Appendix 8

Wirral Winter and Unplanned Care System Sustainability Plan 2018-19

Priority Area 1 - Ambulance & 111						Ref. UC001
Theme	**Programme**	**Description**	**Actions**	**Timescale**	**SDIP Target**	**Acc Owner**
Admission Avoidance	Turnaround Times	Programme of work to reduce ambulance turnaround times to achieve 30 minute standard.	NWAS and WUTH jointly working towards NHS-I Improving handover checklist standards	Sep 18	Handover target 15 mins Turnaround Target 30 mins	Anthony Middleton (WUTH)/Debbie Mallett (NWAS)
	IU-CAS Development (AVS, 111 Online, 111 Direct Booking, APAS, GOOH)	Integrated Urgent Care development, including 111 CAS pathways as an alternative to A&E	Review and redesign of GPOOH's and AVS. Expand 111 CAS pathways Implement direct booking into GP OOH, then into in-hours GP appointments	ongoing		Debbie Mallett (NWAS)/Val McGee (WCT)
	Conveyance Rates	Reduce ambulance conveyance rates by utilising AVS and improving links with other services (links to SPA redesign)	Ensure robust AVS and community offer (SPA redesign) NWAS to ensure that available services are utilised	ongoing		Anthony Middleton (WUTH)/Debbie Mallett (NWAS)/Paul Walton (NWAS)
	NWAS adoption of ARP	NWAS Performance Improvement plan outlines actions required to achieve standards	Reduced conveyances (as above) Increase in double staffed Emergency Ambulances Internal efficiencies and standardisation within the Emergency Operations Centre (call handling) Improvements in hospital turnaround times (as above)	Aug 18		Anthony Middleton (WUTH)/Debbie Mallett (NWAS)
	Frequent A&E Users	Reduction in the number of A&E attendances and non-elective admissions for the top 60 most frequent users of A&E	Approaches will be tailored to each cohort: Drug & Alcohol, Mental Health, Older patients	Sep 18		Anthony Middleton (WUTH)

Priority Area 2 - SPA Redesign Single Point Access (SPA) To support Physical Health, Mental Health & Social Care to bring together the existing models (x3) into a single collaborative SPA model for Wirral. Ref. UC002						
Theme	**Programme**	**Description**	**Actions**	**Timescale**	**SDIP Target**	**Acc Owner**
Admission Avoidance	SPA - IT & Estates	To oversee estates plan and co-location of key (SPA) services and review opportunities to align and/or integrate IT services Develop, revise, design and implement electronic pathways & processes	Co-location to support the vision for Improved integration of current teams & services Develop joint internal professional standards support integration Reduced hand-offs and improved joint working	Aug 18		Val McGee (WCT)/Jacqui Evans (CCG & WBC)
	SPA - Workforce	Work stream established to understand baseline workforce and to develop the current (SPA) workforce.	Develop a robust workforce model with joint internal professional standards and operating hours (7 day service) Develop opportunities for training and cross-discipline working	Sep 18		Val McGee (WCT)/Jacqui Evans (CCG & WBC)
	SPA - Target Operating Model	To reduce the number of inappropriate referrals to the emergency department and to hospital. To support workforce redesign for the future Target Operating Model	To streamline effective and appropriate pathways via a True Single Point Access (SPA) To reduce the number of inappropriate referrals to the emergency department and to hospital. To improve patient access to services for both NWAS and GPs (Primary Care) Utilise PDSA approach and develop joint standard operating procedures (SOPs) to support the new model. Lead the development of appropriate clinical and non-clinical pathways	Sep 18	Admissions avoided, numbers diverted through SPA	Val McGee (WCT)/Jacqui Evans (CCG & WBC)
	SPA - Information & Key Performance Indicators	Work stream established to confirm both current individual data requirements (Each SPA) and develop suite of collaborative data.	To strengthen existing information (including mandated data) and develop robust system-wide reporting process Develop suite of shared and meaningful data to support improvement.	Sep 18		Val McGee (WCT)/Jacqui Evans (CCG & WBC)

Priority Area 3 – Admission Avoidance Schemes — Ref. UC003

Theme	Programme	Description	Actions	Timescale	SDIP Target	Acc Owner
Admission Avoidance	**Non Elective Admission (NEL)**	**Figure derived via a combination of the following services: SPA, Streaming, AVS/GOOH's, RCR, Teletriage, Enhanced GP service to Care Homes & OPAT.**	**Ref: SPA- Priority Area 2, Streaming- Priority Area 5, AVS/GOOH's Priority Area 1, RCR Priority Area 3, Enahnced GP service Priority Area 21, OPAT Priority Area 3**		**Reduce NEL by 3.5%**	Val McGee (WCT)/Antony Middleton (WUTH)/Jacqui Evans (CCG & WBC)
	OPAT	OPAT provides IV antibiotic treatment in the home/community setting. The service supports hospital avoidance and also reduces LOS for people who can be managed within the community.	BCF investment for additional resources will provide focus on inpatients to reduce LOS for suitable patients to be managed within the community	Q1		Val McGee (WCT)/Jacqui Evans (CCG & WBC)
	WIC & Integrated Urgent Care Clinical Assessment Unit	Primary Care support for 'minor' type 3 patients in WiC. Streaming patients from ED or ambulatory patients	Implement Streaming **See Priority Area 5** Extended GP access **See Priority Area 21**	Q3	Zero tolerances of minor breaches. 100% of patients to be seen, treated and discharged within 4 hours.	
	Rapid Community Response	Integrated social care and health team which delivers the Rapid Community Service interventions for up to 72 hrs. The aim of the service is the prevention of admission to hospital or facilitation of discharge	Remodelling RCR, Home first & Reablement by end of Q2 to create one Community Offer that links closely with Dom Care, and remodelling of associated data.	Q2		Val McGee (WCT)/Jacqui Evans (CCG & WBC)
	Links with Planned Care	Effective links with planned care/ICCH's to ensure risk stratification of complex customers, with robust management plans in place to reduce ED attendance and acute admissions.	Regular meeting to be created to ensure joined up approach	Q2		Val McGee (WCT)/Jacqui Evans (CCG & WBC)

Priority Area 4 - Teletriage — Ref. UC004

Theme	Programme	Description	Actions	Timescale	SDIP Target	Acc Owner
Admission Avoidance	Phase 4 Implementation	Teletriage is a 24/7 nurse and OOH GP video conferencing service available to Older people Nursing & Residential homes using ipads and skype for business. Wirral currently has 76 homes involved. The service is an in house service and has access to AVS GP and for Winter Rapid Community Response team.	Phase 4 complete by end of June 2018 76 homes on board	Q1	Min 80% of care Homes live and using Teletriage	Val McGee (WCT)
	Embedding	Year 1 was roll out and initial implementation.	Mobile working for nurses, offering	Q2	100% live and using	Val McGee (WCT)

		Year 2 focus on embedding the service to raise calls to minimum of 4 calls a month from each Care Home.	additional competency training and use of ipad/skype. Embedding the service across all 76 homes and raising calls to a Minimum of 4 per month per car home. Approx. 300 calls per month.	Q3	Teletriage Reduce calls to 111 by 10% 4 calls per home per month	
	Care Home Connector Training	Basic Observation training for all care homes has been provided along with bags of equipment including: BP cuff, thermometer, Oximeter and urine dip sticks, training and prompt cards and escalation guide.	Complete training to all 76 homes by end of June 2018. Provide homes with training video loaded onto the Ipads.			Val McGee (WCT)

Priority Area 5 – Streaming Implementation   Ref. UC005

Primary Care Clinical streaming is nationally mandated to stream appropriate patients from the front door of the Emergency Department into Primary Care. This initiative will reduce crowding within the ED, improve patient safety and support improvements in the national 4 hour standard.

Theme	Programme	Description	Actions	Timescale	SDIP Target	Acc Owner
Effective Assessment , Admission & Flow	Streaming - Operations	Whole system operational group to manage day to day operations of Primary Care Clinical Streaming Service, including • Activity • Rotas • Service provision • Model	Activity to follow national best-practice (ECIP/NHSI) and SDIPs WUTH to establish substantive Streaming Nurse Rota Utilise PDSA approach to improve model and align to ECIP and RCEM support	July 2018 & on-going	25 30% per day (20 - 25 people) streamed out of A&E to primary care or WiC CQUIN -35 per day from July 2018	Val McGee (WCT)/Antony Middleton (WUTH)/Jacqui Evans (CCG & WBC)
	Streaming - Clinical Governance	Whole-system Clinical governance group established to provide overview and scrutiny to • Clinical Activity • Clinical Model (PDSA) • Incidents	Case review of patients who were not streamed Review those patients who returned to the ED Understand destination and outcomes for all patients	July 18 & on-going		Val McGee (WCT)/Antony Middleton (WUTH)/Jacqui Evans (CCG & WBC)
	Streaming - Data & Information	A whole-system data set & report (dashboard) has been established. This provides daily, weekly & monthly reporting to system leaders.	Data and dashboard includes the following. *Total ED Activity *Breakdown of minors and BIBA activity *Total patients streamed (Actual versus expected)	July 2018 & on-going		Jacqui Evans (CCG & WBC)

			*See SDIPs			
Priority Area 6 – ED & Assessment Area Redesign						**Ref. UC006**
Theme	**Programme**	**Description**	**Actions**	**Timescale**	**SDIP Target**	**Acc Owner**
Effective Assessment , Admission & Flow	**4 hour standard**	**ED and WiC at the Arrowe Park Site.**	**Whole System Indicator**	**End of Q2** **Q4**	**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**	Val McGee (WCT)/Antony Middleton (WUTH)/
	Assessment Area Redesign	Review of frailty and acute bed base Review of direct admission to assessment areas from ED Access for assessment areas for diagnostics Levelling GP demand	Currently reviewing frailty & acute assessment bed base. Scoping our access to diagnostic services across assessment areas and performing baseline assessment of factors preventing direct admission to assessment areas. Agreeing criteria for assessment areas for referrals from SPA	Oct 2018	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)	Antony Middleton (WTH)
Priority Area 7 - SAFER Implementation, Stranded & LOS/Capacity – **All inpatient beds, except assessment units and T2A beds**						**Ref. UC007**
Theme	**Programme**	**Description**	**Actions**	**Timescale**	**SDIP Target**	**Acc Owner**
Effective Assessment , Admission & Flow	Senior review	**Senior Review** – by clinician by midday – management & discharge decision	Every ward will have a consultant led MDT Board round every day at 9am Every outlier will have Senior review by Midday	Q1 Q1	Agree implementation plan for SAFER over 7 days 90% patients reviewed by midday	Antony Middleton (WTH)
	All Patients	**All patients –** expected discharge date & clinical criteria for discharge set by assuming ideal recovery and assuming no unnecessary waiting	Daily point prevalence to be completed by discharge trackers and fed back to bed bureau by 10:30 All diagnostics / Specialist review for Inpatients to be prioritised above day case and OPD	Q1	90% patients have an EED within 4 hours.	Antony Middleton (WTH)
	Flow	**Flow** - earliest opportunity from assessment units to inpatient wards. Wards will ensure the first patient arrives by 10am	Afternoon huddles to focus on, Board round action completion, EDDs and golden patients Clinical handover and transfer on Cerner of patients from base ward to Discharge Lounge Ensure TTH & discharge summaries are completed in real time	Q2 Q2 Q3	80% patients arriving on inpatient wards by mid-day.	Antony Middleton (WTH)

	Early Discharge	**Early Discharge -** 33% of patients will be discharged from base inpatient wards before midday.	Clinical handover and transfer on Cerner of patients from base ward to Discharge Lounge Focus on transferring 10 patients (Golden Patients) to the discharge lounge or discharge by midday	Q2 Q3	23% Q1, 28% Q2, 33% Q3 33% of patients will be discharged from base inpatient wards before midday by Q4	Antony Middleton (WTH)
	Review	**Review -** systematic multi-disciplinary team (MDT) review of patients with extended lengths of stay (>7 days)	Senior Clinical Forum attendance to present SDIP contracting agreement and awareness of the ECIP support, to ensure clinical engagement and support ECIP attendance to support the embedding of afternoon huddles ECIP supported site visits to Mid Yorkshire to review their processes Enhance the features of the electronic whiteboard, specifically EDD, Red2Green and flow comments Through Patient Flow improvement group three worksteams over 8 weeks have been formed consisting of full MDT to look at Complex patients, diagnostics & pharmacy and Ward rounding process to ascertain barriers and gaps in delivery	Q1 Q2 Q2 Q2 Q2	See Stranded below. Baseline & trajectory by Q1	Antony Middleton (WTH)
	Stranded and Super Stranded patients	**Stranded patients >7 days. Super Stranded patients >21 days. National stranded LOS target is a reduction of 27%. Agreed Wirral target in SDIP is 37.5%**	**Acute: Targets set within SDIP's for the Acute Trust. Community: T2A Stranded meetings monthly during part of the MDT's. MADE events prior to a Bank Holiday to support flow through T2A beds and increase capacity during Bank Holiday periods.**	**Q1 Q2 Q4**	**From agreed baseline: 80. Reduce 30 MO stranded patients by end of Q2 and maintain Reduce by 50 MO stranded patients by end of Q4 and maintain**	**Antony Middleton (WTH)**
	Acute average LOS & Acute Medical LOS & Acute Capacity	**Reduction required in Acute Average & Medical LOS.**	**Provide improvement plan and trajectory to reduce average length of stay to 4.8 days by end of Q3 (recognising 0.3 a day increase over winter) and Acute Medical LOS to 5.5 by Q3. Max 92% occupancy for acute (allowing 5% flu/infection control issues). System delivered 90% / 95% and occupancy was 90-94%. Therefore**	**Q3 Q3**	**Reduce Average Acute LOS to 4.8 days. Reduce Acute Medical LOS to 5.5 Max 92% Acute occupancy**	**Antony Middleton (WTH)**

			assumed average of 92%.			
	SAFER in T2A beds	Processes to implement the SAFER bundle in the community beds to improve flow across the system.	Weekly MDT to review LOS in T2A Beds based on the SAFER bundle.	Q1	Implementation of SAFER in T2A	Val McGee (WCT)/Jacqui Evans (CCG & WBC)
Priority Area 8 – Discharge Transformation & Sustainability Programme						**Ref. UC008**
Theme	**Programme**	**Description**	**Actions**	**Timescale**	**SDIP Target**	**Acc Owner**
Discharge & Transfers of Care	Transfer of Care Form solution	Transfer of care form in place, on- going monitoring and evaluation of form. Poor quality tocs numbers have significantly reduced Further development of the Toc to roll out to other services i.e OPAT and CHC	Quality assurance process in place and escalation process agreed with providers with regard to quality issues Continuous scrutiny of tocs with monthly RCA programme in place to review all TOCS identified through the escalation process Toc for reviewed to replace nursing needs assessment and referral form to OPAT Training delivered to IDT and intention to develop discharge trackers to complete TOCs	Ongoing Ongoing Ongoing Ongoing	95% of TOCs are not returned due to quality	Shaun Brown (WUTH)
	Integrated Discharge Team	New Operating model reviewed to ensure key deliverables have been achieved Reivew identified that 30% of patients are assessed in hospital and 70% outside, Review of skill mix of IDT to ensure capacity to deliver skilled asset based assessment for	Completed Workshops arranged with clinicians to improve the board meeting focussing on respective challenge models MDT function to be reviewed to ensure most effective communication White board to be placed within IDT with live data to support MDT process Alignment of stranded reviews with IDT MDT	June 18 July 18 June 18 Aug 18 July 18	15% of patients assessed in acute 85% of patients assessed in a Transfer to assess placements	Shaun Brown (WUTH)

		complex patients and timely discharge for people who transfer to T2A Admin to work over 7 days	Admin consultation on going	July 18		
	T2A	Transfer 2 Assess Beds, currently 102 core beds. Individuals who are Medically Optimised and require bed based provision due to not being able to go home will receive assessments & therapy through a MDT approach LOS up to 6 weeks. Target for Winter is 4.2 weeks LOS.	Clarification of Winter Beds through the Capacity Demand Model and potential use of Clatterbridge site and remodelling of MDT's to match the model. Discharge Date to be set within 48hrs.	Q3 Q2	LOS as per spec: 50% LOS 3 weeks max, 25% 72hrs, 25% 6 weeks max. LOS down to average 4.2 weeks	Val McGee (WCT)/Jacqui Evans (CCG & WBC)
	Homefirst	Pathway from Acute that gets people home following a NEL admission, with the support of Health Care Assistants supporting patients for 72hrs while packages of care are being put in place.	Current Community Services Redesign work linking STAR, Homefirst and Rapid Community Response. New service model to be in place by end of Q2	Q1 Q2 Q4	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%	Shaun Brown (WUTH)/Natalie Park (WCT)
	CHC	Ensure greater understanding of CHC processes from a medical perspective and IDT in particular fast track Ensure that 85% of patients assessed outside acute currently over achieving. Reduce the number of patients inappropriately referred for fast track Electronic referral in place	Workshop to review process and documents Process developed with team to include timescales and expectations Educational programme for clinicians to be developed and implemented, senior consultants to have ownership Ensure that all staff are registered and use the electronic referral process	Complete July18 Aug 18 July 18	85% of patients assessed for eligibility outside the acute setting	Shaun Brown (WUTH)/Sam (CSU)/Iain Stewart (CCG)
	Mental Health Pathway	Mental health engagement to support management and flow of patients with mental health issues and to facilitate safe and timely discharges	Education programme to be developed for IDT and clinicians to ensure understanding of mental health Outreach dementia team to be expanded to offer support for patients transferring from hospital to T2A beds	Aug 18 July 18		Shaun Brown (WUTH)

			Training programme developed for discharge trackers Delirium pathway to be developed and understood by all professionals	July 18		
	Trusted Assessor in Care Homes/Dom Care	**Care Homes:** Trusted Nurse to undertake pre admission to Care Home assessments on behalf of the Registered Managers of Care Homes to speed up the Discharge process. **Dom Care:** Several pilots underway with independent Dom Care providers – providers undertaking trusted assessments to either increase or decrease packages of care.	**Care Homes:** MOU finalised and circulated to Care Homes June 2018. Full assessments possible from June 18. BCF funded. **Dom Care:** Implementation and evaluation of Pilots as part of the recommission of Dom Care and links with Community Services Redesign. Recommission	Ongoing Q2 April 2019	100% of Care Homes using TA for Care Homes by the end of Q2	Shaun Brown (WUTH)/Natalie Park (WCT) Jayne Marshall (WBC)/Jacqui Evans (CCG & WBC)
	Integrated Therapy (Therapy Redesign)	Cross organisation review of therapy services the results in a proposal for integrated community based therapy model enhancing streamlined care pathways directly supporting streaming, internal flow and DTOC.	**See Priority Area 14**			Allister Leinster (WUTH)/Natalie Park (WCT)
	Patient Information	Patient information policy completed and in place. Patient leaflets agreed and available on wards	Full implementation still to be realised Ongoing updates to policy require governance oversite and sign off Clarification of ongoing funding, Further work to embed policy across all divisions Review of IT systems, intranets to include for external information	Ongoing July 2018 Aug 2018	100% of policy adhered too 100% patients receive leaflet on admission	Shaun Brown (WUTH)
	Culture & Communication	Improve communication Raise the profile of IDT throughout the trust to ensure greater understanding of the role and function of the team Raise the profile of IDT to external partners to ensure wider engagement and inclusion of community development schemes	Review attendance at medical board rounds Develop plans to attend board rounds on surgery Participate in any community re-design programmes Engage with provider forums to	Q2		Shaun Brown (WUTH)

			maintain good productive relationships			
	Further Provision Opportunities	Opportunity to review site at Clatterbridge to develop provider led medically optimised unit	Review existing T2A models Arrange Pre-tender engagement event to test the market Meeting with Stakeholders to develop plan and identify areas for escalation Increase the numbers of complex patients receiving assessments out of hospital Full implementation plan to be developed following the pre tender event	Q2		Shaun Brown (WUTH)

Priority Area 9 – Redesign & Scale up of Community Services – Ref. UC009

Redesign of key Community services including: Homefirst, Rapid Community Response, STAR to better link with Dom Care market and provide a broader crisis response.

Theme	Programme	Description	Actions	Timescale	SDIP Target	Acc Owner
Whole System	Modelling/Pathway Implementation	Community Services that support Discharge and Hospital Avoidance consist of several separate services: Home first, Rapid Community Response and Reablement (STAR).	Undertake a rapid review of Community Services with a view to re-designing the offer to work closer with Dom Care providers to ensure that people are supported at the right time, right place and with the right service. Implement new model by beginning of Q3 with flex and support across the system	By end Q2 Beg Q3		Val McGee (WCT)/ Jacqui Evans (CCG & WBC)

Priority Area 10 – Development of Workforce Strategy Ref. UC010

	Programme	Description	Actions	Timescale	SDIP Target	Acc Owner
Whole System	Workforce Strategy	Strategic review of: • Reablement, • RCS • Dom Care Acute visiting service	Review Home First Pathway Review of Workforce roles and capacity including safe sustainable staffing review **See Priority Area 9 above**	July 2018 July – Aug 2018 July 2018		Val McGee (WCT)/Antony Middleton (WUTH)/Jacqui Evans (CCG & WBC)

		WIC staffing review to strengthen resilience of 7 day service SPA review and redesign as part of Integrated Gateway Operational review to enhance winter resilience eg schedule training and development outside winter months Workforce Flexible staffing Teletriage Dom Care & Care Homes	Extend AVS service through to March 2019, including in-hours and GPOOH. **See Priority Area 1 above** Review of staffing for 7 day service **See SPA Priority Area 2 above** Review across WCFT to ensure risk based approach and consistency and engagement with staff side Review current models in WCFT and WUTH and maximise benefits of integrated working. Review re optimising this as part of an integrated community offer with GPOOH and neighbourhood nursing teams. **See Teletriage Priority Area 4 above** **See Priority Area 13 Community Care Market - Career Pathway**	July 2018 Aug 2018 Aug 2018 July – Sept 2018 August 2018 Q2		

Priority Area 11 – Capacity & Demand modelling inc. proactive approach to OPEL & escalation management Ref. UC011

Theme	Programme	Description	Actions	Timescale	SDIP Target	Acc Owner
Whole System	Winter Bed modelling	Using the Capacity & Demand model using assumptions plan requirements for winter, creating trigger flags and escalation plans to cope during pressure. *Acute Escalation 48 beds *Community Beds & Wrap around MDT 20 beds	Run Capacity & Demand model & Identify additional beds and create escalation plan against triggers identified from the CDM. See Capacity & Demand modelling **Appendix 2: Capacity & Demand modelling assumptions & Winter Plan narrative.**	End of Q1		Jacqui Evans (CCG & WBC)
	Delayed Transfer of Care (DToC)	**Maintain DToC at 2.67% or under (BCF targets for 18/19 not yet confirmed by National Team, therefore this assumption my need revision).**	**Whole System Indicator**	**Q1-Q4**	**Maintain at 2.67% or below**	**Jacqui Evans (CCG & WBC)/ Anthony Middleton (WUTH)/Val McGee (WCT)**

Priority Area 12 – High Impact Change Model – 8 intervention areas that can support local health & care systems to reduce transfer of care						**Ref. UC012**
Theme	**Programme**	**Description**	**Actions**	**Timescale**	**SDIP Target**	**Acc Owner**
Whole System	Early Discharge Planning	Robust discharge plans in place: elective – prior to admission. Unplanned: to allow discharge date to be set within 48 hours	Working towards Mature **See Priority Area 8** Discharge Transformation & Sustainability Programme - T2A	Q3		Jacqui Evans (CCG & WBC)
	Systems to Monitor Flow	Robust patient flow models for Health & Social Care	**See Priority Area 11** Capacity & Demand modelling including proactive approach to OPEL & escalation management	Q3		Jacqui Evans (CCG & WBC)
	MDT, including Vol & Community Sector	Co-ordinated discharge planning based on joint assessment processes & protocols	**See Priority Area 8** Discharge Transformation & Sustainability Programme	Q3		Jacqui Evans (CCG & WBC)
	Home First/T2A	Short term care & reablement in peoples home or 'step down' beds to bridge gap between hospital and home – assessments undertaken outside of acute setting.	**See Priority Area 8** Discharge Transformation & Sustainability Programme	Q3		Jacqui Evans (CCG & WBC)
	Seven-Day Services	Joint 24/7 working to improve flow of people through the system and across the interface between Health & Social Care, providing better response to people's needs.	**See Priority Area 10** – Workforce Strategy	Q3		Jacqui Evans (CCG & WBC)
	Trusted Assessors	Using Trusted Assessors to carry out holistic assessments – speeding up response times and reducing duplication.	**See Priority Area 8** Discharge Transformation & Sustainability Programme	Q3		Jacqui Evans (CCG & WBC)
	Focus on Choice	Early engagement with patients, families and carers. 3rd sector support so that people can consider their options and considering choice to be able to make decisions about their future.	Further embed the Age UK Right Time, Right Place Co-ordinators within the IDT.	Q2		Jacqui Evans (CCG & WBC)
	Enhancing Health in Care Homes (CHIP)	Offering people joined up, co-ordinated health and care services, can help reduce unnecessary admissions to hospital as well as improve hospital discharge.	**See Priority Area 5** Teletraige Red Bag Scheme Enhanced GP to Care Homes Falls App CHIP plan reiew including improvements to quality and training	Q1-Q4		Jacqui Evans (CCG & WBC)

Priority area 13 – Community Care Market (Domiciliary Care & Reablement)						**Ref. UC013**
Theme	**Programme**	**Description**	**Actions**	**Timescale**	**SDIP Target**	**Acc Owner**
Whole System	Domiciliary Care Trusted Assessor & other Pilots	Trusted Assessor – Dom Care Piloted with 2 providers so far, where they are able to make small temporary changes in POC with an agreed governance and process in place. They also have the ability to request and complete a review of individuals POC this is overseen and validated by as Social Care Assessor Enhanced Dom Care - 3 months pilot with Routes Health Care these are for difficult to place packages of care due to complexity or behavioural issues Electronic Care Monitoring (PASS System) – this is currently being piloted for 6 months with Haven Care to monitor outcomes for individuals and also the open PASS system which allows other professionals, family and carers access to the individuals care plan for real time info / changes to support. Career Pathway – Developing a publicity campaign to raise the awareness of Care Workers to attracted recruitment in this market by mapping out a career pathway for domically care, nursing and social care, exploring initiatives to support this i.e. employee benefits etc. Buurtzorg - this is a pilot that is being led by WCFT which will be piloted in Wallasey with 2 GP practices and Wallasey Community Nursing Team the Domiciliary Care providers are working closely with the CT and will be wrapping care support around this pilot	Pilot initially 3 months this has been extended to 1st Aug with a view of rolling this out to all providers. To be reviewed 1/8/18 1/6/18 – 1/11/18 Publicity Campaign Pilot running	Aug 2018 Aug 2018 Nov 2018 Q2 Q2		Jacqui Evans (CCG & WBC)
	Domiciliary Care	New Commission for Care at Home Services -	New commission go live April 2019	April 2019		Jacqui Evans (CCG

	Recommission	Specification in progress				& WBC)
	Reablement (STAR)	Wirral Short Term Assessment and Reablement Service (STAR) is a Collaborative Service Partnership Model, originally set up between Wirral Council's Department of Adult Social Services, WCFT and the Independent Sector for the provision of short term assessment and reablement services to maximise and promote independence as well as securing longer term efficiencies on local authority expenditure on domiciliary care by ensuring that people have timely support to recover and regain skills and independence following illness or injury. The current service model sees the front-line enablement part of the service provided via 2 independent sector providers ie Community Caring as tier 1 provider backed up by Professional Carers, with the assessment and quality control part of the service provided by WCFT through staff based within locality teams and at Wirral University Teaching Hospital. The home based element of the Reablement service provides personal care, help with activities of daily living and other practical tasks , free of charge for a time-limited period of up to 6 weeks, in such a way as to enable users to develop both the confidence and practical skills to carry out these activities themselves. These services are provided with the support of occupational therapy services which provides a time limited plan for improvements to physical functioning and participation in activities of daily living.	Reablement is part of a Remodelling exercise together with Rapid Community Response and Homefirst services – to be completed by end of September 2018 with the aim of creating one 'Community Offer' that works alongside and links closely with Dom Care	Q3		Val McGee (WCT)/Jacqui Evans (CCG & WBC)

Priority Area 14 – Therapy Redesign						**Ref. UC014**
Theme	**Programme**	**Description**	**Actions**	**Timescale**	**SDIP Target**	**Acc Owner**
Whole System	Development of a New Service Model	Joint recruitment: carried out joint recruitment in relation to band 5 Physiotherapist. Developed joint JD for core physiotherapy post, SLT posts and are in the development of joint core JD's for Dietetics and Occupational therapy Agreed to shared rotation of OT and Physiotherapy rotational staff with the new extended rotations taking place from March 19. This is not happening sooner due to the WUTH September 18 rotations having already been agreed with the rotational staff. Trailed using a shared band system as are in the process of developing a shared bank process to assist in the covering of vacancies. Co-operation agreement in place between the two organisations (WUTH & WCFT) and a Memorandum of understanding and information sharing agreement should hopefully be signed off by end of July allowing staff to cross freely between services and have access to each other's documentation systems. WCFT have already begun to place community staff within the WUTH Un-planned care team environment to improve patient referrals, assist patient transition and "pull" patients from the hospital into the community.	Working with commissioners and other health partners to develop a new shared model of rehabilitation to ensure equity of rehabilitation provided, and utilising pooled resources to improve the quality of service provided and patient outcomes. Working with commissioners to develop a outcome tool kit for rehabilitation and therapeutic intervention which will allow for benchmarking of services and assessment of patient centred outcomes. From September 2018 the AHP integration steering group is changing into the Wirral AHP Managers meeting which will have representation from CWP, WUTH and WCFT to ensure that all issues are shared across the services and resources can be allocated correctly to where required. Thus making integration business as usual. Further work is currently ongoing to look at what other services and pathways can be integrated and all services have be RAG rated in relation to their appropriateness and readiness to integrate.	Ongoing Ongoing Sept 2018 Ongoing		Allistair Leinster/Natalie Park
	Review of Current Therapy Offer in T2A Beds	Review of T2A Therapy capacity and deployment Neighbourhood development	Review the functional allocation of T2A patients to cohort based on acuity and rehab potential Safe Sustainable Staffing review for T2A Engage in development of	July 2018 June 2018 Sept 2018		Allistair Leinster/Natalie Park

			neighbourhood leadership teams Ensure robust pathways linked to neighbourhood model to improve access and timely intervention to prevent admission and facilitating discharge.	 Sept 2018		
	Develop Performance Measures	Currently Service Outcome measures across WCT and WHT. Work commencing on standardising measures across the two organisations	Review of measures with commissioners and standardise the core measures looking at TOM's and BARTHEL	End of Q2		Allistair Leinster/Natalie Park
Priority Area 15 – 7-Day Response						**Ref. UC015**
	Programme	**Description**	**Actions**	**Timescale**	**SDIP Target**	**Acc Owner**
Whole System	Staffing	A seven day working review was undertaken during February and March 2018. Recommendations will be taken forward for further work with providers to ensure a 7 day offer in as many services as possible moving forward.	Embed 7 day principles into all re-design work around community offer and Community bed offer. Implement the recommendation from the review.	Q2 Q2		Val McGee (WCT)/Antony Middleton (WUTH)/Jacqui Evans (CCG & WBC)
	Transport	Transport to facilitate discharges is a key priority over winter. Escalation arrangements with PTS provider (WMAS) include refusing requests for same-day bookings for outpatient appointments in order to reserve capacity for discharges.	A programme of work is ongoing between WMAS, CCG and WUTH to further develop working relationships and refine operational processes in order to maximise use of PTS for discharges.	Ongoing		Ian Williams (CCG)/Nesta Hawker (CCG)/ Shaun Brown (WHT)
	Age UK Transport	Age UK 7 day transport and settling at home service. The aim is to proactively prevent re-admissions by transporting patients home and supporting with immediate tasks and ongoing support from Age UK Homes and Communities service. Particularly for patients with complex social needs.	Continue to embed Age UK Going Home service within discharge lounge and ensure appropriate patients are referred.	ongoing		Jacqui Evans (CCG & WBC)
Priority Area 16 – Flu Planning & Infection Control						
Theme	**Programme**	**Description**	**Actions**	**Timescale**	**SDIP Target**	**Acc Owner**
	Flu Planning	Wirral Seasonal Flu Group (including representatives of Wirral Health and Social Care organisations, Wirral Council and NHS England) meets throughout the year to	**Wirral Seasonal Flu Group to continue monthly meetings through the 2018-19 flu season**	July 2018 onwards	**Julie Webster Acting DPH (WBC)** **Elspeth Anwar (WBC)**	Elspeth Anwar (WBC)/ Paul Simpon (WCT)/Gaynor

		facilitate co-ordination of seasonal flu preparedness. This includes individual organisationalplanning for staff vaccination, population vaccine programme implementation and communications during the season. This enables sharing of intelligence and best practice, reduces duplication, and supports effective surveillance.				Westeray (WHT
		Each local health and social care organisation is responsible for ensuring that plans are in place for effective vaccination of essential staff. This is monitored monthly by NHSE and reviewed in the Flu Group.	Vaccination programmes for staff initiated Monitoring uptake as programs commence.	Sept 2018 onwards	**All Health and Social Care Organisations**	
		All community and acute paediatric and maternity services promote uptake of the seasonal flu vaccine.	Flu vaccination promotion materials sent to community services.	October 2018	**Wirral CCG**	
		Primary Care organisations ensure adequate stocks of vaccine and promote uptake with key population groups.		August 2018	**Wirral CCG**	
		Wirral's Community Infection Prevention and Control (IPC) team continue to actively target higher-risk care homes to strengthen infection prevention and control measures. This includes strengthening hygiene measures, encouraging vaccination of all care home staff and residents, and early recognition and control measures to limit the spread of any illness or outbreak.	IPC team activity reports	Sept 2018	**Wirral Council** **Wirral Community Trust IPC Team**	
		All Wirral care homes are provided with a Seasonal Flu Resource Pack on how to prepare for, prevent, and manage flu outbreaks. They are also supported directly to prepare for the flu season by strengthen infection prevention and control measures and actively providing and encouraging access to flu vaccination for all residents and staff.	Sending out of resource packs. Vaccinations being offered and encouraged across independent sector providers-dom care and residential and nursing homes	Sept 2018 Sept 2018 onwards	**Wirral Council** **Wirral Community Trust IPC Team**	

		Services are commissioned to ensure timely access to antivirals in the event of an outbreak in a care home both in and out of hours. Deliver the school-based vaccination programme. Partners from the Wirral Seasonal Flu Group, including NHS England Screening and Immunisation Team and Wirral Council Public Health work together to identify resources and target a local seasonal flu information campaign to increase vaccination amongst potential transmission groups and 'at-risk' cohorts. Proposed focus on pregnant women, young children and people with long term conditions.	Delivery of agreed seasonal flu campaign actions	Commence Oct 2018 Sept – January 2018/19	**Wirral CCG** **Wirral Community NHS Trust** **Wirral Seasonal Flu Group**	
	Infection Control	WCT & WUTH have Infection Control protocols in place and more detailed Winter plans will be developed. PENDING WUTH INPUT	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 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	Q2 Q2 Q2 Q2		Paul Simpon (WCT)/ Joe Allan (WHT)/Lorna Quigley (CCG)

Priority Area 17 – CHC

Theme	Programme	Description	Actions	Timescale	SDIP Target	Acc Owner
	CHC	Wirral CCG and DASS have commissioned Transfer to assess (T2A) beds in a nursing home. MDT support, to ensure timely assessments. IDT (acute) transfer all potential CHC patients to T2A, and checklists are				Iain Stewart (CCG)

Theme	Programme	Description	Actions	Timescale	SDIP Target	Acc Owner
		completed outside of the acute. In order to facilitate the process a transfer to assess form has been developed.				
		Assessments in acute setting = less than 15%	Maintain current performance for 18/19 (cumulative position Q4 17/18 = 13%)	On-going		
		Positive Checklist and decision made within 28 days = 80% of cases	Improve performance from 76% at Q4 17/18 to 80% - additional nursing staff investment agreed for 18/19 (4.0 wte)	By end Q2		
		Fast Track process optimised – 90% of packages in place within 48 hours	Improve performance from current 75% to 90% - dedicated CHC team member assigned to in-reach to acute-setting to optimise fast track process Implementation of IEG4 to digitalise NHS CHC & Complex care, to improve patients journey, deliver robust timely patient assessments, and use resources effectively and efficiently	By end Q2		

Priority Area 18 – 7 Day Exec Cover

Theme	Programme	Description	Actions	Timescale	SDIP Target	Acc Owner
	7 Day Exec Cover	Agreeing 7 day Exec cover for the urgent care system. Review of daily escalation and conference call. To be implemented mid October 18.	Discussions and agreement at Exec with recommendation to A&E Delivery Board	Mid October 2018 until April 2019		Janelle Homes (WUH) Anthony Middleton (WUTH(Jacqui Evans (CCG & WBC) Val McGee (WCT)

Priority Area 19 – Mental Health Services

Theme	Programme	Description	Actions	Timescale	SDIP Target	Acc Owner
	Mental Health Services	Mental health crisis care - working through the crisis care concordat group to focus on improving mental health crisis support across Wirral. Beyond places of safety DOH bid	Psychiatric liaison - core 24 service implemented (additional psychology and nursing resource in situ) to reduce both A&E attendances (for repeat	Sept 18 – March 19		Jo Watts (CCG) Suzanne Edwards (CWP) Sarah Quinn

		successful which will result in development of alternative place of safety (calm zone – 2020/21) and the development of an alternative mental health assessment area to be in place at Springview during 2018/19. Children and young peoples out of hours advice line has now been launched and will result in reduced attendance at A&E and increase in Mental health assessments to be undertaken out of hours to paediatric wards.	attenders) and also reduce LOS for patients with mental health needs. Monitoring metrics in process of being agreed. Street triage – extension of hours in street triage with the police and NWAS. Aim to reduce section 136 and A&E attendances for patients in crisis and also reduce NWAS conveyances too A&E. Project group developing PID with agreed timeframes relating to Calmzone and MH assessment area.			(CWP)
Priority Area 20 – Contingency Plan B – OPEL 4/Non delivery of plan						
Theme	**Programme**	**Description**	**Actions**	**Timescale**	**SDIP Target**	**Acc Owner**
	Contingency Plan B – OPEL 4/Non delivery of plan	Contingency Opel 2/3/4/ Planning – will be based on triggers identified from the Capacity & Demand Modelling.	Contingency plan to be developed during July & August 2018	July – Aug 2018		Janelle Homes (WUH) Anthony Middleton (WUTH(Jacqui Evans (CCG & WBC) Val McGee (WCT) Suzanne Edwards (CWP)
Priority Area 21 – Primary Care						
Theme	**Programme**	**Description**	**Actions**	**Timescale**	**SDIP Target**	**Acc Owner**
	Primary Care supporting Winter Plan	GP Urgent Care Access	Increased GP appointments compared to 17/18 via the Wirral GP Access Hubs service (180 hours per week or 720 appointments per week) All GP practices will be advised to focus on urgent care needs over the XMAS/New Year Period 2018/19. All practices are advised to ensure	Q1-Q4		Martyn Kent

			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) Enhanced GP service to Care Homes rolled out to 50% of Dual registered Care Homes plans to roll out to all homes by end of Q4 Online consultations will be rolled out from Summer 18 in some GP practices.	Q4 Q2		