Wirral Health & Care Commissioning

NHS North West Ambulance Service NHS Trust

cwp Cheshire and Wirral Partnership NHS NHS Foundation Trust

NHS Wirral University Teaching Hospital NHS Foundation Trust

Wirral Community NHS NHS Trust

Wirral Winter and Unplanned Care System Sustainability Plan 2019-20

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Contents:

1. Winter Plan Background:

Wirral has maintained a strong “System Focus” over the past 12 months, in order to improve and deliver resilient unplanned care services for Wirral residents.

During the past year, the system has moved forward with integration particularly between commissioning (CCG & WBC) and the embedding of the transfer of social care to Wirral Community Trust (year 2) and the more recent transfer of social care specialist teams to CWPT. We have continued to meet weekly as an urgent Care COO group to improve governance and grip, with the operational group overseeing transformational detail and improvement plans.

We have continued to utilise the work completed with Venn on whole system capacity and demand modelling. Modelling for 18/19 was accurate in determining capacity requirements and impacts felt against areas of non-delivery. A similar approach is being taken in 19/20.

Urgent care remains a key priority for Healthy Wirral partners, with pro-active improvement plans in place. Financially, the system is challenged; effective delivery of urgent care is a key factor in moving towards system sustainability.

The BCF continues to support 7 -day services, focussed upon admission avoidance and timely discharge. Whilst we have seen much improvement, we are crucially aware of key areas we must deliver against:

- Rapid assessment, triage and streaming (internally and externally)
- Eliminating corridor care and timely ambulance handover and turnaround
- Reducing Long Stay Patients

We have an understanding and appreciation of the challenges we face in these areas. ECIST is supporting the system to practically address the issues and move forward positively.

We have reviewed and learnt from the positives and negatives of last year and have implemented some key changes to support effective flow. Our priority efforts now are in reducing LOS and long stay patients in both acute and community settings.

2. Learning from Winter 18/19:

Wirral concluded a review of winter, to ensure learning has informed plans for 19/20 (see appendix 1).

2.1 What worked well last winter:

- 4.8% reduction in type 1 ED attendances compared to 17/18.
- NEL for patients aged 65+ reduced by 2.7%. However, overall NEL remained static/as observed fluctuation in paediatrics and younger adults.
- Walk in Centres / Minor injury units continued to achieve 99/100% against 4- hour standard.
- DTOC target (max 2.67%) consistently achieved.
- WUTH commission of GDU (30 beds) supported acute winter capacity planning.
- Pro-active market management with domiciliary and reablement providers, saw 16% increase in activity in 18/19
- Extended Access GP appointments available from APH site providing additional GP resource to support system – WIC/ ED
- Delivery of High impact change model requirements including evidenced delivery of;
    - Trusted Assessor – accelerating discharges to care homes
    - Teletriage – achieving 10% reduction in ambulance conveyances and further reduction in 111 contacts
    - Implementation of new 111 requirements
    - Support to care homes
- System wide capacity and demand modelling with VENN informed commissioning plans. Modelling proved accurate and system pressures and areas of 'heat' were understood and acknowledged.
- Improved system escalation, grip and utilisation of daily calls

2.2 Key Challenges to inform 19/20 plans:

a) Admission Avoidance

Whilst focus on frailty saw a 2.7% reduction in ED attendances, NEL remained broadly static overall. Single Point of Access (SPA) identified as a priority to redesign and maximise technology solutions, increasingly diverting patients to primary and community services, where appropriate. Streaming, whilst streaming improved on overall numbers streamed away from ED over the past year, there is far more we can and need to do to support ED and stream effectively into relevant assessment areas as part of the SDEC requirements. Furthermore, an action plan and trajectory have been developed to move to a position of 20% of ED attendances being streamed to Primary Care, this equates to 60 patients.

- **Actions for 19/20:**
  - Targeted neighbourhood focus on High Intensity Users, (frailty/Drug and alcohol and paediatric)
  - Implement revised and improved Target Operating Model for Single Point of Access, utilising technology to maximise admission avoidance
  - Improve utilisation of Urgent Care GP (previously AVS) by NWAS and Falls pick up services
  - Divert NWAS pathways to primary and community services where appropriate.
  - Falls pathway agreed for collaborative working across NWAS and Medequip to enable rapid assessment following a fall and where possible avoiding conveyance caused by long waits following fall
  - OPAT capacity – streamlining the pathway and linking in GP stream to ensure if patient needs OPAT it is being facilitated rather than admission
  - Implement revised and improved Target Operating Model for Rapid Community Response Service and Home First
  - Maintain 7 day tele triage service
  - PDSA approach and fully implement acute frailty services at the front door, with support from ECIST.
  - Implement new streaming model (internal and external) supported by ECIST, increasing numbers of patients streamed delivered through:
    - ED collaborative streaming – primary care nurse and GP supporting simple and complex streaming
    - GPs supporting ambulance corridor using the ‘pull’ model to identify patients that could be managed within WIC
    - POCT to be implemented to eliminate need for cohort of patients to be seen in ED/Assessment units
    - GP direct access to x-ray and potentially other diagnostics
    - Collaborative working to enable minor injuries to be seen within WIC
    - Enhance frailty at front door to work alongside unplanned care team to turnaround patients at front door of ED

- NWAS to convey directly to WIC
- Targeted condition specific care – trialling respiratory nurse in ED to support COPD patients and where possible support discharge from A&E working closely with the unplanned care team. Access to patient advice lines for patients attending A&E but not admitted are also being looked at along with advice line for HCPs requiring support to prevent an admission.
- Maximising D2A pathways to ensure rapid turnaround from assessment units to maintain flow and avoid unnecessary admissions

b) Ambulance handover and turnaround:

We fell short in performance. Ambulance turnaround deteriorated to an average position of 00.37.29 (01/11/2018 – 28/02/2019). Consequently, this led to corridor queues. Type 1 (ED) 4 hr performance deteriorated during winter 18/19, dropping from average 73.5% (1/11/17-28/2/18) to 63.4% (1/11/18-28/2/19). Acute occupancy over winter did not drop below 97%, typically reporting 98/99%. High occupancy and long length of stays placed the acute and wider system under pressure, patient flow was adversely affected, the impacts directly manifesting in ED and assessment areas.

- **Actions for 19/20:**

  - Engagement with Super Six Programme
  - Dedicated nurse to support corridor care reducing paramedic delays
  - Temporary **r**edesign of ED and assessment areas to create capacity, with reverse 'cohorting' ahead of UTC development
  - Implement learning from NWAS audit:
    - Streamline falls pathway across providers
    - Consider primary care impacts
    - Consider improvements to respiratory and cardiology pathways.
    - Implement learning from PDSA approach to Rapid assessment and triage, supported by ECIST.

(*Key links to patient flow and acute LOS occupancy level's pls refer also to section C)

c) Internal Flow:

Our key priority to ensure we deliver a safe winter is to reduce LOS in both acute and community. Whilst our DTOC has effectively delivered, Long Stay Patient numbers remain high, negatively impacting acute occupancy and adversely effecting patient flow. It is one of our 3 top priorities to reduce LOS and consequently improve acute occupancy and patient outcomes.

- **Actions for 19/20:**
  - Implement long stay patient actions and address themed delays. 2 key reasons for LSP's which remain our priority focus to improve:
    - Ward based care approach
    - Integrated discharge team form and function

  - Additional priorities to be addressed to reduce LLOS and improve weekend discharges include:
    - Criteria led discharge to be accelerated ensuring all wards are utilising to maximise weekend discharges
    - Pathway redesign for management of homeless patients – discussion between council, WCT, WUTH & CWP – this will support reduction in LLOS across both acute and community

d) Discharge and Community Care Market Capacity

An additional 23 winter T2A bed -based capacity was commissioned for winter 18/19. However, in totality the full commission was spread over too many sites (9). Consequently, this diluted the workforce, exacerbated by recruitment challenges, leading to an increased LOS and adversely impacting flow across the system. The current specification was also challenged, as independent sector providers were not able to consistently accept discharges over 7 days, due to the nature of the D2A model and increased levels of acuity. The need for enhanced MDT and clinical support was identified as key going forward. Re-admission rates remained high, approx. 20%.
We have completed a bed -based review to analyse outcomes, costs and LOS and make recommendations for future model of intermediate services.

The VENN modelling confirms Wirral has more acute and community beds than are needed, if the system were optimised. However, there continues to be an over-reliance on beds, as part of double running arrangements, as other services establish and are trusted to deliver. We continue to need to address and improve cultural issues across the system as part of our transformational priorities, to ensure services are fully optimised across the whole patient pathway.
We also recognise we currently only utilise approximately 5-10% of the T2A bed base for step up support. We recognise we could increase this to approximately 15%.

As part of the BCF review, we recommissioned our home first model, to ensure the service was able to support demand requirements. The new model went live June 19. The model will be scaled up by winter 19, to support the home first pathway. Reablement and domiciliary care services are evidencing good flow overall and are a key factor in supporting winter capacity and good patient outcomes.

- **Actions for 19/20:**
  - Revise service specification with providers for winter, to improve response and support to care homes.
  - Review and re-commission the clinical support element to increase focus and support, reducing LOS.
  - Readmission rate from T2A/GDU (20%) will be reduced, this will be supported through updated specifications across providers, MDT and GP support
  - A portable flu machine will be added to WIC / GPOOH to enable testing of patients within T2A bases (and on attendance to WIC) to avoid closures within homes, maintaining flow.
  - Implement new TOM for Rapid community services, to increase 7- day support across bed and home based services, including therapy.
  - Pro-active work with infection control to ensure continued appropriate management of risk and flow
  - Progress new T2A commission/tender process in parallel over Q3/4 to implement Q3 20/21
  - Fully embed new home to assess model
  - Protocols are being agreed for out of area patients within the hospital to ensure smooth and efficient discharge

e) Workforce challenges

Increasing workforce capacity during winter across community and acute proved difficult and by increasing acute and community bed base further workforce issues were exacerbated. Providers struggled to recruit to the additional posts, agency staffing was utilised but costly and staff as a whole were spread too thin. The Independent Sector market was also stretched to capacity.

- **Actions for19/20:**

- Focus on reducing LOS in both acute and community to negate the need for additional winter beds by creating capacity via improved performance. System agreement to target MDT's 7 days for more effective outcomes and optimisation of resources. Linked to VENN modelling. Focus on reducing acute long stay patients in line with trajectory which will significantly reduce occupancy and restore flow
- Reduce overall LOS in acute through ward based care and IDT redesign
- Reduce LOS within T2A to achieve agreed position of 5.2 weeks, this will lead to increase of 10-15 beds across system
- Existing wards permanently staffed.
- Cohorting of medically optimised patients with alternative staffing solutions provided by Independent sector or economy collaboration. (GDU)
- Develop workforce strategies, implement generic worker opportunities and blended organisational approaches.
- Maintain effective recommission of domiciliary care and in year (further 17% activity growth in 19/20) support. Continue Council wide focus to support recruitment and retention of staff.

3. Wirral's approach for 19/20

As outlined above, Wirral is committed to delivering a safe winter, avoiding the need to commission additional community Nursing beds or opening additional acute escalation beds. The rationale for this is multifaceted, including:

- Financial challenge- The system has a significant deficit which has to be addressed
- Workforce – core staff recruitment challenges evident across the board with particular issues in therapies, ability to recruit additional staff above core would be extremely challenging, staff are reluctant to do overtime even when remunerated very generously, additional beds would run serious risk of overstretching core staff further, diluting focus and adding to a deteriorating situation
- Capacity and demand– the system has a high number of beds supporting the population, compared to other systems. VENN modelling demonstrates that reducing LOS within T2A to a realistic 5.2 weeks would in effect give the system an additional 10-15 beds, if this could be further reduced to target of 4.2 weeks this would be 32 beds. Likewise, if the proportion of long stay patients is reduced by 40% as per trajectory, occupancy will improve, negating the requirement for additional beds. The modelling suggests that if admissions, internal flow and discharges were managed effectively, the system has an excess of acute beds.

It is therefore our intention to optimise the current pathways and processes to release capacity, by reducing LOS. Following the bed-based review, we will revise the current service specification for winter, addressing the gaps from 18/19. A key element will be to review and improve the clinical support to these beds, with a new TOM in place to improve the MDT support across the Community bed base and home first pathways.

- Domiciliary, reablement and home first capacity is evidencing flow and positive outcomes. Expectations are factored into the modelling, as viable alternatives to bed- based support, improving patient outcomes and experiences.
- Review of need has highlighted a shortfall in dementia T2A services. We will be increasing our commission over winter from **5 to 8 residential EMI beds.**
- With regards Mental Health support, an **additional crisis support worker** will be in place.
- Work is underway with OLA's to agree arrangements for improving SW presence on site to support flow over winter.
- We will continue with a single system plan, incorporating BCF and winter capacity intentions and monitoring via single dashboard incorporating tolerances and triggers.
- We will continue to utilise the VENN capacity and demand model to respond to any changes across the system. The model informs us of the impact of failure on one of our key dependencies i.e. patient flow, rapid response/ home to assess and transfer to assess bed base. This demonstrates the knock- on effect of failure to enable us to plan and respond rapidly. We have modelled based on an occupancy of 95% but have factored in the impact of high demand and pressures across winter to ensure a realistic position.
- Our system wide focus to ensure a 'safe' winter is captured in section 2 with details provided in app 6. However, our key 3 system priorities supported by ECIST are:
  - Embed an effective and sustainable streaming model (internal and external) to reduce overcrowding in ED, eliminating corridor care and ensuring timely ambulance handover and turnaround. This includes use of both primary care nurses and GPs to maximise the numbers of patients that can be streamed (see below)
  - Implement a rapid assessment and triage model at the front door
  - Reduce long stay patients with a LOS 21 days or more in line with trajectory

Mental Health

- Mental health services are scaling up to support system over winter period, this includes the following:
  - Daily bed management calls with clear system escalation
  - Additional investment in crisis home treatment team, plus e-rostering
  - Psychiatry Liaison team is compliant with Core 24 standards
  - Duty workers embedded with Physical Health / Social care. Work ongoing to ensure appropriate management of physical care for our mental health patients potentially reducing LOS within acute mental health inpatient unit
  - Enhanced street triage services
  - AMPH rota expanded to 3 duty workers a day
  - Focus on reducing 30+ and 60+ LOS patients from inpatient unit to enable capacity for any complex mental health patients being managed within WUTH

Primary Care

- Uptake of primary care appointments will be monitored with expectation that GP practices will provide a minimum of 70 minutes prescribing clinician appointments/week per 1000 patients.
- An additional 360 extended access appointments available compared to 18/19

Independent/ 3rd Sector

- Working to ensure 7day services - homeless support, equipment and unplanned carers respite services.

Flu Planning 19/20

- Wirral Seasonal flu planning group held a debrief of last seasons in May 2019 and has agreed an action plan with the aim of improve vaccine uptake across the system.
- Wirral Seasonal Flu Group will continue meeting monthly throughout the 2019-20 flu season to ensure oversight of delivery of agreed priority actions and will monitor activity throughout the season.
- Wirral Intelligence Flu Vaccination Uptake Briefings for last season 2018/19 to be sent out to all Primary Care Networks highlighting variation in uptake between practices for the different cohorts.
- WHCC to promote GP practices having a “prescribing clerk” who can identify priority eligible targets who didn’t get vaccinated in 2018/19 and share with pharmacies by adding info to B side of prescriptions. Which will encourage community pharmacies to proactively engage these hard-to-reach patients.
- WHCC to contact lowest performing GP practices from 2018/19 flu season.
- Review variation in uptake between GP practices share data with Primary Care Networks monthly throughout the flu season. New population health Power BI dashboard being developed by Wirral Intelligence.
- QI team to utilise the on-line forum and managers meetings to promote free flu vaccine and the Gold/Silver/Bronze NHSE accreditation scheme - Individual care homes to self-report their staff flu uptake levels to NHSE regardless of where staff receive their vaccine.
- QI team and IPC team to provide support to care homes including training session on flu preparedness and outbreak management.
- QI team shared the PHE Cheshire and Merseyside Care Home Flu resource pack with care homes.
- Wirral Ways to Recovery to continue to vaccinate at risk service users and promote flu vaccines through the Recovery Café, and through the needle exchanges.

- Community midwives are trained to vaccinate. Midwives shop in Birkenhead to be utilised to administer vaccination. Community hubs/GP surgeries also to be utilised for antenatal clinics to administer vaccine. Antenatal outpatients including clinic and Triage will provide vaccination on request.
- PHE comms toolkit for HCWs 'Help us to help you' shared to all health & care providers.
- Develop and implement a local targeted media campaign aimed at improving uptake in 2&3-year olds.
- Promote uptake of flu vaccine in people who have a BMI over 40 via the tier 2 / tier 3 weight management service.

Proactive Infection Control

- IPC team to provide support to care homes including training session on flu preparedness and outbreak management.
- IPC team to promote use of the PHE Cheshire and Merseyside Care Home Flu resource pack with care homes.
- Antiviral pathway to be agreed with WCT IPC service to coordinate the provision of anti-virals as part of their response to outbreaks of Flu/ILI in care homes.

3.1 System modelling with VENN and planned Intentions for 19/20:

VENN modelling has been refreshed to account for changes to pathways / trajectories agreed for 2019/20. Winter schemes have been embedded within the model and high demand periods were used to assess maximum resources required. Assumptions are being tested to examine the impact of failure to meet each of our set trajectories. This is where the contingency measures will be instigated. This will also enable surges and triggers to be measured across community and acute to enable a system wide planned response ahead of crisis point.

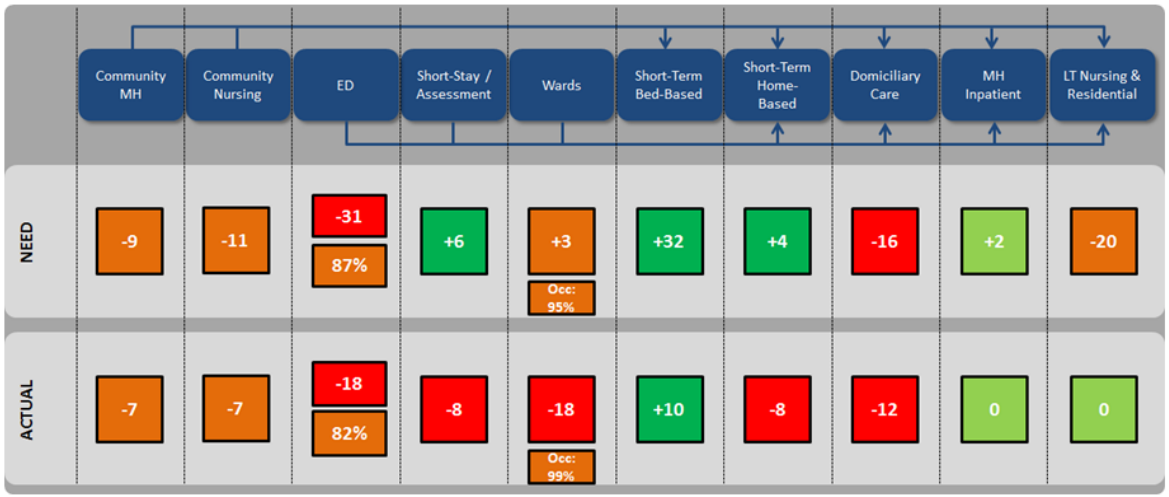
- The modelling considered baseline position, assuming typical day with no delays in the system and no admissions that could have be avoided. This suggested a position of +48 beds.
- However, when current performance is factored in without any improvement being made, we are -38 beds with a 102% occupancy.
- The single biggest mitigation against reaching this point is ensuring grip and improvement on our long length of stay patients.
- The next modelling position assumes 22 acute beds are closed as per contractual plans for October 2019 and it flows through the highest demand activity predicted over the period. It further assumes trajectories are partially met and winter schemes are implemented to give a more realistic position as to where the system will be over winter.
- This position suggests if discharges are efficient and admissions all appropriate, the system is +3 beds with a 95% occupancy. However, if current practice remains, the position is -18 beds with a 99% occupancy. It is important to note that this is depicting the highest demand days, with 22 acute beds closed. It is also taking a more conservative position on trajectories. (i.e. 145 LLOS and 25 a day streamed to primary care)

The schemes taken into the model include:

Scheme		Assumptions	Impact
1	Patient Flow	Enhance % discharges <12 (20%) Reduce LLOS to 145 ED Streaming-25 per day Reduce 22 beds from WUTH Occupancy at 95%	• Reduction: Hospital bed requirement (HIGH) • Increase: T2A Beds, community step-down services (LOW)
2	Rapid Response	Pre-admission step up response Enhanced caseload Up to 72 support	• Reduction: Hospital bed requirement (MEDIUM), T2A Bed requirement (LOW) • Increase: Community step-up services (HIGH)

3	D2A Transport, assessment and wrap around care	4 slots per day	• Reduction: Hospital bed requirement (MEDIUM), T2A Bed requirement (LOW) • Increase: Community step-down services (MEDIUM)
4	IMC Beds	Reduce Length of Stay to 5.2 days Re-admission rate to Acute remains (c.20%)	• Reduction: IMC/T2A Bed requirement (HIGH) (releases approx. 15 beds)
5	Home First model	Absorption of residential T2A capacity- Additional 1 person per day who would have previously discharged to IMC Bed (Residential)	• Reduction: Hospital bed requirement (MEDIUM), IMC/T2A Bed requirement (HIGH) • Increase: Community step-down capacity (HIGH) • Increase: Dom Care demand (LOW)
6	Frailty Pathways	Frailty at the front door Enhanced frailty support in community	• Reduction: Hospital bed requirement • Increase: Dom Care Demand/ Community Rapid Response / Community Nursing?
7	Respiratory pathways	TBC - Exploring respiratory nurse within ED Access to advice line for patients discharged from ED (currently available following admission) Access to COPD coordinator for GPs/Paramedics requiring advice to avoid admission	

- **NEED** based on:
  - 'Calculated' capacity
  - Actual needs of people within Wirral
- **ACTUAL** based on:
  - 'Calculated' capacity
  - Actual needs, plus any 'backfill' into that provision based on under-capacity in other elements of the system



Assumes all schemes will be delivered in full

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It is evident from our modelling that the biggest variables contributing to system position are:

- Long length of stay in acute
- Length of stay T2A
- Streaming activity

The challenge will be for the system to 'right size' itself quickly, if a high demand period is experienced.

3.2 Mitigations:

The system has agreed the following actions if the above plan fails to deliver and trajectories are missed.

- Retain 22 beds (ward 24) – escalation beds
- Primary care role – focus on urgent rather than routine e.g. QOF, admission prevention work with practices and PCNs. EHCP needs to better utilised
- 12 Bed Reverse Cohorting Area at Arrowe Park to be staffed 24/7
- Spot purchase additional T2A beds
- Enhanced Medical and Nursing support to be provided at Arrowe Park through additional payment and block booking of NHSP
- Prioritisation of staff to support flow across the system

4. Governance Approach in 19/20

- We have an agreed joint approach to governance, having recently revised our governance arrangements, TOR and agreed principals for unplanned care.
- We have recently introduced an improved version of our system reporting arrangements for urgent care. (see appendix 3 system performance report).
- A and E delivery board, supported by the urgent care COO's will oversee escalation of risk and exception reporting from the Urgent Care Operational Group. Wirral A&E Delivery Board will receive monthly summary of escalated issues and summary status.
- A new escalation protocol has been agreed across providers and commissioners to ensure delays are minimised
- Daily escalation calls are in place to ensure flow and appropriate escalation of issues/delays.

5. Proactive Approach to Escalation of Risk:

We have agreed a joint approach to escalation and have reviewed and updated escalation points at all levels across the system.

This approach supports the OPEL arrangements and is intended to provide early warning of potential pressure in order to facilitate a pre-agreed system response.

This approach will be in line with national and local operational arrangements and include robust operational management arrangements.

5.1 Key Risks Identified:

Risk	Mitigations
• Workforce Capacity - Health and social care providers - Independent sector market	• Implementation of recommendations • Workforce strategy plans underway • Discussions underway between acute and primary care to explore support into ACU at times of pressure. • Active support for recruitment and retention

• Culture and Behaviours	• ECIST support • System focus to address collectively • Revised governance and agreed principals. • Weekly urgent care COO meetings
• Insufficient Clinical implementation capacity and therefore delays in implementation.	• Robust oversight of plans • Read across with SDIP's, contractual oversight • Additional Transformation capacity funded though BCF • Revised governance and escalation of risks/delays to COO's and A&E Delivery Board
• Financial deficit and ability to meet cost for any additional winter demand	• Healthy Wirral Exec to oversee performance and financial shortfalls • Healthy Wirral Exec exploring opportunity for collaboration and financial sustainability

6 Appendices

Appendix 1	Winter Review and Learning	Learning Review - Winter 2018 02.05.19.

Appendix 2	Capacity and Demand Modelling Assumptions	Winter Plan Slides 19-20_v2 (004).pptx
Appendix 3	Wirral System Urgent Care Reporting pack inc. trajectories	New Template for AE Delivery Board v6.xlsx