Wiltshire Council
Where everybody matters

NHS
Wiltshire
Clinical Commissioning Group

Wiltshire Sustainability (Winter) Plan and Preparedness

Health and Well Being Board

17.10.18

'The right healthcare for you, with you, near you.'

WORKING FOR CARERS

1st submission (06.07.18)

- Builds upon lessons learnt within BSW from best practice and from winter 2017- 2018
- Evaluates winter resilience schemes from the 2017-2018 with recommendations
- Builds on the delivery and potential of Integrated Urgent Care as commenced May 2018
- Incorporates the on-going work on reducing length of stays in hospital and will build on the demand and capacity analysis across STP
- Confirm the 5 priorities through LDB
- Wiltshire data and narrative input into BaNES and Swindon system plans

2nd submission (31.08.18)

- Following feedback from NHSE review (08.08.18)
- Review against KLOEs
- LOS improvement plan – actions and dashboard (for sign off LDB 16.08.18)

3rd submission (05.10.18)

- BSW rep at Regional Winter Event – 6th September
- NHSE feedback 14th September / Review against Pauline Phillips Preparation for Winter letter 7th September
- Reviewed at LDB 18th September
- Separate returns to NHS on winter planning: primary care, digital and quality / patient safety
- Taken to WCCG Governing Body in public and PCCC - 25th September
- CCG deep dive to understand what is driving demand across systems by postcode, diagnosis, referral and age
- Review of Demand and Capacity modelling for the South (as part of STP work)
- IA service commenced – 1st October
- Weekly Expert Panel commenced - 3rd October
- *Q2 IAF BSW Focus on Winter – 9th October*
- *"Fit for Winter" simulation planned – 10th October*
- *LDB focus on Risk Summit – 16th October to refine the Risk Register*
- *Winter Plan on Wiltshire Health and Wellbeing Board – 17th October*
- *Escalation Training (NHSE) – 13th November*
- *SWAST winter workshop – 13th November*

Wiltshire feedback 14.09.18 (NHSE and NHSI)

- On-going BSW/STP approach to planning and continuous assessment of where a shared programme would benefit patients
- **Trusted Assessor** - options for accelerating (from Nov) and contingencies – ***paper to JCB 05.10.18***
- Clarify progress on **Choice Policy – *picked through Expert Panel and workshop planned***
- **Workforce** – robust workforce plan showing sufficient staffing, vacancy and sickness, staff well-being – ***driven through Wiltshire Integration Board Action Plan***
- **Third Sector Involvement – *review of Age UK home from hospital service at SFT (funded BCF) meeting 11.10.18***
- **Timely discharges** – assessment, placement, equipment and choice; and domiciliary care and POC – ***Expert Panel commenced 03.10.18***
- **Wiltshire Health and Care** – fuller work on opportunities and risks facing 3 systems - ***updated Winter Plan received***
- **Ambulance** – local solutions; ***SWAST winter workshop13.10.18*** (include SCAS).
- Bespoke and stretching **fitness for winter exercise – planned *10.10.18***
- **Standing item** at LDB
- **Local clinical oversight and leadership** for planning and final sign off – ***CCG Governing Body and HWB in public***

Leadership Approach – South Wiltshire

Proactive approach:

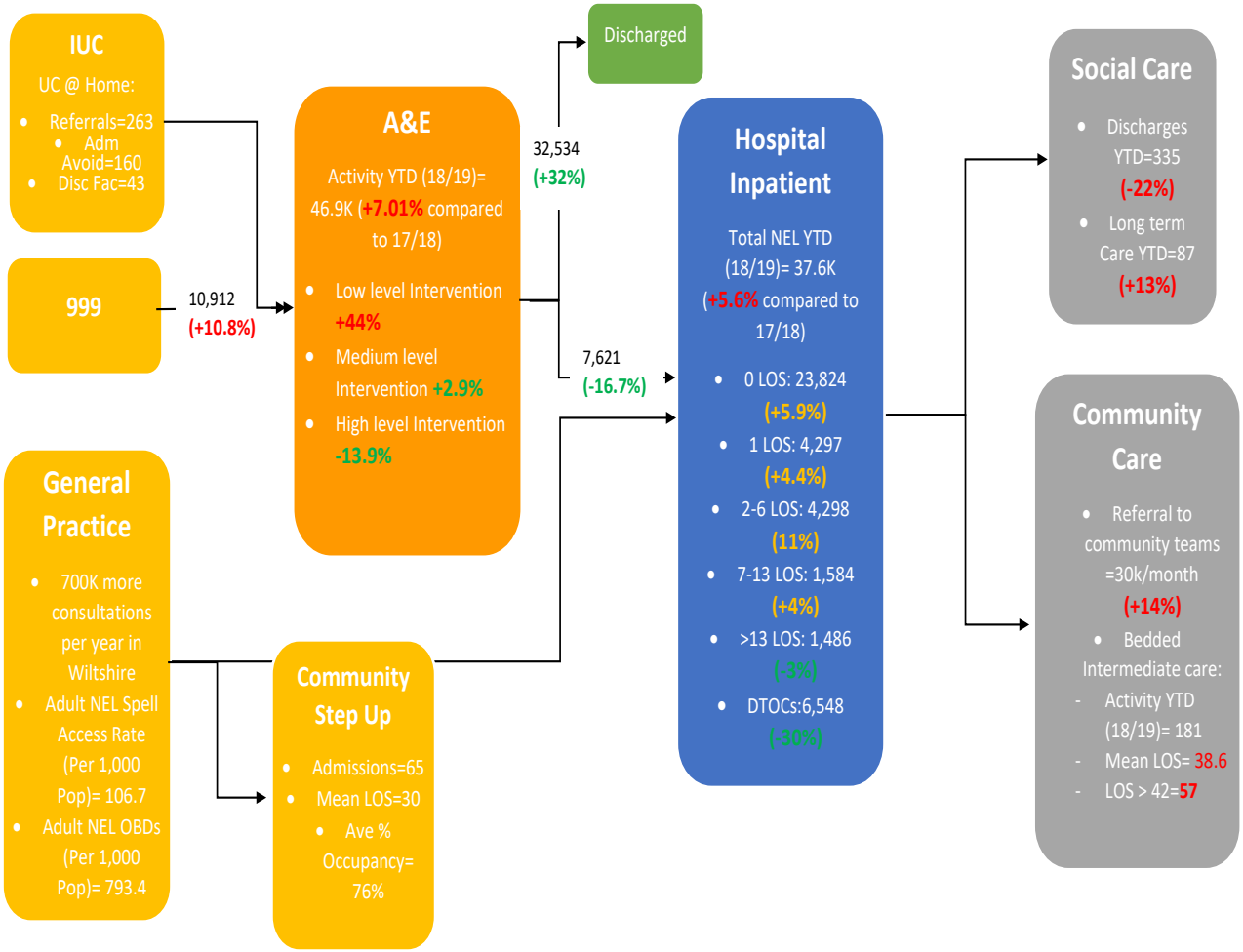
- Weekly operational level meetings and calls
- Clinically led Expert Panel (all long stay patients) from 1st Oct (x3 week)
- Weekly Senior Decision Makers meetings (F2F)
- System escalation call training planned for Q3

Reactive (Escalation) approach

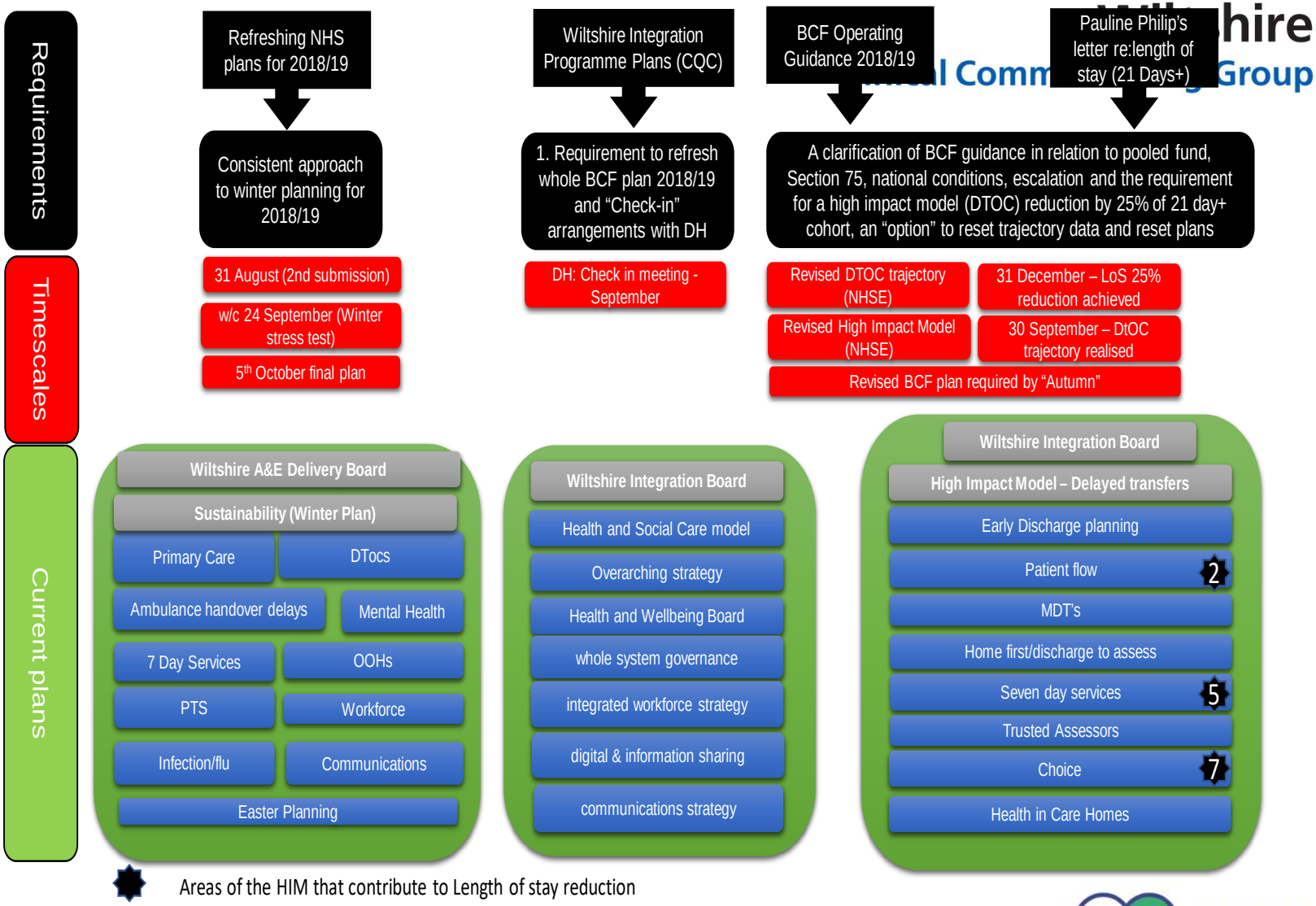
- System agreement to follow national OPEL criteria framework to trigger GOLD escalation calls
- Alerts to CCG on call via Single Point of contact agreed through LHRP

System metrics, drivers and priorities

Wiltshire Patient Flow Through Non-elective System (2018/19M4 and comparison with the same period previous year)



Hierarchy of Plans – Wiltshire system



Areas of the HIM that contribute to Length of stay reduction

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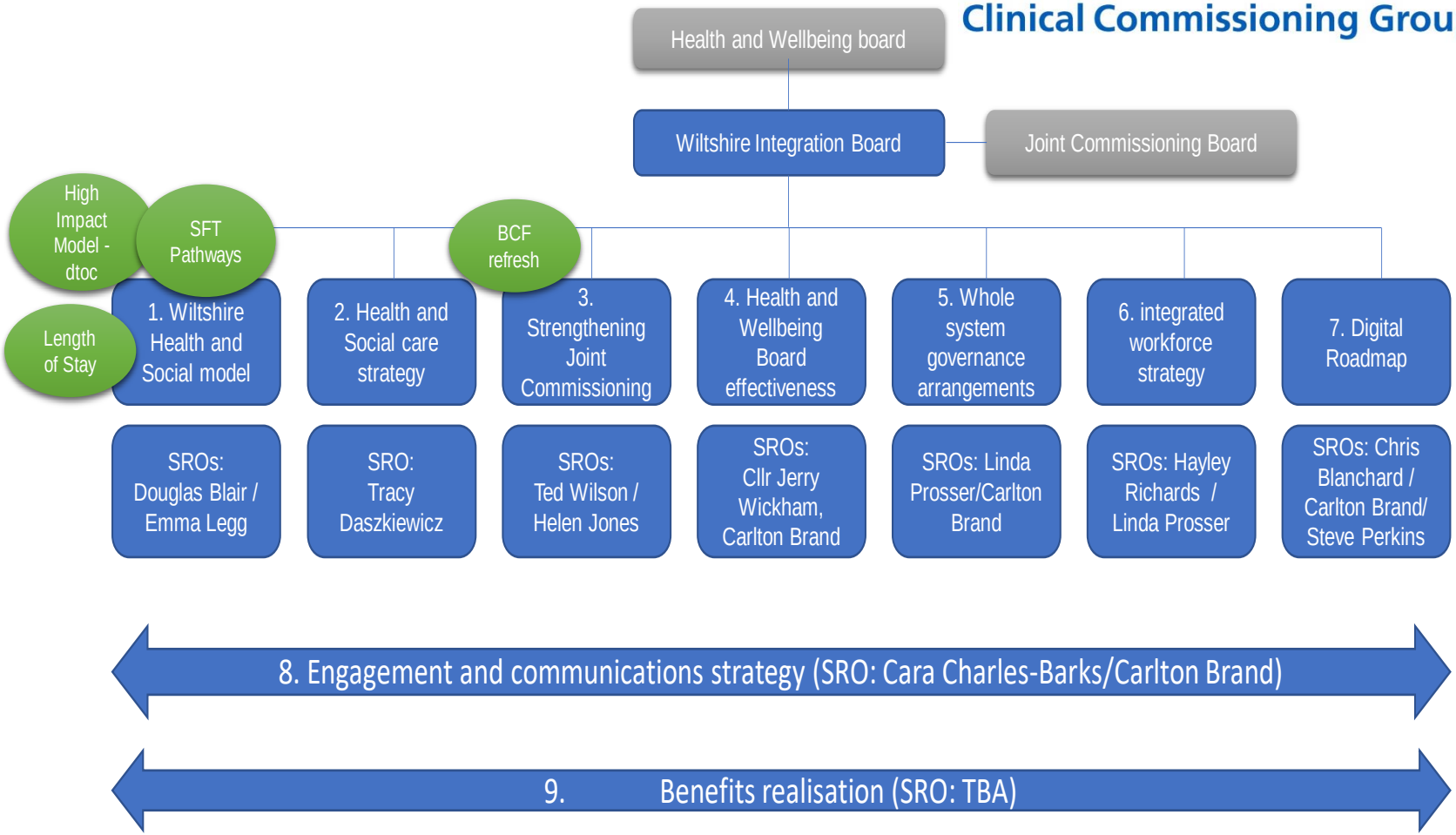
Wiltshire Integration Programme Structure

NHS Wiltshire Clinical Commissioning Group



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NHS Wiltshire

Total inpatients unallocated to discharge pathway

0

Normal expected range:

not yet set

Unallocated + 21 days

0

Pathway 0 - No additional support - Ward led

Not ready:	Ready:	Of ready, For discharge today:	Not ready	Already D/C	Discharged (last 7 days):
0	0	0	*0*	*0*	0
Normal range not yet set	Normal range not yet set	Normal range not yet set			Normal range not yet set

Pathway 1 - Can go home with additional support - Home First. Ward led

Not ready:	Ready:	Of ready, For discharge today:	Not ready	Already D/C	Discharged (last 7 days):
0	0	0	*0*	*0*	0
Normal range not yet set	Normal range not yet set	Normal range not yet set			Normal range not yet set

Pathway 2 - Temporary Bed. IDS supported

Not ready:	Ready:	Of ready, For discharge today:	Not ready	Already D/C	Discharged (last 7 days):
0	0	0	*0*	*0*	0
Normal range not yet set	Normal range not yet set	Normal range not yet set			Normal range not yet set

Pathway 3 - Complex - discharge needs to be assessed. IDS managed

Not ready:	Ready:	Of ready, For discharge today:	Not ready	Already D/C	Discharged (last 7 days):
0	0	0	*0*	*0*	0
Normal range not yet set	Normal range not yet set	Normal range not yet set			Normal range not yet set

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Wiltshire LDB priorities to support reducing +21 days LOS

SFT	Wiltshire	West Hampshire	Dorset	System assurance
• Reviewing all long stay patients (> 7 days)	• Participation in expert panels • Home first and re-ablement integrated pathway • Daily review of all over 21 day patients	• Establish a task and finish group focussed on ensuring discharge plans for longest staying patients within next week.	• Health and Social Care Coordinators involved in daily board rounds, and MDTs • Social workers integrated with ward staff	Medium

Wiltshire LDB priorities to reduce DTOC

SFT	Wiltshire	West Hampshire	Dorset	System Assurance
• Integrated discharge service in place • Right place, right time, first time = <3 moves per patient • Embed SAFER across all wards	• Focused work in reducing community hospital DTOCs to 10-15% • Six day a week social workers – BH and 7 day cover being expanded ad hoc initially • Review of discharge pathways for stroke and delirium (Sep 18) • Stranded and super stranded daily review via WICC	• CHC: Wider roll out of D2A pathways in Hampshire • Increase forward planning of spinal patients discharge • Effective flow and discharge forum to review process and communication between partners • Weekly West Hants Dtoc call	• Community input into stranded patient meetings • D2A model for CHC and End of Life patients • In-reach to support rapid discharge of fail older people	Medium

Wiltshire LDB priorities to reduce ambulance handovers

SFT	Wiltshire	West Hampshire	Dorset	System assurance
• Sustain current performance of handover delays, and to continue to seek improvements 'with no delay appropriate' approach • Review existing SOP with both ambulance providers to ensure it reflects latest guidance on improving handover delays and wrap up times (Aug 18) • Ensure patient flow from hospital to create pull effect from Front door	• Maintaining MIDOS rollout to support tough books to support alternative pathways – analysis of searches to support pathway redesign and education • Joint STP action plan for ARP monitored via LDBS • Medvivo and SWAST strategic partnership MOU to share cases	• TBC	• Joint STP action plan for ARP monitored via LDBS	Medium

Wiltshire LDB priorities to support 7 day working

SFT	Wiltshire	West Hampshire	Dorset	System assurance
• Maintain existing 7 day service level • Review	• Acute trust liaison nurses 7 days a week to support integrated flow • Improved access in primary care delivered 7 days per week from October	• Red bag scheme- rollout Autumn • FST supporting patients at weekends	• Improved access in primary care utilising the ED streaming model	Medium

Wiltshire – Primary Care

18/19 Initiatives / Plans

- Continuation and expansion of clinical hub, remote triage, elective referral management centre and POD (prescription support service) to support resilience and reduce preventable demand

- Improved Access – collaborative approach including local providers, Wiltshire GP Alliance and CCG to deliver 235 hours of additional capacity from Oct 2018

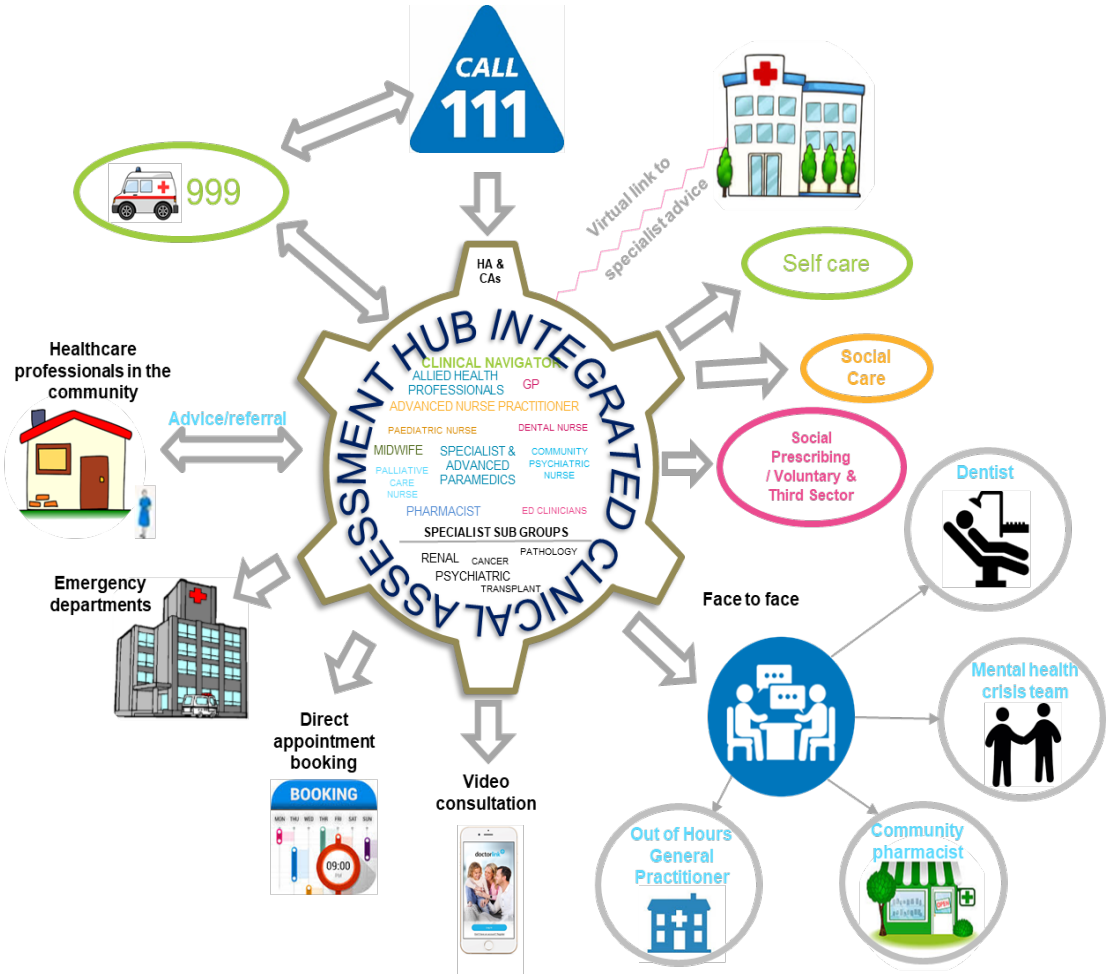
- Ensuring integration between services – in hours, extended access and improved access and OOH

- Collation of locality proposals underway with hub and spoke arrangements – working at scale/primary care networks

Wiltshire Primary Care (2)

- Primary Care Offer in place – including TCOP, Care Home and locality services. Reduction in care home attendances and admissions.
- Locality workforce review to increase shared posts including back office functions
- Development of Wiltshire GP Alliance
- Piloting use of one GP online tool to improve access, increase efficiency and reduce administration
- Collection of primary care data into dashboard – phone calls, F2F and home visits from selection of practices

Out of Hours and 111 (IUC)



- Key service features include localised patient pathways:
  - Direct access for palliative patients;
  - Bespoke pathways for the over 80s and under 5s;
  - Clinical validation of ED and Category 3 and 4 Ambulance dispositions.
- The service is already consistently achieving ED and 999 referrals rates below the national averages and further development work is underway.

Integrated Urgent Care plan

Focus	Impact	Metrics	Timescales
UNDERSTANDING THE ACTIVITY - building a granular overview of STP wide system activity	Ability to track whole system flow and outcomes. The service is already presenting activity which is consistently above the contracted forecast. Where is the activity coming from and why? Is this the new 'normal'? Henry Clay from the Primary Care Foundation has been commissioned to support this piece of work.	Patient and activity volumes including calls, cases, source, activities, demographics, referrals and outcomes etc.	Initial data set delivered in September.
SCOPE AND TARGET EXISITING AND NEW PROVISION - utilise the above to identify areas of challenge and opportunity	Improved outcomes for patients and enhanced flow for the system for areas identified such as mental health (AWP scoping project), repeat medication (POD & LPC partnership projects), care home support etc. Developed CAS with additional specialties both physically and virtually	Detailed monitoring of the above in order to track patients, service and system change / progress	AWP / Medvivo MH Scoping: Phase #1 Jun to Sep 2018 Non-Prescribing Triage: October 18 – Feb 19
MANAGE AND SUPPORT 111 - work closely in partnership with our 111 partner so the service is part of the solution not part of the problem	Overall improved performance such as call answering and improved case flow for patients e.g. HCP access, under 5s appts, over 80s CAS transfer, 999 & ED validation all targeted to get the patient to the right outcome in the shortest time / most practical route	Detailed monitoring of the above including key metrics such as 999 and ED referral rates. Associated impact on system metrics such as ED performance	Huge progress has already been made in this area with providers working closely together to understand each others challenges and to support improvements e.g. joint delivery @ FTH and cross service working. On-going

Integrated Urgent Care plan (2)

Focus	Impact	Metrics	Timescales
DEVELOP THE WORKFORCE - support and grow the existing workforce disciplines and introduce new ones both internally and in partnership with others	Flexible and resilient delivery resource that can upscale effectively e.g. opening additional bases, increasing direct transfer from ED, supporting in hours primary care capacity. Increased career pathways, mixed roles and rotational opportunities	Workforce disciplines and rota fill	Prescribing Pharmacist Development Programme: June 2018 – June 2019 Non-Prescribing Triage: October 18 – Feb 19
DIGITAL - support the roll out and embedding of digital solutions / workflow	Greater patient empowerment to access appropriate support with a drive towards self-care. Enhanced in hours support including in hours GP resilience. Enhanced DoctorLink trials including IUC integration and direct appt booking commencing shortly	Call volumes, service referrals, service capacity including in hours primary care	Enhanced DoctorLink Delivery Trials: Sept 2018 111 Digital: Oct 2018
ADMISSION AVOIDANCE & DISCHARGE FACILITATION - continued delivery and development of services such as the ATC (inc. ATLs), UC@H and the services they support e.g. HomeFirst and IDS	Multi-skilled resource that can be targeted to problem areas e.g. improving flow, bridging capacity for H2L@H, transporting patients or medication, proactive reassurance support for vulnerable patients, non-injury falls support for the Ambulance Service, on the ground review of care delivery in order to focus available capacity	ED performance, Stranded and Super-Stranded, LoS and lost bed days. Flow and delays in areas such as ICT and UC@H	Demand & Capacity Planning Tracking: Commenced and supported by ATC Clinical Leads Oysta Trial: Oct 2018

SFT: Improved inpatient processes

What	Who	How	Expected outcomes
Reviewing all long stay patients (> 7 days)	Peter Holloway/ Emma Cox	Weekly review process in place for Top 5 wards with highest volumes and process for reporting. Weekly stranded patient call in place between SFT and community. MSK/Surgical wards to commence in July	Super Stranded - 80 patients Stranded - 90 patients
Reviewing patient pathways and LoS against each speciality and/or HRG code	Emma Cox/Lauren Pittman	Elective and non-elective pathway plans in progress. All LoS across all Directorates available and engagement with lead clinicians	Medicine - 6.68 days MSK - TBC Surgery - TBC
Improve work at the front door (including ambulatory emergency care)	Lisa Clarke	Development of the OPAL service and early identification at the front door/flow to Acute Frailty Unit	
Implement validated frailty tool for over 75's to ensure routine screening	Anita Whalley (OPAL)	OPAL service using CGA. Frailty alert being developed within Lorenzo. Icon being developed for use on e-whiteboards for easy identification of patients.	

SFT: Improved inpatient processes (cont.)

What	Who	How	Expected outcomes
Reduce number of patient ward moves to ensure patient receives care in right place, right time, first time	Peter Holloway/Sarah Knight	Clear identification of patients to 'push' and 'pull' to ensure correct patients on correct specialty wards, thereby reducing outlying patients and improving flow/quality/safety for patient.	< 3 moves per patient
Review time of discharge and discharge process	Peter Holloway/ Janet Hope/Emma Cox	Development of dashboard at ward level with time of discharges is being implemented. Wards implementing 'Golden patient' initiatives	33% by mid-day
Embed SAFER across all wards	Peter Holloway/Emma Cox	Detailed project plan in place incorporating all elements of SAFER	
Improve 7 day services	Andy Hyett	Development of new business cases to factor in 7 day service delivery	
Process improvement and increase flow	Peter Holloway/Emma Cox	Review of the internal processes as part of the fortnightly ward level huddles engaging with other service leads when needed	

Wiltshire Improvement Plan

Scheme	Lead	Date	Benefit
Pathway 1: Home first plus	Lisa Hodgson WHC & Emma Legg WCC	30th Nov 2018	0.5 bed day per discharge: 8 bed days saved per week
Pathway 2: Social care assessment beds	Emma Legg	Oct 2018	Initial estimate 4 beds for SFT to ensure long term support planning in the community. This in addition to existing ICB
Pathway 2: Maintaining DTOC in community hospitals at average of 12.5%	Lisa Hodgson	Oct 2018	Year on year comparison: additional 309 bed days saved in October to March compared to 2017/18
Pathway 3: Trusted assessor	Emma Legg/Tony Marvell	Nov 2018	initial estimate is 98 bed days per annum gained, along with qualitative improvements.
Pathway 3: Help to live at home alliance framework	Emma Legg	Oct 2018	TBC
All pathways: Review of decision making & accountability for system flow	Lisa Hodgson	Oct 2018	To be modelling to be undertaken once scoping work complete

Public Health

Influenza and Outbreaks Planning

Influenza 18/19 Plans

- Learning event to review and plan (4th July 2018)
- Increase staff vaccinations
- Implement staff education sessions across all provider types
- Comms plan – 2&3 yr old vaccs, carers, self care
- Joint (CCG, Acute trusts, community services, PHE, LA and CQC) letter to care homes; setting out expectations and support for symptomatic discharges
- Plans for near patient flu testing in community – community hospitals and care homes
- Development of patient 'So You Have Flu' leaflet to support health providers

Communication Strategy

- Collaboration across all STP partners to support communications coordination
- The Winter Plan programme will be incorporated into this wider communications planning and will be in line with national campaigns e.g. Stay Well This Winter.
  - *NHSE Winter Planning meeting on 3 September*
  - *Draft plan progress but waiting on national guidance from NHSE and public health for timelines and messaging*
- Use of all media and social media.
- Some elements of the Winter Plan will require separate, additional communications support across a number of key partners.