when a patient / resident moves between care home and hospital.
- Targeted training to support admission avoidance from harms e.g. falls prevention, Pressure injury prevention
- Training in early detection and management of deteriorating residents
- Training in quality improvement tools and methodology to promote safe practice and improve quality
- Promoting best practice through lessons learnt from serious incidents
- Living well to the very end - Patient and family-centred care collaborative approach to improving End of Life Care in Wolverhampton Residential Homes.
- Multiagency approach in admission avoidance through monitoring of harm free care and quality

2.6 Service and system escalation processes

The CCG has invested in the Regional Capacity Management Team (RCMT) for a number of years in order to support robust planning and capacity management across the system. The RCMT can provide support to providers across the system and through a number of means can support the management of pressures as they emerge and robust planning.

The RCMT is able to provide regular data and information in real time, retrospectively and predictively which the CCG utilises and shares with partners as appropriate.

The RCMT also hosts the Escalation Management System which offers a mechanism for providers to communicate the current level of escalation and particular pressure points quickly to all parts of the system. This comprises a set of triggers which give

detail of particular pressure points and lead to the generation of an overall escalation level. Key urgent care services are utilising this functionality on a daily basis which is aiding a wider understanding of flows and pressure points.

As pressures are identified and alerts cascaded out across the system, organisations should refer to the agreed escalation action cards and undertake the appropriate actions to facilitate de-escalation at the earliest opportunity. Our shared ethos is not only to manage current pressures but to also prevent any further escalation. As part of declaring an escalation level, providers are required to estimate time to de-escalation and this is based upon all partners fulfilling their agreed responsibilities. At higher levels of escalation multi agency teleconferences can be convened where actions are agreed collectively and constructive challenge is employed.

The health economy are expecting to implement the OPEL framework again this winter and will maintain oversight of reporting to ensure speedy response where required.

The CCG Executive team also participate in an on-call rota to ensure Executive level input is available across the Black Country out of hours to respond to incidents and pressures in the system. This rota is in effect year round and covers holiday periods. The CCG maintain an in-hours rota of senior managers.

2.7 On-Call Arrangements

During the In-hours period, Wolverhampton Health Economy have on-call arrangements in place. This is managed through a CCG rota of senior managers/executives. The CCG also have 3 x Weekly teleconferences with RWT where system pressure is discussed.

During the Out of Hours period, the CCG is part of the Black Country Exec on-call rota. This is managed by Sandwell Switchboard who have the latest rota.

Both In-hours and out of hours, any provider or local authority can escalate issues directly with the CCG.

The acute and community provider has a 3 tiered on call system. The first is the on-site, patient flow and local bleep holder cover. There is a silver tier on call manager on call 24/7, supported by a gold level, director level on call support 24/7. Both silver and gold command are on site 7/7.

2.8 Communications

AE Delivery Board recognises the benefits to having robust communication with patients/public. For economy of scale, the CCG work with the CSU who manage the standard media campaign on behalf of the Black Country.

The objectives from the 2017/18 campaign will be:

Clinical perspective:

- Increase flu vaccination take-up in the target groups:
  -Carers
  -Pregnant women
  -Long term conditions
- Reduce pressure on urgent care and A&E using V08 data/ A&E attendance figures
- Increase calls to 111

Marketing perspective:

- Facebook engagement and evaluation
- Twitter engagement and evaluation
- Media reports
- Web statistics
- Video and animation views and engagement
- Benchmarking data through quizzes
- Face to face engagement and feedback

The overarching aim is to encourage people to take ownership of their health and to access the right service for their health needs.

In relation to Flu, the campaign will target:

- Long term conditions (e.g. asthma)
- Pregnant women – continuing success in 2016/17
- Children aged 2-4
- Carers

In relation to encouraging self-care:

- Frail older people
- Carers
- Parents of 0-5s
- Voluntary & community sector – e.g. Age UK, carers groups, children's centres

To complement the NHS England winter Stay Well campaign, locally we will ensure that we are communicating details of service opening times over all bank holiday periods and

ensuring that the directory of services is updated where there are variations to operational hours.

We are currently exploring opportunities within the STP for aligning our winter communications plans to ensure consistency of message and best use of available resources. As part of this we are looking at novel and innovative mechanisms to engage with local populations.

Our escalation plan also sets out how, as a system, we will manage communication with one another. Our principles for communication are as follows:

- All partners will sign up to the Escalation Management System (EMS) and opt to receive notifications when organisations escalate
- Organisations will proactively initiate communication with relevant partners to resolve issues at an early stage
- Teleconferences will only be called where delivery of benefits to the system can be identified, when they are required all relevant organisations must commit to participating in the call
- WCCG will ensure that all relevant messages are communicated across its member general practices
- A joined up approach will be taken across all health and social care organisations when communicating messages

We understand that NHS England is likely to deploy the OPEL framework again this winter. We will review reporting requirements once they are released and consider whether we should amend how the level is calculated/weighted.

2.9 Flu campaign

2.9.1 Public Health campaign

Public Health are working with and supporting NHS England priorities and programmes. In addition they have worked with and supported RWT in proposing new ways of reaching the eligible population for flu vaccination whilst patients may be accessing other services within the trust I.e. Those on dialysis, seeing consultants, pregnant women through maternity checks etc.

Public Health are working in conjunction with the CCG to look at both good and not so good performing GP practices with the view to assist them in improving vaccination rates (not just for flu). In addition there is work ongoing with pharmacists in encouraging flu vaccines through them in the community.

Finally Public Health will be writing to all care and nursing home owners/managers to promote flu vaccination for residents and staff. We are hoping to try and capture these figures to help us focus resources next year.

2.9.2 Flu Campaign – UCC

Flu Vaccines to be promoted to all staff within the UCC to ensure all staff take part. Agreed escalation plans are in place and daily calls in place to assess the shift rota fill. Local Management will be on site to manage pressures.

2.9.3 Flu Campaign – RWT

Each year the NHS prepares for the unpredictability of flu. For most healthy people, flu is an unpleasant but usually a self-limiting disease with recovery generally within a week. However, there is a particular risk of severe illness from catching flu for:

- older people
- the very young
- pregnant women
- those with underlying disease, particularly chronic respiratory or cardiac disease
- those who are immunosuppressed

For the 2016/17 campaign RWT vaccinated 72% of its front line staff. For the 2017/18 campaign we are aspiring to achieve 70% uptake.

The organisation is fully committed to supporting the national campaign and employs a small Occupational Health & Wellbeing Service who currently provides the year Flu campaign. The organisation is aware that the Flu is a key factor in NHS resilience. It impacts on those who become ill, the NHS services that provide direct care as a result, and on the wider health and social care system. The annual immunisation programme helps to reduce unplanned hospital admissions and pressure on ED. It is therefore a critical element of the system-wide approach for delivering robust and resilient health and care services during winter.

Learning from success and failures from last year's campaign a working group has been established with previous managers involved. Within the team it has been highlighted that senior management, time & resources are required in order to sustain an effective Flu campaign, vaccinating our front line staff, to ensure our staff, patients, and families are not affected but also achieving the CQUIN.

CASE FOR IMPROVEMENT

The 2016/17 campaign was a difficult campaign and we didn't reach our target until December which was the last month which counted towards the uptake in vaccines. There was no allocated funding available to the campaign which resulted in OH&WB to endure the cost. Reduced staffing levels within the OH&WB team, admin services and no bank work provisions resulted in restricted delivery of service. Due to less admin services we were unable to have real time data and unable to target areas efficiently.

Additional Resource has been approved to support this years' campaign.
Admin support – to ensure data entry into the ESR system is accurate, up-to-date and efficiently input. This will allow real time data to be presented at the relevant meetings and for Trust Board. This will allow the Flu team to target areas where necessary and can identify where myth busting/education & training may be required.

Additional bank hours - at an enhanced rate for peer vaccinators to continue the vaccinating in their own time. 24/7 service required for a 24/7 organisation.

IPAD's – IPDA'S to be issued for peer vaccinators to use when they are vaccinating. The data input will be sent directly to the admin support for ESR who will be managing this.

Renovation – Renovation to a room at RWT so fridges to store the Flu vaccines can be kept.

Fridges – The Pharmacy Department are unable to store the Flu vaccines due to capacity issues. Fridges will need to be ordered to avoid disruption to the campaign.

Advertisement – Schedules, myth busting and other Flu posters will need to be printed via RWT's medical illustrations team.

Donation – It has been agreed by senior managers that a donation will be made to a charity following closure of Flu campaign 2017. The donation will be based on the percentage of those vaccinated.

2.9.3 Flu Campaign – Mental Health Services

[wording to be inserted when received from Denise Tooth]

2.10 RED BAG Initiative

2.10.1 The Red Bag Project is based on the Vanguard Project and aims to deliver a variety of key outcomes including, meeting NICE guidance for transfer of care along the hospital pathway (NG27), reduced length of stay in hospital, increased communication and patient experience. In Wolverhampton we have combined this project with the CCG quality team to deliver advanced end of life care plan training in conjunction with the Red Bags.

2.10.2 An implementation group consisting of LA, CCG, Ambulatory care, RWHT and care home staff has been formed. To date 9 care homes supporting 267 residents have agreed to participate, currently awaiting confirmation from the remaining homes in the city.

2.10.3 The paperwork and implementation guidance has been received from the Vanguard Team and localised paperwork is completed in draft form. Training and implementation is due to commence early September with identified care homes. The first 50 bags are due for delivery mid-September with the remaining 950 bags due on 7th November. An official launch of the project is being scoped for October 2017 with the training commencing prior to the delivery of the bags to ensure care homes can implement the process without delay.

2.11 Investment underpinning System Resilience

In 2017/18 the AE Delivery Board has received a financial resource of £1.3m to reinvest into Wolverhampton health economy. In addition the CCG has allocated both sanctions money and incentives money into the AE Delivery Board budget to reinvest in to the urgent and emergency care system resulting in approximately £1.7m.

AE Delivery Board has committed a large proportion of these funds already. See table 1 below. This leaves a contingency fund which the AE Delivery Board will need to consider for investment over the Winter Period.

Table 1 - 2017/18 schemes

GP support to Resource Centres (CCG)	£24,000.00
Wolverhampton Voluntary Sector Council Scheme (WVSC)	£123,504.00
Additional Social Workers for Ward Huddles	£224,944.00
P3 Homeless Charity	£109,540.00
Dementia project	£16,989.00
Increased AMPs	£50,000.00
Additional Patient Flow Co-ordinators	£213,415.00

Additional Porters	£105,000.00
4 hour Minors Trial	£76,666.00
Red Bag Initiative (via LA)	£40,000.00
Extended Access in Primary Care (Bank Holidays and Christmas)	£67,973.88
WMAS Handover delays	£1,887.00
Ambulance activity NEPTS	£20,000.00

3. PATIENT FLOW – ACCESS ROUTES TO NON-ADMITTED CARE

3.1 Referral Routes

Where ever possible, there are options available to avoid unnecessary admissions to the Acute Trust. To facilitate this, Wolverhampton Urgent Care Triage & Access Service (WUCTAS) is a single point of access for GPs and Health Care professionals in the community to access services for patients. The options available include both services in the community as well as those within the Acute Trust.

Community Services:

3.1.1 Admission Avoidance Team

The Admission Avoidance team are an integrated team providing a number of key functions to support the healthcare system. The team provide a rapid response to patients suffering an exacerbation of a health condition. The team accept referrals from Primary Care, Urgent Care, WMAS and other Community based nursing services.

The team provide a time limited intervention to ensure the patient is assessed, a care plan developed and treated at home, thus reducing demand on the Acute Trust.

The team also consists of a dedicated support function for the care home sector by the **Home Intervention Team**. This team support residents to remain in their usual place of residence whilst being treated for an acute episode, again reducing the demand on the Acute Trust. They are supported by a Consultant Geriatrician and a Respiratory Consultant who provide telephone support and input into a virtual ward round.

Both teams provide a seven day service across the city.

The CICT service operates seven days per week providing rehabilitation support to people in their usual place of residence to reduce the need for extended length of stay in hospital. They operate in an integrated manner with the Rapid Intervention and home intervention teams to ensure a holistic approach to out of hospital care.

The team work in partnership with the **Local Authority reablement** teams ensuring patients requiring ongoing reablement are assessed and referred for support to remain in their usual place of residence.

Their aim is to:

- Prevent hospital admissions (and re-admissions)
- Support patients in their usual place of residence to remain as independent as possible following a hospital admission
- Prevent patients from having to move into a residential home until absolutely necessary

The **Hospital at Home** team provide a seven day service delivering time limited interventions to support patients with acute illness. The aim of the service is to reduce hospital admissions by providing community based care for any individual who requires intensive treatment and/or support to prevent hospital admission or facilitate early hospital discharge. The service operates from 8am – 10pm seven days per week.

The CCG also commissions a '**step up' bed facility** to support the Admission avoidance teams. These beds are clinically managed by the Rapid Intervention team supported by a local GP. The aim of the service is to provide a community bed based service to support the following cohort of patients

- Those who following an intervention from Community Rapid Intervention services, require a monitored/supervised period of care

Access is to the beds is via the Rapid Intervention team. Length of stay is limited to up to seven days to ensure maximisation of capacity and a reduction in reliance on bed based care.

This facility is available seven days per week.

3.1.2 Urgent Care Centre

The Urgent Care Centre in Wolverhampton has been commissioned as a Type 3 AE which sees, as a minimum, minor illness/minor injury. The service operates 24 hours a day, 7 days a week and is expected to meet the four hour national standard. This service is accessible either directly as a walk in patient, booked via NHS111 or triaged from ED. The benefits of this service being co-located with ED means that patients who choose ED, can be redirected to the GP led UCC which is situated directly above ED.

3.1.3 Primary Care Streaming at front door of ED

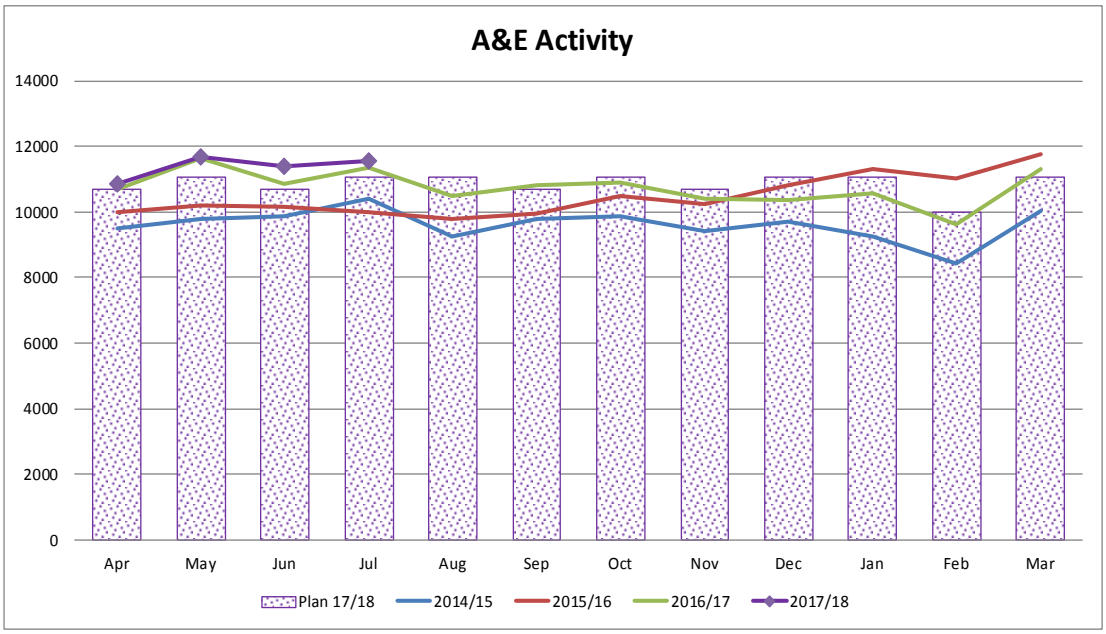
For those patients who present to ED either inappropriately or are unsure which service will meet their needs, Wolverhampton implemented streaming at the front door of ED in April 2016 when the co-located Urgent Care Centre was opened.

However, this proved to be challenging for a number of reasons including confidentiality and inability to undertake initial physical assessment. To develop streaming further, staff at the Urgent Care Centre are trained to undertake ED Triage and now work with ED colleagues to jointly triage patients that present to ED. The number of patients who are passed between the UCC and ED has dropped since the development of Joint Triage. This leads to a smoother patient journey and reduced time to be treated.

Acute Trust Services:

Once a patient has accessed ED either via ambulance or by self-presenting, every effort is made to ensure the patient is managed within the four hour standard and is only admitted to a bed where clinically required. Activity trends in ED are detailed in table 2 below.

Table 2 – Activity Trends



3.1.4 Clinical Input into ED/Admission Avoidance

Physician A Model

- Previously all medical consultants contributed equally to an on-call rota with 2 consultants working in the AMU each day from early afternoon to early evening during the week, and just 1 consultant 'on take' in AMU at the weekend. This has been remodeled into 2 rotas.

- Physician A – 12 acute medicine and acute-minded consultant physicians supported by an SpR and 2 junior doctors work in ED 10:00 to 21:30 7 days per week on a 12 person rota.
- Physician B – The remainder of the medical consultants working in AMU from 13:00 to 21:30 performing a rolling post take ward round tailored to the patient needs and dependent on previous Physician A input and handover.
- This model was co-designed by a clinically led work stream including membership from the ED and Medical teams as part of the development of the new Urgent and Emergency Care Centre. The model launched when the centre opened in November 2015. The estate developments included a modest increase in ED cubicle capacity (10%) but no change in AMU beds. The old acute medicine ambulatory area was closed and not recreated and the aim was to deliver elements of ambulatory care from ED.

The principles behind the new model were:

- Create a small team of like-minded medical consultants that could adapt to a changing landscape, keep up to date with evolving ambulatory options and develop good working relationships with the ED team
- Patients will be assessed and prioritised according to clinical need and in an area where rapid treatment escalation is possible – all medical patients would be assessed by the ED team in the first instance
- Joint, face to face senior decision making between ED and Medical teams allowing both to understand each other's aims and challenges and to learn from each other. Previously the ED team received negligible feedback on patients after admission to AMU
- Senior decision making at the earliest opportunity, improving diagnostic accuracy and efficiency and facilitating early interventions in time critical conditions. Patients receiving a consultant review within 14hrs
- Equity of service for all patients independent of day of week of attendance or mode of referral
- Acute medicine philosophy including championing the 'home first' principle
- Brokering with specialties to facilitate review and treatment in HOT clinics or other ambulatory settings where possible
- Support the ED team with first assessments of medical patients during surges in demand

The impact of the Physician A model is evident in table 3 and 4 below.

Table 3 – Non Elective Activity (as a %)

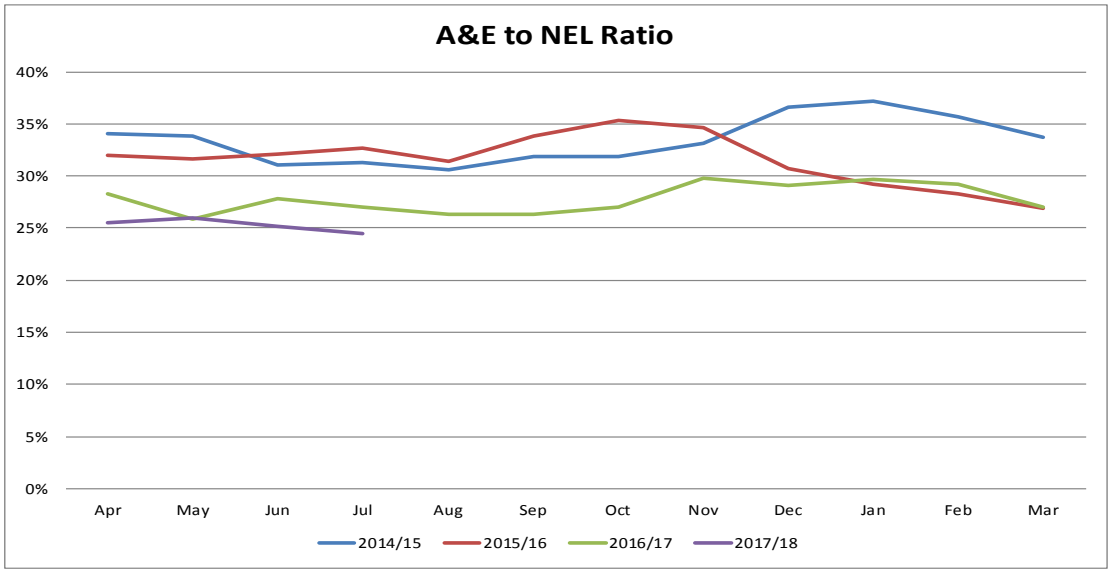
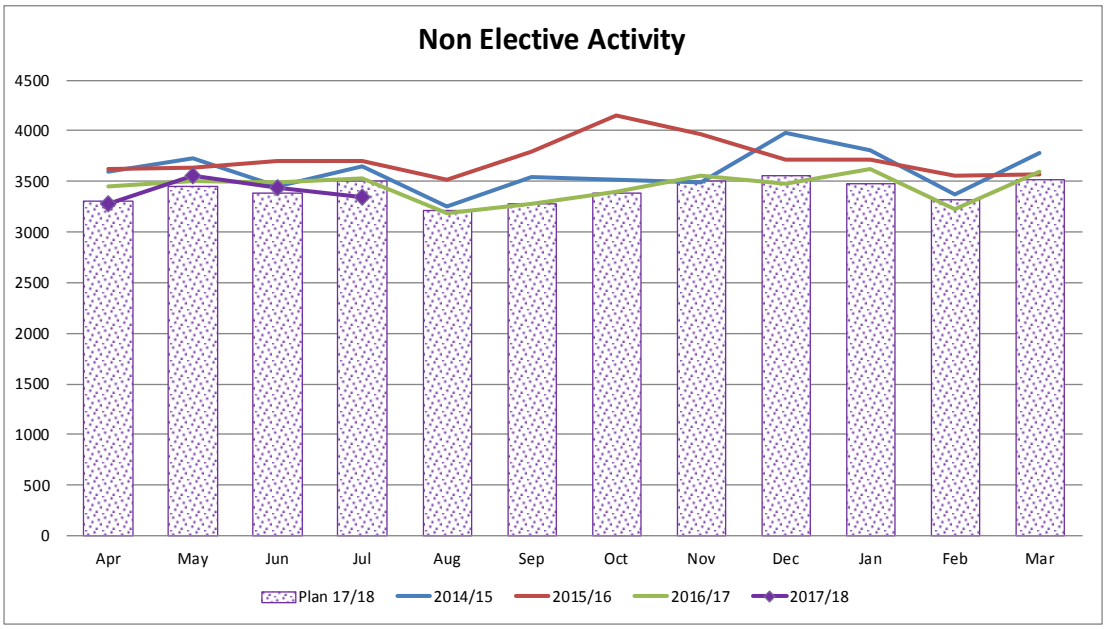


Table 4 - Non Elective Activity (actual) against plan



3.1.5 Preventing Avoidable Breaches

The Trust has developed a recovery action plan to reduce the number of patients breaching the 4 hour target. This has resulted in the overall performance increasing from 88.9% in Q4 2016/17 to over 92.5% for every month in 2017/18. There are a number of key elements contained within the plan, some of which are already mentioned in this document.

In summary, the key developments are:

- Introduced Patient Flow coordinators to support faster decision making and patient flow
- Continue with dedicated portering support for Emergency Department and AMU

- Recruited to a number of key posts including 3 Paediatric Consultants, 1 Adult Consultant, 1 Specialty doctor and 2 MTI doctors.
- Joint triage implemented with ED with UCC staff to enable observations and physical assessment to take place. This facilitates more effective triage and ultimately patients are moved faster
- Development of frequent attenders project with CCG and WMAS – looking at earlier intervention and development
- Patient Flow rapid improvement events facilitated by Human Factors Project. To look at new ways of working in Majors and Minors, combination of staff groups to include: Consultants, Middle Grade, Junior Doctors, Nurses, HCA and Physician A.
- Human factors training for all relevant staff to be rolled out with all relevant staff trained by October

3.1.6 Mental Health Services

AWAITING UPDATE FROM DENISE TOOTH - BCPFT

3.1.7 Ambulatory Care/HOT Clinics

In the 1st September the Trust was informed that a capital bid to develop a frailty and ambulatory care unit, next to the current Clinical Decision unit was approved.

Subject to internal and external (CCG) business case approval, the trust will further develop the Ambulatory care model from January 2018, providing a facility designed to assess, diagnose and treat patients in a day case facility who would otherwise have had a 0-2 length of stay.

4. FLOW WITHIN THE HOSPITAL SYSTEM

4.1 Use of Safe Hands Technology

Safe hands technology allows the Trust to used real time information to manage the hospitals hot site (New Cross Hospital) bed capacity.

In order to ensure maximum utilisation of the technology, The Trust has established a Patient flow Group which reports into the SafeHands Delivery Group, chaired by the Chief Operating Officer. The Patient Flow Group has a work plan and progress is monitored via a suite of key performance metrics. The metrics capture admission, transfer, discharge, Discharge to Assess, Safer bundle and Red to Green initiative.

In real time, the Trust is currently achieving 61% against a target of 70% for capturing pending discharge dates and 56% against a target of 90% for confirmed discharges within

the SafeHands system. Progress is being supported by the huddles in medicine and ward rounds within surgery.
Good progress is being made on the number of patients discharged by 16.00; again work is progressing within the wards and directorates to increase this percentage.

Work is on-going on how to capture Red to Green results within the SafeHands system as currently this is not captured in any of the available modules. The Trust is one of the four National pilot sites for the utilisation of Tele-Tracking and once the other Trusts go live we will be able to benchmark progress against agreed key performance indicators.

4.2 Use of daily huddles and super huddles on medical wards

Huddles/ board rounds provide the single point of reference, ideally at the start of each day, when key multi agency staff come together to review the clinical and discharge needs of each patient. The multi-disciplinary team must verify daily discharges and prediction of patients who will leave hospital within the next 48 hours. Accurate information will be entered into tele- tracking at time of the huddle/ward round, giving date and time of discharge. Key elements of the process include:

- The Consultant is accountable for the safe transfer of patients. The Consultant is the final decision maker regarding the decision to transfer a patient from the care of RWT. They are responsible for balancing the risks of remaining in hospital versus discharge on a daily basis. The role can be delegated to an appropriate medical grade.
- Band 7/ Shift Coordinator nurse is responsible for ensuring the required patient information is available and completion of action log/Safe Hands is up to date.
- Flow assistant provides support to clinical and therapy staff, advising and updating on progress of individual patient discharge plans
- Social care advises on suitability of patients for social care and progress of current social care assessments including any current barriers within the system
- Therapist advises on the progress of therapy assessments. This includes any further Physiotherapy or Occupational Therapy requirements and whether they are mandatory before discharge or can be delivered outside of the hospital setting with bridging support where necessary

4.3 Red and Green days

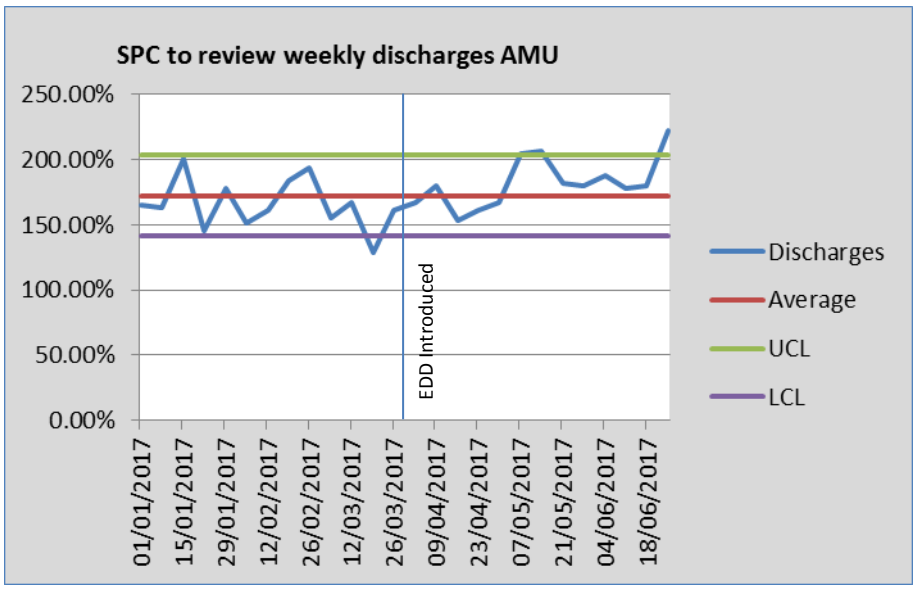
Red and Green Bed Days' are a visual management system to assist in the identification of wasted time in a patient's journey. A Red day is when a patient receives little or no value adding acute care. A Green day is when a patient receives value adding acute care that advances their progress towards discharge. Key elements of the process include:

- It is the responsibility of the board round lead at the daily huddle to ensure that All patients should be marked as a RED day, for the MDT to discuss whether or not status can be changed to green.

- When delays relate to awaiting tests/results, delays of over 12 hours for diagnostics, assessments, reviews etc. will be followed up. If they cannot be resolved that day, the delay should be highlighted to the Directorate management team to take appropriate action and resolve.

4.4 Use of Expected Discharge Date

RWT report on the proportion of patients admitted who have an expected discharge date on a weekly basis. These reports are distributed widely and reviewed at the Trust's Patient Flow Group, Clinical Directors meeting and individual directorate's performance meetings. The use of EDD in the Trust has been seen to have a positive effect in AMU. Once introduced at their Daily MDT, there was a significant rise in the number of discharges:



4.5 Use of SAFER bundles

The Trust is pioneering the use of the SAFEHANDS system to review the SAFER bundle. The elements of SAFER are:

- S – Senior Review for patients prior to 12pm
- A – All Patients have an EDD
- F – Flow, patients will be pulled from assessment wards prior to 10am
- E – Early Discharge. 33% of patients will be discharged from base wards before midday
- R – Review. A systematic MDT review of patients with extended lengths of stay

The SAFEHANDS system is used to record information against all of these metrics. These reports are monitored at the Trust's Patient Flow Group, Clinical directors meeting and Individual directorate's Performance meetings.

4.6 Stranded Patients

Patients whose delayed discharge relate to internal issues are addressed at the daily huddle MDT meetings. The review of patients under SAFER is presently focussing on those stranded patients who are medically fit but are delayed discharge due to external factors. These patients are discussed at the twice weekly senior MDT meeting to facilitate their safe discharge to an appropriate destination. This includes all delayed patients irrespective of age.

4.7 Occupancy rates

The Trust has closed two wards over the past year. The first was a rehabilitation ward that was closed due to clinical staffing levels; the second was a medical ward that was closed following the enhancements in ED and the reduced level of emergency admissions. This has had a hugely positive impact across the health economy and the level of bed occupancy has been at a safe level throughout this period.

Month	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	YTD
% Occupied	92.43%	93.35%	91.90%	91.62%	89.86%	83.81%	86.15%	86.00%	83.96%	88.18%	88.57%	89.31%	88.76%

Month	Apr-17	May-17	Jun-17	Jul-17
% Occupied	85.03%	85.67%	86.67%	85.89%

The Trust is planning for a similar level of bed occupancy for 2017/18 winter period. There is a small amount of escalation capacity that can be opened in extremis.

4.8 7-day Services

The Trust continues to ensure that access to a Consultant is available every day of the week. Additional support to these Consultants is provided from the junior doctors. The Trust is also planning to provide more senior nurses and therapists to ensure that care and flow for non-elective admission is the same on every day of the week

5. DISCHARGE

5.1 Eight High Impact Changes

5.1.1 Wolverhampton has undertaken a partnership self-evaluation against the High Impact Change Model for Managing Transfers of Care and has produced an initial action plan that will be submitted as part of the Better Care Fund 2017/19 Plan Submission with ownership by the A & E Delivery Board and oversight by the Better Care Fund Programme Board.

5.1.2 Partners have committed to the forming of a Task and Finish Group that will ensure that actions are clarified and detailed timelines established for delivery. The group will also ensure that the action plan is co-ordinated, delivered and reported back to A & E Delivery Board and BCF Programme Board for governance purposes.

5.1.3 The table below provides an overview of the result of the self-evaluation and where Wolverhampton expects to be in terms of implementation of the model by November 2017:

Change Description	**Self-Evaluation (as at August 2017)**	**Expected position by November 2017**
Change 1 Early Discharge Planning. In elective care, planning should begin before admission. In emergency/unscheduled care, robust systems need to be in place to develop plans for management and discharge, and to allow an expected date of discharge to be set within 48 hours.	**Plans in Place**	**Established**
Change 2: Systems to Monitor Patient Flow. Robust Patient flow models for health and social care, including electronic patient flow systems, enable teams to identify and manage problems (for example, if capacity is not available to meet demand), and to plan services around the individual	**Some aspects have Plans in Place and some Mature**	**Some aspects have Plans in Place and some Mature**
Change 3 : Multi-Disciplinary/Multi-Agency Discharge Teams, including the voluntary and community sector. Co-ordinated discharge planning based on joint assessment processes and protocols, and on shared and agreed responsibilities, promotes effective discharge and positive outcomes for patients	**Established**	**Exemplary**
Change 4 : Home First/Discharge to Access. Providing short-term care and reablement in people's homes or using 'step-down' beds to bridge the gap between hospital	**Established**	**Mature**

and home means that people no longer need wait unnecessarily for assessments in hospital. In turn, this reduces delayed discharges and improves patient flow		
Change 5 : Seven-Day Service. Successful, joint 24/7 working improves the flow of people through the system and across the interface between health and social care, and means that services are more responsive to people's needs	**Mature**	**Mature**
Change 6 : Trusted Assessors. Using trusted assessors to carry out a holistic assessment of need avoids duplication and speeds up response times so that people can be discharged in a safe and timely way.	**Plans in Place**	**Established**
Change 7 : Focus on Choice. Early engagement with patients, families and carers is vital. A robust protocol, underpinned by a fair and transparent escalation process, is essential so that people can consider their options. The voluntary and community sector can be a real help to patients in supporting them to explore their choices and reach decisions about their future care.	**Mature**	**Mature**
Change 8 : Enhancing Health in Care Homes. Offering people joined-up, coordinated health and care services, for example by aligning community nurse teams and GP practices with care homes, can help reduce unnecessary admissions to hospital as well as improve hospital discharge.	**Established**	**Established**

5.2 Discharge Capacity

5.2.1 Social Care Reablement services currently operating at capacities at least 25% above the same period last year due to improvements achieved through Red2Green programme implemented in Bradley Resource Centre and HARP to reduce service user length of stays.

5.2.2 In the 2017 Spring Budget, central government announced additional funding for Adult Social Care over a three-year period. A number of proposals had been approved including the commissioning of additional homecare reablement from the independent sector. This would enable the twin tracked provision of both the internal reablement service provided by the City of Wolverhampton Council (CWC) and substantially increase independent sector reablement support. This Service will be inclusive for people with dementia and will be an occupational therapy led model.

5.2.3 Home Care Reablement embeds a philosophy and approach which supports people to build on their current assets and abilities which empowers individuals to 'do things for themselves' rather than having things done to them. This is a short-term provision, and encourages individuals to develop the confidence and skills to carry out these activities themselves and, consequently, removes or reduces the need for ongoing care, and other forms of support. It is recognised that maintaining and improving people's independence to enable them to return to their own homes remains the priority.

5.2.4 The Service approach will be one of enabling in order to:

- Prevent avoidable hospital admission
- Reduce/delay admission to residential care
- Facilitate safe discharge from hospital or other bed based facility
- Maintain or improve levels of independence.

5.2.5 It is anticipated that this Service will;

- Work with individuals to deliver reablement goals within the specified time period
- Reduce the need for longer term ongoing support from social care
- Deliver a high level of customer satisfaction
- Enable people to remain in their own home for longer
- Skills and tools to manage the challenges of living with dementia
- Increase confidence and self-esteem to remain independent for as long as possible in their own home.
- Reduce feeling of social isolation
- Improve emotional well-being

5.3 Placement without Prejudice

Within Wolverhampton a local policy is in place to use 'without prejudice' arrangements to facilitate discharge in circumstances where agreement has not been reached regards responsibility for funding future care requirements.

5.4 Discharge to Assess

Discharge to Assess (D2A) is currently being piloted across 4 wards with New Cross Hospital. There is a comprehensive role out plan which will embed the process throughout the trust by November 2017.

There has been significant engagement with a wide range of stakeholders to provide an understanding of the programme and the use of 3 distinct pathways to facilitate timely discharge from acute care.
The number of assessments completed within an acute setting will be minimised and a 'Home First' approach will maximise the potential for individuals to return to, and remain within, their usual place of residence.
An email address is in place for all D2A communications and tripartite funding has been agreed, initially on a 6 month basis, for dedicated clinical and administrative support to provide additional assurance around the new process.

5.5 Trusted Assessor

The model developed within Wolverhampton requires the appropriate clinician to complete the detail pertinent to their aspect of patient care.

The trusted assessor process is working effectively on the pilot wards and an electronic version of the document is under development and will be in place by mid –September. This will enable safe sharing of patient information with the services delivering support on discharge, streamlining the process.

6. DEMAND

6.1 Predicted Demand

The health system utilises predictive data that is generated by the RCMT, and data can be forecasted up to twelve weeks in advance. WMAS also provide forecast data based on previous activity. At the time of submitting this plan predictive data is not yet available for the majority of the winter period. System partners intend to review the activity projections as they are released by the RCMT and ensure capacity is planned accordingly.

The UCC uses historical data to predict/forecast activity numbers. The service has now been operational for 18 months and activity patterns can inform Winter planning. The service also takes learning from services across the country to aid in predicting peaks in ambulance activity.

6.2 Christmas & Bank Holiday Demand

Wolverhampton Doctors Urgent Care (WUCC) are carrying out statistical forecasting to provide a robust view of the calls anticipated over the winter period specifically focusing on the key dates throughout December 2017 and into January 2018. The forecasts will be agreed with the Executive Team and will be shared with CCGs / NHSE England reporting for analysis and assurance where required.

The key elements that are being undertaken to drive the forecasting model for the Wolverhampton UCC will include previous data from 2016 and 2017 to assess anticipated demand with modelling variations included to account for uplifted activity due to the weekend Christmas and New Year holiday period.

The priority activity days will be identified. The intraday breakdowns will be reviewed and, if required, actual activity can be tracked by hour over the key periods against predictions.

Forecasting identifies that, against standard activity assumptions additional shifts are required to enhance the rota over the 4 day Bank Holiday period. The rotas have been published based upon last year's staffing model using Boxing Day activity as this is one of the busiest days, whilst a full review is undertaken. From early December there will be a leave embargo during the peak activity dates. Enhancing the rota will include:

- Extending shifts for all staff
- Approved Agency usage
- Enhanced financial incentives for shift cover over the 4 day bank holiday
- Early promotion of key shifts / skill mix

7. RESILIENCE & CAPACITY (UCC)

7.1 Workforce capacity

The WUCC will be continually reviewed with shift amendments made closer to the priority activity dates to maintain optimum cover throughout, as well as on shift capacity management. With regard to increased service line capacity (ensuring service is delivered against key performance indicators) WUCC has access to mutual aid from across the Vocare Group with regard to remote triage and this will be invoked proactively to ensure service level compliance. We will also be sharing key updates of shift fill and ensuring the service has communication plans in place with agreed thresholds of contact with the CCG. These will be agreed prior to entering the busy periods.

Given the operational pressure normally encountered during Winter, local senior leadership with operational experience will form part of a local on-call system with on-site presence during the priority activity days. This will provide crucial oversight to the system during the Key periods. For assurance, organisational protocols are in place for system-wide communication and escalation.

WUCC aims to meet the current trajectory (KPI compliance) on each of the priority activity dates including streaming times. This will be continually monitored to ensure the best

possible performance achieved. Daily monitoring and reporting will be increased through the priority activity days and will include:

- 9.30 am Risk Assessment Shift meetings held – establishment of key activities, volumes, hotspots and actions to be taken if needed along with a review of previous 24 hours activity
- 10:00 am Internal Group wide Operational SITREP telephone conference led by Operational on call focussing on operational issues affecting delivery (eg: staffing, backlogs, weather) and agreeing corrective action across the group including mutual aid support.

*Additional SITREP meetings will be arranged where there are concerns raised for urgent action and follow up

7.2 Staffing (clinical and non-clinical)

All previous workforce engagement workstreams to improve clinical and non-clinical capacity to meet demand will be in fully implemented by the end of November 2017. The use of Agency will be for short term circumstances only. This means that the staffing of rotas will be managed in line with current rotas.

7.3 Weather and transport

WUCC receives weather warnings via the clinical commissioning group as well as weather alerts and forecasts from the Meteorological Office. This allows the organisation to put into operation the appropriate plans in a timely fashion. In the event of adverse weather such as snow, ice and flooding a control room will be activated in Staffordshire House, so there is a single focussed controlled event room. In addition, we will be encouraging staff to plan ahead and develop their own contingency plans.

Drivers will be available to use the GP OOH cars so that staffs are able to attend work. Contingency will include remote management of activity either with remote clinicians logging in or diverting calls elsewhere within the Vocare Group.

Any adverse conditions affecting the GP OOH service, all vehicles have 4x4 capability and access permitting critical home visits will, where possible continue, although, the majority of patients will be managed virtually or requested to attend a fixed base for an appointment.

Emergency Preparedness, Resilience and Response (EPRR) contingency will be invoked as appropriate.

7.4 Risk Management

The Key risk to delivering this Winter Plan will be the ability to manage demand should this present above forecast due to the alignment of Christmas over a weekend period, and to some extent represents a level of unmet need due to the prolonged closure of primary care. Pharmacy provision will reduce the immediate risks of increased demand and we will be

working closely with all stakeholders including the NHS111 & CAS services to ensure a stream lined process.

An annual leave embargo has been put in place to avoid a reduction in workforce during the highest demand period of the calendar. Senior managers will be available on site on each of the priority activity days working alongside the National Operational On Call Manager to maintain a local consistent presence and to support the Receptionists to maintain patient flow. We will also have access to IT & Clinical on Call throughout the period.

8. RISKS TO DELIVERY OF THIS WINTER PLAN

8.1 Staffordshire

As depicted in the Programme Plan, there has been tremendous progress in terms of taking forward many of the mandatory areas along with the locally agreed areas of work. However the risks associated to engagement from Staffordshire holds the largest risk to the local health economy. This is evident through the challenge in achieving the Delayed Transfers of Care targets of 3.5%. This risk has been added to the AE Delivery Board Risk Register and has been escalated to NHSE/I as it spans more than one health economy. AE Delivery Board, Acute Trust and Local Authority continue to progress this with urgency.

Staffordshire have developed and shared a SOP for recording and monitoring delayed transfers of care. This will be reviewed, agreed and monitored across the health economy.

Need to add in more assurance maybe

8.2 UCC

As detailed in the media, the provider of the Urgent Care Centre, Vocare, has been rated as Inadequate by the CQC. This will undoubtedly have an impact on staffing, recruitment and retention which in turn will impact on service delivery. The CCG are mindful of this and have put in place numerous steps to ensure there is high level of scrutiny and governance of the service and of the arrangements Vocare are putting in place. At the time of writing this report, the CCG are confident that Vocare have reviewed previous activity over the Christmas, New Year and Easter Period to ensure they are prepared to demand in 2017/18.

Appendix 1 AE Delivery Board Programme Plan

To be inserted once updated

Appendix 2 – WMAS Winter Plan

WMAS WINTER PLAN Version 2.1.pdf