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 2018-19

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Contents:

1. Winter Plan Executive Summary

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.

Our position going into winter 17/18 was not strong, seeing us in the bottom quantile nationally for performance against the 4 hour standard.

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 and impending transfer of social care specialist teams to CWPT, we have established an urgent care executive to improve governance and grip and utilised the work completed with Venn on whole system capacity and demand modelling.

As a result of the focus, Wirral saw a 5% improvement in system performance (4 hour standard) over the winter period, and has seen a 10% improvement since last summer. This has been achieved by a strong whole system transformation plan and improved system leadership and accountability. However, there is recognition that we need, and can do more, to improve system performance.

2. Learning from Winter 17/18:

Wirral concluded a review of winter, to ensure learning has informed plans for 18/19 (see appendix 1).

2.1 What worked well last winter:

- 5% improvement in system performance (4 hour standard) over winter period.
- 5.51% increase in discharges during winter period. System maintained very healthy DToC rate throughout winter, between 2.8% and 1.4%. Well below mandated max of 3.5%. One of only 3 systems in north -west to maintain over winter.
- Phased approach to commissioning additional block winter T2A community beds. % go-live 1st Dec and % go-live 2nd Jan. Supported maintenance of flow.
- Improved governance-exec oversight of dashboard and reporting as a system-RAG rated.

- Winter and BCF funded GP capacity to support clinical streaming at the front door and enhanced primary care availability/AVS, improved access to same day appointments and supported ED.
- Dom care prioritised for acute and community bed flow, small waiting list throughout winter.
- Developed with Venn and utilised capacity and demand model to inform commissioning plans

2.2 Key Challenges to inform 18/19 plans:

a) Admission avoidance

Not delivered at the scale necessary. Focus was on discharge, and whilst BCF schemes delivered within their own parameters, this was insufficient as a whole system.

- Action 18/19:
  - Remodelling of admission avoidance target and associated schemes to ensure delivery.
  - Review and redesign of SPA
  - Review and redesign of GPOOH's and AVS
  - Gradual implementation of new IUCCAS
  - Implementation of enhanced primary care
  - Implementation of phase 2 streaming
  - BCF investment in AVS and IV antibiotics at home.

b) Ambulance turnaround/handovers:

We fell short in performance against ambulance turnaround / handovers.

- Action 18/19
  - Acute grip and investment in staff within ED to support improved performance patient quality
  - Key system priority and reporting monthly.

c) Year 1 of home first:

Insufficient scale to really make a difference, with T2A beds and Re-Ablement / Dom care being the community deliverables.

- Action 18/19:
  - Review and redesign of model and approach for home first and therapy offer underway with implementation beginning Q3.

- Workforce strategy plans developing and new approaches being piloted for dom care. New commissioning model underway, with go live planned for June 19. This will include health care assistants as part of the model, to support increased levels of acuity.

d) Out breaks of Flu and D and V:
Wirral experienced Infection Control issues, both within the acute and community bed based settings. Disproportionate risk management plans, advised by Infection Control, negatively impacted on flow through to community.

- Action 18/19:
  - Pro-active work with infection control to ensure more appropriate management of risk and flow
  - Full briefings/support to care homes

e) Workforce challenges:
Workforce capacity challenging to scale up during winter. Independent Sector market also stretched to capacity.

- Action 18/19:
  - Existing “unfunded” wards permanently staffed.
  - Co-horting of medically optimised patients with alternative staffing solutions provided by Independent sector or economy collaboration.
  - Develop workforce strategies, implement generic worker opportunities and blended organisational approaches.
  - Recommission of domiciliary care and in year support and focus to recruit and retain staff. Remodelling of approach with key health providers.

f) 7 day services:
Lower numbers of discharges, creating challenges into Monday/Tuesday pattern.

- Action 18/19:
  - Implementing actions following review of 7 day services, inc increasing staff available over 7 days, including pharmacy and transport, acute and community.
  - Increased MADE events for B/H’s and improved activity for Xmas/new year.
  - Ensure 7 day access to care homes with flexible numbers of admissions. Consider 7 day trusted assessor model, currently 5 days.

g) SAFER and ED /assessment flow:
Full safer bundle requires implementation across all medical wards. Recognised that ED & assessment areas require redesign of pathways and use.

- Action 18/19:
  - Redesign of ED and assessment areas to improve flow.
  - Stronger grip on full SAFER model to support ED.
  - Both areas agreed in SDIP
  - SAFER to be implemented in commissioning T2A bases.

h) Streaming:
Variation in approach and numbers due to changes in model and recruitment delays.

- Action 18/19
  - Phase II of model to be fully implemented in Q2
  - Zero tolerance of minor breaches
  - T&F group overseeing implementation with robust data analysis

3. Wirral's approach for 18/19

We will continue with a single system plan, incorporating BCF and winter capacity intentions.
As a system we will build upon the successful capacity and demand (CDM) work initiated with VENN in 17/18, by continuing to use the CDM to inform required capacity across the system. (See appendix 2 for full details) Given that Wirral worked with Venn to develop the model and applied learning in 17/18, we have a significant degree of confidence in the model and its application for 18/19. Commissioners and providers have validated the assumptions and believe we are in a much stronger position, compared to previous years, in our ability to confidently predict demand requirements across the system.

A key factor in this is to improve our LOS in both acute and community beds in order to increase sustainable capacity and improve patient outcomes. However, we have built in a degree of tolerance assuming some degree of Flu and Infection Control pressures. We have worked to achievement of 92% occupancy.

In calculating LOS for acute we have worked an average 4.8 days LOS. 17/18 was 4.08. We saw 0.3 of a day increase over winter. For the community we have agreed on average LOS of 4.2 weeks in T2A beds. This again provides a buffer for 10% of patients who extend beyond 6 weeks; whilst we intend to focus energy on reducing LOS and stranded patients, for the modelling we have built in acceptable tolerances. The Better Care fund is fully supporting the

agreed system priorities. Funding supports commissions which include (see appendix 3 for summary of BCF priorities and appendix 11 for breakdown of winter funding):

- AVS
- OPAT
- Winter community capacity
- Teletriage

3.1 Key Intentions for 18/19 that are different to 17/18:

Primary Care:	○ Increased GP appointments compared to 17/18 via the Wirral GP Access Hubs service (180 hours per week or 720 appointments per week) ○ General Practice will be encouraged to prioritise urgent care patient's needs over the festive and new period e.g. Increasing same day appointments compared to annual health checks, screening or immunisation appointments. ○ GP Streaming at Arrowe Park Hospital Emergency Department provides an additional 52.5 hours a week of additional GP appointments during core contract hours (over 17/18 baseline) ○ Primary care exploring with Community nursing opportunities to deploy additional resource over winter pressure periods, via de-prioritisation of non-urgent appointments ○ All practices are advised to ensure anticipatory care plans are in place for vulnerable patients over winter e.g. COPD Exacerbation plan/Flu Immunisation ○ Subject to additional funding and workforce availability offer additional GP appointments via (1) GP practices in hours and (2) Wirral GP Access Hubs out of hours (over and above the 180 hours)
Acute and community winter capacity (see appendix 2):	○ 48 planned acute escalation beds ○ 20 additional T2A community beds over winter ○ 6 residential MH beds commissioned as core ○ 3 additional MH beds commissioned over winter ○ Additional mental health crisis response worker ○ Re-Ablement capacity sufficient ○ Domiciliary capacity – waiting list to be maintained to 25 as a maximum total across the system

	(maximum 6 in acute setting, maximum in T2A community setting)
Support to care homes:	○ Teletriage will be fully implemented across 76 care homes by Quarter 2. ○ Roll out of falls app FRAT tool to support homes by Quarter 3 ○ CHIP plan review ○ Roll out Red Bag scheme ○ Community paramedic support ○ All care homes are advised to actively engage with support and guidance on infection prevention and control, and preparation for the flu season. ○ All care homes are advised to ensure all staff and care home residents are offered, encouraged, and supported to have a flu vaccination as soon as vaccinations for this season are available. ○ Enhanced GP service to 50% of homes providing weekly ward rounds further roll out during 18/19 to remaining homes
IUCAS support for winter:	○ Directly bookable appointments into primary care ○ Effective signposting to alternate community provision ○ Expansion of APAS/ 111 CAS pathway to in-hours to divert more patients away from A&E (previously only live during OOH period) ○ 111 online go live in June 2018 with soft launch. Will be used in winter comms plans to direct patients, particularly for cold and flu advice. ○ Direct booking live in GP OOH from June 2018. Directly bookable appointments be rolled out to in-hours urgent GP appointments
Flu Immunisation:	○ Wirral Seasonal Flu Group to continue monthly meetings through the 2018-19 flu season July 2018 ○ Vaccination programmes for staff initiated Sept 2018, monitoring uptake as programs commence. ○ Flu vaccination promotion materials sent to community services. Oct 2018 ○ Active support to Care Homes, advice, flu resources and vaccinations. ○ WCT will repeat the successful flu campaign for Trust staff ○ WCT will continue to work with commissioners to develop a model for antiviral provision in care homes
Proactive Infection Control approach and support.	○ WCT will continue to provide specialist advice, support and training for Care Homes, this includes outbreak management working closely with GPs ○ The WCFT IPC service follows PHE national guidance ○ This is aimed at reducing avoidable admission and improving care home bed occupancy
Transformation plans:	○ New ED/assessment area pathway to increase zero LOS and support corridor management and

	NWAS handovers. ○ New SPA model in place to reduce NEL admissions. ○ Revised home first and domiciliary model in place increasing scale of offer. ○ Improved T2A LOS and remodelling of use of beds at Clatterbridge Cancer Centre/Arrowe Park Hospital ○ Fully implement streaming model ○ Fully implement SAFER ○ Planned care strategy, neighbourhoods priority frailty. Effective management of patients to reduce NEL and readmissions ○ Focus on reduction of stranded patients ○ Workforce strategy plan

3.2 System Response for Urgent Care

Wirral is determined to improve performance building upon the positives in 17/18 and addressing the identified areas for improvement.

We have taken account of the learning from 17/18, reviewed BCF impacts, transformation work to date and duly considered recent national guidance.

We have considered the recently circulated NHSE guidance, Wirral's response is summarised below:

NHSE Priority Areas	Deliverables
I. Realistic capacity planning Assumptions include: – 4.8 days average acute medical LOS (recognising 0.3 a day increase over winter) – 4.2 weeks average LOS in T2A (building in 10% tolerance of delays) – Max 92% occupancy for acutes (allowing 5% flu/infection control issues). System delivered 90% / 95% and occupancy was 90-94%. Therefore assumed average of 92%.	– System will deliver minimum 90% against 4 hour standard – 95% by end March 2019 – 92% occupancy – Included in SDIP **See System Plan Priority Areas:** – 7 – Discharge Transformation & Sustainability Programme

	– 8 – SAFER/Stranded/LOS/Capacity
II. Reducing LOS, stranded and super-stranded (see above also) Assumptions include: – 91 bed days released from baseline of 338	– Minimum 27% reduction in stranded / super-stranded patients – Included in SDIP **See System Plan Priority Area:** – 7 – Discharge Transformation & Sustainability Programme
III. Zero tolerance of minor breaches / streaming – Streaming assurance exercise being completed – Awaiting further national guidance on good practise to be adopted.	– Minimum 25-30 patients per day to be streamed to Primary Care – Included in SDIP **See System Plan Priority Areas:** – 3 – Admission Avoidance Schemes – 5 – Streaming Implementation
IV. Managing Monday surge – Awaiting national tool to improve capacity planning.	– Increase 7 day discharges – Implement findings from 7 day review (see attached appendix 10) – Reduce pressure in flow on Mondays, following weekend. **See System Plan Priority Areas:** – 15- 7-Day Response
V. Eliminating corridor care	– Roving ‘discharge’ teams led by a consultant on the weekend to review all potential discharges on the general acute wards which don’t benefit from job planned weekend reviews from specialty teams. – Potential discharges are identified the evening before and the discharge consultant will pick the list up from Bed Bureau on the Saturday and Sunday morning. – Discharge teams perform “mini-board rounds” with the senior sister on ward to identify further potential discharges.

	Will be included in System Plan Priority Areas: – 1 – Ambulance & 111 – 6 – ED & Assessment Areas.
VI. Timely ambulance handovers	– Handover 15 minutes/Turnaround 30 mins – Included in SDIP – Increase see and convey rates – WUTH, NWAS and CCG are working to ensure compliance to all guidance detailed in NHS I improving handover checklist. – WUTH are working through action plan. Key actions include recruitment to ED nursing vacancies and consistent staffing of ambulance handover nurse role. – Included in SDIP – Increase see and convey rates **See System Plan Priority Areas:** – 1 – Ambulance & 111
VII. Continued focus on unplanned care transformation – UTC consultation scheduled from 11th July. – DTOC target of 2.67% included – Primary care & IUCAS development programme underway	– Options developed. Capital bid submitted. Clinical service model being developed – DTOC to remain under 2.67%. Focus on stranded patients. – Additional same day appointments – Continuation of AVS dedicated resource pilot, also including APAS CAS pathway. GP Federation delivering in-hours elements and working in collaboration with GP OOH to provide seamless 24 hour urgent primary care offer. **See System Plan Priority Areas:**

	– 11- Capacity & Demand Model & Escalation
VIII. Operational arrangements – Operational management cover arrangements – Refine OPEL / proactive approach	– Proactive triggers / tolerances agreed as a system – System plan to respond to tolerances / triggers – Maintain system performance within tolerances agreed **See System Plan Priority Areas:** – 11- Capacity & Demand Model & Escalation

3.3 Plan Overview:

Wirral Winter and Unplanned Care System Sustainability Plan Summary 2018-19

Priority Area	Project / Programme	Description	Senior Responsible Owner (SRO)	Timescales	SDIP Targets
Admission Avoidance					
1	Ambulance & 111	Turnaround Times, IU-CCAS Development (AVS, 111 online, 111 direct booking, APAS, GOOH), conveyance rates NWAS adoption of ARP	Debbie Mallett (NWAS)/Anthony Middleton (WTH)	Sep-18	Handover target 15 mins Turnaround Target 30 mins
2	SPA Redesign	IT & Estates, Workforce, Target Operating Model, Information & Key Performance Indicators.	Val McGee (WCT)	Sep-18	Admissions avoided, numbers diverted through SPA
3	Admission Avoidance	OPAT, Enhanced GP service, Rapid Response,	Val McGee (WCT)/Jacqui	Sep-18	Zero tolerances of minor breaches. 100% of patients to be seen, treated and discharged within 4 hours.

	Schemes	Homefirst, T2A	Evans (CCG & WBC)		
4	Teletriage	Phase 4 Implementation, Embedding, Development	Val McGee (WCT)	Oct-18	Min 80% of care Homes live and using Teletriage Q1 100% live and using Teletriage Q2 Reduce calls to 111 by 10% Q2, 4 calls per home
Effective Assessment & Flow					
5	Streaming Implementation	Operations, Clinical Governance, Data & Information	Anthony Middleton (WTH)/ Val McGee (WCT)/ Jacqui Evans (CCG & WBC)	Jul-18	25 30% per day (20 -25 people) streamed out of A&E to primary care or WiC
6	ED & Assessment Area Redesign	ACU, AMU and OPAU	Anthony Middleton (WTH)	Apr-19	Arrowe Park Site (ED & WiC) 90% patients to be seen, admitted or discharged within 4 hours by end of Q2. 95% by the end of Q4. 30% of non-elective medical patients are discharged the same day. 65% of all non-elective medical patients should have a length of stay less than 72hrs (including the 30% above)
7	SAFER Implementation, Stranded, LOS & Capacity	SAFER, Stranded & Super Stranded, SAFER in T2A, LOS and Capacity	Anthony Middleton (WTH)	Q2-4	**Senior Review**: Agree implementation plan for SAFER over 7 days. 90% patients reviewed by midday. **All patients**: 90% have an EDD date within 48 hrs**. Flow:** 80% patients arriving on inpatient wards by mid-day. **Early Discharge**: 23% Q1, 28% Q2, 33% Q3 33% of patients will be discharged from base inpatient wards before midday by Q4. **Review**: See Stranded below. **Stranded/Super Stranded**: Baseline & trajectory by Q1. From agreed baseline: Reduce 30 MO stranded

					patients by end of Q2 and maintain equivalent to 5% Reduce by 50 MO stranded patients by end of Q4 and maintain equivalent to 8%. **LOS:** Reduce Average Acute LOS to 4.6 days. Reduce Acute Medical LOS to 5.5 days **SAFER in T2A**: Implementation of SAFER in T2A. **Capacity:** 92% in Acute
Discharge and Transfers of Care					
8	Discharge Transformation & Sustainability Programme	ToC form, IDT, T2A bed Base, Homefirst, CHC, Mental Health Pathway, TA in Care Homes/Dom Care, Patient Information, Integrated Therapy, Culture & Communication, Further Provision Opportunities.	Shaun Brown (WTH)/Natalie Park (WCT)	Ongoing	**Transfer of Care Form:** 95% of TOCs are not returned due to quality **LOS IDT:** 15% of patients assessed in acute, 85% of patients assessed in a Transfer to assess placements **T2A:** LOS as per spec: 50% LOS 3 weeks max, 25% 72hrs, 25% 6 weeks max. LOS down to average 4.2 weeks. **Homefirst:** Support the System to From agreed baseline: Reduce 30 MO stranded patients by end of Q2 and maintain equivalent to 5%.Reduce by 50 MO stranded patients by end of Q4 and maintain equivalent to 8%. **CHC:** 85% of patients assessed for eligibility outside the acute setting **TA Care Homes:** 100% of Care Homes using TA for Care Homes by the end of Q2. Patient **Information:** 100% of policy adhered to 100% patients receive leaflet on admission
9	Redesign & Scale Up of Community Services	Homefirst, Rapid Community Team, Reablement	Val McGee (WCT)/Jacqui Evans (CCG & WBC)		
Whole System					
10	Development of Workforce		Anthony Middleton (WTH)/ Val McGee		

	Strategy		(WCT)/ Jacqui Evans (CCG & WBC)		
11	Capacity & Demand modelling & escalation management		Jacqui Evans (CCG & WBC)	Q1-Q4	**DToC:** Maintain at 2.67% or below
12	High Impact Change Model	8 Areas	Jacqui Evans (CCG & WBC)		
13	Care Market Strategy (Domiciliary Care, Reablement)		Jacqui Evans (CCG & WBC)		
14	Therapy Redesign		Allister Leinster (WTH)/Natalie Park (WFCT)		
15	7-Day Response	Transport, Age UK Transport, Staffing,	Jacqui Evans (CCG & WBC)		
16	Flu Planning & Infection Control		Elspeth Anwar (WBC)/Natalie Park (WCT)		
17	CHC		Iain Stewart (CCG)		
18	7 Day Exec Cover		Janelle Homes (WTH), Anthony Middleton (WTH)/Val McGee (WCT)/ Jacqui Evans (CCG & WBC)		

19	Mental Health Services		Jo Watts (CCG)/Sarah Quinn (CWP)/Suzanne Edwards ()		
20	Contingency Plan B - OPEL 4/Non delivery of Plan		Janelle Homes (WTH), Anthony Middleton (WTH)/Val McGee (WCT)/ Jacqui Evans (CCG & WBC)		
21	Primary Care		Martyn Kent (CCG)		

Our system urgent care performance report is attached in appendix 9.

Our Wirral Winter and Unplanned Care System Sustainability Plan 2018-19 is attached in appendix 12.

3.4 Wirral System Urgent Care Report (high level for A&E Delivery Board)

Wirral System Urgent Care Reporting - (A&E Delivery Board)						
Reporting Period:	Jun-18		**Meeting Date:**	19-Jun-18		
	Target	**Current month performance: April 18**	**Previous months performance: March 18**	**SDIP / Definition**	**Source**	**Tractor**
4 hour standard (ED)	(90% end Q2) (95% end Q4)	⇧ 76.87%	71.86%	WUTH3	SUS	WUTH 3
(APH Site)		⇧ 83.49%	80.27%			
(Wirral wide DSIT)		⇧ 89.86%	87.74%			
Executive narrative:						
Ambulance handover	<=00:15:00	⇧ 00:20:38	00:28:00	WUTH7	NWAS	WUTH 7
Ambulance turnaround	<=00:30:00	⇧ 00:40:35	00:48:48			
Executive narrative: The SDIP for ambulance handover requires it takes no longer than 15 min. BI will need to develop a report to provide this information.						
Numbers diverted through SPA (Admission Avoidance) - A20	>=85% By Q3/4	⇧ 79.10%	69.00%	WCT6	Urgent Care Performance Dashboard	WCT6
NEL admissions (G&A)	3.5%	2.9% (April – All Providers)			SUS	
Executive narrative:						
Streaming numbers (% Streamed)	>25-30% per day (20-25 pts)	6.5% (May)		WUTH1 WCT7	Urgent Care Performance Dashboard	WUTH 1
Executive narrative:						
Assessment area	>=30% same day discharge	⇧ 30.48%	28.99%	WUTH2	Local Contracting tables	WUTH 6
	65% LOS < 72hrs	⇧ 99.76%	99.54%			WUTH 6
Executive narrative:						
SAFER (C5)	33% discharges by midday	⇧ 17.80%	13.70%	WUTH4	Urgent Care Performance Dashboard	7. SAFER
Executive narrative:						
Stranded patients	Reduction 30 pts Q2 50 pts Q4 based on ave 80 pts	⇩ 84	81	WUTH5		
Executive narrative:						
Acute Medical LOS (Non Elective)	<5.5 days Q3	⇩ 5.01	⇧ 4.47	WUTH6	Local Contracting tables	WUTH 6
Acute LOS (All Combined)	<4.8 days	⇩ 4.3	⇧ 4.2			
Executive narrative:						
DTOC (Proportion of Beds Occupied by DTOC)	<=2.67%	⇩ 2.30%	⇧ 0.50%		Urgent Care Performance Dashboard	DTOC
Executive narrative:						
Average LOS T2A	<=4.2 Q3	⇧ 5.8	⇩ 6.6	WCT8	Urgent Care Performance Dashboard	11. LOS T2A - Trajectory
Executive narrative:						
SAFER in Community				WCT8		
Executive narrative: T2A are carrying out SAFER reviews weekly, Stranded reviews monthly and MADE events prior to bank holidays to improve LOS						
Dom Care Waiting list (C19)	25 By Q3 (Suggested Target)	⇧ 49	⇧ 56		Urgent Care Performance Dashboard	13. DOM Care Wait - Trajectory
Executive narrative: The previous quarter average was 94% so there has been a marked improvement over the past couple of months.						
% package picked up same day (C20)	>=90%	⇩ 32.70%	⇧ 53.30%		Urgent Care Performance Dashboard	14. %Packed_Pick - Trajectory
Executive narrative:						
Re-ablement (C14) % of people still at home post reablement intervention	85%	⇩ 83.2%	⇧ 86.5%		Urgent Care Performance Dashboard	15. Re-ablement - Trajectory
Executive narrative:						
Re-admissions (T2A)		19% (16 pts)	17.5% (14 pts)	WCT8		
Executive narrative: Avg. length of stay for hospital re-admissions = 3.0 weeks 2% of people discharged from hospital to T2A are re-admitted within 72 hours 4% within 7 days 9% within 14 days						

Last Updated 28 June 2018

4. Governance Approach in 18/19

- We have agreed a joint approach to governance, having recently revised our governance arrangements, TOR and agreed principals for unplanned care (see attached appendices 6, 7 and 8 for A&E Delivery Board, Exec and Operational Groups)
  The intention to improve system grip and accountability, making better use of meeting time for systems leads.
- We will be investing time with leadership centre to further develop our system culture and behaviours.
- Building upon the work completed in 17/18 on system reporting, we have refined our approach (see appendix 9 system performance report)
- Commissioners have agreed Service Development Improvement Plans (SDIPs) with providers to ensure read across with unplanned system priorities. Key timescales, KPI's are detailed. (See appendix 4 & 5). This approach will improve assurance and accountability to deliver within required timescales. Transformational change programmes will drive incremental improvement in performance, improving patient quality and outcomes.
- Urgent Care Executive Group 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.

5. Proactive Approach to Escalation of Risk:

We have agreed a joint approach to escalation of risks by way of an early warning system with agreed triggers.

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.

Pathway		Target	Tolerance to Trigger
NWAS	See & Convey	68%	68.5%
Front Door & Streaming	Volumes	Daily Average 265	+20% (318)
	Streaming Rate	25% Minors	23%
Hospital Capacity & Flow	Four Hour Standard	95%	TBC
	Beds	92%	Bed Capacity 95%
	LoS	5.2	+5% (5.5 days)
	Stranded	976	TBC
T2A Capacity & Flow	Capacity	80%	90%
	LoS	4.2	+10% (4.6 weeks)
Dom Care	Waiting List	25	+20% (30)

We will be finalising these details during Q2 and updating our system responses to escalated risks. This will be in line with national and local operational arrangements, and include robust operational management arrangements.

6. Key Risks: Identified

Risk	Mitigations
• Workforce Capacity	• 7 day review completed (see appendix 10) • Implementation recommendations • Workforce strategy plans underway • Discussions underway between acute and primary care to explore support into ACU at times of pressure.
• Culture and Behaviours	• Investment with leadership centre developing system approach. • Revised governance and agreed principals. • Fortnightly urgent care executive group 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 Exec and A&E Delivery Board

• Gaps in data sets across the system	• Additional BI support agreed. Priority to review data sets. • System BI support and reporting
• Insufficient project management support	• PM agreed shared across system. • Commissioners providing overarching PM of whole programme.
• Financial deficit and ability to meet cost of demand	• Healthy Wirral Exec to oversee performance and financial shortfalls • Healthy Wirral Exec exploring opportunity for collaboration and financial sustainability

7. Appendices

Appendix 1 Winter Review and Learning

winter analysis.docx

Appendix 2 Capacity and Demand Modelling Assumptions

Winter Planning_Wirral_Mode

Appendix 3	BCF Priorities for 18/19	 Appendix 3..docx
		 Appendix 3.docx
Appendix 4	SDIP – WUTH	 SDIP 4 4 18 Final version .docx
Appendix 5	SDIP – WCT	 CT SDIP 2018 19 V5.docx
Appendix 6	TOR – A&E Delivery Board	 DRAFT WIRRAL AE DELIVERY BOARD TE
Appendix 7	TOR – Urgent Care Executive Group	 DRAFT URGENT CARE EXECUTIVE GR
Appendix 8	TOR – Urgent Care Operational Group	 DRAFT URGENT CARE OPERATIONAL

Appendix 9	Wirral System Urgent Care Reporting pack inc trajectories	 Appendix 9.docx
Appendix 10	7 Day Review	 Self-Assessment High Capity DemandF
Appendix 11	Break down of BCF winter funding	 Appendix 11 break down of BCF winter fi
Appendix 12	Wirral winter and unplanned care system sustainability plan	 Appendix 12 - Winter Plan 28.06.18(1).doc