REPORT TO:	Health & Wellbeing Board
DATE:	7th October 2020
REPORTING OFFICER:	Leigh Thompson, Chief Commissioner, NHS Halton CCG
PORTFOLIO:	Health Care
SUBJECT:	Winter planning
WARD(S):	Borough-wide

1.0 PURPOSE OF REPORT

1.1 The purpose of the paper is to appraise the Halton Health & Wellbeing Board of the 2020 Winter Planning requirements and the Mid Mersey System Winter Plan Submissions.

2.0 RECOMMENDATION

RECOMMENDED: That the H&WBB

(1) *A*cknowledge the winter planning requirements

(2) *S*upport the 2 local system winter plans and the Mid Mersey submission.

3.0 SUPPORTING INFORMATION

3.1 The attached Mid Mersey Winter Planning document and the 2 local system Winter plans have been derived from local system partnerships of Warrington and Halton and St Helens and Knowsley.

The 2 local plans have been simply aggregated to form a Mid Mersey introduction into the system response to Winter. On receipt of our plans the Urgent and Emergency Care Network and the Cheshire & Merseyside Health & Care Partnership will aggregate the plans up as a Cheshire & Merseyside response. In a parallel and complementary manner, the work of the Acute hospital Cell and the Out of hospital cell Phase 3 planning response plus the A&E Delivery board will have oversight of delivery and implementation. The local systems will need to continuously assess local delivery for any new challenges for the winter planning task ahead. It has been agreed that the foundation or building blocks are at a place and will maintain performance and stakeholder involvement.

4.0 **POLICY IMPLICATIONS**

4.1 N/A

5.0 **OTHER/FINANCIAL IMPLICATIONS**

5.1 N/A

6.0 **IMPLICATIONS FOR THE COUNCIL'S PRIORITIES**

None

6.1 **Children & Young People in Halton**

6.2 **Employment, Learning & Skills in Halton**

6.3 **A Healthy Halton**

6.4 **A Safer Halton**

6.5 **Halton's Urban Renewal**

7.0 **RISK ANALYSIS**

7.1 *N/A*

8.0 **EQUALITY AND DIVERSITY ISSUES**

8.1 N/A

9.0 **LIST OF BACKGROUND PAPERS UNDER SECTION 100D OF THE LOCAL GOVERNMENT ACT 1972**

Document	Place of Inspection	Contact Officer

Executive Summary

This executive summary is a short preface into the 2 local system winter plans that make up a Mid Mersey Sub System within the Cheshire and Merseyside Health and Care Partnership.

This winter is likely to place unique pressures on the health and care system. COVID-19 remains a concern with seasonal flu and other viruses, seeing an increase in transmissions over the winter period. These pressures create risks to the health and wellbeing of both people who need care and support and our workforce who provide it.

In our worst-case scenario, four additional challenges would exacerbate pressures on the health and social care system in winter 2020/21, increasing demand on usual care as well as limiting surge capacity:

1. A large resurgence of COVID-19 nationally, with local or regional epidemics.

2. Disruption of the health and social care systems due to reconfigurations to respond and reduce transmission of COVID-19.

3. A backlog of non-COVID-19 care that has accumulated as routine clinical care has been suspended during the first outbreak.

4. A possible influenza epidemic that will be additive to the challenges above.

These factors have all been considered in the attached winter plans and mitigations for a resurgence of COVID-19 this winter has substantially changed the local response to that used for previous winter planning and the first wave of infection in spring 2020.

3 overarching principles for our local systems are:

- **Ensuring everyone who needs care or support can get high-quality, timely and safe care throughout the autumn and winter period**

- **Protecting people who need care, support or safeguards, the health & social care workforce, and carers from infections including COVID-19**

- **Making sure that people who need care, support or safeguards remain connected to essential services and their loved ones whilst protecting individuals from infections including COVID-19**

It is therefore essential that we “local partners” work closely together to ensure that we are prepared for the additional pressures that we will face this winter, particularly a growing resurgence of COVID-19 cases. These 2 local systems (Warrington & Halton and Knowsley & St Helens) have worked seamlessly together to converge and set out the clear and robust steps we are taking to ensure the Mid Mersey system is prepared for winter, and that we offer sustainability, consistency and mutual aid.

The plans have been presented to the Mid Mersey Accident & Emergency Delivery Board and the Urgent and Emergency Care network where a set of Key Lines of Enquiry where presented back to us to ensure we met the necessary requirements for a robust winter response.

Throughout the planning of these 2-winter resilience plans the partners have extended support to ensure close working across health and social care. Therefore, within these plans we will continue to see:

- Continuous work with local authorities, given the critical dependency of our patients – particularly over winter - on resilient social care services. Ensuring that those medically fit for discharge are not delayed from being able to go home as soon as it is safe for them to do so in line with Department of Health & Social Care/Public Health England (DHSC/PHE) policies

- Sustaining current staffing, beds, and capacity, while taking advantage of the additional £3 billion NHS revenue funding for ongoing independent sector capacity, Nightingale hospitals, and support to discharge patients quickly and safely from NHS hospitals through to March 2021.

- Deliver a very significantly expanded seasonal flu vaccination programme for Department of Health & Social Care (DHSC) determined priority groups, including providing easy access for all staff promoting universal uptake. Mobilising delivery capability for the administration of a Covid19 vaccine when a vaccine becomes available.

- Expanding the 111 First offer to provide low complexity urgent care without the need for an A&E attendance, ensuring those who need care can receive it in the right setting more quickly.

- Maximum use of 'Hear and Treat' and 'See and Treat' pathways for 999 demand, to support a sustained reduction in the number of patients conveyed to Type 1 or 2 emergency departments.

- Continue to make full use of the NHS Volunteer Responders scheme in conjunction with the Royal Voluntary Society and the partnership with British Red Cross, Age UK and St. Johns Ambulance which is set to be renewed.
- Extend the support to care homes and social care through the Primary Care Networks and local federations.

The plans build upon initiatives and partnership working already in place, embedding in pathways and processes to support enhanced discharge planning, admissions, and attendance avoidance, including both local and national initiatives such as NHS 111 First and Community Rapid Response. The plans are likely to adapt and adopt due to the changing nature of Covid-19 and the global pandemic.

The Health & Wellbeing Board is asked to note the submitted plans and Key Lines of Enquiry and to support the Mid Mersey system response to Winter pressures.

Mid Mersey Winter Planning 2020

Contents

Introduction

This document is the introductory aggregated Winter Planning submission for the Mid Mersey AED board system. The Mid Mersey Winter Planning document provides an overview of the two place based operational system winter plans. The two local place based plans have been derived from local system partnerships of Warrington and Halton and St Helens and Knowsley.

This planning document is not to replace the 2 local plans but to summarise the Mid Mersey position and to support the planning process.

This document has been sent to NHSE/I, Winter planning experts at the Urgent and Emergency Care Network (UECN), the Mid Mersey AED Delivery Board and to the Halton and Warrington Urgent Issues Committee.

On receipt of our plans the Urgent and Emergency Care Network and the Health & Care Partnership have shared with us initial comments (Appendix 1) for which we have to update our response and plans by Monday 7th September 2020 for final submission on the 21st September 2020.

The 'plans' are seeking to answer the NHSE/I KLOEs across the five current dimensions of demand, capacity, workforce, exit flow and external events, but not to the exclusion of locally specific challenges and circumstances which local plans must clearly include and where possible address.

Once completed the HCP and the UECN will summarise, in a parallel and complementary manner the work of the hospital and out of hospital cells Phase 3 planning. The local systems will need to continuously assess if this creates any new challenges for the winter planning task ahead. It has been agreed that the foundation or building blocks at a place / AED Delivery Board system level in Cheshire and Merseyside would be as follows (including our local authority and other key partners):

- North Mersey
- S&O
- Mid Mersey
- Wirral
- Cheshire (incorporating potentially three 'Trust' system based plans)

The Mid Mersey system comprises of 4 CCGs, 4 Local Authorities including Public Health, health and social care providers, 2 Acute Hospitals, a Mental Health Hospital, a range of Community Care Providers, Primary Care, Voluntary and 3rd Sector providers. The 4 local places of Halton, Knowsley, St Helens and Warrington support

and manage the local populations health, care and wellbeing needs to provide local place based plans with a responsibility to respond to anticipated events such as Winter pressures, Flu, Covid19 and local and regional surges in demand.

Due to complexities of the provider landscape there is a need to engage with the wider system partners such as North Mersey, Cheshire's, Wirral and Southport and Ormskirk when seeking mutual aid and or clinical pathway adherence.

The governance for the Mid Mersey system lies with the respective organisations and does not take authority away from the local organisations including legal duties and powers.

Within this document there will be reference to the Warrington and Halton Winter plan and the St Helens and Knowsley Winter plan. Both plans are fully integrated responses to the anticipated winter pressures including a specific response to the increasing demand on restoration and recovery following Covid19.

The System is also cognisant of the requirements as part of the Phase 3 Recovery and the NHS Peoples Plan, with the need to consider the impact of the additional pressures on the front line staff and particularly those with vulnerable characteristics, to address inequalities in access to care and support and the differential outcomes, to support vulnerable and isolated members of the community, including children, shielded patients and those presenting with new anxiety and mental health concerns.

Collaborative work with the local Public Health Teams and Public Health England to restore the population health programme and to continue the reaching out to the shielded and vulnerable groups to ensure no one is left behind.

Mid Mersey System

The Mid Mersey System is made up of the two planning systems of St Helens and Knowsley and Warrington and Halton, consisting of the respective boroughs and based around the primary catchment of the two acute hospitals. Although recognising there are cross boundary relationships between both the planning systems but also with other systems outside of Mid Mersey.

The Winter Planning documents for the 2 systems are attached and reflect the collaborative working within across partners to provide a support network across the partners in the management of the populations health, the demands on any part of the system and the efficient and effective flow on any patients journey.

The 4 boroughs have a population just in excess of 670,000 residents, with pockets of high deprivation, poor levels of health and a high need for health and social care support.

St Helens and Knowsley	Warrington and Halton
• St Helens and Knowsley Teaching Hospitals NHS Trust • North West Brought NHS Foundation Trust • NHS St Helens CCG • NHS Knowsley CCG • St Helens Council • Knowsley Council	• Warrington and Halton Hospitals NHS Foundation Trust • Bridgewater Community Healthcare NHS Foundation Trust • NHS Warrington CCG • NHS Halton CCG • Warrington Borough Council • Halton Borough Council

The attached plans detail the local service provision and integrated approach to pathway management designed to mitigate fluctuations in demand and to maintain people safe and well in their own homes and communities wherever possible.

Background

The need for health and social care undergoes large seasonal fluctuations, peaking in the winter. The NHS and social care systems typically operate at maximum capacity in the winter months, with bed occupancy regularly exceeding 95%. Four additional challenges have great potential to exacerbate winter pressures this year by the increasing demand on usual care as well as limiting surge capacity and social distancing measures being put into place.

In our worst-case scenario, four additional challenges would exacerbate pressures on the health and social care system in winter 2020/21, increasing demand on usual care as well as limiting surge capacity:

1. **A large resurgence of COVID-19** nationally, with local or regional epidemics.

2. **Disruption of the health and social care systems** due to reconfigurations to respond and reduce transmission of COVID-19. This has had knock-on effects on the ability of the NHS to deal with non-COVID-19 work.

3. **A backlog of non-COVID-19 care** that has accumulated as routine clinical care has been suspended during the first outbreak.

4. **A possible influenza epidemic** that will be additive to the challenges above.

These factors need to be considered in the context of winter when:

- Pressures on NHS services are high and the NHS and social care systems are typically operating at maximum capacity.
- Availability of health and social care staff (including care home, domiciliary and residential care staff) and facilities (including support facilities such as laboratories) may be reduced due to winter health impacts and winter weather disruption (e.g. snow and flooding).
- Availability of PPE and appropriate equipment and resources to support provider delivery.
- Finally, the increase in local outbreaks and increases in surge response.
- Combine all of the above factors, means that mitigations for a resurgence of COVID-19 this winter will need to be substantially different to that used for previous winter planning and the first wave of infection in spring 2020.

Winter Planning Requirements

This plan will follow the below winter planning timetable.

1. Five system plans to be completed by cop **Monday 24th August** and submitted to Urgent and Emergency Care Network Board (UECNB)

2. UECNB to review the plans against NHSE/I system flow assessment template and Phase 3 letter (Table 1 below)

3. Any immediate omissions or matters of concern fed back by UECNB to systems cop **Wednesday 26th August** (changes to be made if required)

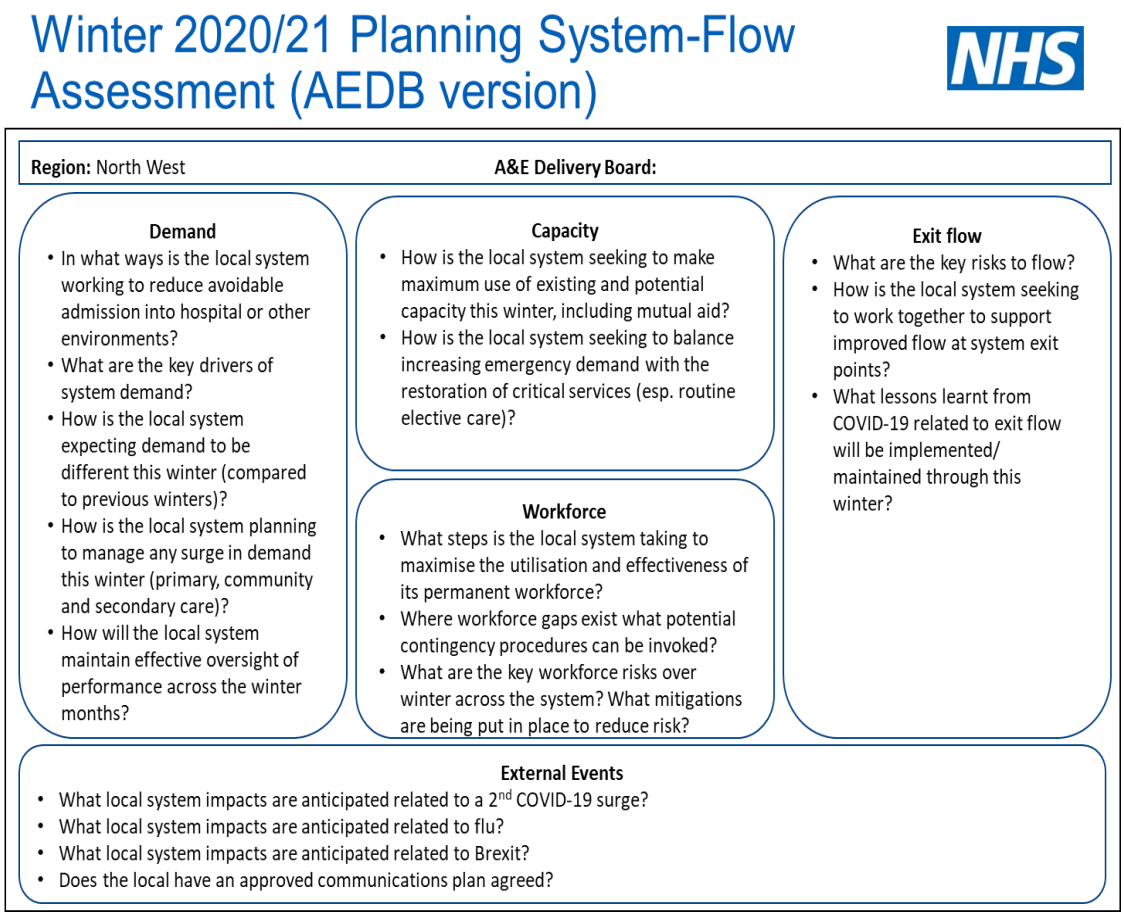
4. Summary of high level system risks shared by UECNB with Acute, Out of Hospital and Mental health and Primary Care cells to inform Phase 3

5. Health & Care Partnership summary completed by UECNB team and submitted cop **Tuesday 1st September**

6. Final Phase 3 plans submitted 12 noon **Monday 21st September**

The next section will respond to the Key Lines of Enquires (KLOE's) and provide an overview of the content within each local winter plan.

Key lines Of Enquiry Part 1.



1. Demand

In what ways is the local system working to reduce avoidable admission into hospital or other environments?

- Both local systems are preparing to reset and enhance community services to provide timely response to patients for both health and social care needs.
- Community response services, including the new Rapid Community Response Service in Warrington as part of the early implementer programmes. Also including frailty, falls, respiratory, heart failure, assessment and reablement services.
- Urgent Treatment Centres are available to all patients across the Mid Mersey System as an alternative to A&E.
- The 111 First programme will be phased into operation prior to winter with Warrington going live in September and St Helens in November.

- The 111 providers are sustaining the 111 CAS capacity and NWAS are planning to increasing the number of calls that will be managed through either hear or see and treat rather than conveyance to hospital.
- Proactive community management of long-term conditions through the PCN anticipatory care programmes will aim to reduce exacerbation of chronic disease.
- The Voluntary and 3rd Sector partners will continue to provide support to patients in their own homes and communities.

What are the key drivers of system demand?

- The elderly population are in general the highest users of health and care services and this increases during the winter months with exacerbation of respiratory conditions, plus addition respiratory, gastric and urinary infections, and deterioration of frail status.
- Post Covid patients are experiencing long term respiratory issues as well as levels of PTSD. The pandemic has also seen an increase in patients who are seeking MH crisis support particularly younger people, shielded presenting late with conditions, and people trying to navigate the care systems to access services they think are safe and responsive.

How is the local system expecting demand to be different this winter (compared to previous winters)?

- Difficult to predict the overall impact of demand on service this winter with the level of variability and changes in working practices due to distancing and PPE requirements. The hospital and out of hospital cells are developing 4 scenarios to model the potential demand and their discharge flow and these are being used to ensure there is adequate baseline capacity across the system, with additional escalation opportunities if the need arises.
- The reports on the winter flu season in Australian look favourable potentially due to public behaviour improvement for infection control and self-care during the pandemic.
- Conversely due to some patients holding off their presentation with symptoms there are cases of higher acuity and deterioration.
- Workforce loss will continue to be the primary risk and concern entering the winter with both genuine loss of staff through infections and sickness, but also in being lost through the test and trace process.

How is the local system planning to manage any surge in demand this winter (primary, community and secondary care)?

- Primary Care are continuing to restore service as much as possible to provide face to face assessments.
- The UTCs are implementing bookable appointments and will be configured with the 111 First programme.
- Community services are planning for all services to be operational and with some offering extended hours.
- There are expansions in acute bed stock, assessment for the need of additional community beds, secured care home beds, additional domiciliary care packages.
- All services responded quickly and effectively to the national requirement for the 1st wave of the pandemic and the as the redeployed staff have returned to their normal roles they have retained the "muscle memory" to be able to respond again to any surge in demand that require service to be redeployed again.

How will the local system maintain effective oversight of performance across the winter months?

- The Mid Mersey System has a structure of collaborative meetings that allow front line staff to discuss individualise issues on a daily basis through to strategic decision making at a senior level.
- Patient flow
- Local System Recovery
- Urgent Care Oversight Group
- Mid Mersey System Management Group
- A&E Delivery Board
- A Mid Mersey MADE event is being considered to ensure all preparations are in place and any gaps or blockages are raised and addressed.
- As part of the monitoring of the daily situation for capacity, PPE requirements and outbreaks the Out of Hospital Capacity Tracker is being utilised by the local systems to keep a watchful eye for any issues.

2. Capacity

How is the local system seeking to make maximum use of existing and potential capacity this winter, including mutual aid?

- During the pandemic the services within the system had to work very different to the original norm and solutions and improvements were found that will continue into the new norm as part of the system recovery. These include virtual triage, assessment and treatment, implementation of single point of access pathways, collaboration in enhanced discharge and management, integration of teams caring for the same client groups.
- Organisations have learnt new ways to work more agile and utilise their workforce and facilities to redeploy resources across their organisations and with partners to meet the demands.
- The use and partnership with the NHS Volunteer Responders and the local Voluntary and 3rd Sector services will continue during the winter period to provide additional support to patients and people in the community.
- Mutual aid will continue with the hospital and out of hospital cell demand and capacity planning and within the system for TTTC and the distribution of PPE and other enablers.

How is the local system seeking to balance increasing emergency demand with the restoration of critical services (esp. routine elective care)?

- Mid Mersey is fortunate that both acute hospitals have two sites and have already reconfigured services to allow a clean site to continue to manage elective case during any further COVID outbreaks.
- Utilisation of the IS sector for elective diagnostic and treatment services, as well as care placements in the community.
- Increased facilities for diagnostics, bed base at both acute trusts, escalation capacity if required.
- Community support to provide alternative options to A&E, maintain patients safe in their own homes and ensure effective discharge of patient to reduce any delayed transfers of care and reduce the number of super stranded patients occupying acute beds.

3. Exit Flow

What are the key risks to flow?

- Changing demand on A&E due to the public behaviours navigating the care system.
- Significant increase in complexity and acuity of patients increasing the length of stay and the requirements for packages of care.
- The loss of residential and care home and domiciliary care provision either through financial viability or through outbreaks.
- Loss of workforce from self-isolation requirements.

How is the local system seeking to work together to support improved flow at system exit points?

- The enhanced discharge process for both Trusts has improved the exit flow significantly with reductions in DTOC and rapid deployment of appropriate packages of care relating to the 4 pathway profiles.
- Trusted assessor, discharge to assess and reablement first are all embedded into each of the trusts and the places.
- The community response offer and the enhanced care home support will allow efficient hand overs of clinical responsibility and continuity of care plan delivery.

What lessons learnt from COVID-19 related to exit flow will be implemented/ maintained through this winter?

- The enhanced discharge processes will remain, the additional domiciliary care capacity with be sustained over winter.
- Effective intermediate care processes have seen the length of stay reduce to around 15 days allowing increase productivity and reduced occupancy to ensure step-up and step-down capacity is available.

4. Workforce

What steps is the local system taking to maximise the utilisation and effectiveness of its permanent workforce?

- People plan identifies the value of the workforce and the need to support them in their roles. All staff will be considered for their needs and their risks to work in their roles. All staff will be offer timely vaccination and provided with the appropriate PPE and equipment to allow them to work safely and not put themselves or their patients at risk of nosocomial infection.
- Staff will have where possible agile working arrangement to be able to see patients virtually and face to face to mitigate productivity losses from social distancing and decontamination requirements.
- When necessary staff will be fluid in the work to be able to be redeployed in outbreaks occur.
- Clean site arrangements have been put into place to allow routine work to continue.
- NHS responders and the voluntary sector will continue to support the patient's wider needs.

Where workforce gaps exist what potential contingency procedures can be invoked?

- Mutual aid arrangements will continue to operate across the system and the work being undertaken within the Hospital Cell will consider the ongoing management of capacity mutual support for the management of waiting lists.
- Providers are reviewing their establishment and their absence levels and utilising bank and agency staff as required.
- If additional bed capacity is required within the community, additional multidisciplinary staff will be needed to run the facilities, without depleting the existing teams. Consideration will be made on staffing models and partnership mechanisms to provide cover.

What are the key workforce risks over winter across the system? What mitigations are being put in place to reduce risk?

- Loss of staff from infection or through TTTC.
- PPE and staff safety, particularly for shielded and vulnerable staff groups.

5. External Events

What local system impacts are anticipated related to a 2nd COVID-19 surge?

- The Mid Mersey system managed the 1st wave extremely well and had excess capacity in all sectors and did not need support from other systems and did not have to rely heavily on IS capacity.
- The learning from wave 1 will allow a second wave or a local outbreak to be managed more effectively with less impact on support services. Clean sites have been designated to ensure routine activity can continue as long as safely possible.
- Test protocols are in place for all patients and IPC approved pathways and facilities are defined.

What local system impacts are anticipated related to flu?

- Flu vaccination campaign will ensure all identified cohorts are offered vaccination, continued campaigns regarding social distancing, hand washing, face hygiene and face covering will limit the spread of any respiratory infections.

What local system impacts are anticipated related to Brexit?

- Staffing and drug availability are not currently a concern and will continue to be reviewed.

Does the local have an approved communications plan agreed?

- The local system is developing a communication plan for the winter campaign, including winter warmth, Covid warning, flu advice, ideally in line with the national winter campaign.

6. Assumptions

- All service will ensure that the Quality, Safety and Care of staff and patients remains paramount.
- There is an assumption that no additional winter funds will be made available to the system to provide additional capacity or contingency measures.
- If material outbreaks of infection occur existing resources will be redeployed to meet surges in demand and may require suspension of some routine services.
- Restoration and maintenance of all services will continue in advance of the winter period.
- Local Authority Reset for social care and public health will continue in line with the national guidance.
- Public Health will continue to monitor and report on localised outbreaks and provide outbreak management and control measures.
- Providers will continue to maintain routine elective services for as long as clinically and safely possible during any future outbreaks.
- The recovery of routine activity backlogs will continue over winter and will deliver the trajectories to return to pre-covid waiting lists and times by March 2021.

7. Risks and Mitigations

What are the top three identified risks for the A&E Delivery Board ahead of winter?	What mitigating actions will be/have been put in place to reduce the risk ahead of winter?	*Please RAG rate mitigating actions in terms of risk to delivery, i.e. GREEN = low risk to delivery/very achievable; RED = high risk to delivery/dependent upon multiple factors/stakeholders to ensure delivery*
1. Workforce. Staffing absences due to COVID impacting upon service capacity and overall system flow. (Acute/Community/Social Care).	Additional capacity for staff testing with quick turnaround across health and social care. Agile working arrangements. Remote assessment approaches and telemedicine maximisation. Use of Agency staff and provider workforce recruitment plans as enacted during COVID Peaks. Mutual aid approaches	Amber
2. Bed capacity – Acute and Community.	Additional capacity identified for surge planning acute and community. Home First approaches Trust contingency plans – 1a can be used for acute capacity during winter. Daily review of EMS/capacity tracker to inform system escalation and decision making. Mutual aid approaches	Amber
3. Infection Prevention & Control Capability.	Daily monitoring via EMS/capacity tracker (PPE/staffing). Linked to escalation governance. Agile working. IPC plan developed in line with national guidance. Mutual aid approaches. Executive oversight.	Amber

8. Work Continuing

- The Hospital and Out of Hospital Cells will continue to model the anticipated demand and capacity requirements

- The Mid Mersey System Management Group will meet monthly to maintain the collaboration and react to any rising issues.

- A Mid Mersey Wide MADE Event will be arrange as part of the Urgent Care Oversite Group to ensure all preparations are in place

- The Winter Communication Campaign will continue to be developed.

- Analysis of demand scenarios, undertaken by PA Consulting and Venn will inform the strategic and operation requirements and the Capacity Tracker will monitor the local situation reporting.

- Place based Intermediate Care Reviews will be completed and implemented.

- The option analysis for the potential need and means of delivery for Seacole type sub-acute beds will provide a recommendation for the Mid Mersey Capacity and Demand Group

- New models of working and care, identified during the 1st wave of the pandemic, will be mainstreamed. Including the roll out of new initiatives such as 111 First.

- Development work for respiratory and frailty programmes will be fast tracked to identify the “quick wins” to reduce the risk of hospital attendances during winter.

- Working with the Public Health Aging Well and Living Well team there will be a reach out to the vulnerable population, who may be isolated and lonely and at risk of decompensation.

Table 1

Prepare for winter by:

- Sustaining current NHS staffing, beds and **capacity**, while taking advantage of the additional £3 billion NHS revenue funding for ongoing independent sector capacity, Nightingale hospitals, and support to quickly and safely discharge patients from NHS hospitals through to March 2021.

- Deliver a very significantly expanded seasonal **flu vaccination** programme for DHSC-determined priority groups, including providing easy access for all NHS staff promoting universal uptake. Mobilising delivery capability for the administration of a Covid19 vaccine if and when a vaccine becomes available.

- Expanding the **111 First** offer to provide low complexity urgent care without the need for an A&E attendance, ensuring those who need care can receive it in the right setting more quickly. This includes increasing the range of dispositions from 111 to local services, such as direct referrals to Same Day Emergency Care and specialty 'hot' clinics, as well as ensuring all Type 3 services are designated as Urgent Treatment Centres (UTCs). DHSC will shortly be releasing agreed **A&E capital** to help offset physical constraints associated with social distancing requirements in Emergency Departments.

- Systems should maximise the use of 'Hear and Treat' and 'See and Treat' pathways for 999 demand, to support a sustained reduction in the number of patients conveyed to Type 1 or 2 emergency departments.

- Continue to make full use of the NHS Volunteer Responders scheme in conjunction with the Royal Voluntary Society and the partnership with British Red Cross, Age UK and St. Johns Ambulance which is set to be renewed.

- Continuing to **work with local authorities**, given the critical dependency of our patients – particularly over winter - on resilient social care services. Ensure that those medically fit for discharge are not delayed from being able to go home as soon as it is safe for them to do so in line with DHSC/PHE policies

9. C&M Strategic KLOE Part 2.

Area	Key line of enquiry
Winter plans (demand)	• Have escalation plans been properly tested; what brokerage arrangements are in place? • Where are there problems in putting in place staff and estate availability? What is being done to address these issues? • Who takes performance oversight and what interventions can they deliver? • Acute/Community beds - Local care systems are under extreme pressure, viability of homes is an issue - what actions are being taken to address this? particularly as these beds will be crucial.
Winter plans (capacity)	• Are there detailed implementation plans in each system to deliver the initiatives? Are any likely to be delayed or at risk? • Management of long term conditions – lack of information as to planning for how to do this: who and what community services have been included? • Telehealth – expansion of the detail around this would have been beneficial, i.e. cost/service for care sector • Deflection of patients in to other parts of system following assessment of needs – what does that look like?
Winter plans (workforce)	• Where are the workforce issues, is recruitment likely to be successful? Is there any use of mutual aid or at least collaborative working to avoid poaching? Will mutual aid be across both health and social care?
Winter plans (Exit Flow)	• How will staff be supported to move towards a home first mindset and to avoid risk aversion? How will cultural change be delivered?
Winter plans (External Events)	• Communication plans – do they include social care sector to share vital messages?

Area	Key line of enquiry
Winter plans (demand)	• Have escalation plans been properly tested; what brokerage arrangements are in place? ✓ Escalation plans have been discussed and tested locally specifically in light of Covid and have been revised to reflect the current system needs. ✓ Brokerage arrangements are in line with the national Enhanced Discharge guidance and have been specifically strengthened in all areas and tested throughout the COVID period. SOP's, protocols and DOS have been updated to reflect these changes. • Where are there problems in putting in place staff and estate availability? What is being done to address these issues? ✓ Acute Trust Capital bids have been submitted to address service capacity and IPC regulations. Due to Covid restrictions and IPC requirements new and innovative ways of working have been tested and mobilised in all areas. ✓ The use of telephony, video conferencing and mobile technology has only helped with the restrictions. Staffing has and will remain a risk but organisations within the systems have supported priority areas through mutual aid and where appropriate redeployment of staff to areas of greatest need. Estate issues are being addressed locally and wherever possible the restoration and recovery phase3 plans are supporting winter planning requirements. Access to diagnostics is a concern particularly (AGP). ✓ The requirement to comply with enhanced personal protective equipment (PPE) and infection prevention and control measures in order to keep staff and patients safe inevitably impacts on the levels of patient activity and types of treatment that can be undertaken. Latest national guidance remains that following an aerosol generating procedure (AGP), which produces small airborne particles which may contain viruses such as COVID-19, there is a need to vacate the room for up to an hour, dependent upon the type of ventilation system in operation in each individual clinic, after the procedure to allow the aerosol droplets to settle and for the room to be then cleaned before the next patient is seen. ✓ Collaborative work taking place between CCGs, NWB and CSP; ✓ Children returning to school presents potential impact on Track and Trace system.

Area	Key line of enquiry
Winter plans (demand)	• Who takes performance oversight and what interventions can they deliver? ✓ The local system leaders take oversight of plans and in each area local performance is managed and reviewed as before Covid. With reset and recovery meetings picking up the phase 3 planning requirements. We have an established AED board, Urgent Care Oversight Group (UCOG) and now the newly formed Mid Mersey System management group, which supports the Mid Mersey sub system response to Winter planning, capacity management and flow. ✓ Individual organisation's have their local responsibilities specifically to deliver local intervention ✓ Providers are adhering to the attached Hospital Discharge Service: Policy and Operating Model document (page 47), which provides an overview of discharge decision making and escalation. • Acute/Community beds - Local care systems are under extreme pressure, viability of homes is an issue - what actions are being taken to address this? particularly as these beds will be crucial. ✓ Acute capacity established e.g. Bevan Court (56 – not all additional) in STHK and K25 (18) at WHHFT. ✓ Current occupancy levels in residential and care home settings is reported at 70% with both bed availability and opportunities for surge expansion. Spot purchasing and block arrangements are available as and when required and are captured with the winter plans locally. ✓ With home first and additional Dom Care the bed situation in Mid Mersey is stable and has taken into account the possible resurgence of COVID and additional pressures from Flu. ✓ Each authority has a care home resilience plan in place, and are undertaking regular risk analysis and actions to mitigate risks in this system

Area	Key line of enquiry
Winter plans (capacity)	• Are there detailed implementation plans in each system to deliver the initiatives? Are any likely to be delayed or at risk? ✓ Detailed plans are in place and the only likely risk to implementation is the impact of a resurgence of Covid and Winter Flu on workforce. ✓ Local Authorities have detailed plans around care home resilience, but there is a significant risk to the sector. • Management of long term conditions – lack of information as to planning for how to do this: who and what community services have been included? ✓ Local NHS community providers plus primary care (PCN's and federations) plus Local Authority Public Health teams and DAS's (plus Children's leads) have all been engaged in the planning and the design and implementation of the winter plans. ✓ There are specific schemes in place for the management of exacerbations of LTC particularly frailty 7 respiratory conditions. • Telehealth – expansion of the detail around this would have been beneficial, i.e. cost/service for care sector ✓ The enhanced care home sector with the support from the CCG's have increased connectivity and equipment to support virtual MDTs', ward rounds and advice and guidance. ✓ This has been funded through the health COVID easement monies and has not negatively impacted on the care sector. • Deflection of patients in to other parts of system following assessment of needs – what does that look like? ✓ For all deflection services currently in operation are detailed within the local winter plans. ✓ NHS111 fully operational in Warrington and St Helens roll out will be November.

Area	Key line of enquiry
Winter plans (workforce)	• Where are the workforce issues, is recruitment likely to be successful? Is there any use of mutual aid or at least collaborative working to avoid poaching? Will mutual aid be across both health and social care? ✓ Workforce issues are apparent in all health and care sectors but contingency plans have been evoked and plans have been put in place. Locally in Mid Mersey we established a workforce redeployment group that has currently been stood down but if necessary could be re-established. ✓ Mutual aid and local system support is agreed in principle and can be enabled if necessary. ✓ Local Authority mutual aid across care homes is in place, this will create a 'bubble' system.

Area	Key line of enquiry
Winter plans (Exit Flow)	• How will staff be supported to move towards a home first mindset and to avoid risk aversion? How will cultural change be delivered? ✓ The integrated discharge teams are already working on a home first model and have been doing so since March 2020. The enhanced discharge pathways and system reset plans have supported staff in managing the risks and are fully supported by the local system leaders. ✓ Trusted assessor arrangements are in place, enhanced discharge pathways are agreed between all system partners and regular strategic MDT's are carried out to identify any blockages and to improve flow. ✓ A discharge to assess philosophy is being adopted in line with the new Hospital Discharge Service: Policy and Operating Model. Initial assessments to transfer to a place of safety will be undertaken in hospital for those who no longer have a right to reside and assessment of long term need undertaken in the community; ✓ Discharge review has taken place, this has already been highlighted within winter plan.

Area	Key line of enquiry
Winter plans (External Events)	• Communication plans – do they include social care sector to share vital messages? The Winter Communications Plan was agreed and implemented across the Mid Mersey footprint for 19/20 was reviewed and evaluated in February 2020. The key outcomes and learnings had been shared with the AED board and will be incorporated into the planning process and activities for 20/21. Discussions are being held with NHS E/I and the CMHCP regarding a C&M approach to the winter communication plan. Weekly meetings are taking place with a view to the development of a C&M wide plan, with a single approach in terms of the call to action, campaign materials, key messages etc. Whilst this will be a C&M wide plan, each locality will retain the ability to flex the messages and approach to meet local need. The benefit of doing a C&M plan is to ensure consistency of messaging and increase outcomes due to the level of impact! which brings in all parts of health an Social Care including Public health, 3rd sector and the peoples voice.

APPENDIX 1

St Helens & Knowsley Winter Plan 2020/21

DRAFT 5

INTRODUCTION

The draft winter plan aims to answer a series of KLOES as set out by NHSE/I that clearly demonstrates how the health, social care and voluntary sector system partners within the St Helens & Knowsley Hospitals catchment area have planned for winter. The plan is informed by the Cheshire & Merseyside Cell capacity and demand modelling, local modelling assumptions, lessons learned from COVID including managing surge and also in the event of another COVID wave during winter. The plan summarises the key system risks and mitigating approaches across the partnership.

The plan builds upon initiatives and partnership working already in place or embedding in relation to discharge planning, admissions and attendance avoidance, including both local and national initiatives such as NHS 111 First.

System partners have developed this plan with the key aims of managing acute bed occupancy, nosocomial infections and community based infection rates for COVID-19. Phase 3 reset and recovery guidance in relation to elective recovery and capacity has also informed the capacity planning and risk assumptions.

In summary the plan covers:

1. Capacity and Demand, with a key focus upon bed capacity
2. Exit Flow
3. Hospital
4. Workforce
5. Risks and mitigation
6. System oversight and Governance
7. Appendices and external events

1. CAPACITY AND DEMAND.

How we are currently working to reduce avoidable admission and attendance and other environments to improve discharge flow:

- **NHS 111 First Implementation**

  St Helens & Knowsley; A project group has been established to oversee implementation of the NHS 111 First programme for St Helens & Knowsley. Partners are working with the Regional Team to assess state of readiness in preparation for the December 1st Go Live date (likely by 23rd November). Progress is attached within the initial assurance assessment (below). The plans will ensure opportunities for alternatives to A&E are maximised and enable increased out of hospital direct booking and referrals, including the key priority of direct booking into A&E and direct referrals to key specialities such as Frailty and Respiratory.

  111 First assurance template Mid Mersey

  Warrington & Halton Hospitals are in the first phase of NHS 111 First and due to go live on the 8th September. Learning from system partners will be taken on board as part of the St Helens & Knowsley implementation.

  One of the key aims from the change in public message and access is to demonstrate a 20% shift of existing unheralded attendances (self-referrers/walk ins) to ringing NHS 111 First. The overall outcome aim is then a reduction in unheralded attendances by 10%.

- **Hear & Treat /See & Treat**

  The Table below illustrates the See and Treat opportunities available to NWAS crews across Mid Mersey. A project group is established (with membership from NWAS and CCGs) to expand the scope of the St Helens admissions/attendance avoidance car and develop a STHK footprint Frailty Response Vehicle by October 2020. This will raise the S&T % across the footprint. During Covid the S&T CCG breakdowns have been unavailable but prior to Covid 19 the St Helens % was highest at 27%.

  Halton and Knowsley circa 24% in December 2019. It was identified through the collaborative breakthrough NWAS workshops that some ED footprints had a S&T rate of 34%. If this level of success was emulated across the STHK CCG footprint it would

result in a decrease of mean 18 ambulance attends per day. It was however noted that that socioeconomic and geographical factors play a part in this.

To support S&T maximisation, each CCG area has updated its section in the NWAS Clinical Handbook via the Blackpool team. Locally, rotation of NWAS crew members across the patch to include coverage on the Avoidance car has proved to be effective in encouraging more reticent paramedics to use the S&T potential available in the community.

S&T and Mental Health – North Mersey has access to 3 vehicles; the British transport police MH vehicle, NWAS MH vehicle and Merseyside police MH vehicle. There is no similar offer in Mid Mersey. NWAS operational Staff in the East Sector consider this to be a significant gap.

Due to unique commissioning arrangements in St Helens the GP OOH stop taking S&T requests from crews at 7am and OOH finishes at 8am but AVS is not available until 8:30am. There is a 90 min gap. The commissioners will address this with the provider by the end of September 2020 in readiness for Winter 20/21.

A session where the stakeholders discussed S&T in detail produced the following key themes that need addressing:

- Crew behaviours and confidence of paramedics to apply MTS fully are factors to variation in S&T rates per paramedic and it is recognised that change in culture/ practise from ‘scoop and run’ to S&T will take time to embed.
- Capacity is an issue – the S&T offer in the community is not ring-fenced to support paramedics only. It is an ‘add on’ to existing service and not part of the core service. In the majority of cases it is not commissioned and the provider is not contractually obliged to provide the service. In GP OOH the service is offered through an MOU with NWAS.
- Consistency of offer across Mid Mersey is a contributory factor – there are significant differences across the 3 CCGs especially with regard to UTC / WIC (convey non ED)
- Availability – 90 min gap weekdays mornings in St Helens.
- Availability - no dedicated MH vehicle in mid Mersey yet 3 in North Mersey

See & Treat in mid Mersey	AVS	MH	OOH GP	Frailty	Falls	Respiratory	WIC / UTC	Other
Halton **December 2019 S&T rate was 24%**	24/7 2 + PC24	NWB 24/7 Operation Emblem Street Triage	Halton Assessment Team Mid week 19.00-08.00 Weekends 6.45-22.00	Halton Integrated Frailty Service Mon-Fri 09.00-17.00	Integrated Assessment Team & Capacity and Demand Team	Resp car pilot 0700-2100 7 days	Widnes 08.00-20.00 Runcorn 08.00-09.00 (currently booking by phone)	CAS for 111 and S&T response for crews available 24/7
Knowsley **December 2019 S&T rate was 24%**	24/7 2+ PC24	NWB 24/7	As AVS	Aintree FAU direct access weekdays 9-4pm Frailty urgent response team 2 hr response	Falls service provided by NWB linked to Frailty service.	24/7 2 hour response 0800-2000, can be called overnight to review next day & Resp car pilot 0700-2100 7 days	2 WIC's planning to take direct booking and from 111 first	CAS for 111 and S&T response for crews available 24/7
St Helens **December 2019 S&T rate was 27%**	8.30am – 6:30pm ROTA	NWB 24/7	6:30pm – 7am weekdays for Rota (25 practices) 6:30pm – 8am	Direct line for NWAS crews 9am -5pm weekdays Patient criteria - older people living with frailty Typical responses will include either • Tel advice by Frailty Nurse /	St Helens NWAS avoidance car operates 7-7 weekdays	Resp car pilot 0700-2100 7 days	Protocol agreed between NWAS and UTC re MTS amber outcomes to be conveyed.	CAS for 111 and S&T response for crews available 24/7 at BH and weekends with gap of 90 mins for S&T on weekdays.

			weekdays for PC24 (9 practices)	Consultant to paramedic OR • visit within 2 hours • Agreement to meet crew in Whiston E.D				Alert meds mgmt. if pts are stockpiling Contact Cares for pts who need minor clinical support and / or social care input

Current Mid Mersey Performance around S&T and H&T is not available due to the pandemic.

Respiratory car – the respiratory car is at an advantage as the clinician can do blood gases and prescribe.

It is worth noting that the A&E Board prioritised Frailty, Respiratory and OOH (S&T) for system review to enable understanding and discussions of variance in outcomes across the boroughs and sharing learning in relation to models that could be influencing different outcomes in the area. The gap analysis and assessment has continued throughout COVID and will be reviewed presented to the A&E Board when it reconvenes. The aim is to reduce variation and standardise approaches where it makes sense to do so.

- **UTCs**

St Helens Urgent Treatment Centre

The St Helens UTC had enabled Direct Booking from 111 from December 2018 (May 2020 5 slots available per day available during shift handover period and also GP on site). The utilisation of the slots improved during 2019 following some analysis of 111 daily traffic consequently the utilisation rate ranges from 50 – 100% . As part of the NHS 111 First implementation, the volume, times and codes applicable to the appointments are being reviewed with on the onsite team and the Liverpool CCG DOS team pre winter 2020. The St Helens Codesets were modified in August 2020 as a response to some inappropriate 111 referrals.

The UTC in Widnes (Halton – STHK facing) will be set up to take DBs ahead of winter. There is a conscious effort between the provider and commissioners that the Widnes and St Helens UTCs mirror each other as much as possible to ensure some level of standardisation for NWAS conveyances and 111 outcomes. The UTCs in St Helens and Widnes (and WIC in Huyton to certain extent) need the same protocols and criteria to support crews to avoid ED conveyance or advise self-care and this forms part of the phase 2 UTC plans. From July 2020 the ST Helens UTC has an ultrasound Scan on site with radiographer, this is primarily to support the implementation of a community DVT diagnostic service at the UTC and to reduce unnecessary attends at the Trust GP assessment unit.

In addition to the appointments available to 111 call handlers there is an agreement in place between STHK ED and the St Helens UTC to make 2 appointments available the next day for individuals who turn up during the evening at ED with minor injuries or illness (weekdays only for now). This commenced in Jan 2020 and it is evident that the patient is much more compliant to leaving ED and attending the UTC the following day if they have an appointment. This is something that can be mirrored in other WICS / UTCs locally.

Halton Urgent Treatment Centres

Halton UTCs are now both fully UTC accredited and will achieve all of the 27 core standards and there will be 5 slots available per day for 111 direct booking. The aim of the new model of care is to ensure the service is integrated into primary and community care to offer patients with low acuity, minor injuries and illness, same day access to urgent care services. This new model aims to decrease Halton A&E activity for the two acute trusts by up to 20% per year. This will ensure patients are seen in the right place, at the right time by the right health care professional.

Knowsley UTC/WIC

Knowsley have 3 Walk in Centres and 2 of which are in the areas, geographically which generate the footfall to Whiston Hospital. The Walk in Centre due to COVID -19 has currently adopted a booking approach following telephone triage. The CCG will, as part of the implementation of 111 first, ensure there are direct booking slots for the centres to deflect unheralded patients from the ED. This is initially planned at 5 slots per day.

The UTC's original commitment was to develop the 'end state' model and have this agreed by Aug 2020, this has been clearly impacted by COVID response so progress has been delayed. All WiCs remain open (operating on total triage basis in line with community services COVID S.O.P) and outline intention remains that they will not be subject to future designation as UTCs, instead transitioning to primary care access hubs in line with PLACE plans being developed.

- **IUC**

The IUC infrastructure is to be considered as part of the NHS 111 First Implementation Group in St Helens. Direct Booking into in-hours primary care is in place, including OOH primary care and the UTC. The DoS profile for each CCG area will be reviewed to optimise any opportunities to signpost or DB the public into appropriate clinical settings.

- **CAS (Clinical Assessment Service)**

Each CCG area has 24/7 CAS capability (that is accessed via 111) within AVS and Out Of Hours primary care . A pan Mersey procurement for OOH and 24/7 CAS took place in 2019/20 with the successful bidder commencing the service in April 2021 . The CAS resource for this winter will be in line with the CAS resource in winter 2019 /20 . However, additional CAS capacity is currently provided by the national Covid CAS as part of the online 111 offer. CAS capacity locally is also under consideration as part of NHS 111 First implementation.

- **SDEC/Direct access pathways**

An SDEC Steering Group is well established across St Helens & Knowsley. Key priorities in year have focussed upon:

  - Opportunities to enable enhanced community pathways to reduce referrals into the Trust
  - Acute SDEC
  - SDEC CQUIN implementation.

- UTI analysis and review to inform quality improvements
- Flu and pneumonia review audit to support quality improvements
- Analysis of variation in LoS across Merseyside Trusts to inform local priorities for redesign,
- Frailty and Respiratory SDEC and direct access
- Mental Health admissions audit to inform priority improvements

In summary the key priorities continue to be:

- Implementation of community DVT pathway for winter making use of UTC and primary care resource, DVTs are the highest reason for GP referrals to the assessment unit
- IV therapy – ongoing review of ESD and admissions avoidance opportunities. Medicines access has been reviewed in the community to enable direct access to the teams ensuring adequate supplies where access issues were raised.
- Hypertension pathway
- Direct access frailty and increase in SDEC frailty
- Respiratory admissions avoidance team in A&E ongoing – review direct access pathway to the service as part of NHS 111 First
- GP streaming pathway
- Mental Health 24/7 and admissions avoidance

- **Mental Health**

Halton:

Earlier this year, NHS Halton CCG commissioned North West Boroughs to establish and run a 24-hour Mental Health Crisis Line. The purpose of establishing the service was to ensure that the Halton population had access to crisis support 24/7 during COVID-19.

The service offers telephone support to both adults and children (no age restriction) and is staffed by North West Borough Mental Health Practitioners who are able to assess people over the phone and if necessary, signpost them onto other services for support. The crisis line can also make direct referrals into other mental health services.

The service will continue to operate and provide support during Winter 2020-21 and will support admissions avoidance.

St Helens:

St Helens also commissions aa 24 hour Mental Health Crisis Line and in addition has recently commissioned the quell counselling service for age 26 upwards.

Knowsley:

NHS Knowsley commissions 24 hour Mental Health Crisis Lines with both of our Mental Health Trusts – NWBH and Mersey Care. While the purpose of bringing forward the implementation of this service by 12 months was to ensure that the Knowsley population will have access to crisis support during the COVID 19 period, the service will continue as we move out of this period. This is part of the CCG's commitment to implementing the Mental Health Long Term Plan with the aim of providing alternative support for people experiencing a mental health crisis and supports the wider goal of admission avoidance.

Medicines Management:

Community pharmacy continues to play an active role in prevention and attendance avoidance at practices and A&E across boroughs, below summarises the range of services in place:

- **Improved Access**

  These services support improved access to primary care and avoidance of unnecessary admissions where treatment could safely be provided within the community. Two of the services also support the self-care agenda which is vital to ensuring best use of NHS resources, particularly during the winter period.

- **Minor Ailments Service**

  This scheme is operated across the majority of pharmacies and so there is wide geographical coverage. Patients can self-refer to any pharmacy delivering the service and request to be treated under this scheme. The scheme covers specific minor ailments and illnesses and medication can be provided from an agreed local formulary of over the counter medicines free of charge if patients are exempt from NHS prescription charges. The scheme will be jointly reviewed with neighbouring CCGs, St Helens and Knowsley, during Autumn 2020 to ensure it is in line with NHSE guidance and the local self-care work programme. At this time there is a reciprocal agreement across Knowsley and St Helens so that Halton patients can be

treated under the scheme in any of these areas. This supports and encourages patient to seek advice and support from the right place first time and so improving access within the system. We all have a reciprocal agreement

- **Avoidance of Admissions (IV Antibiotics access)**
  This ensures rapid treatment in the community without the need for a hospital admission.

- **Avoidance of Admissions (Access to Palliative Care Medicines)**.

  A number of pharmacies stock an agreed list of end of life medication to improve access to these vital medications in a timely manner at a very critical time for patients and carers and ultimately will avoid patients having to be admitted to a hospice or secondary care unnecessarily to obtain the correct medication. During COVID the CCG commissioned two of these pharmacies to provide an urgent one-hour delivery service for suspected or confirmed COVID patients to manage end of life symptoms, this service will be continually reviewed as we go into Winter to assess its ongoing suitability and ensure it is fit for purpose. All palliative pharmacies in Halton have also been provided with a mobile phone to ensure timely communication between prescribers and dispensers and to support resolution of issues.

- **Minor Eye Conditions Service (MECS) – Pharmacy Support Service**

  In Halton and St Helens, patients seen by local opticians, as part of this service, who require medication as a result can be supplied this from a pharmacy free of charge if they do not pay for their prescriptions

- **Improved Medicines Optimisation to reduce non-elective admissions**

  In line with the national medicines optimisation agenda the CCG Medicines Management Pharmacists and Technicians focus is on high priority areas that can support a reduction in unnecessary admissions and the out of hospital agenda. As we go into winter, priorities will focus around respiratory, cardiovascular and antimicrobial resistance as well as refocussing on safe use of opioids for chronic pain. Structured medication reviews will continue for complex patients with long term conditions and specifically for care home residents. The reduction in polypharmacy and de-prescribing in appropriate patients will support a reduction in unnecessary admissions due to adverse effects related to medication and will also support more effective use of NHS resources.

- **Community services**

  Both North West Boroughs and STHK have reviewed their community and mental health services and have considered which services could be stepped down if staff are required to cope with a surge. They have assessed their services in to High, Medium and Low priority and will be considering which services each staff type could support in the event of a Covid surge.

  We will link in to the out of hospital cell for consistency in planning for the impact on community and mental health services in the event of a surge of cases.

  Telemedicine:

  The Merseycare telehealth model has been considered at a St Helens level to support the management of patients with Heart Failure and COPD living in the community. A full Mersey approach to adopt the merseycare infrastructure was suggested by the HCP and a business case has been submitted to St Helens CCG to assess viability of 300 St Helens patients being monitored in this way. A local proposal was put to the exec team in the CCG in July 2020. The St Helens community teams are selecting the patients currently and have worked in partnership with colleagues in Liverpool to further understand how this can be used most effectively to maximise resources and support shielding patients/admissions avoidance. This approach further supports learning from COVID in use of telemedicine where outcomes are clearly demonstrated.

  Community nursing:

  Community Nursing Teams continue to support delivery of the enhanced discharge pathway guidelines and explore telehealth models across all providers.

  Specialist teams across respiratory, cardiac and frailty services offer a 2 hour crisis/urgent response across boroughs supporting admissions and attendance avoidance for patients.

- **Primary Care;** please refer to Appendix 1

- **Pro-active care / risk stratification**

St Helens:

Following a successful pilot across 6 practices demonstrating reductions in use of both primary care and attendances / admissions to hospital, a business case was developed to support roll out across all practices. Should this be successful, the CCG will continue to work in partnership with the LA and practices to phase in wider practices throughout winter. The model uses the Welsh predictive tool for risk stratification to identify high risk patients and creation of a MDT plan to wrap around each patient.

The outcomes monitored are:

- Reduce avoidable hospital A&E attendances and resultant non-elective admissions
- Reduce relevant Ambulatory Care Sensitive Condition A&E attendances and resultant non-elective admissions (NELs)
- Reduce cost associated with above
- Increase number of patients feeling able to manage their long term condition/their heath
- Increase ability of patients to self-care
- Review the care of 100% of target cohort

Halton:

The High Intensity User (HIU) service offers a robust way of reducing high intensity user activity to A&E and aims to reduce the number of non-elective admissions and GP contacts as a natural by-product.

The aim of the service is to catch the “frequent attenders” at A&E and to drive a case management approach that prevents this cohort of patients from returning time after time to A&E time, as they can be better managed elsewhere.

In addition, the HIU service will aim to:

- Work with multi-agency and existing professional services to negotiate a new and innovative way forward
- Reduce the impact on unscheduled care services and the wider health economy resulting from reduced 999 calls, which otherwise would have attended A&E and possible admission or a call to the police

- Actively seek safe solutions for this cohort through community and service connections and the voluntary sector in order to support them to flourish.

The Halton HIU Service launched in July 2019. However, due to data sharing issues the service didn't become fully operational until October 2019. Discussions with St Helens & Knowsley Hospital are currently ongoing to increase the number of referrals into the service, especially ahead of winter.

Due to COVID-19, face-to-face client interaction hasn't been possible, Therefore, the HIU lead has mainly communicated with patients by either phone or video calls, which hasn't been ideal and has since led to some HIU patients relapsing. Nationally, this has been recognised, as an issue as the success of the HIU programme relies on that person-centred 1-1 approach.

Knowsley:

Risk stratification tools are in place (via Aristotle), it is being utilised to support care home work and this is also being assessed for use in flu planning to (e.g. what %age of patients are in high risk groups so would be called into practices for LTC reviews and provide vaccination as part of the appointment). For if low risk there is potential for remote LTC reviews and use of the drive through/walk through facility).

- **Infection prevention and control - community**

Influenza (please also refer to Appendix 5 for Borough plans)

The Infection control teams will provide care home "Preparation for influenza" training. PHE Care home Influenza resource pack will be distributed and monitored. Influenza outbreaks will be monitored by the quality team. This will include:

- Arrangement of swabbing to aid diagnosis,
- Advice to the care home on infection control measures to be implemented. Liaison with PHE re outbreak management.
- Facilitate antiviral medications via the agreed antiviral pathway.
- Encouraging and monitoring uptake of influenza vaccine in residents and staff.
- Liaison with Communications to advice on information to be sent out.
  Update the Infection control web pages to ensure that there is current information for the 2020-2021 flu season.
- All Infection control team members are trained and updated in Immunisation and are able to vaccinate in emergency situations.
- Working as part of the St Helens Flu Planning team.

Covid19 management

The Specialist teams provide infection control advice to partners in the CCGs and the Local authorities. This includes;

- Information regarding PPE, Isolation, transfer queries, hospital discharge queries.
- Advice and work with appropriate teams to introduce any new initiatives that are recommended from Nationally, e.g. Point of care testing in care homes for Covid19 and Influenza A/B.
- Working closely with the care home staff to advice regarding changes in guidance for management of Covid19.
- Facilitate referrals for Covid19 testing for community patients in their own homes.
- Management of Outbreaks of Covid19
- Working with the care homes to ensure prompt identification of suspected and confirmed outbreak of Covid19.
- Ensuring all infection control precautions are in place during outbreak.
- Cascading information as required regarding outbreaks of Covid19 to all partners in the CCG and the local authority.
- Liaise with PHE regarding suspected/confirmed outbreaks of Covid19.
- Supporting the care home staff with whole care home testing of residents and staff and ensuring actions are taken when positive results are obtained.

NHS & Social care staff coronavirus testing

Borough strategies include testing for patients, NHS staff, care home residents and staff and testing for the general public. The aim of the testing plan is to support the management of COVID in the boroughs, to reduce as far as possible outbreaks, and to keep critical staff in work in health and care wherever possible. The strategy sets out the plan for:

- Care home testing of residents and staff, both routine testing and symptomatic testing. This aims to support care homes in keeping people safe in the homes and supports our care home sector, who are a vital part of the health and care system in the borough, to operate safely over winter;
- Testing of patients in hospitals, to keep hospitals as safe as possible for patients and to minimise the impact of Covid as far as possible;
- Testing of NHS staff, both routine and symptomatic testing, to ensure out health workers have regular access to testing as far as possible;
- How we support the most vulnerable people in our community by ensuring access to testing;
- How we will escalate testing in the event of increasing numbers of cases or local outbreaks.

Local drivers of demand:

St Helens & Knowsley Teaching Hospitals (All CCGs) | April 2019 - June 2020 | All Referrals A&E Attendances by Top 10 Diagnosis

Source: SUS

All-Referrals

	Financial Year
Top 10 Diagnosis - A&E Attendances	**2019/20**
Diagnosis not classifiable	13,936
Respiratory conditions	10,998
Nothing abnormal detected	10,895
Gastrointestinal conditions	9,427
Cardiac conditions	6,719
Laceration	6,255
Dislocation/fracture/joint injury/amputation	6,051
Contusion/abrasion	5,619
Sprain/ligament injury	5,256
Urological conditions (including cystitis)	5,164
Grand Total	**80,320**

All-Referrals

	Financial Year
Top 10 Diagnosis - A&E Attendances	**2020/21**
Nothing abnormal detected	3,103
Gastrointestinal conditions	2,129
Diagnosis not classifiable	1,946
Laceration	1,542
Cardiac conditions	1,536
Dislocation/fracture/joint injury/amputation	1,444
Respiratory conditions	1,276
Urological conditions (including cystitis)	1,198
Unknown	1,183
Contusion/abrasion	1,136
Grand Total	**16,493**

The latest A&E information on attendances further reaffirms the system approach to prioritisation of frailty and respiratory pathways and models of care. In addition, as part of the Think NHS 111 First approach, Respiratory, Gastro, minor injuries, 'nothing abnormal detected' and urological conditions are being prioritised for 'deep dive' analysis to inform out of hospital pathway improvements and 'streaming out' from A&E pathways as part of the integrated NHS 111 First plans, including targeted communications.

Admissions data:

St Helens & Knowsley Teaching Hospitals (All CCGs) | April 2019 - June 2020 | A&E Admissions by Top 10 Diagnosis

Source: SUS

All-Referrals

	Financial Year
Top 10 Diagnosis - A&E Admissions	**2019/20**
Chest pain, unspecified	882
Lobar pneumonia, unspecified	1,499
Maternal care for other specified fetal problems	1,767
Pain localized to other parts of lower abdomen	1,038
Pneumonia, unspecified	987
Precordial pain	856
Sepsis, unspecified	1,357
Singleton, born in hospital	2,439
Supervision of other normal pregnancy	955
Urinary tract infection, site not specified	942
Grand Total	**12,722**

Ongoing review of admissions data and also GP referrals has fed the SDEC project priorities in-year and a series of clinical audits to inform quality improvements across the system e.g. UTIs and pneumonia. Work continues with system partners regarding out of hospital pathways and SDEC as we head into winter.

How we expect capacity and demand to look this winter compared to previous winters:

- **Acute**

The Cheshire & Merseyside Hospital Cell is charged with building a robust acute capacity management plan. Four scenarios of future Covid demand have currently been modelled based on the Cheshire and Merseyside population and historic Covid activity:

- **Slow decline of Covid** over the coming months; no surge capacity required, normal bed capacity maintained, 90% occupancy, elective activity restarts
- **Second peak** over coming months; shift to surge capacity where Covid demand exceeds CC available capacity, 90% occupancy. Including loss of theatres and G&A beds
- Many **smaller waves of Covid**; 90% occupancy, short term shift to surge as required
- **Second smaller peak** over coming months; shift to surge capacity where Covid demand exceeds CC available capacity, 90% occupancy. Including loss of theatres and G&A beds

Summary:

- A slow decline of Covid activity allows elective activity to return to 40-50% of historic levels in most trusts. It is anticipated this would be higher at SHK due to the 'cold-site' arrangements.
- There is no overall shortfall of beds across the system, although at times in the period there are insufficient beds for both non-elective and elective activity in some trusts, leading to the shortfall lines/bars.
- **A second peak** falling in winter will lead to a significant shortfall – approaching 50% - of NEL beds unless this demand is substantially reduced or directed to other services.
- The difference between phase 2 surge and full surge is minimal on elective activity. This is due to G&A beds constraining elective activity even though theatres remain available in the phase 2 surge model.
- The 40-50% of remaining elective activity is due to specialist trust capacity and is not likely to continue given the need to absorb NEL demand from other hospitals.
- **For a second peak** falling in winter will there are sufficient Covid CC beds under Phase 2 levels but <u>not</u> under full surge levels.

- There is a significant shortfall of NEL CC beds which would likely impact the ability of the specialist trusts to continue elective surgery.
- Under full surge there are sufficient beds across the system to absorb all activity providing patients can be transferred between sites.
- **A smaller peak** falling pre-winter still has a significant impact on the bed availability for elective surgery resulting in most non-specialist trusts not able to continue elective programmes outside of cold sites.
- There is a shortfall of NEL beds which will further diminish the ability of trusts to continue elective activity.
- **With a smaller peak** the system should be able to cope within Phase 2 critical care levels.
- The shortfall of non-elective beds will likely further diminish the elective programmes, particularly in specialist trusts.

This plan is aiming to demonstrate the whole system approach to capacity planning, demand management and surge as outlined within our current approaches outlined earlier in the plan, such as NHS 111 first and out of hospital approaches and the sub-acute and surge capacity and system governance that follows below.

- **Sub-acute**

The Cheshire & Merseyside Out of Hospital Cell as set out in the mandate from NHSE/I is charged with ensuring that adequate capacity is available in out of hospital settings and to oversee the management of the hospital discharge process to achieve targets set.

Despite the lack of expected demand for additional non acute beds, the modelling undertaken for the phase 3 capacity plan indicates that the C&M system would need up to 1543 OOH beds to manage surge demand (Covid and Winter). This, coupled with instructions from NHSEI, has led to the development by the Cell of its plan for up to 300 intensive rehabilitation (Seacole) beds for Cheshire and Merseyside. The Mid Mersey proportion of this is estimated to be 120.

Despite the NHSE planning requirement, it is reported to be unlikely that funding will be made available for the Seacole beds. The C&M modelling is still underway and has not concluded, added to this is the variation across areas in specific bed breakdown across the patch. Prior to the Seacole aspirations, the Mid Mersey system already had in train varying plans for additional bed capacity based upon previous local analysis and VENN capacity and demand analysis. SHK Trust have commissioned a 52 bedded modular ward to improve the frailty offer and admissions avoidance capacity, this also includes an additional 12 assessment areas. In addition, ward 1a

is being used as part of the Trust contingency (32 beds) from the Frailty ward move to Bevan Court as outlined below, this will be resource dependent. Within St Helens Borough Council, there is potentially 59 additional care home beds for COVID surge planning as part of winter and discussions are underway with this proposal. This is in addition to the expected redeployment and flexible use of existing sub-acute and intermediate care beds as follows:

- **Mid Mersey bed base (St Helens/Knowsley/Halton):**

The core function of the current sub-acute bed base is summarised in table 1. The Table provides an overview of core IMC capacity and sub-acute capacity and capability to support COVID + patients and surge, as part of system flow and bed management from existing plans.

Table 1 winter sub-acute capacity

Name of unit	IMC bed or transitional (GTG AW other)	Location	Total beds on site	Total beds available for step down	Max number of c19 positive at any one time	Does it take GTG patients AW POC or placement - non covid	Bed occupancy rate % Q1 20/21 and 19/20	Has unit been used for P3 covid+ patients for 14 days to date	Max number of beds ring-fenced for covid - July 2019 onwards
Duffy	IMC	St Helens hospital	28 (2 ring-fenced for day surgery cases)	26	0	Yes as determined by gatekeepers to support surge	95% 19/20 75% Q1 20/21 (improved Q1 from previous year).	no - cold site	0 Cold Site
Seddon	Neuro rehab	St Helens hospital	20	20 (neuro rehab patients take priority over IMC)	0	No – TBC as part of surge plan with Network.	92% mean 19/20 75% Q1 20/21	no - cold site	0 – cold site
Oakmeadow	IMC	Halton	29	29	debbie Coburn to check	No - strictly IMC	TBC	no - strictly IMC	none
B1	IMC	Halton	22	4	4	No - strictly IMC	TBC	no - strictly IMC	4

Brookfield	both	St Helens	30	29	12	yes can be enacted to support surge	19/20 mean 53% Q1 20/21 25%	yes	18
Newton	IMC	St Helens Newton le Willows	30	24	depends on other factors such as O2 use , acuity and staffing	Takes GTG P3 positive. If necessary can take GTG AW POC but there are other places for this.	TBC	yes - only hot site suitable for NH patients	C specify number as depends on levels of acuity on unit, if on O2 and other factors .
St Barts	IMC	Knowsley	19	19	0	No - due to the multiagency admission process it is difficult to admit patients who are not true intermediate care. Anecdotally those with social or behavioural problems are not considered to be suitable candidates.	80% general year round occupancy	no - strictly IMC	0
Appleby Court	IMC	Knowsley - North Mersey	4	4	0	as St Barts	TBC	No - strictly IMC. Long term residents on site need	0

								to be considered.	
Bevan court 2 (new development)	Frailty/Short stay / GTG	Whiston	52 beds and 12 assessment (frailty unit - 22 IP, 12 assessment and 30 non-acute IP).	30 non acute for both admissions avoidance and step down.	TBC	Yes	N/A	N/A	tbd
TOTAL			234 (Inc 12 AX)	Will vary depending on flow.	16				22

- **Bed utilisation trends**

The system has experienced a reduction in utilisation of the IMC/sub-acute capacity during the coronavirus compared to previous levels. Insight gained, reports that the cause is multi-factorial, due to the availability of community beds, domiciliary care capacity and general position generated through reported additional family support in place from agile working arrangements, thus resulting in less displacement to facilities as interim measures to manage bed flow. This is in addition to the enhanced discharge pathways approach has impacted upon improved flow across most units. It is however expected that demand will / may resume to normal or near normal levels and therefore the following system plans are in place to address including the escalation governance arrangements.

- **COVID testing policy – discharge**

The current agreed policy is that all patients will be tested prior to discharge from IP. Should a care home not be able to safely receive the patient due to other factors in the home such as an outbreak or inability to ensure social distancing, then alternative interim solutions will be sought via sub-acute capacity and community bed capacity.

- **Surge plan – sub acute Beds**

Newton and Brookfield units (BF St Helens only) have flexibility to support both COVID + patients and also short term transitional to support general flow in terms of capability to flex existing bed use to manage surge. This proved successful during COVID and will be enacted through existing discharge governance and operations in the event of further surge / COVID.

Seddon Suite is a neurorehabilitation unit. Seddon beds could be utilised for Surge capacity should a second significant peak occur but this would be in agreement with the Network and Hospital Cell. (Non-COVID) for general intermediate care or transitional capacity from rebasing of the existing bed base as seen during COVID. This would be considered as part of the local escalation governance approach in terms of system pressures.

Bevan Court is a significant development on the Whiston Hospital site, which will offer a total of 52 beds and 12 assessment areas, this has involved the relocation and enhancement of the frailty offer and capacity, SDEC and also the capability to 'step-down' patients who do not have right to reside and awaiting community support. This creates capacity of 52 IP beds and 12 assessment spaces. The reconfiguration also freed up much needed bed capacity on the hospital site to support discharge flow on the previous 1a frailty unit of 30 beds which can be used as part of winter contingency planning. Overall, the implementation of the new frailty assessment unit, will include 22 inpatient beds and 12 acute assessment spaces, collocated with a 30 bedded non-acute inpatient ward, this will support a reduction in bed occupancy and improved flow of older patients away from the Emergency Department (ED) and admission units. The proximity to the ED will allow for pull of patients into the frailty unit for same day emergency care (SDEC), assessment for acute inpatient admission or short stay admission into the non-acute ward. This model of care will result in timely flow of patients from the ED and acute medical units, moving patients that normally stream through the acute medical take to appropriately skilled staff, providing them with an elevated standard of care in the process.

The frailty practitioners and consultants in ED, along with the therapy team who work in all areas, will identify and pull people from ED, creating flow and timely assessment by the multi-disciplinary team. This will also allow appropriate direct access to the clinicians/service and facilitate reliable handover reducing duplication often seen in the assessment process.

The increase in ambulatory capacity will allow a larger group of our older population to be transferred quickly from ED, to a more appropriate and comfortable environment and will free up capacity in the ED, which in turn will reduce overcrowding and support compliance with social distancing.

The new unit will also allow for planned assessments stepped up from the community frailty services for St. Helens, Knowsley and Halton, avoiding ED attendance without compromising standards.

With regard to the non-acute unit, the intention is to utilise this capacity for the bulk of patients who enter the medical admission system with little or no acute medical need, but cannot be immediately discharged due to their need for ongoing support such as POC, rehabilitation or transitional placement etc. There are also those reviewed via the SDEC stream who require a short stay admission but not intensive support, who could be accommodated within this bed base, which in turn would support the respective community frailty teams in Knowsley, Halton and St. Helens.

Further development of this model could see a wholescale restructure in outpatients for DMOP. Traditional outpatients could be replaced by telephone/tele-med follow ups, with rapid access in ambulatory or community review by the respective teams replacing 'new' outpatient appointments. For example, frailty or falls clinics would be better accommodated in the unit where they can be seen by an MDT for comprehensive assessment, rather than the current traditional outpatient set up. Consultant clinic time would then be fluid across the week for planned urgent review in the unit.

Local authorities – plans including surge approach

St Helens:

- **Contact Cares (St Helens integrated SPA) ED social work function**; The service is currently undergoing a restructure that will see a 7 day a week 8.00am to 10.00pm service in time for this winter. This includes an increase of approximately 39% in the social care hours allocated to this function. The working pattern will mirror that of the Contact Cares Crisis Response function providing further flexibility to move staff resource to follow demand around both avoid admission pathways and to support the increase in ambulatory care in the ED department through initiatives like the Bevan Unit.

  Both the increase in resource, achieved through the re-designation of posts, and the restructured working patterns will enable more efficient support of discharge pathways at times of high demand.

  This initiative should contribute to reduced attendances/ admissions, readmissions and bed days.

- **Contact Cares Reablement Restructure**; Currently undergoing a restructure that centres around a change in working patterns and uplifts all staff to the role of Intermediate Care Support Worker, this will enable a more flexible, responsive service with all staff being able to deliver on non-complex hospital discharges around those awaiting care packages and therapy led programmes that have a rehabilitative focus. With the new working patterns anticipated to commence on the 14th September, recruitment to any vacancies that remain post restructure should see this embedded for late October/ early November with

increasing improvements in reduced length of stay anticipated throughout 20/21. This resource will also contribute to avoid admission through its ability to support primary care and locality MDTs in maintaining people at home.

- **Trusted Assessor;** Now assessing for all but the more specialist homes in St Helens, 24 in total.

- **Contact Cares Test & Trace;**The Test & Trace functions of Contact Cares are currently being increased to include Contact Tracers and an Assistant Manager (Test & Trace). This will provide an integrated link with Public Health to enable shared learning and resources around those who need to self-isolate etc. Inclusion in the Contact Cares Front Door will ensure prompt alerts to local outbreaks so that Contact Cares can assist the system in responding quickly to reduce risk wherever possible.

- **DNLO/ Rapid Discharge Function;** Since winter 19/20 these functions have become part of the Contact Cares Front Door and indications are that this has improved the quality of information at discharge enabling more efficient discharge and reduced likelihood of readmission amongst this cohort of patients.

- **Agile Working;** The Covid 19 pandemic has accelerated the local authority's agile working plans and so we have very quickly rolled out technology that facilitates this to much higher numbers of staff and to a much higher specification to that previously available. This has increased efficiency and given us a higher level of resilience in terms of being able to deliver functions remotely when required, including in adverse weather conditions.

Nursing Homes and Care Homes:

The demand for bed-based provision has reduced considerably since the start of the pandemic. Prior to COVID-19 occupancy levels across all bed types in the borough of St Helens was regularly between 95% and 97%. Since the outbreak of the virus occupancy levels dropped to approximately 80% and have remained at this level for the last 13 weeks. On 07 August, there were 230 empty care home beds in the borough, of which 156 were available. These were 35 residential beds, 42 residential with dementia beds, 58 nursing beds and 21 nursing with dementia beds. The remaining 74 were unavailable, 46 of these beds were unavailable due to 2 closed wings in a care home that is in the process of being sold and 28 due to an outbreak of COVID-19 in 2 separate care homes. The care home sector is aligned to trusted assessor model for hospital discharge.

- **Surge Plan**

Whilst there are more beds than we have seen going in to winter in previous years, we will have to manage potential outbreak situations in care homes throughout the winter period, and this could mean beds become unavailable at short notice and this could change on a regular basis. We are working with care homes on an ongoing basis to support them throughout the pandemic to minimise the impact on their residents and bed availability.

The care home described above which is currently in the process of being sold and which has 2 empty wings could potentially be opened for surge capacity, for either Covid or non Covid cases. In addition, there is a respite service in St Helens that is currently closed to admissions and seeking to diversify its business model in the short/medium term. We are working with these homes on how quickly they can be mobilised. In addition to the 156 available beds, this gives surge capacity of up to 59 beds.

Domiciliary Care

The demand for domiciliary care provision has also reduced considerably since the start of the pandemic. It is reflective of people wishing to reduce the footfall through their household and making alternative arrangements to be supported by family members, friends and neighbours. Following the peak of the pandemic demand has begun to rise slightly. However, there remains plenty of capacity in the market with care packages being picked up swiftly.

The current process for allocating care packages is to initially offer them to tier 1 providers and in the event of tier 1 providers not being able to accommodate a care package then it is offered to tier 2 providers. If there is no response from either tier 1 or tier 2, then it is offered again to both tiers until the package of care can be accommodated by a provider. Currently the majority of care packages are being quickly accepted by tier 1 indicating ample capacity in the current market. There have been a few exceptions that needed to be sent to tier 2, were they have accommodated immediately.

This is an unusual position and we have previously kept a log of packages that have taken longer than a week to procure and have been round the system multiple times e.g.

- 21st August 2018 18 packages had been waiting more than 10 days.
- 11th December 2018 it was 34
- 15th August 2019 it was 5
- 19th December 2019 it was 7

Throughout the Covid period there have been no delayed packages of domiciliary care. In the event of surge in demand we anticipate meeting this demand by a combination of existing capacity in tier 1 and by utilising tier 2 providers.

Knowsley

Nursing and Residential homes:

The CCG and LA continue to work closely to identify and utilise capacity where available particularly for EMI patients, live bed tacking information is available which will help support any demand and capacity requirements for the market.

Halton:

The bed based service remains in place where home is not possible with a dedicated MDT approach to improve function and continue rehab at home. This model has been used throughout the pandemic successfully reducing length of stay and therefore increasing bed based capacity. Care homes are currently running at a 17.5% vacancy rate.

Social Care:

Social work team remain operational in the community and supporting hospital discharge. Care home sector is aligned to trusted assessor model for hospital discharge. The care home sector will be supported to manage current and ongoing COVID situation. An additional block purchased 500 hours of domiciliary care commenced February 2020 and will continue through winter. This has successfully managed flow both out of hospital and bed based services.

The approach is to maintain an average LoS between 14 and 21 days during winter in short term bed bases which will really impact on available capacity. The role that community services (Reablement, domiciliary care, care homes, community health services) have with home first and the enhanced discharge pathways is key to this. Daily board rounds and review within IC services in relation to discharge and movement on to home / long term service has resulted in significant reduced LoS and therefore increased capacity. This approach will continue.

- **Surge Plan - Mutual aid approaches**

In advance of winter, the Mid Mersey system flow group has developed a draft MOU in support of mutual aid approaches. This will be subject to 'testing' across known areas of challenged capacity in advance of winter to inform operational escalation and implementation of the MOU.

- **Restoration and recovery of elective work**

The phase 3 reset and recovery guidance is very clear in the expectation to reintroduce as much activity as possible, bringing capacity back to levels seen pre-COVID for Cancer, Elective/diagnostics, Mental Health community and primary care. During COVID, much of the routine elective and community capacity was redeployed in line with NHSEI guidance to support implementation of the emergency planning approaches within Acute Hospitals and pathways such as discharge facilitation into the community. Clearly, bringing this capacity back in to reintroduce routine service capacity impacts on the ability for the system to maintain existing redeployment approaches to manage surge and staff absences. The ability to introduce capacity is being risk assessed across services routinely with contingency plans agreed should we experience a second significant COVID Phase.

2. EXIT FLOW.

How we are working together on system flow:

- **Discharge pathway and discharge to assess.**

  The national discharge guidance commenced review and implementation from March 2020. The SHK catchment now operates a single point of access for St Helens, Knowsley & Halton Borough discharges from the Trust to further support same day discharge performance. All referrals for pathways 1, 2 and 3 are facilitated via St Helens Contact Cares Integrated Discharge Team. In addition to further improve the quality and timeliness of referrals, a single discharge form and digital solution is being developed with pilots of the single form underway. Further remote assessment and solutions have also been tested during this period to support infection control measures across the wards with the borough teams.

  The discharge pathway is attached in Appendix 2.

St Helens, Halton and Knowsley will continue to operate home first, discharge to assess for Pathway 1 hospital discharge and crisis response in the community with Reablement care, therapy and community nursing support. Implementation and ongoing review will be continuously monitored by the Strategic Discharge Group.

Community and Acute Therapy:

A six week project will commence in September to further improve the 'hospital to home' therapy pathway and model. This is a joint initiative across the Acute Trust and Community Therapy Teams with commissioners. Discharge to assess and home first principles have been applied both prior to and during the COVID period and the system partners are committed to continuous improvement in relation to integrated pathways supporting the model. Both St Helens & Knowsley CCGs have Trusted Assessor models in place.

Governance is in place to both oversee and implement system flow (refer to section 6).

- **Lessons learned from COVID**

  The key learning from COVID has been captured with the patient flow board remit using insight from a recent system workshop, this outlines how the system will continue to use and embed learning from COVID (section 6).

3. HOSPITAL – Whiston, St Helens and Newton Hospitals.

- **Eliminating overcrowding in ED – maintaining IPC distancing measures.**

  The Trust has invested in an additional temporary waiting area pod to support social distancing/IPC, and also create additional capacity for winter in the event of second surge in COVID. Appendix 3 details the SOP for management of overcrowding in A&E at St Helens & Knowsley Hospitals.

- **Rapid COVID testing**

  We are expecting that a Rapid COVID testing Unit will be available for Whiston ED from Mid-September (likely to only have capacity to undertake rapid tests for 16 patients per day as the test takes 90 minutes to process). This will enable a quick decision for some patients to plan appropriate treatment and better patient flow/bed utilisation. Ideally we would like to have additional machines available to increase the numbers of patients that can be tested and excluded as having COVID.

- **Additional physical capacity to support non elective patient flow and increased demand during winter**

    - ED Stretcher triage capacity has recently increased from 5 to 8 which will help to support timely handover of ambulance patients
    - Additional temporary waiting area capacity to support social distancing in ED is now in situ.
    - Additional 30 beds (step down and admission avoidance) will be available from 25th August 2020 (Bevan Court)
    - Potential to open an additional 32 winter surge beds from December to March 21 (resources dependent)
    - Additional discharge lounge capacity is scheduled for January 2021, will enable the accommodation of patients who require a bed or trolley, therefore freeing up acute bed capacity earlier.
    - A capital bid has gone in to increase ICU capacity by 7 beds. The Trust is awaiting the outcome of this bid. This will increase capacity from 14 to 21 ICU beds.

- **Capacity planning and elective activity restoration.**

  The Trust is well underway with activity and plans to restore elective waiting lists to pre covid levels and return to as closely as possible to pre-covid levels of activity. In line with Phase 3 planning guidance, the Trust is assessing its position and trajectory for elective capacity until the end of the financial year, recognising the challenges of IPC/Social distancing needs and PPE. Activity in the independent sector will need to continue to support the recovery programme for plastic surgery, orthopaedics and MRI.

  Capital and short term revenue funding has been received to establish a fourth endoscopy room in St Helens Hospital to restore activity and reduce waiting times back to pre-covid levels. This is expected to open in November 2020. Please see appendix 4 for the Trust clinical support service winter plan.

- **Flu**
  The Trust will be commencing its flu campaign earlier this year. It is envisaged this will be September.

- **High intensity users**
  The Trust high intensity user meetings have been re-established with partners and will be convening regularly to review repeat admissions cases as part of a system wider approach to admissions avoidance.

- **Mental Health**

  Psychiatric Liaison Service:

  Patients presenting at either Warrington or St Helens & Knowsley ED departments with a mental health condition are currently assessed by the Mental Health Practitioner from the Psychiatric Liaison Service (PLS) in the ED. Patients are either signposted to other mental health services of receive intervention as required. The aim of the PLS is to help reduce the number of mental health admissions into secondary care, reducing length of stays in hospital for patients. The service currently operates 24/7.

  PLS also works with clinical staff on the wards to assess whether mental health patients are suitable for discharge and help the patient to get home sooner with community mental health support. PLS aims to reduce unnecessary admissions into secondary care and contributes towards reducing the length of stay for patients.

  24/7 Crisis Response Resolution & Home Treatment: this forms part of crisis offer. Secondary care service to help support and maintain patients at home step down into community services and support. Became a 24/7 service offer from 1st April 2020. Helping reduce length of stay in a mental health patient bed.

4. WORKFORCE.

In addition to mutual aid approaches across services, organisations have worked well during COVID to implement the national guidance for service cessation and redeployment and more recently the system reset and recovery guidance across all organisations.

The system will continue to work towards recovery of elective services as per the guidelines issued and continue to risk assess the situation in terms of supporting ongoing system surge and recovery. Organisations are in a position where they are continually matching the services to the changing demands / circumstances and will continue to do so and partners are working continually within these principles.

Decisions relating to redeployment and capacity for restarting and also surge will be taken both at organisation level and via the system escalation governance should this be required.

Agile working, home working and telehealth approaches will continue to further support infection prevention and social distancing in addition to capacity for testing.

5. RISKS AND MITIGATION.

Top three identified risks for the Mid Mersey A&E Delivery Board ahead of winter?	What mitigating actions will be/have been put in place to reduce the risk ahead of winter?	*Please RAG rate mitigating actions in terms of risk to delivery, i.e. GREEN = low risk to delivery/very achievable; RED = high risk to delivery/dependent upon multiple factors/stakeholders to ensure delivery*
1. Workforce; Staffing absences due to COVID impacting upon service capacity and overall system flow. (Acute/Community/Social Care).	Additional capacity for staff testing with quick turnaround across health and social care. Agile working arrangements. Remote assessment approaches and telemedicine maximisation. Use of Agency staff and provider workforce recruitment plans as enacted during COVID Peaks. Mutual aid approaches	Amber
2. Bed capacity – Acute and Community.	Additional capacity identified for surge planning acute and community. Home First approaches Trust contingency plans – 1a can be used for acute capacity during winter. Daily review of EMS/capacity tracker to inform system escalation and decision making. Mutual aid approaches	Amber
3. IPC capability.	Daily monitoring via EMS/capacity tracker (PPE/staffing). Linked to escalation governance. Agile working. IPC plan developed in line with national guidance. Mutual aid approaches. Executive oversight.	Amber

SUPPORT REQUIREMENTS:

Is there any further support to winter planning that could be provided to the A&E Delivery Board by either the NHSE&I North West regional/national team?
1. Revenue funding to support workforce contingencies/bed capacity. 2. Hand on support to teams delivering improvement projects. 3. Capital funding in line with bids submitted.

6. SYSTEM GOVERNANCE.

The Mid Mersey A&E Board will operate throughout the winter period to oversee implementation of plans and system risk. The Mid Mersey Operational Group will continue to meet monthly to oversee/implement priority work-plans for UEC/Board, such as NHS 111 First, Respiratory and Frailty plans and Out of Hospital.

The Mid Mersey System Flow Board will continue to work within the Hospital and Out of Hospital Cell direction and liaise with the A&E Board on matters of system flow and mutual aid and surge management in line with the Terms of Reference.

- **SHK Strategic discharge group; achievements and ongoing approach:**

  For the SHK catchment, a strategic operational group has been active since March 2020. The group is represented by:

  - SHK
  - St Helens, Knowsley and Halton CCGs /LAs
  - NWB
  - Bridgewater

  The key aim has been to implement and oversee performance in relation to the COVID Enhanced Discharge capacity guidelines and protocols. The group meets twice weekly to review and oversee operational matters and is in the process of developing digital solutions to further enhance the timeliness and quality of the assessment process and pathways across health and social care. Outcomes are monitored via a Dashboard that has been developed and agree across partners. In additional daily discharge meetings are held to review the discharge tracking lists with the SPA/MDT staff. Escalation approaches are being reviewed to further enhance the approach as we head into winter. As this has evolved, the group is now completing the priority digital solutions and assessment priorities.

  Going further into winter a System ‘Patient Flow Board’ will established in September to:

  - Continue to develop the tools and methods to oversee patient flow across the system; through community services and hospital.

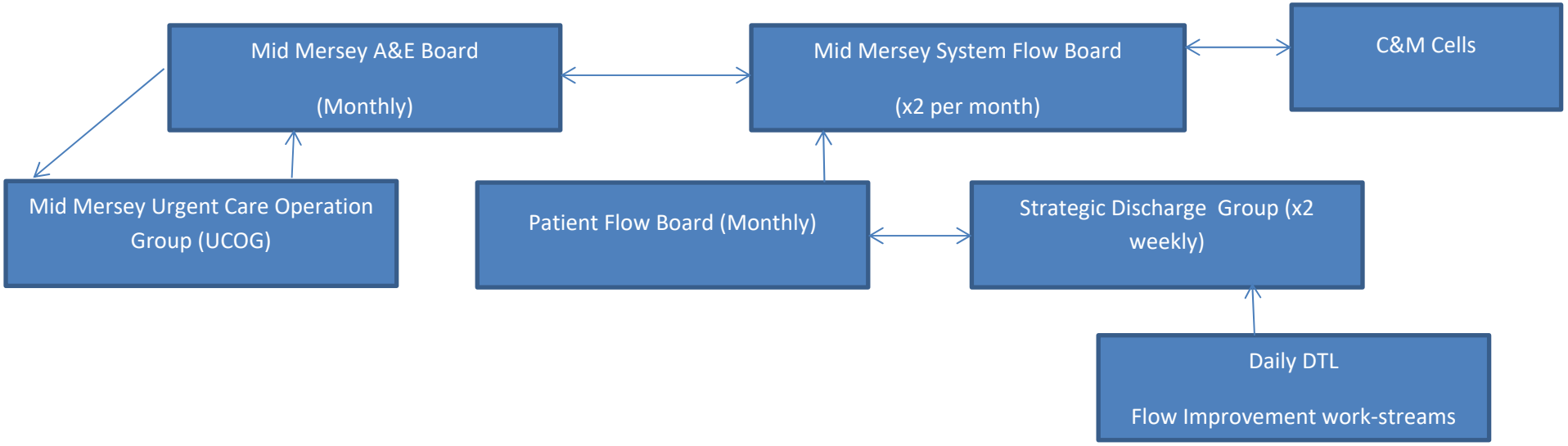
- Focus on the three Boroughs of Halton, Knowsley and St Helens; comparing efficiency in delivery of pathways with a view to sharing learning and providing mutual aid.
- Lead the delivery of digital solutions to support virtual working within the hospital and within localities.
- Embed the Enhanced Discharge Pathway following COVID-19 and the Stage 3 letter from NHSE/I.
- Programme manage the output of the Enhanced Discharge Pathway projects
    - One form to support patient discharge across all pathways
    - Oversight and development of bedded options across the footprint
    - Development of discharge to assess approaches across all pathways in line with national guidance
- Develop and lead the strategic vision for the programme of work.
- Oversee and support preparation for winter and COVID scenarios.

- Oversight and escalation governance (EMS/OPEL/Discharge and flow governance and oversight.
- Performance metrics and trends

An escalation workshop will take place in September and will take on board a 'peer' review approach to further strengthen local approaches to escalation and risk management.

The capacity tracker and EMS systems are currently operational across Mid Mersey and are regularly updated (the aim is daily) by system partners. They will be used proactively to monitor trends and enable early intervention in relation to risk management across partners. This provides an overview of staffing, beds, PPE, etc to inform local escalation discussions.

Mid Mersey System Governance (SHK)



7. APPENDIX / EXTERNAL EVENTS.

Appendix 1; Primary care plans

St Helens Primary
Care WInter Plan sum

Halton Primary
care.docx

Appendix 2; Discharge Pathway

Discharge To Assess
Process Reviewed Au

Appendix 3; IPC policies; Overcrowding and IPC measures in ED SHK

Overcrowding and
IPC measures in ED.c

Appendix 4; Clinical Support Service Winter Plan SHK

Clinical Support
services winter plan S

Appendix 5; Communication Plans

Each area is required to produce a comms/engagement plan as part of the national assurance documents to be submitted. (These are yet to be published together with the NHSE Template).

In terms of the approach this year for the winter comms planning across Mid Mersey we are in a very different position to last year with Covid-19 and the added complexity re the flu vaccination programme and NHS 111 First.

Discussions are underway with AEDB leads, NHS E/I and the CMHCP regarding a Cheshire & Merseyside (C&M) approach to the winter communication plan.

The outcome of the initial discussions is the proposal to take a C&M approach with the support of the C&M Health and Care Partnership to co-ordinate the development and implementation of a C&M wide plan, with a single approach in terms of the call to action, campaign materials, key messages etc. Whilst this will be a C&M wide plan, each locality will retain the ability to flex the messages and approach to meet local need.

This approach will not only be more consistent but should make best use of our collective resources.

Proposals are in the process of being developed by A&E Delivery Board and HCP comms leads to ensure this aligns with the NW regional winter plan with CCG reps (myself) joining the group to help with development of the plan.

Appendix 6; Flu Plans

Delivery of St Helens Flu Vaccination Progr

- Halton Flu summary:

The 2020-21 flu campaign will commence mid-September and intensively run through until the end of November 2020, though opportunities for individuals meeting the influenza criteria will be eligible for the immunisation until 31st March 2021.

During the first phase, NHS Halton CCG's priority is to vaccinate the 65+ age group as well as 18-64 age group with underlying identified health conditions, with the aim of increasing uptake rates on previous years. The CCG is currently awaiting guidance from NHSE regarding the vaccination of an additional cohort group which will target healthy individuals between the ages of 50 and 64 years. It is anticipated that the

latest cohort eligible for the flu vaccination will be offered later in the flu campaign and the CCG is exploring suitable venues such as local church halls and community centres in order to deliver the vaccination programme on a much larger scale.

The purpose of vaccinating eligible cohorts with influenza immunisation is to help reduce the circulation of flu and the co-allegiance of COVID-19 with the aim of reducing the numbers of patients presenting at ED and being admitted to secondary care particularly with the potential of exacerbation of co morbidities .

PHE have specified that communication regarding influenza vaccine is promoted individually and not in collaboration with COVID 19. This is to ensure the population we serve are aware of the importance of influenza vaccines and how it can reduce the spread of the virus within the community and consequently reduce the impact of illness produced by the flu infection.

The CCG aims to support providers to review the uptake and delivery of the influenza immunisation within the identified eligible 2 and 3-year old cohorts. By reducing the spread of influenza infection from children this will enhance herd immunity as well as reducing the carriage of infection to vulnerable and elderly populations.

Currently a review is being supported by the CCG alongside Primary Care, Acute Trusts and Community Providers reviewing capacity, demand and workforce to ensure the complexities and demands of the influenza programme will be delivered timely, effectively and to the health and wellbeing benefit of individuals within the localities we serve.

A joint flu action group for Warrington and Halton localities are ensuring consistent and collaborative working is established across all areas of the Health and Social care environment. A communications campaign is being developed locally, with the support of any national information and publications jointly with Halton and Warrington Borough Councils using social media and local media to promote initiatives, information and signposting to populations of Warrington and Halton.

- Knowsley position statement:

Primary care plan; The Knowsley Flu plan is going to Primary Care Committee in September. The focus is upon mass vaccination (drive through/walk through) model to be in place from (likely mid) Sept to compensate for impact of IPC/social distancing requirements on General practice ability to manage ‘traditional’ flu clinics and offer additionality for expanded cohort model. This will also support potential later programme of COVID vaccination and drive through delivery of additional phlebotomy and may be adapted/adopted for COVID assessments (e.g. O2 sats monitoring for symptomatic patients to inform decision to admit).

System flu plan is in development.

Warrington and Halton System Winter Plan 2020-2021

Contents

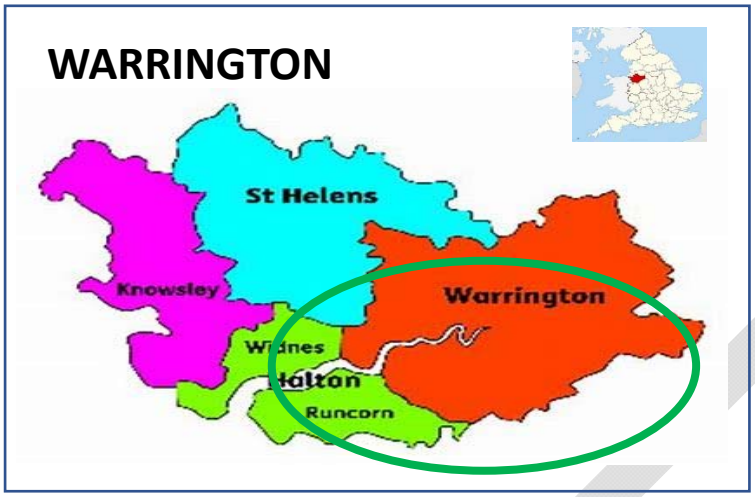
1.0 Version Control and Endorsement Information

Date	Version	Author	Comments
30.07.2020	V 0.1	Tricia Cavanagh-Wilkinson	2020-2021 – Initial System Submissions
13.08.2020	V 0.2	Sara Garratt	Revised Formatting, order, and gaps
13.08.2020	V 0.3	Tricia Cavanagh-Wilkinson Sara Garratt	Primary Care Halton Revised formatting & order
17.08.2020	V0.4	Tricia Cavanagh-Wilkinson	Updated WHHFT Sections Bridgewater workstreams Primary Care Warrington
17.08.2020	V0.5	Sara Garratt	Reviewed content, revised order and link to KLOE's Respiratory section added
18.08.2020	V0.6	Tricia Cavanagh-Wilkinson	Appendices added, proof reading, KLOE check, small amends.
19.08.2020	V0.7	Sara Garratt	Review of 2019/20 Conclusion National Guidance
20.08.2020	V0.8	Tricia Cavanagh-Wilkinson / Sara Garratt	North West Boroughs Meds Optimisation KLOE reference update
21.08.2020	V0.9	Sara Garratt	Intermediate Tier Service Escalation Endorsement Table Final Formatiing

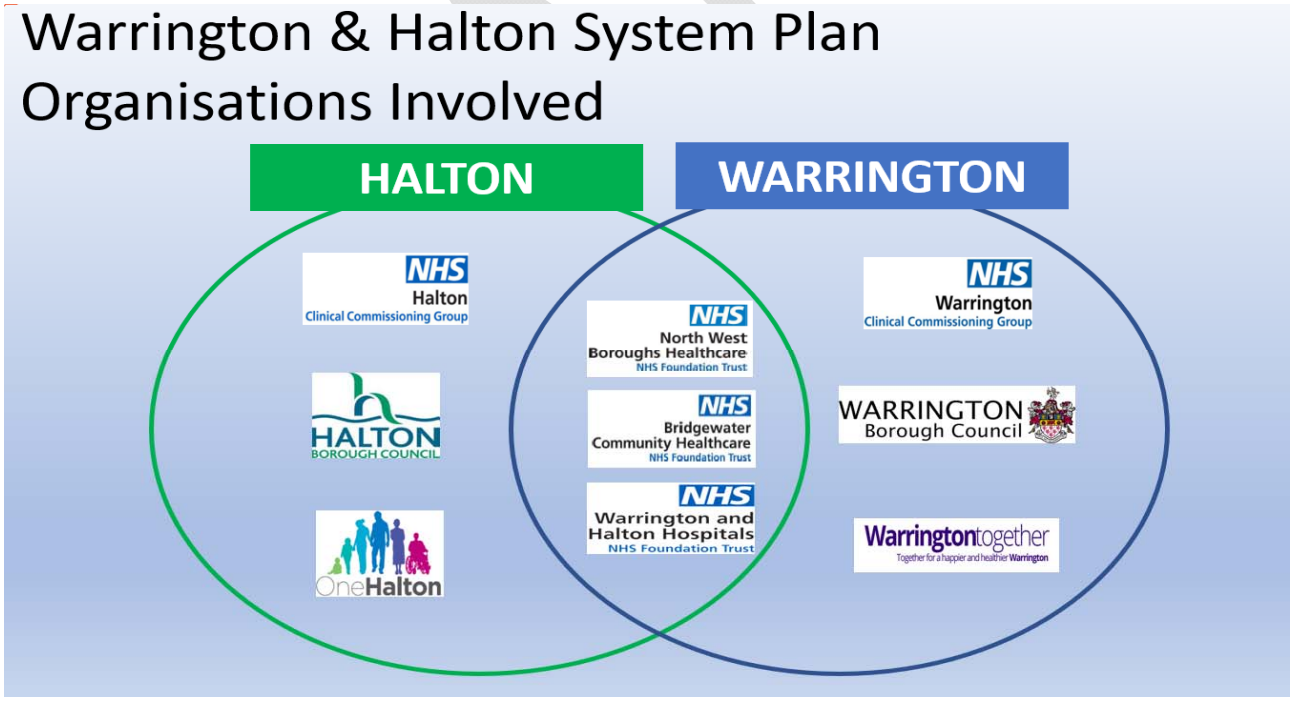
Endorsement		
Detail	**Date**	**Comments**
Governing Body	07.09.20	
Joint Urgent Issues Committee	29.07.20 26.08.20	Recommendations Noted TBC
NHSE/I check and challenge	TBC	
Health & Well-Being Board	TBC	
Warrington Health Forum	TBC	
Warrington Primary Care Oversight Group (PCOG)	TBC	
Bridgewater:- • Executive Management Team • Senior leadership team, • Borough operational meeting	TBC	
Warrington LA, Senior Management Group	TBC	
Halton Borough Council Senior Management Team	TBC	
WHHFT, Strategic Executive Oversight Group	TBC	
North West Boroughs Senior Management Team	TBC	

2.0 Introduction and Purpose

2.1 Introduction



Each constituent organisation represented has made a commitment to deliver consistent and timely support to enable all parts of the system to work collaboratively together to continue to improve patient safety, experience, and outcomes.



The Warrington System is defined as the population catchment that ordinarily uses WHHFT. This broadly covers Warrington CCG and the Runcorn part of the Halton CCG population.

2.2 Brief Review of 2019/20

The winter of 2019/20 brought challenges but also many successes for the Warrington System. The winter months of 2017/18 were the worst experienced for a while. During that period and into the summer of 2018, whole system working started to develop.

In 2018/19 we started working with the VENN group and we embedded the model to determine our priority work areas. Many of those actions were implemented through the winter months and some followed on into the summer.

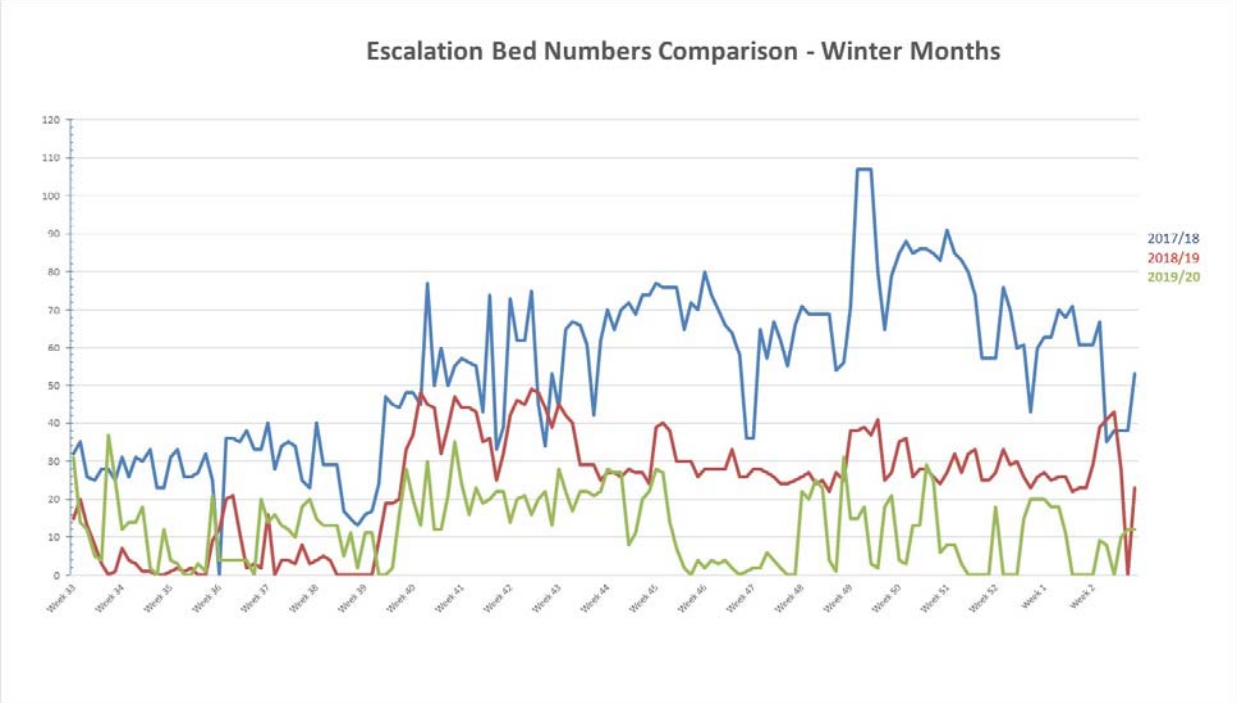
During the winter months of 2019/20 those actions were embedded. System working blossomed and we designed more key activities featured in our winter plan for 2019/20 that were also successfully implemented.

Because of our whole system approach there were many benefits experienced. Listed below are a few of those benefits:-

Escalation Capacity

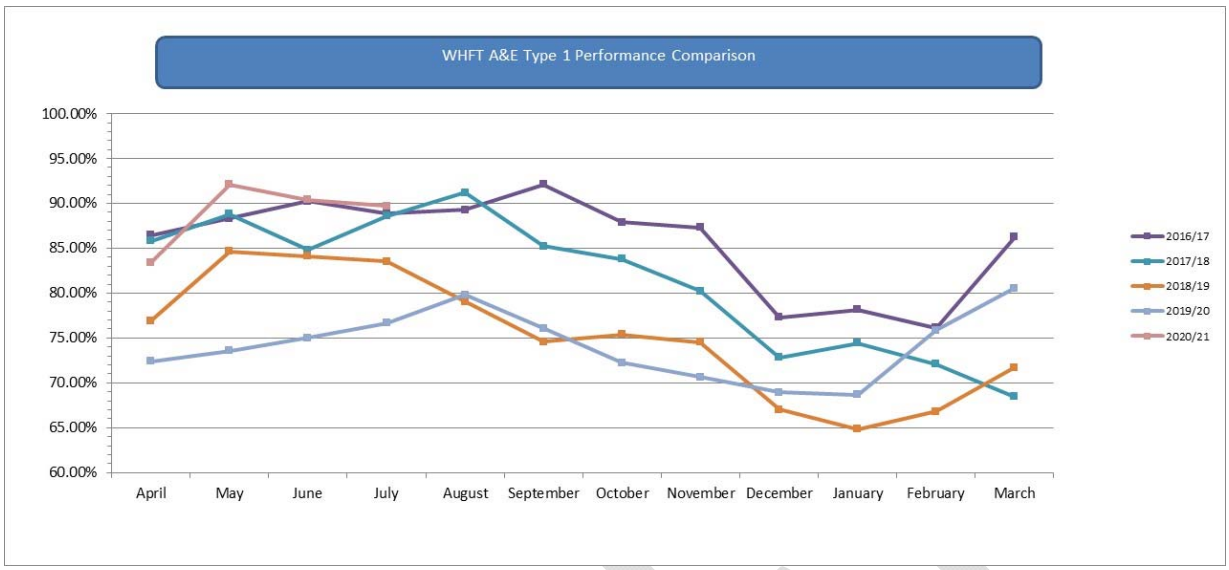
During the winter months (October – March) of 2017/18 we used c. 9338 escalation bed days. In 2018/19 that reduced to c. 3808.

During the winter months of 2019/20 our use of escalation bed days reduced again to c.2,604 meaning in that 2-year period we reduced the use of escalation bed days by 72%. The chart below shows that reduction.



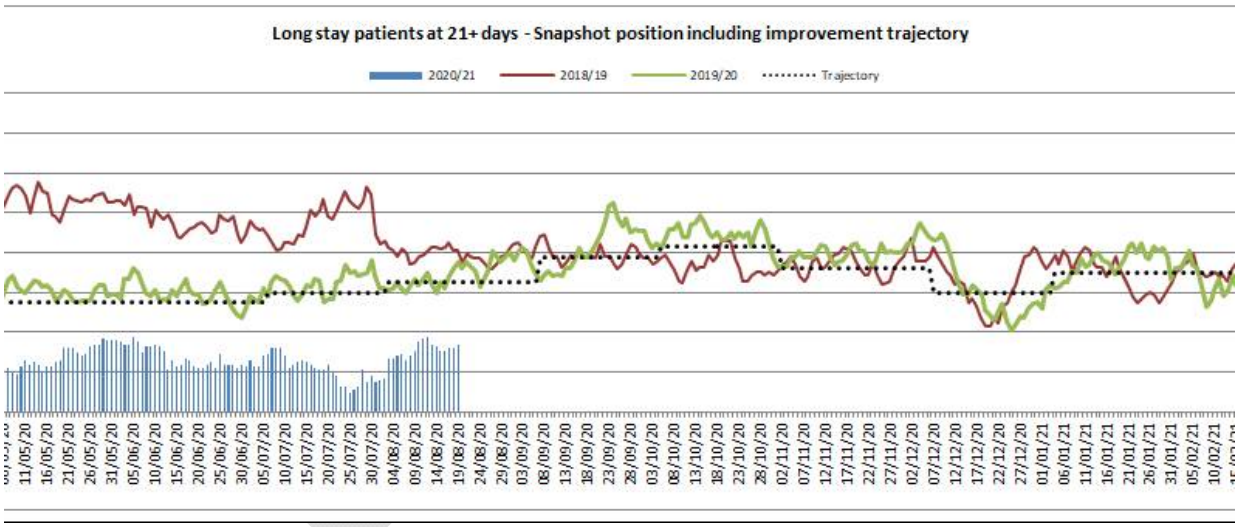
Improved Type 1 ED 4-hour performance standard

Type 1 performance in 4 of the 6 winter months of 2019/20 compared to 2018/19 improved



Reduced Super stranded compared to previous year

Overall sustained reduction in the number of super stranded patients



Reduced number of arrivals by ambulance

Continued downward trend of arrivals by ambulance.

2.3 National Guidance

Following the release of the letter from Simon Stephens and Amanda Pritchard, winter planning has centred around these expectations which are summarised below:-

Preparation for winter

Systems are asked to prepare for winter by:

- Sustaining current NHS staffing, beds, and capacity, while taking advantage of the additional £3 billion NHS revenue funding for ongoing independent sector capacity, Nightingale hospitals, and support to quickly and safely discharge patients from NHS hospitals through to March 2021.
- Deliver a very significantly expanded seasonal flu vaccination programme for DHSC-determined priority groups, including providing easy access for all NHS staff promoting universal uptake. Mobilising delivery capability for the administration of a Covid19 vaccine, if and when a vaccine becomes available.
- Expanding the 111 First offer to provide low complexity urgent care without the need for an ED attendance, ensuring those who need care can receive it in the right setting more quickly. This includes increasing the range of dispositions from 111 to local services, such as direct referrals to Same Day Emergency Care and specialty 'hot' clinics, as well as ensuring all Type 3 services are designated as Urgent Treatment Centres (UTCs). DHSC will shortly be releasing agreed ED capital to help offset physical constraints associated with social distancing requirements in Emergency Departments.
- Systems should maximise the use of 'Hear and Treat' and 'See and Treat' pathways for 999 demand, to support a sustained reduction in the number of patients conveyed to Type 1 or 2 Emergency Departments.
- Continue to make full use of the NHS Volunteer Responders scheme in conjunction with the Royal Voluntary Society and the partnership with British Red Cross, Age UK and St. Johns Ambulance which is set to be renewed.

- Continuing to work with local authorities, given the critical dependency of our patients – particularly over winter - on resilient social care services. Ensure that those medically fit for discharge are not delayed from being able to go home as soon as it is safe for them to do so in line with DHSC/PHE policies (see A3 above).

In addition, it's important to note that Primary Care is still working under directions and in accordance with the national standard operating procedure for primary care. Currently at version 3.4

2.4 WARRINGTON CCG Population – Key Information

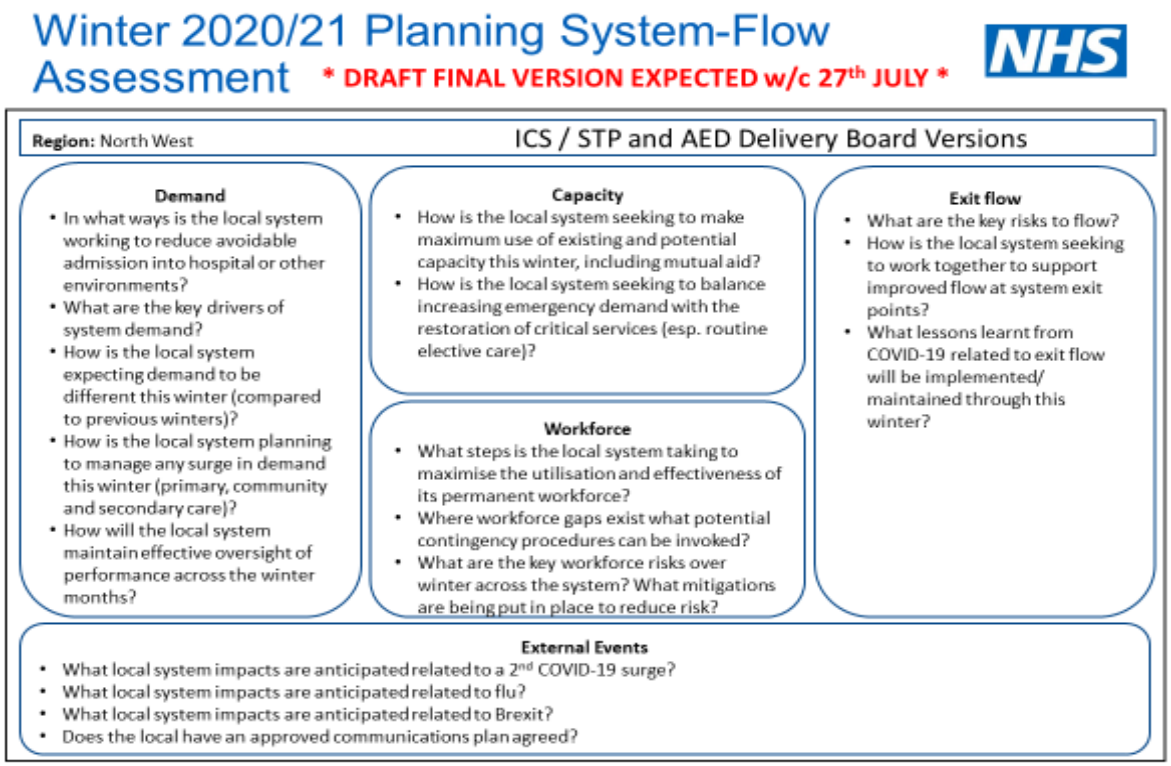
- Estimated 209,700 resident population (2017 MYE)
- Life expectancy (2015-17)
    - Males = 78.9 years
    - Females = 82.4 years
- Warrington Borough Council unitary local authority
- 26 GP practices, 5 Primary Care Networks (PCN's).
- Registered GP population 220,940
- Warrington Together is our Integrated Care Partnership
- Main NHS providers:-
    - Acute - Warrington & Halton NHS Foundation Trust (WHHFT)
    - Acute – St Helens & Knowsley NHS Foundation Trust (STHK)
    - Community - Bridgewater NHS FT (BCHT)
    - Mental Health – North West Boroughs Healthcare Foundation Trust (NWBHFT)

2.5 HALTON CCG Population- Key Information

- Estimated 128,432 resident population (2018 MYE)
- Life expectancy (2015-17)
    - Males = 73.5 years
    - Females = 76.7 years
- Halton Local Authority
- 14 GP practices, 2 Primary Care Networks.
- Registered GP population at 1st April 2020 133,410
- One Halton is our Integrated Care Partnership
- Main NHS providers:-
    - Acute - Warrington & Halton NHS Foundation Trust (WHHFT)
    - Acute – St Helens & Knowsley NHS Foundation Trust (STHK)
    - Community - Bridgewater NHS FT (BCHT)
    - Mental Health – North West Boroughs Healthcare Foundation Trust (NWBHFT)
    - PC24
    - GP Extra

2.6 Purpose

This plan defines the response from the Warrington and Halton health and social care and wider system to the escalation, capacity, and health outcome challenges of winter on the demand for urgent care. The plan also aims to answer the Key Lines of Enquiry (KLOE's) set out by NHSE/I as described below.



Winter 2020/21 Planning System-Flow Assessment * DRAFT FINAL VERSION EXPECTED w/c 27th JULY *

NHS

Region: North West

ICS / STP and AED Delivery Board Versions

Demand

- In what ways is the local system working to reduce avoidable admission into hospital or other environments?
- What are the key drivers of system demand?
- How is the local system expecting demand to be different this winter (compared to previous winters)?
- How is the local system planning to manage any surge in demand this winter (primary, community and secondary care)?
- How will the local system maintain effective oversight of performance across the winter months?

Capacity

- How is the local system seeking to make maximum use of existing and potential capacity this winter, including mutual aid?
- How is the local system seeking to balance increasing emergency demand with the restoration of critical services (esp. routine elective care)?

Workforce

- What steps is the local system taking to maximise the utilisation and effectiveness of its permanent workforce?
- Where workforce gaps exist what potential contingency procedures can be invoked?
- What are the key workforce risks over winter across the system? What mitigations are being put in place to reduce risk?

Exit flow

- What are the key risks to flow?
- How is the local system seeking to work together to support improved flow at system exit points?
- What lessons learnt from COVID-19 related to exit flow will be implemented/ maintained through this winter?

External Events

- What local system impacts are anticipated related to a 2nd COVID-19 surge?
- What local system impacts are anticipated related to flu?
- What local system impacts are anticipated related to Brexit?
- Does the local have an approved communications plan agreed?

3 |

Appendix 1 details the references for each KLOE.

Throughout the document footnotes of the KLOE reference numbers are included where each entry meets each KLOE for ease of review.

3.0 Context and Challenge for 2020/21[1]

On 3rd March 2020, a national major incident was declared in response to the Covid-19 pandemic. Warrington and Halton Teaching Hospitals NHS Trust and St Helens and Knowsley Teaching Hospitals NHS Trust instigated level 4 incident control and management.

From this point on, both Trusts started to reduce elective surgery to support planning and preparedness of the anticipated impact of Covid-19. This was to release staff for refresher training, release bed capacity for Covid-19 patients and theatres/recovery facilities for adaptation work.

On 17th March 2020, official notification was received from NHS England directing providers to plan to postpone all non-urgent elective operations from 15th April at the latest, for a period of at least three months. Emergency admissions, cancer treatment and other clinically urgent services

[1] KLOE 4a

continued unaffected. Use of the independent sector for additional surgical and diagnostic capacity was enabled.

Both local hospitals have been able to manage all the pressures of the pandemic with adequate bed and critical care capacity. Although they have seen significant numbers of staff having to self-isolate, for either personal or family infections, the staff redeployment programme and the mutual aid scheme have ensured the continuation of safe and effective services.

Cheshire and Merseyside Health Care Partnership (HCP) and the Covid-19 Hospital Cell have been working with all acute hospitals to determine operation capacity, backlog and productivity.

In April 2020 NHS England (NHSE) released directions relating to Phase 2 Recovery. The national requirement had two elements:

- First six weeks to July to deliver urgent surgery
- July 2020 to March 2021 to bring elective activity back towards normal levels

There is an expectation, that because of infection control requirements for distancing there will be a reduction in beds by approximately 20%. Also, the ability to run outpatient clinics while maintaining distancing could at least half the productivity for elective services.
Phase 3 guidance has recently been released by NHS England and requires Trusts to return in September to at least 80% of their last year's activity for both overnight electives and for outpatient/day case procedures, rising to 90% in October.

To ensure that patients continue to receive timely care and treatment, urgent and emergency services have continued during the Covid19 pandemic. It is nationally recognised that the impact of the pandemic will increase clinical waiting times, review, and treatment. Therefore, it is important that all Trusts have a process in place to manage this.

3.1 Warrington and Halton Hospital NHS Trust

In response to the guidance, initially, all urgent and cancer two week wait patients on the admitted PTL were reviewed to identify the correct priority level for each patient. Each patient had a clinically led review to assess the correct waiting time priority, supported by the specialty Clinical Business Unit (CBU) management team. This process is monitored via the Trust's Performance Review Group (PRG) twice weekly, which is supported by a newly developed information dashboard. The Trust has also initiated a Recovery Board that convenes twice weekly to monitor the reintroduction of services.

To ensure that governance standards are maintained, no services have re-started without the appropriate documentation to ensure patient safety. This includes information relating to the provision of personal protective equipment and standard operating procedures where appropriate. This documentation has been signed off at the Recovery Board.

The management of the RTT PTL is reviewed by the Trust's RTT Business Manager and is monitored via the Performance Review Group weekly and the Key Performance Indicator (KPI) Subcommittee monthly.

RTT performance is also impacted by outpatient and diagnostic services. These services form part of the overall recovery plans being instigated, and innovative ways of working are being developed.

A weekly report is sent out to the Clinical Business Unit (CBU) teams detailing whether any of their respective patients have waited more than 40 weeks. Clinicians and CBU teams are asked to review

the information provided and escalate accordingly. Patients over 40 weeks are reviewed by the Trust's PRG.

Progress is discussed monthly at the NHS Warrington CCG Clinical Quality Focus Group and at quarterly Contract Review meetings with the Trust.

The Trust's Chief Operating Officer and key CBU Managers meet fortnightly with the CCG Chief Commissioner and Key commissioning managers to ensure that the Trusts recovery is aligned with wider system recovery.

The Trust has been able to contain its own cancer activity to date without the need to use the Cancer Alliance surgical hubs. The Trust has a weekly catch up with both CCGs and their Cancer GP leads to ensure that there is cohesive approach to recovery.

3.2 St Helens and Knowsley Hospital Trust

St Helens and Knowsley Hospitals Trust has operated a full command and control structure internally with daily briefings from the frontline services being clinically and managerially reviewed through the bronze command centre and escalated when necessary. The Trust has set the principles of safety, quality and outcome for patients, families and staff and has restructured and redeployed staff in line with national guidance and local infection control requirements.

The Trust has operated hot and cold sites between Whiston and St Helens, as well as utilising the independent sector capacity, to ensure cancer patients and urgent patient referrals are seen and have access to diagnostics and treatment. Non-elective care has largely been uninterrupted, while elective care has been held back but restarted in May and is being restored as quickly as guidelines and staffing levels allow.

All specialities are now available on the Electronic Referral Service (eRS) for booking and all referrals are being triaged by the clinical team to determine urgency, diagnostic needs, and suitability for virtual or face-to-face appointments. Any patients requiring admission are advised of their requirements for self-isolation and swabbing prior to their admission.

The Trust is working closely with the Hospital Cell for the restoration and recovery of all services, which is being supported by PA Consulting to develop the capacity and demand trajectories and scenario planning for any further waves of COVID-19 outbreaks or winter pressures.

The Trust, during the initial outbreak, continued to provide all cancer services that were possible within the national guidelines. Diagnostics and procedures that are aerosol generating had to be suspended initially until national infection control guidance was issued, and all services are now operating, albeit currently at lower productivity owing to decontamination times between patients. The Trust has a number of long waiters, due to patients being shielded and the risks of infection being greater than their condition. This group will now be booked in for treatment as shielding has finished.

The Trust is a mutual aid hub for skin and gastrointestinal cancer for the Network and there are currently discussions with the Countess of Chester to support them with their skin cancer backlog.

3.3 Moving into Winter

Moving into the winter months the planning continues to meet the challenge of the Phase 3 requirements in parallel with usual winter planning to ensure demand is met in the most appropriate place for patients with an urgent clinical need.

System wide, our main areas of focus remain:-

Element of Whole Pathway	Potential Areas to explore (Can consider any combination)
Avoid Admissions	Specific admissions avoidance schemes that can be put in place
	Working with General Practice – Extended hours / additional resource
	Acute Visiting Service and closer working with NWAS
Hospital Front Door	More significant presence at front door to 'pull' people out once attended. Perhaps enhancement of Frailty pathways. Link to enhanced short-term home-based offer. Link to clinical 'risk'
	Enhance capacity – Available space and resources in ED and/or potential of a enhancing short-stay / assessment capacity to enhance flow (without removing Ward capacity)
Beds	Enhance capacity on Short-Term / Intermediate Care Beds (Wards if not available)
	Enhance overall LoS (stranded / super-stranded / discharges)
	Review discharge approach and timeliness
Short-Term Home-Based Care	Enhance current services by: bringing together health and social care elements, supporting more individuals who are higher-need, developing single pathway and referral (Home First pathways)
Long-term Home Care	Discuss potential of enhancing Domiciliary Care market through additional recruitment / uplift in cost. Enhance discharge pathways through Integrated Discharge approach
Community Mental Health	Support growing demand for Mental Health services: Assess requirements for Psych Liaison and Home Treatment over Winter / Support additional Community Mental Health demand

4.0 Key Workstreams

4.1 111 FIRST – System Catchment[2]

NHS 111 First will ensure that patients can access the clinical service they need, first time, both in and outside of hospital, with the convenience of a booked appointment or time slot. Importantly, it will help to reduce the risk of transmission of COVID-19 between patients and to staff by reducing crowding in waiting areas across services.

Warrington is one of two northern systems to be an 'early-implementer' of NHS 111 First. Following the success of NHS111 in the COVID-19 pandemic, most patients are now comfortable contacting the telephone triage service.

The 'call-before-you-walk' system requires patients to call their GP in the first instance or NHS 111 before attending the Emergency Department (ED). The new model will go live from the 8th September 2020 supporting the assessment and streaming of patients who would normally present unannounced.

Patients validated for arrival to secondary care through NHS 111 and the Clinical Assessment Service (CAS) will be given appointments at either the Emergency Department, Minor Injuries Unit and ED Ambulatory. Patients validated for arrival to the Urgent Care Centre and primary care will also be

[2] KLOE 1a, 1c, 1e

offered appointments where these are available. Many patients will be directed into other services and many will be given self-care advice and information.

The project team are responsible for delivering the model, services, and operational process. Once mobilised, the group will monitor impact and continue to refine the offer making best use of all services across the system.

This will improve patient experience, reduce overcrowding, reduce avoidable admissions, unplanned and longer than necessary stays in hospitals, resulting in lower risk of nosocomial and other infections and de-conditioning for patients.

Appendix 2 NHS 111 First – Additional Information

4.2 Rapid Response

Warrington Rapid Community Response Service (RCRS)[3]

A redesign of intermediate tier services has progressed to address the current system capacity deficit and to deliver services that meet the needs of the population.

Phase 1 developed an interim solution, which in the context of the overall Intermediate Tier Service Review and Redesign Project and in agreement with the Warrington Better Care Fund (BCF) focused on the design and implementation of a co-ordinated Rapid Community Response Service to reduce hospital attendance and admission and emergency admission to respite care.

Phase 2 is in progress to develop the long-term model for Rapid Response supported by NHSE as one of seven national accelerator programmes.

Purpose:-

- Facilitate hospital discharge and prevent hospital admission by providing a rapid response to individuals experiencing a crisis which puts them at risk of hospital attendance/admission or residential care admission.
- Prevents dependency where with some intense input from relevant disciplines the individual can be supported to maintain/regain their independence.
- Keeping people at home longer, maximising their independence and increasing quality of life.

Principles:-

- The Rapid Community Response Service is available at least from 0800 to 1900, 5 days per week and will extend to 7 days over winter. Additional recruitment is underway to move from the 14 team members currently in post to the full complement of 40 team members.
- A Rapid Community Response Service which is a multi-disciplinary team of health and social care staff, working closely with PCNs. The focus is on maintaining people in their own home and preventing avoidable admission to acute hospital or residential care.
- Referrals into the service is via a single point of access. The team triages all referrals and responds to all those that require an assessment/intervention within 2 hours. Those referrals which do not require a 2-hour response and those following assessment that do not require urgent intervention are redirected to the appropriate service.
- Care and treatment to be provided for up to 72 hours. Necessary onward referral to community health or social care services is made to ensure continuity of care is provided.

Service Model:-

[3] KLOE 1a, 1b, 2b, 3a, 4b

Provides an enhanced rapid response service through:-

- Co-location of elements of existing rapid response services to form a new Rapid Community Response Service.
- Enhancing the capacity of the new service with additional roles.
- Developing clearer pathways and joint working relationships between the Rapid Community Response Service and other community services that can 'respond rapidly'.
- Co-location with Primary Care's Home Assessment Service.

Halton Integrated Frailty Service (HIFS) – (Investment needed – further work required)[4]

The Halton Integrated Frailty Service (HIFS) identifies and manages frailty syndromes in people over 65 years, before they require hospital admission. It is a responsive service that supports people living with frailty, their carers, GPs, health, and other care workers to collaboratively manage frailty as a long-term condition, optimising the frail person's independence, health and wellbeing.

This is a three-fold development to widen both the scope and the operating hours of the service, whilst augmenting working practice with allied services.

At present, the service only accepts people aged 65 and over; this development will widen that scope to include people aged 18 and over. Furthermore, the development will see an extension of the hours of operation from a Monday to Friday service to seven days a week. In addition to this, the Trust's specialist nursing resource in Halton, including the Heart Failure, Stroke, Falls and Community Matron Services will increase focus on supporting HIFS to deliver the frailty pathway and management of deterioration and admission avoidance.

There is also an opportunity to align HIFS with the Halton Rapid Access and Rehabilitation Service (RARS), to deliver a Home First discharge pathway with deterioration management capability.

Benefits of the Development:

- Service available to a wider segment of the population in Halton
- Service available at weekends
- Minimisation of unplanned ED attendances and admissions linked to frailty and deterioration
- Availability of multi-disciplinary expertise and input into the HIFS service

4.4 Care at Home[5]

Warrington

Reablement is a short-term service that is delivered at home. This service is currently offered to people with disabilities and long-term conditions who may be recovering from an injury or illness or are experiencing an exacerbation of their long-term condition. The service supports patients to regain skills and build confidence. The service takes people from the hospital and the community and provides (not limited to):-

- Assistance with personal care
- Continence care
- Meal preparation
- Medication administration

[4] KLOE, 1a, 2a, 4b
[5] KLOE 1a, 1d, 2a, 3a, 4b

The capacity within the service can support 60-70 people at any one time depending on the case mix. Between March 2019 and March 2020, 40% were discharged from reablement not requiring any ongoing support and 10% had a reduction in their ongoing care needs. It is usual for circa 5 people on any given day to be waiting for this service. Waiting times are generally around 6 days as demand for the service has increased.

An additional 214 hours of capacity has been provided across the system, operational from November 2019. A further 186 hours is still in the recruitment phase and a further 259 hours has been recruited to for the Rapid Community Response Team to access.

This additional capacity will: -

- Enable access to reablement, striving towards the 2-day access standard.
- Enable the acceptance criteria to be widened meeting more unmet demand and should eliminate waiting times in the acute trust and enable a discharge to assess model.
- Created additional capacity for patients to access this from the Community, Intermediate Care Bed Base and the acute trust which should improve flow and handover across the whole system.
- Enhanced support to the rapid response service ensuring it can handover patients to continue any required interventions ensuring the rapid response capacity remains fluid and able to respond immediately to people in crisis and immediate risk of admission

Halton[6]

Social work team remain operational in the community and in supporting hospital discharge. The care home sector is aligned to the trusted assessor model for hospital discharge and will be supported to manage the current and ongoing COVID situation. An additional block purchased 500 hours of domiciliary care commenced February 2020 and will continue through winter. This has successfully managed flow both out of hospital and bed-based services.

4.5 COVID RESPONSE Planning and Preparedness[7] - System Catchment

At WHHFT, the Recovery Board continues to meet twice weekly to coordinate the Trust's response to the COVID-19 pandemic and the recovery of services in line with the requirements set out in the third phase of the NHS response to COVID-19.

The key activities identified will be reviewed constantly with the changing situation and through direction from the system and NHSE.

An exercise was carried out on 3/8/2020 to steer our second wave planning alongside winter planning. Aspects of planning taking place prior to winter include: -

- Testing capability – sustained collaboration with the local network to provide capacity for testing, rapid testing, and adaption to changes.
- Participation in the SIREN study from the end of August 2020 to enhance in-house testing.
- Medical equipment – Critical Care equipment allocation to support winter pressures and equipment pressures linked to a potential second wave of COVID-19.
- Training – opportunities for training on new equipment.
- Simulation training with key staff groups.

[6] KLOE, 1d, 2a, 3a, 4b
[7] KLOE, 1b, 1c, 1d, 2a, 3a, 3b, 3c, 4c, 5c

- Escalation planning and Full Capacity Plan. Our phase one COVID-19 Escalation Plan has been reviewed to support our winter pressures and COVID-19 management. This incorporates escalation planning across ED, all wards, Paediatrics and Critical Care.
- PPE – FFP2 testing plan and longer-term planning of PPE supplies. Involvement in mutual aid. FFP3 planning in collaboration with the network.
- Workforce – staff welfare plans, debrief, resilience and deployment planning.
- Robust workforce risk assessments.
- Redeployment hub- in place to support potential staffing requirements to manage second wave pressures.
- Impacts of Brexit – keeping up to date with potential risks to flows of supplies of consumables, PPE, and medicines.
- Patient placement SOP- to support COVID-secure pathways and cohorting of patients.

Surge and capacity plans have been considered.

The Trust has an 18 bedded modular build (K25) on site to help support winter demand. The intention is for this facility to be used to support surges in demand and provide additional capacity at peak times. A staffing model has been approved for this ward.

In addition, ward B3 at Halton offers a 26-bed space that can be stepped up as part of our escalation planning.

Any further surge demands will be managed in collaboration with the region.

It is anticipated that there may be some additional demands this winter: -

- Managing influenza alongside COVID-19
- Increased demands on our capacity related to COVID-19
- Restoring elective activity safely alongside any resurgence of COVID-19
- Socially distancing in ED

WHHFT will use learning from the first and second phase response to COVID-19 to prepare for additional pressures this winter.

4.6 FLU[8] - Warrington and Halton

The 2020-21 flu campaign will commence mid-September and intensively run through until the end of November 2020, though opportunities for individuals meeting the influenza criteria will be eligible for the immunisation until 31st March 2021.

During the first phase, the priority is to vaccinate the 65+ age group as well as 18-64 age group with underlying identified health conditions, with the aim of increasing uptake rates on previous years. CCGs are currently awaiting guidance from NHSE regarding the vaccination of an additional cohort group which will target healthy individuals between the ages of 50 and 64 years. It is anticipated that the latest cohort eligible for the flu vaccination will be offered later in the flu campaign and the CCGs are exploring suitable venues such as local church halls and community centres in order to deliver the vaccination programme on a much larger scale.

[8] KLOE, 1a, 1b, 1c, 2a, 3a, 4b, 5b, 5d

Eligible flu cohorts for 2020/21:

In 2020/21 groups eligible for the NHS funded flu vaccination programme are the same as last year, although this may change if the programme is expanded, and include:

- All children aged two to eleven on 31 August 2020 (DOB: 1.9.2009 - 31.8.2018 inclusive).
- Children of appropriate age for school year 7 (DOB: 1.9.2008 – 31.8.2009).
- Those aged six months to under 65 years in clinical risk groups.
- Pregnant women.
- Those aged 65 years and over.
- Those in long-stay residential care homes.
- Carers.
- Close contacts of immunocompromised individuals.
- Health and social care staff employed by a registered residential care/nursing home, registered domiciliary care provider, or a voluntary managed hospice provider.
- Household contacts of those on the NHS Shielded Patient List. Specifically, individuals who expect to share living accommodation with a shielded person on most days over the winter and therefore for whom continuing close contact is unavoidable.
- Health and social care workers employed through Direct Payment (personal budgets) and/or Personal Health Budgets, such as Personal Assistants, to deliver domiciliary care to patients and service users.

The purpose of vaccinating eligible cohorts with influenza immunisation is to help reduce the circulation of flu and the co-allegiance of COVID-19 with the aim of reducing the numbers of patients presenting at ED and being admitted to secondary care, particularly with the potential of exacerbation of co-morbidities.

PHE have specified that communication regarding influenza vaccine is promoted individually and not in collaboration with COVID 19. This is to ensure the population we serve are aware of the importance of influenza vaccines and how it can reduce the spread of the virus within the community and consequently reduce the impact of illness produced by flu infection.

The CCGs aim to support providers to review the uptake and delivery of the influenza immunisation within the identified eligible 2 and 3-year old cohorts. By reducing the spread of influenza infection from children this will enhance herd immunity as well as reducing the carriage of infection to vulnerable and elderly populations.

Currently a review of capacity, demand and workforce is supported by both CCGs, Primary Care, Acute Trusts and Community Providers. This will ensure that the complexities and demands of the influenza programme will be delivered in a timely and effective way and to the health and wellbeing benefit of individuals within the localities we serve.

A joint flu action group for Warrington and Halton localities is ensuring consistent and collaborative working is established across all areas of the Health and Social Care environment. A joint communications campaign is being developed locally by Warrington & Halton CCGS and Warrington and Halton WBCs making use of any national information and publications. The campaign will use social media and local media to promote initiatives, information, and signposting to populations of Warrington and Halton.

Bridgewater – Vaccinations (Investment needed – further work required)

This development will see the implementation of the following plans:

Drive in vaccinations at Widnes Urgent Treatment Centre and other Community settings

- Community Nurses to vaccinate all housebound patients in their case load, to reduce GP workload.
- All services to deliver flu vaccinations to all patients they treat as routine.
- Internal vaccination programme to deliver 80% compliance rate.

Benefits of the Development:

- Prevention of a spike in flu to free up resource to deal with any potential second spike in Covid-19.
- Reduced demand on services across both acute and community.
- Increased internal resilience against flu.

Bridgewater – Flu Testing (Investment needed – further work required)

This development will expand the use of Point of Care Flu testing kits that are currently used by the GP Out-of-Hours service and the Enhanced Care Home Support Team by rolling this out to Warrington and Halton Community Matrons, Care Homes, and HIFS service in Halton. This will provide the capability for these services to deliver a 10-minute diagnosis of flu and the ability to start therapy straight away.

Benefits of the Development:

- Early diagnosis and commencement of anti-viral treatments
- Reduced ED admissions of patients age 18+ years
- Reduce inappropriate use of antibiotics

Appendix 3 – Halton and Warrington Flu Action Plan

4.7 Integrated hospital discharge

Warrington[9]

Discharge to assess pathway to be established by end of October 2020. This is including commissioning of specialist bed capacity and additional home care via Reablement services.

Halton

Integrated team operates on the Warrington Hospital site managing pathways 1 – 3 discharges. In addition, the team 'track' all Halton people aged 55+ admitted to the trust to enable timely assessment and discharge. The focus is on a home first / discharge to assess model with IC MDT community services being the first point of discharge. IC bed capacity is available in the exceptional circumstance that this is required and operates a discharge to continue rehab model ensuring increase capacity through reduced length of stay. The same model operates at Whiston hospital.

4.8 Intermediate Care Bed Capacity

Warrington [10]

The main bed based intermediate care (IMC) unit is at Padgate House. It's a council owned 35 bedded IMC Nursing unit. Four beds are dedicated to Stroke patients. The care and social work element of the

[9] KLOE 1d, 2a, 3a, 3c, 4b
[10] KLOE, 1a, 1d, 2a, 3a, 4b, 4c, 5a

service is delivered by Warrington Borough Council (WBC) adult services and the nursing/therapy input is delivered by Bridgewater Community Trust.

The second bed-based unit is a 14 bedded nursing unit at Brampton Lodge in Appleton. The building is owned by a private provider who delivers the care component, whilst Bridgewater Community Trust provide the therapy input and WBC adult services deliver the social work support.

Unusually, both these establishments offer nursing, as opposed to only residential intermediate care bed capacity. A previous snapshot audit identified that 64% of service users' needs could have been met in a residential environment.

This has led to the commissioning of 8 intermediate care residential beds at Woodleigh. These beds are utilised for the intermediate care cohort, as well as flexing remaining capacity for patients awaiting commissioned services.

Additional intermediate care bed / flex bed capacity:

During the COVID 19 pandemic, there has been experience of delays in accommodating COVID positive patients in the intermediate care bed bases. This has resulted in the commissioning of 7 beds at Whittle Hall to accept COVID positive patients only. This allows the remaining intermediate care bed cohort to maximise their full bed capacity.

95% of the Intermediate Care bed capacity is accessed via the acute hospital discharge process of admission avoidance, these are also accessed via an attendance to ED rather than from the community setting.

The aim of the additional capacity is to prevent avoidable hospital admissions, facilitate early hospital discharge and will provide:

- An alternative to hospital admission where a service user's medical or care needs requires 24-hour residential care with GP oversight.
- Comprehensive assessment, treatment and advice to service users and carers participating in a rehabilitation programme.
- Service users will have medical oversight, provided by a general practitioner.
- Service users will receive a fully integrated multi-disciplinary review including medical, nursing, therapy, and social care input if appropriate.
- Service user will receive physiotherapy and occupational therapy according to their needs which will be provided by the Intermediate Care Service.
- Where service users require support for continence this support will be provided by the Bladder & Bowel Service following assessment and referral.
- The additional capacity will provide reablement, therapy and care offering an alternative to hospital admission for those directly referred from the community for rehabilitation and for service users requiring a continued period of rehabilitation in transition from acute hospital care. We would not expect length of stay to exceed six weeks and discharge planning will commence on admission to ensure their needs can be met in an appropriate setting.
- Capacity for intermediate care for COVID 19 positive patients.

The target group for the service are those people:

- Aged 18 years or older.
- A resident of Warrington or in a neighbouring authority with a Warrington GP.
- Assessed as requiring intermediate care by the Intermediate Care Trusted Assessor.
- Willing to consent to care and/or therapeutic input.

- Have the ability and be motivated and in agreement to engage in their rehabilitation plan.
- Considered to gain a benefit from intermediate care/ rehabilitation.
- Medically stable.
- Must not require specialist input to manage their behaviour or be considered a risk to themselves or others.

There has also been a recent view of Warrington's intermediate care bed base offer. This has resulted in the implementation of a standard and less restrictive criteria across all three bed bases.

Halton[11]

Halton will continue to operate home first, discharge to assess for Pathway 1 hospital discharge and crisis response in the community with Reablement care, therapy, and community nursing support.

Bed based services remain in place where home is not possible with a dedicated MDT approach to improve function and continue rehabilitation at home. This model has been used throughout the pandemic, successfully reducing length of stay and therefore increasing bed-based capacity.

4.9 Intermediate Tier Services Escalation Plan - Warrington[12]

Appendix 4 - Please see for the Intermediate Tier Services Escalation Plan

4.10 24/7 Mental Health Crisis Line – System Catchment[13]

Earlier this year North West Boroughs was commissioned to establish and run a 24-hour Mental Health Crisis Line. The purpose of establishing the service was to ensure that the Warrington and Halton populations had access to crisis support 24/7 during COVID-19.

The service offers telephone support to both adults and children (no age restriction) and is staffed by North West Borough Mental Health Practitioners who are able to assess people over the phone and if necessary, signpost them onto other services for support. The crisis line can also make direct referrals into other mental health services.

The service will continue to operate and provide support during Winter 2020-21 and will support admissions avoidance.

4.11 HIU – System Catchment[14]

The High Intensity User (HIU) service offers a robust way of reducing high intensity user activity to ED and aims to reduce the number of non-elective admissions and GP contacts as a natural by-product.

The aim of the service is to catch the "frequent attenders" at ED and to drive a case management approach that prevents this cohort of patients from returning time after time to ED time, as they can be better managed elsewhere.

In addition, the HIU service will aim to:

- Work with multi-agency and existing professional services to negotiate a new and innovative way forward.
- Reduce the impact on unscheduled care services and the wider health economy resulting from reduced 999 calls, which otherwise would have attended ED with a possible admission, or a call to the police.

[11] KLOE, 1a, 2a, 4b
[12] KLOE 3b, 3c, 4a
[13] KLOE, 1a
[14] KLOE, 1a

- Actively seek safe solutions for this cohort through community and service connections and the voluntary sector in order to support them to flourish.

Due to COVID-19, face-to-face client interaction hasn't been possible, therefore, the HIU service mainly communicated with patients by either phone or video calls, which hasn't been ideal and has since led to some HIU patients relapsing. Nationally, this has been recognised as an issue as the success of the programme relies on that person-centred 1-1 approach.

4.12 Volunteer and at Home Support - Warrington[15]

Building on the success of the 'Safe and Well' offer mobilised in the Borough during Covid, it is proposed to retain and build on the volunteer force to commission a pilot 'good neighbour scheme' from Autumn 2020. This scheme will focus on connecting people to their communities to reduce feelings of isolation/loneliness, promote health and wellbeing and offer practical support to help people to regain and maintain their independence. The scheme will include support to people to settle in back at home after a stay in hospital/intermediate care and will also provide informal breaks for carers to support them in their caring role.

4.13 Reconfiguration of ED – System Catchment[16]

In response to the demands associated with COVID-19, the department adapted to support the safety and appropriate isolation of patients accessing the department. The emergency department is configured to triage patients safely based on their presenting symptoms, including pathways for patients with respiratory symptoms. The clinical teams present are responsible for determining the safest place for patient placement.

Appendix 5 - ED department configuration

Patient Placement

Following patient assessment, there is a clear process in place to manage the placement of patients. All patients are screened for COVID-19 upon admission (Emergency or Elective).

Appendix 6 – Admission Process Flowchart

4.14 WHHFT Workforce Risk and Mitigation[17]

Gaps in our workforce generally exist within both our Nursing and Medical staff groups. Contingency plans we are seeking to put in place are international recruitment, improved bank recruitment/fill rates and to increase the number of substantive clinical support roles.

It's predicted over winter the key workforce risks will exist within our Staff Nurse roles and a small number of Medical roles.

To address the Staff Nursing shortages the Trust will be embarking on the International Recruitment of 30 Staff Nurses, we hope to have these in place by the end of the year. To supplement this, the Trust are also increasing the number of clinical support roles, (HCAs) and are currently recruiting these; we hope to have an additional 40 to 60 substantive HCAs in post by late 2020.

The Medical Gaps are harder to fill substantively, however we continue to work with WWL and their international recruitment programme, we are also building up our Medical Bank; to supplement this

[15] KLOE 1a, 3a
[16] KLOE 2a
[17] KLOE 3b, 3c

we're currently in discussions about joining the doctors in training bank, which will give the Trust access to greater numbers of trainee bank doctors.

4.15 Elective Plan[18] - System Catchment

The Trust has developed a proactive elective plan to sustain the process of the delivery of elective activity over the winter period. The Planned Care working group continue to develop this to support the delivery of elective activity as part of recovery, the third phase of the response to COVID-19 according to the guidance and to increase activity in the coming months. This plan will provide the capacity to deal with emergency activity, deliver the elective activity, and to support restoration and improvement against the Referral to Treatment performance (RTT), whilst ensuring access to urgent, cancer services and long waiters are met in according to the third phase NHS response guidance.

As part of our restoration plans, the Captain Sir Tom Moore Building (formerly CMTC) AND Florence Nightingale Building are being developed as The Halton Elective Centre. The development of the elective hub continues and supports resilience for potential winter pressures. This provides a safe and COVID-light pathway to deliver elective treatment to category 1 and 2 patients and those with >52 weeks wait.

The plan, which is focussed on elective work, will reduce the number of cancellations, and ensure elective patients receive their treatment in a safe way on a COVID-light pathway. Activity will continue to be delivered on the two sites however, escalation plans to manage COVID-19 pathways could lead to all elective activity occurring at the Halton Elective Hub.

Actions

The key components of the plan are:

Responding to the priorities identified in Third Phase of Response to COVID-19, including:-*Accelerating the return of non-Covid health services, making full use of the capacity available in the window of opportunity between now and winter*

- We aim to restore full operation of all cancer services. This work will be overseen by a national cancer delivery taskforce, involving major patient charities and other key stakeholders.
- We continue to recover the maximum elective activity possible between now and winter (August – October).
- In September, we plan to achieve at least 80% of last year's activity for both overnight electives and for outpatient/day case procedures, rising to 90% in October (aiming for 70% in August).
- This means that we need to very swiftly return to at least 90% of last year's levels of MRI/CT and endoscopy procedures, with an ambition to reach 100% by October.
- We aim to achieve 100% of last year's activity for first outpatient attendances and follow-ups (face to face or virtually) from September through the balance of the year.
- Clinically urgent patients should continue to be treated first, with next priority given to the longest waiting patients, specifically those breaching or at risk of breaching 52 weeks by the end of March 2021
- Waiting lists are scrutinised frequently through the Patient Review Group, Planned Care Group meetings and updates are subsequently reported to Recovery Board on a weekly basis. These updates are shared with the Strategic Executive Oversight Group.

[18] KLOE, 1c, 1d, 1e, 2a, 2b

- In the months leading up to the Planned Care Group will develop plans to ensure full utilisation and plan for additional activity to sustain our elective plan in line with the third phase guidance.
- We plan to continue our collaboration with Spire Cheshire to support the elective programme in Theatre Radiology and Endoscopy through the national ISP contract.
- The Planned Care Group continues to manage the elective process and support patient and staff safety through the elective pathway.
- Evening and weekend elective activity plans have been submitted to support increase in activity and a reduction in waiting lists in Endoscopy.
- The Winter Plan will start 21st December until 31st January 2021. The end date for the Warrington site will be reviewed in January to determine if longer is required. The Halton Elective Centre will continue to be fully operational during this time
- We will schedule am Day Cases activity only on Christmas Eve and New Year's Eve across all three sites.
- During the 2-week Christmas period there will be a focus on Day Case activity at the Halton Elective Centre and any inpatient activity will be reviewed should we need to undertake inpatient lists. Particular attention will be paid to those patients >52 weeks in line with the priorities outlined in the phase 3 response to COVID-19.

4.16 Long Length of Stay – System Catchment [19]

Long length of Stay (LLOS) stay patients, specifically those that stay in hospital for more than 21 days account for 7% of all NEL admissions and 20% of hospital stays nationally. As well as being better for patients, reducing LLOS also releases capacity. In line with other trusts and planning guidance, NHSE have challenged acute trusts to achieve a 40% reduction of long length of stay patients by March 2020. Locally, this equates to having no more than 95 patients at any time in Warrington Hospital with a stay more than 21 days.

Significant progress has been made from the 2019/20 baseline position with the reduction in long length of stay patients supported by:

- Long length of stay reviews
- Clinical engagement
- Roll out of the SAFER bundle
- Same day emergency care
- Acute frailty services
- Daily discharge situation reporting
- Transitional care
- Care home discharge coordinator
- Intermediate care

March 2020 saw a significant reduction in LLOS due to the Covid-19 pandemic. NHSE tasked all hospitals to reduce the acute bed capacity by 50% to ensure that capacity was available to meet the increased demand for secondary care.

[19] KLOE, 1b, 1d, 2a

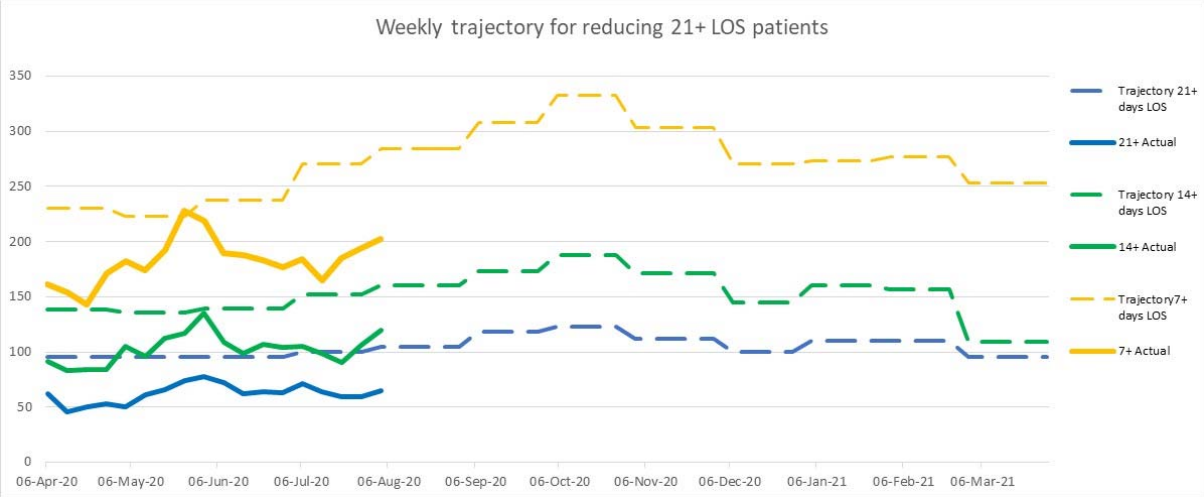
For winter 2020/21, delayed transfers of care will be further reduced which will contribute to the overarching LLOS measure by introducing additional capacity within:

- Rapid Response (see 4.2)
- Reablement service (see 4.4)
- Intermediate care (see 4.9)

These services provide assessment, care and rehabilitation at home for 11 people per week with a plan for 37 people per week when the services are forecast to reach full establishment in January 2021.
Initiatives within WHTHFT and across the intermediate care tier including:

- Where Best Next
- Home for Lunch

The chart below describes both the agreed trajectory and actual performance for patients in Warrington Hospital.



Within this total, there are of course, several non-Warrington and/or Halton CCG patients.

Appendix 7 - Current LLOS position

4.17 Where Best Next[20]

NHSE has challenged our system to achieve a 40% reduction in the number of patients staying in hospital in excess of 21 days. Whilst a long length of stay may be clinically appropriate for some patients, for most patients' long lengths of stay are associated with deconditioning, increased dependency, and an increased risk of contracting a hospital acquired infection. The clinical case for reducing long lengths of stay is clear and success to this approach is entirely dependent upon the support of our key partners from across the Health and Social Care system.

WHHFT completed a Where Best Next campaign in October 2019, December 2019, and January 2020. Key objectives of the campaign centred on the five key principles:

- Plan for discharge from the start

[20] KLOE, 4b

- Involve patients and their families in discharge decisions
- Establish systems and processes for frail people
- Embed multidisciplinary team reviews
- Encourage a supported 'Home First' approach

WHHFT arranged for a training session, open to all staff, based around NHS England and NHS Improvement five key principles which can help ensure that patients are discharged in a safe, appropriate, and timely way.

The session took place in October 2019 and was supported by external partners.

Where Best Next has continued daily on three in-patient wards identified as having the highest lengths of stay and for all medically optimised/ fit in-patients.

In collaboration with the Integrated Discharge team at WHHFT, the intermediate care tier plan to launch where best next within the Intermediate care bed bases, launch planned in conjunction with the "Home for lunch" project on 13/08/2020. Both initiatives intend to support safe and timely discharge from Hospital and Intermediate care, reducing overall LLOS.

4.18 Care home discharge coordinator - Warrington[21]

The Care home discharge coordinator role was introduced at WHHFT in December 2018/19 with the objective to:

- Support improvement in hospital discharge arrangements from hospital to Nursing and Residential Homes in Warrington, improving patient experience, clinical safety and patient flow.
- Facilitate discharge where issues have arisen which could compromise the quality or timeliness of discharge from hospital, working with all relevant staff across organisational boundaries with a problem-solving approach.
- Track Care home patients from EDD to discharge to enable timely discharge and support arrangements e.g. provision of equipment, therapy input etc.
- Work with the hospital discharge team based at Warrington hospital, to act on behalf of Care Home providers, to support appropriate assessment and facilitate timely and safe discharges from hospital to Care Homes within Warrington.

The Care home trusted assessor has continued to act on behalf of care home providers, to support appropriate assessment and to facilitate safe and timely discharges from hospital. The average length of stay for care home residents prior to the commencement of the role in November 2018 was 12.11. Today the average LLOS for care home residents in WHTHFT is 11.2.

The role of the care home discharge coordinator is currently funded via the better care fund; this is due to be reviewed in December 2020/21.

4.19 Brexit Planning – System Catchment[22]

Brexit planning will be monitored through the Event Planning Group ahead of the UK's exit from the European Union. Our response will continue to be guided by the publication of additional supporting

[21] KLOE, 1d, 2a, 3a, 4b
[22] KLOE, 5c

information from NHSE with regards to the UK exit strategy. The impacts on supplies of medicines and consumables will be monitored closely.

4.20 Minor Ailments Service – Halton[23]

This scheme is operated across the majority of pharmacies in Halton so there is wide geographical coverage of the service across the whole locality. Patients can self-refer to any pharmacy delivering the service and request to be treated under this scheme.

The scheme covers specific minor ailments and illnesses and medication can be provided from an agreed local formulary of over the counter medicines free of charge if patients are exempt from NHS prescription charges.

The scheme will be jointly reviewed with neighbouring CCGs, St Helens, and Knowsley, during Autumn 2020 to ensure it is in line with NHSE guidance and the local self-care work programme. At this time there is a reciprocal agreement across Knowsley and St Helens so that Halton patients can be treated under the scheme in any of these areas. This supports and encourages patient to seek advice and support from the right place first time and so improving access within the system.

4.21 Avoidance of Admissions (IV Antibiotics) – Halton[24]

This service is provided by two Halton pharmacies. They stock an agreed list of IV antibiotics to support access in the community when needed for the OPAT team and to avoid an admission to secondary care purely to access this medication.

4.22 Avoidance of Admissions (Access to Palliative Care Medicines) [25]

Halton

This service is provided by five Halton pharmacies. They stock an agreed list of end of life medication to improve access to these vital medications in a timely manner at a very critical time for patients and carers and ultimately will avoid patients having to be admitted to a hospice or secondary care unnecessarily to obtain the correct medication. During COVID the CCG commissioned two of these pharmacies to provide an urgent one-hour delivery service for suspected or confirmed COVID patients to manage end of life symptoms, this service will be continually reviewed as we go into winter to assess its ongoing suitability and ensure it is fit for purpose. All palliative pharmacies have also been provided with a mobile phone to ensure timely communication between prescribers and dispensers and to support resolution of issues.

Warrington

This service is provided by nine Warrington pharmacies. They stock an agreed list of end of life medication to improve access to these vital medications in a timely manner at a very critical time for patients and carers and ultimately will avoid patients having to be admitted to a hospice or secondary care unnecessarily to obtain the correct medication. During COVID the CCG commissioned three of these pharmacies to provide an urgent one-hour delivery service for suspected or confirmed COVID patients to manage end of life symptoms, this service will be continually reviewed as we go into Winter to assess its ongoing suitability and ensure it is fit for purpose. All palliative pharmacies

[23] KLOE, 1a, 1d, 2a, 3a
[24] KLOE, 1a
[25] KLOE, 1a

have also been provided with a mobile phone to ensure timely communication between prescribers and dispensers and to support resolution of issues.

4.23 Minor Eye Conditions Service (MECS) – Pharmacy Support Service - Halton[26]

The CCG is in the process of commissioning the pharmacy element of the MECS service. Patients seen by local opticians, as part of this service, who require medication as a result can be supplied this from a pharmacy free of charge if they do not pay for their prescriptions. This is primarily to support treatment of urgent eye conditions during the COVID period but will remain in place to support the ongoing MECS service as they move back towards recovery and routine consultations.

4.24 Improved Medicines Optimisation to reduce non-elective admissions[27]

Halton

In line with the national medicine's optimisation agenda, the CCG Medicines Management Pharmacists and Technicians focus is on high priority areas that can support a reduction in unnecessary admissions and the out of hospital agenda. As we go into winter, priorities will focus around respiratory, cardiovascular and antimicrobial resistance as well as refocussing on safe use of opioids for chronic pain. Structured medication reviews will continue for complex patients with long term conditions and specifically for care home residents. The reduction in polypharmacy and de-prescribing in appropriate patients will support a reduction in unnecessary admissions due to adverse effects related to medication and will also support more effective use of NHS resources.

Warrington

In line with the national medicines' optimisation agenda the CCG Medicines Management Pharmacists and Technicians focus is on high priority areas that can support a reduction in unnecessary admissions and the out of hospital agenda. As we go into winter, priorities will focus around respiratory, cardiovascular and antimicrobial resistance as well as refocussing on safe use of opioids for chronic pain. The team is also supporting the frailty workstream and de-prescribing in appropriate patients will support a reduction in unnecessary admissions due to adverse effects related to medication and will also support more effective use of NHS resources.

4.25 Urgent Treatment Centres – Halton[28]

Two Urgent Treatment Centres which provide a new model of care will be available in the Borough from October 2020. The aim of the new model of care is to ensure the service is integrated into primary and community care to offer patients with low acuity, minor injuries and illness, same day access to urgent care services.

This new model aims to decrease Halton ED activity for the two acute trusts by up to 20% per year. This will ensure patients are seen in the right place, at the right time by the right health care professional.

The UTC's will align with the NHS 111 First model and enable 111 to book appropriate patients into the services. Both Warrington and Halton populations will be able to use these services. It is also a minimum standard that the UTC sites will be able to receive patients via ambulance arrival, again those that are appropriate which will also reduce the demand into both acute ED departments.

[26] KLOE, 1a, 2a
[27] KLOE, 1a
[28] KLOE, 1a, 1d, 2a, 3a

4.26 Psychiatric Liaison Service - Halton[29]

Patients presenting at either Warrington or St Helens & Knowsley ED departments with a mental health condition are currently assessed by the Mental Health Practitioner from the Psychiatric Liaison Service in the ED. Patients are either signposted to other mental health services or receive intervention as required. The aim of the PLS is to help reduce the number of mental health admissions into secondary care, reducing length of stays in hospital for patients. The service currently operates 24/7.

PLS also works with clinical staff on the wards to assess whether mental health patients are suitable for discharge and help the patient to get home sooner with community mental health support. PLS aims to reduce unnecessary admissions into secondary care and contributes towards reducing the length of stay for patients.

4.27 24/7 Crisis Response Resolution & Home Treatment – Halton & Warrington[30]

Part of crisis offer. Secondary care service to help support and maintain patients at home step down into community services and support. Became a 24/7 service offer from 1st April 2020. Helping reduce length of stay in a mental health patient bed.

4.28 Community IV Team[31]

The IV therapy service plays a pivotal role in hospital admission avoidance, by offering access to intravenous therapy treatment to residents of Halton and Warrington in a community setting or their own homes. The current service offer is a seven-day service operating between 08:00 – 17:00 and the focus of this development is to increase the operational hours of the service to 07:00 – 20:00.

This change will be achieved by a reconfiguration of the current staffing model to "spread" the capacity more effectively across the widened hours of operations. A demand and capacity exercise has been completed to inform the new model and has provided confirmation that the team are able to effectively accommodate the extended service offer.

Benefits of the Development:

- Reduce the number of avoidable ED attendances and hospital admissions and/or readmissions by providing an intravenous therapy service in the community.
- Contribute to effective discharge pathways and smooth transition between providers across health and social care.
- Provide safe, flexible, and responsive services which meet patient and population needs, release capacity and maintain high quality care.
- Improve pathway efficiency through positive communication between provider partners and promotion of Bridgewater services.
- Reduce unnecessary hospital admissions through use of active admission avoidance and early intervention pathways.
- Reduce hospital-based length of stay through pro-active discharge management and early supported discharge (ESD) pathways.
- Support Enhanced Care Home Service to maintain people in their usual environment.

[29] KLOE, 1a
[30] KLOE, 1a
[31] KLOE, 1a, 2a

4.29 Central Equipment Store (Investment needed – more work required)[32]

The Trust's Community Equipment Stores provides equipment services that support independent living for residents of all ages in Halton and Warrington. The provision supports early hospital discharge into the community setting and reduction in avoidable hospital admissions.

This development centres on expanding the operational hours of the service from Monday to Friday 08:00 – 16:00 to a seven-day provision, with a two-hour response time for priority dispatches that the meet essential criteria.

Benefits of the Development:

- Reduced avoidable hospital admissions by enhancing independence at home
- Minimise delayed discharge from hospital into the community
- Service availability at weekends

4.30 Halton Bladder and Bowel Service[33]

The Halton Bladder and Bowel Service is available to people aged 18 and over who are experiencing issues with bladder or bowel continence. The service aims to improve quality of life, by providing support and advice on the self-management of incontinence, including provision of appropriate aids and products, and training on continence issues to patients, their families/carers and other health professionals.

This development introduces the Warrington style catheter service, to enable a quicker response to blocked catheters and failed TWOC (trial without catheter) and will ensure provision of a consistent responsive catheter support service across Halton and Warrington.

Benefits of the Development:

- Improved quality of service
- Reduction in unplanned hospital admissions
- Consistence of offer across Halton and Warrington

5.0 Primary Care[34]

General Practice is often the first point of contact for the health care needs of patients; general practice provides continuity of care over a lifetime and often across generations.

During the winter months, primary care providers, like all other system providers, can find demand for their services increased significantly compared to the summer months. This can mean that the capacity for bookable appointments is used quickly requiring practices to extend clinics. In turn this can of course mean that clinics run late. Like the rest of the system, this can contribute to staff feeling exhausted and anxious.

Whilst the Primary Care Network Directed Enhanced Service has enabled the introduction of additional clinical staff through the 'Additional Roles Reimbursement Scheme', Warrington still has a per head shortage of clinical staff and therefore the additional patient demand during the winter months does increase pressure on and within the primary care system.

[32] KLOE, 1a
[33] KLOE, 1a
[34] KLOE, 1a, 1b, 2a, 2b, 3a, 3b, 3c, 4c

Primary care like most other services has been severely affected during COVID-19, and GP Practices are delivering their commissioned services in accordance with the National Standing Operating Procedure (SOP), which is currently V3.4. (August 2020).

NHS Priorities for Primary Care SOP V3.4

- General Practice, to restore activity to pre-Covid levels where clinically appropriate and reach out proactively to clinically vulnerable patients and those whose care may have been delayed.
- Practices should open for delivery of face to face care, whilst triaging remotely in advance wherever possible.
- Ensure online consultation systems are in place to support total triage.
- Ensure video consultations are available to support clinical needs.

5.1 Warrington

Total Triage

Primary Care remains at the forefront of the coronavirus "challenge" and whilst COVID changed the method of delivery to a total triage platform overnight all practices have remained open and treating their patients.

The new total triage way of working includes telephone consultations, new digital ways of working, on-line consultations (known locally as eConsult) and video consultation, this new way of working is embedded for future care delivery.

Primary Care for patients who do not have symptoms of COVID-19 is all delivered from a patient's registered practice however patients who have any symptoms of COVID-19 or indeed live in a household where COVID-19 symptoms are present must be treated in a separate environment by separate clinical staff. In Warrington there is one COVID face to face assessment centre used by all 26 practices.

Making every contact count is still very much the embraced ethos within primary care, embedded within the processes of the total triage systems, primary care actively signposts their patients to the most appropriate part of their workforce within the health system to ensure that patients are seen by the right person, at the right time in the right place.

Every contact to primary care is first clinically triaged. It is important to note that if it is deemed clinically appropriate, an appointment will be made for a face to face consultation within the practice or the COVID face to face assessment centre with a suitable clinician. Alternatively, patients may be signposted to another service more appropriate for their needs, e.g. pharmacy, RCRS, Warrington Wellbeing Service (for social needs) or IAPT services for any low-level mental health needs.

On-line consultations have significantly increased across Warrington over recent months, the CCG is working with eConsult and GPs to review the pathways to ensure the service continues to be safe but responsive. A review will be undertaken to determine if this digital method of accessing primary care can be developed into the out of hours service to assist the ways of working within that service.

COVID Face to Face Assessment Centre

From 1st August 2020 a single face to face assessment centre is in place across the Warrington population to ensure patients with COVID symptoms are examined and treated in a safe, infection control compliant environment. This service extends to patients who are resident in a household where there are COVID symptoms and is not just for patients who have possible COVID.

From 1st November 2020 the face to face assessment service specification will be varied to enable the service to meet the winter pressures of patients who have both COVID and influenza like symptoms (which are very similar). The service specification will link directly into other winter schemes across the health system to ensure that people who can be safely managed in the community are and that admissions to hospital can be avoided where necessary.

GP Home Visits

Each Practice offers a GP Home visiting service under the core contract. In response to COVID-19 the CCG commissioned a Home Assessment Service for shielded patients, the service was paramedic led and complemented the Rapid Community Response Service managed by Bridgewater Foundation NHS Trust. The two services were co-located and complemented each other in service delivery.

The CCGs commissioned service recently ended however, Bridgewater has now employed the paramedic for a further 12 months to develop a proof of concept. This service will support winter pressures with admission avoidance.

Workforce

GPs and clinical staff in primary care work in small teams, where most other NHS providers often work as part of a larger team. Across Warrington, there are four practices with sole medical practitioners responsible for a surgery ('single handed' practice). This equates to approx. 11,569 patients. So, should a GP or clinical staff member in these practices become unwell, that patient population may be without a medical practitioner having a knock-on effect across the system. There is also potential for a whole practice having to self-isolate which is a significant risk for primary care.

PCN's and the CCG are working together to assess the level of impact and through completion of risks assessments, mitigations are being agreed and plans are being developed in response to any notable risks raised.

Additional Roles Reimbursement Scheme (ARRS)

To support the delivery of the national specifications, PCNs will have access to funding to employ specific clinical roles within their networks. The Additional Roles Reimbursement Scheme will fund 100 per cent of the cost of some roles which will be developed during the contract term. This team will support the identified workforce shortage in General Practice and increasingly become involved in-patient care.

The roles include:

- Clinical pharmacists, who will review patient medications.
- Social Prescribing Link Workers, who will address non-clinical issues such as isolation.
- Physiotherapists, who support recovery and mobility.
- Pharmacy Technicians, who support patients to get the best out of their medicines.
- Physician Associates, who can take medical histories and blood pressures, complete insurance forms and explain treatments, freeing up the GP.
- Health and Wellbeing Coaches, who work alongside patients who may need additional support.
- Care Co-Ordinator's, who are trained health professionals that help to manage patient's care.
- Dieticians, who diagnose, treat, and educate on dietary and nutritional problems.
- Podiatrists, who diagnose and treat conditions of the feet and lower limb.
- Occupational Therapists, who can support with everyday activities which have become difficult.

Across Warrington, PCNs are currently completing their workforce plans as directed by NHS England under the Network Contract DES. A rapid recruitment processes will be mobilised to enhance the workforce and fully utilize the ARRS resource.

Primary Care Restart

Primary Care in Warrington has responded extremely well over the past 5 months to the global pandemic to minimise its impact on our population and to manage the virus in those who have been affected. All practices have adopted the national Standard Operating Protocol and practices have all ensured that patients are seen safely.

In accordance with the letter received on 9th July 2020 from NHS England, Primary Care is now starting to restore activity to usual levels. The letter outlined the next stage of the COVID-19 response which

is to move primary care into a 'recovery' stage, focusing on, where possible, restoring routine care to patients.

Local Enhanced Services (LES)

The CCG commissions a LES to support the practices to deliver the Warrington Brand. This ensures that all practices offer similar enhanced services that deliver bespoke Warrington services meeting our local needs. In March 2020, NHS England instructed that all LES schemes, unless supporting COVID, should be paused. The intention was to ensure that GP/primary care capacity was released to focus on the response to the demands of COVID-19.

NHS E has recently confirmed that LES programmes can now restart. Therefore, the CCG is currently reviewing all service specifications to ensure they are fit for purpose and complement delivery of the national SOP v3.4. Once defined and agreed, the services will commence from September 2020 – March 2021 (6-month period).

Network Contract Directed Enhanced Service (Network Contract DES)

The "Network Contract DES" was first introduced in the Directed Enhanced Services Directions 2019. The Network Contract DES placed obligations on practices and commissioners and granted various entitlements to practices with effect from 1 July 2019. An objective of the Network Contract DES in 2019 was for primary medical services contractors to establish and develop Primary Care Networks ("PCNs").

The Network Contract DES forms part of a long-term, larger package of general practice contract reform originally set out in Investment and Evolution: A five-year framework for GP contract reform to implement the NHS Long Term Plan.

During 2020/21, the DES sets outs obligations for PCN's across several areas, these are: -

- Enhanced Health in Care Homes
- Structured Medication Reviews and medicines optimization
- Early cancer diagnosis, and
- Social Prescribing Services

Enhanced Health in Care Homes

There are 55 CQC registered care homes across Warrington including homes for patients with a mental health disability. PCNs are aligned to each home, along with Clinical Leads identified for each home.

PCNs are working closely with community providers to plan the next stages of the enhanced health in care homes, which will: -

By 30th September 2020 – develop and coordinate a multidisciplinary team (MDT) with community service providers and other relevant partners.

By 1st October 2020 - Commence weekly ward round with every care home and commence MDTs to enable the development of personalised care and support plans with people living in the PCN's Aligned Care Homes.

This proactive and pre-emptive approach to managing residents within care homes will support the winter plan by reducing the number of admissions to hospital and by enabling faster discharge.

Primary Care working with community providers will ensure that care is provided appropriately and will endeavor to keep patients in their own homes.

Structured Medication Reviews and Medicines Optimisation

From the 1 October 2020, the PCNs are required to identify and prioritise PCN patients who would benefit from a structured medication review, which must include patients:

- in care homes
- with complex and problematic polypharmacy, specifically those on 10 or more medications
- on medicines commonly associated with medication errors
- with severe frailty, who are particularly isolated or housebound patients, or who have had recent hospital admissions and/or falls; and
- using potentially addictive pain management medication

This detailed review is a practical and proactive review of the most vulnerable who are often the patients who end up being admitted to hospital. By linking in with other services it is envisaged that admissions to hospital during winter for this cohort of patients will be reduced.

Early Cancer Diagnosis

From 1 October 2020, PCNs are required to:

- review referral practice for suspected cancers, including recurrent cancers.
- review the quality of the PCN's Core Network Practices' referrals for suspected cancer, against the recommendations of NICE Guideline and make use of:
- practice-level data to explore local patterns in presentation and diagnosis of cancer

Social Prescribing Service

PCNs are encouraged to have social prescribing link workers in place across primary care. In Warrington, the local authority commissions a wellbeing service which offers a similar service. To avoid duplication and to ensure seamless pathways are in place that will benefit patients and practices a Task & Finish group has been established. A public engagement event has taken place and the next phase of the project is for PCNs to recruit into post in readiness for winter 2020/21.

PCNs are currently seeking advice for the implementation of this service, which will be in place for Winter 2020.

Potential COVID second wave outbreak

During COVID-19, GP Practices responded to the outbreak effectively to manage to patient populations. Should a second wave occur, primary care will activate their business continuity planning that was put into place from March 2020. A high-level overview of the primary care COVID response is described below: -

- Total triage processes were put into place which included amending how access to premises takes place (via intercom to reduce foot fall).
- Practices zoned their premises and patient flows.
- SOPs were put into place to support the changes.
- Five COVID face to face assessment centre's were established across the Warrington Borough (this is now just one centre for the Warrington population).
- Patient taxi transport services were commissioned to transport patients to primary care COVID and non COVID services across the town.

Improved Access to General Practice

Extended Access Service

The CCG commissions Bridgewater Foundation NHS Trust to deliver an extended access service. The service is available from 5.30pm – 8pm weekdays, Saturdays 10am-4pm and Sunday 10am – 2pm. The total capacity commissioned is 3660 minutes (equivalent to 17.26 hours per 1,000 weighted population). The CCG working with the PCNs is currently exploring how the service can be improved and expanded to meet patient demand.

GP Extended Hours Service (DES requirements)

Through the Network DES, GP Practices are delivering an extended hours service, which offers patients 30 minutes per 1000 registered patients per week.

This is broken down across the Networks as described in the diagram below: -

PCN	**Hours delivered each week**
Central East	19.6
Central &West	23.65
East	16.4
WIN	26.7
SWaN	24.6
Total	111 additional hrs

GP Out of Hours Service

Bridgewater Foundation NHS Trust is commissioned to deliver a GP Out of Hours Service from 6.30pm – 8.00am Monday – Friday and a 24hr service during weekends and bank holidays.

The CCG are currently exploring if online consultation systems can be embedded into the EA and GP OOH Services.

ECGs in Primary Care

The CCG has commissioned a 12-lead ECG service in Primary Care, which is currently live across 24 Practices. The next stage of development is a 24hr tape service.

The CCG and the Acute Trust are currently mobilising the service, which will be in place for winter 2020/21.

5.2 Halton[35]

Total Triage

Primary Care remains at the forefront of the coronavirus "challenge". NHS England continues to require practices to operate under a total triage platform.

Total Triage includes telephone consultations, on-line consultations (known locally as eConsult) and video consultations. Every contact to primary care is first clinically triaged. If a patient clinically requires a face to face appointment this is offered.

Primary Care for patients who do not have symptoms of COVID-19 will be delivered from a patient's registered practice. Patients who have any symptoms of COVID-19 or indeed live in a household where COVID-19 symptoms are present must be treated in a separate environment by separate clinical staff through the local operationalised COVID response service.

COVID Service

Both Halton Primary Care Networks covering the populations of Runcorn and Widnes continue to ensure access to services are available for patients with suspected/confirmed Covid-19 and their household members. The specific separate services available during the peak are being adapted.

Plans are being developed to provide this service from the two Urgent Treatment Centres with the ability to scale up the provision should a second peak occur. This service includes home visits where required.

Additional Roles Reimbursement Scheme (ARRS)

The Halton PCNs are reviewing workforce and intend to maximise the funding available via the Additional Roles Reimbursement Scheme. This will increase the number and enhance the skill mix of staff within primary care to support demands over winter. This will assist total triage in directing patients to the most appropriate member of the primary care clinical workforce.

Improved Access

Extended Access

Primary Care in Halton will continue to provide evening and weekend appointments, or extended access, at two sites. In Runcorn this is provided at Heath Road Medical Centre whist in Widnes this is provided within the Urgent Treatment Centres. All patients across Halton can attend either site. Appointments are available between 6.30pm-9pm weekdays and 9am-3pm weekends and during bank holidays.

Prior to the pandemic NHS 111 were able to directly book patients into this service. Whilst this was switched off during the initial pandemic peak, direct booking is being re-introduced and will once again be available over the winter.

Discussions also continue to improve the links between the Extended Access service into the Urgent Treatment Centre and vice versa allowing patients to be seen by the most appropriate healthcare professional; and the development of robust pathways.

[35] KLOE, 1a, 1c, 2a

Extended Hours

Following the introduction of the 2019/20 PCN Enhanced Service for Extended Hours, all practices now offer additional early morning or evening appointments. Whilst this service was stood down during the pandemic, this is now fully re-instated and will be available this winter.

Care Navigation

Halton Care Navigators have been established since September 2018. One of the top ten high impact actions outlined in the GP Five Year Forward View, care navigation supports patients to make informed decisions on how they access services as an alternative to waiting for a GP appointment. Whilst the pandemic had disrupted access to these services, this is being re-instated as the local system returns to pre-Covid service levels. Patients can be signposted to the following services:

- Community Pharmacy
- Health Improvement Team
- Minor eye conditions (MECS)
- MSK service
- Sexual health
- Wellbeing Access

Primary Care Network Enhanced Health in Care Homes & Provision of Anti-Viral medication

Since 2017 GP practices have been aligned to specific care homes, ahead of the new PCN DES requirements. Whilst patients retain the choice to decide which practice, they would like to remain registered with, the scheme promotes registration with the aligned practice offering an improved and less reactive model of care by providing regular ward rounds.

This scheme has been invaluable during the Covid-19 Pandemic with ward rounds being held virtually to ensure continuity of care. Both Halton Primary Care Networks are fully implementing the new national requirements and are looking to retain the additionality that the local scheme brings to ensure patients in care homes continue to receive pro-active primary care provision.

In addition, the CCG will continue to commission PC24 to provide anti-viral medication to care homes in the event of a Flu outbreak.

6.0 Respiratory[36]

A number of key activities are in place across the system to improve the care of respiratory patients.

During 2019/20 Cheshire and Merseyside were working across the region to roll out a Transformation Change Programme and to develop a “good pathway” for the system. The Programme is expected to continue its rollout throughout Winter 20/21 and be fully operational again in 2021.

Respiratory development currently sits within multiple CCG workstreams including respiratory ambulatory care, the flu vaccination programmes and a Post COVID follow up pathway. The CCG has mandated a local Respiratory Work Programme Post COVID which outlines the priority projects. They are:-

Improve Pneumonia Management

- Point of Care Testing
- Vaccinations
- IV Team Support

[36] KLOE, 1a

Optimise Long Term Conditions

- Medication Optimisation (Rescue Packs, Physician Associates)
- Pulmonary Rehab
- Palliative Care
- Enhanced Care Homes

Minimise COVID Cross Contamination

- Rapid response community IV Therapy
- Supporting in Close to Home environment

Appendix 8 – Respiratory further detail

7.0 North West Boroughs response to the Capacity Challenge

There will be an enhanced service to meet the capacity challenge in 2020/21.

Whilst we have maintained a psychiatric liaison service, the core hours will be extended to provide a 24/7 service, with visibility at the acute hospital. Known as "Core 24", this is a funded service to provide psychiatric input for service users who require assessment and intervention.

This service will be available to ED. The service provision with extended delivery commenced on the 10th August 2020, and a night practitioner, (registered mental health nurse), commenced on the 17th August 2020. It is expected by the end of September in preparedness for the 'Winter Months', our service care model will include psychology as well as the existing nursing and medical staff.

The above cover will be available 7 days a week, 365 days a year. It will need to be established how this model aligns itself with the WHHFT intent of implementation of NHS 111 First, given that model would want to signpost service users and limit 'on foot' attendance, however it is expected we will have a cohort of mental health users who may present with physical health interventions in the first instance and the availability of mental health support is to be welcomed. More information can be found in 4.25.

On the 14th April 2020, the trust launched its 24/7 crisis line, (brought forward given the national pandemic), and this is a helpline available to service users, and very much fits in with the NHS 111 First approach. Again, alignment with the philosophy of NHS 111 First is to be established as a 'pathway' for mental health users. More detail can be found in 4.9.

In response to service users who may be an inpatient at WHHFT but have further or identified mental health needs, the response for assessment will be enhanced given the increase in capacity with the development of the 24/7 in reach service.

With NWBH, twice daily bed management calls have been developed, (as an enhanced response to Covid19 and form a strong component of business continuity), which now include medical/consultant representation to enhance clinical decision making and patient flow. A 'RAG' rated admission criterion for beds has been established and will be launched in preparation for the winter months.

It is to be noted that there will continue to exist a 'community provision' – Park House which can support an identified care package for crisis intervention and will be utilised appropriately to support the existing bed stock and demand at the trust.

All other internal measures established in the winter plan for 19/20 will continue.

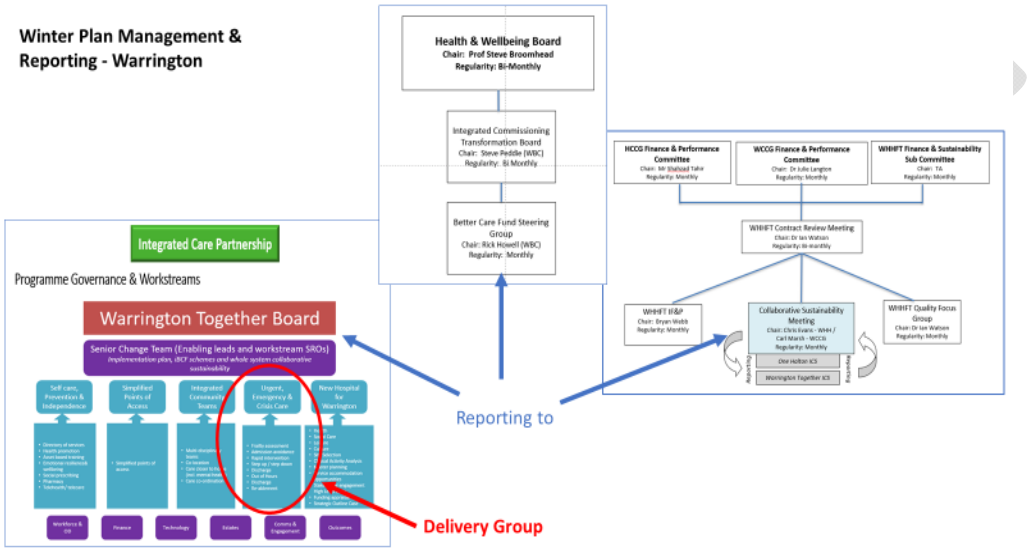
8.0 System Wide Communication Plan[37]

The Winter Plan which was agreed and implemented across the Mid Mersey footprint for 19/20 was reviewed and evaluated in February 2020. The key outcomes and learnings will be incorporated into the planning process and activities for 20/21.

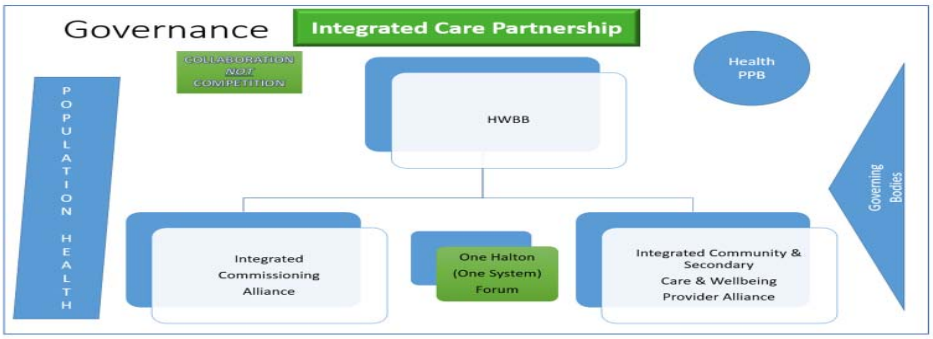
Discussions are being held with NHS E/I and the CMHCP regarding a C&M approach to the winter communication plan. Weekly meetings are taking place with a view to the development of a C&M wide plan, with a single approach in terms of the call to action, campaign materials, key messages etc. Whilst this will be a C&M wide plan, each locality will retain the ability to flex the messages and approach to meet local need.

9.0 Management & Reporting[38]

Across the Warrington System, the monitoring of the winter plan will be conducted through several forums. The below describe the different groups across Warrington and Halton.



Winter Plan Management & Reporting - Halton



[37] KLOE, 5d
[38] KLOE, 1e

10.0 Conclusion

The 2020/21 winter planning process and plan development has been derived using learning from the previous winters, guidance following the world-wide pandemic and system expertise.

The whole system has contributed to the plan, detailing each part of system response to winter and the ask in the KLOE's.

The plan will be implemented to ameliorate winter pressures and will be underpinned by robust escalation and planning processes that are outlined below:

- weekly winter system-wide planning meeting attended by representatives from all system health and care partners.
- weekly system escalation calls, if required, attended by operational leads from all health and care partner organisations.
- fortnightly system escalation calls, if required, attended by executive leads from all health and care partner organisations.
- weekly winter pressures call, hosted by NHS England/ Improvement and attended by all key decision makers, if required.
- frequent updates by partner executives to the relevant executive management teams, and.
- monthly meeting of Better Care Fund Steering Group that oversees performance of interventions aimed at reducing winter pressures.

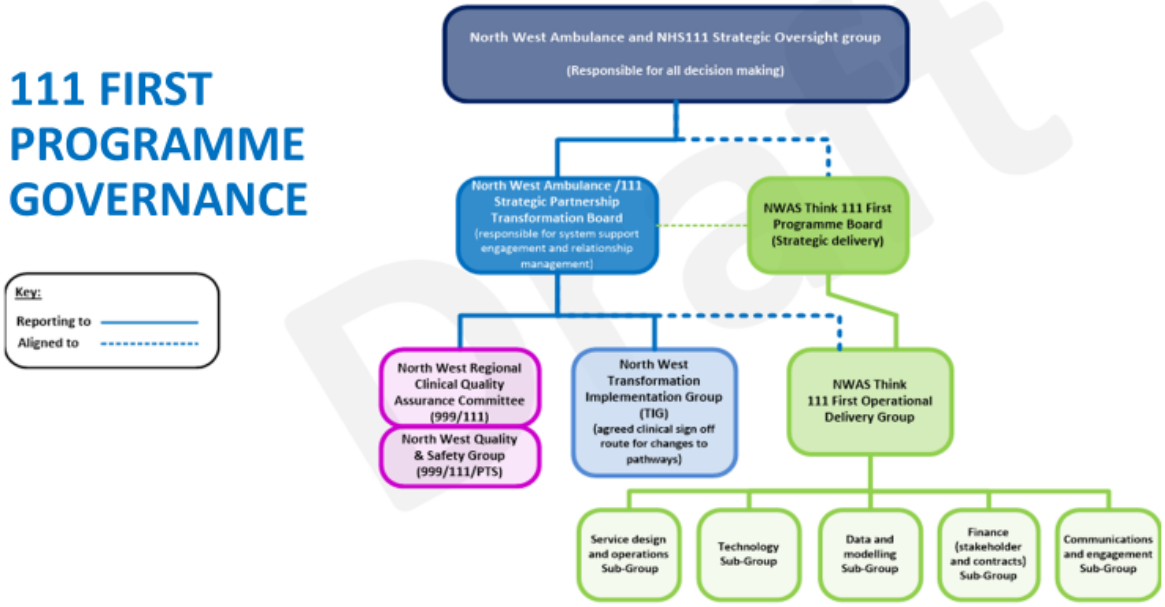
Appendices

Appendix 1 – KLOE reference table

DEMAND		Number of References in the plan
1a	In what ways is the local system working to reduce avoidable admission into hospital or other environments?	24
1b	What are the key drivers of system demand?	5
1c	How is the local system expecting demand to be different this winter (compared to previous winters)?	5
1d	How is the local system planning to manage any surge in demand this winter (primary, community and secondary care)?	10
1e	How will the local system maintain effective oversight of performance across the winter months?	3
CAPACITY		EVIDENCE
2a	How is the local system seeking to make maximum use of existing and potential capacity this winter, including mutual aid?	17
2b	How is the local system seeking to balance increasing emergency demand with the restoration of critical services (esp. routine elective care)?	3
WORKFORCE		EVIDENCE
3a	What steps is the local system taking to maximise the utilisation and effectiveness of its permanent workforce?	12
3b	Where workforce gaps exist what potential contingency procedures can be invoked?	3
3c	What are the key workforce risks over winter across the system? What mitigations are being put in place to reduce risk?	4
EXIT FLOW		EVIDENCE
4a	What are the key risks to flow?	1
4b	How is the local system seeking to work together to support improved flow at system exit points?	10
4c	What lessons learnt from COVID-19 related to exit flow will be implemented/ maintained through this winter?	3
EXTERNAL EVENTS		EVIDENCE
5a	What local system impacts are anticipated related to a 2nd COVID-19 surge?	1
5b	What local system impacts are anticipated related to flu?	1
5c	What local system impacts are anticipated related to Brexit?	2
5d	Does the local have an approved communications plan agreed?	2

Appendix 2 – NHS 111 First Additional Information

111 FIRST PROGRAMME GOVERNANCE



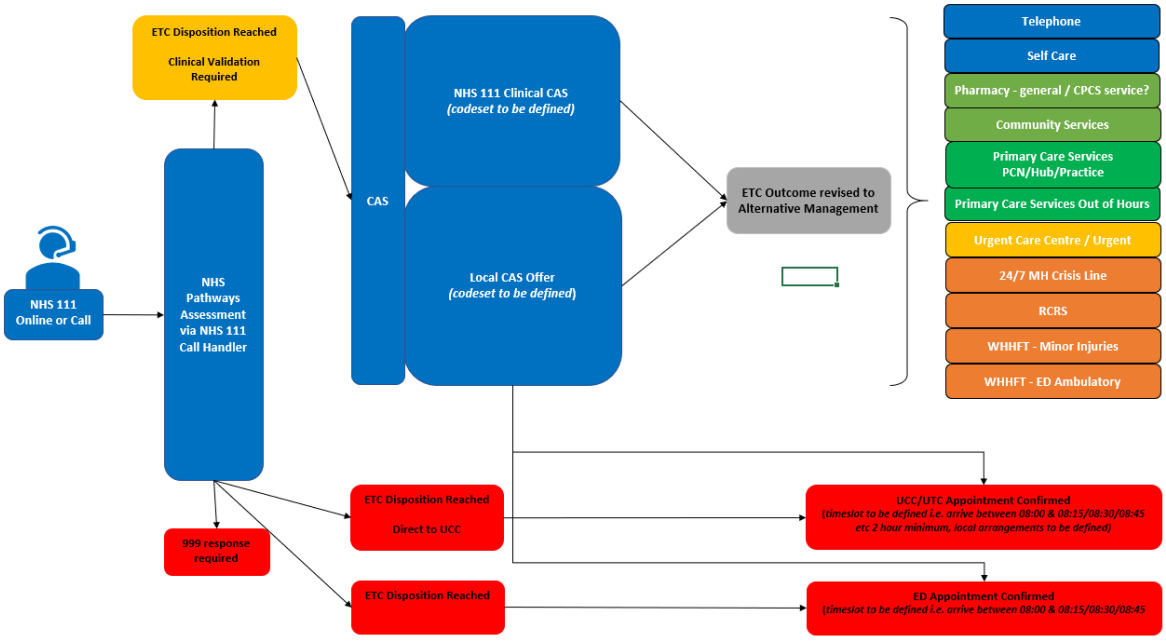
N.B. Contract management groups have been removed from the structure as have local engagement meetings further to NHS E & NHS I agreement

111 FIRST OVERVIEW

CONTEXT	WHAT IS 111 FIRST?	WHAT IS THE NATIONAL EXPECTATION?
In the NW approximately 60% of ED attendances are "unheralded" and the majority are during the day and early evening, which has implications for managing social distancing in waiting rooms, the risks of nosocomial spread and staff safety. During the COVID-19 pandemic NHS 111 was at the forefront of the response and demonstrated its potential to support the wider UEC system. With COVID still a real and present risk we must maintain our adapted responses to delivery: • Remote assessment and management where possible • Avoiding crowding in EDs and other F2F services (to minimise nosocomial infection) • Ensuring we look after vulnerable patients • Maintaining staff safety	A development of the current NHS 111 service to offer patients a different approach to the way they access and receive healthcare NHS 111 or your GP practice (both online and telephony) are the first places to go when experiencing a health issue that is not immediately life threatening: • Encouraging people to access remote assessment first, before attending any services • Ideally using digital routes to care, but supporting telephony and improved F2F where patients, e.g. in vulnerable groups, need them • Deploying the optimal level of clinical assessment via the CAS • Using new technologies to the limits of their capabilities • Opening up new direct referral routes into services and opportunities to book attendance slots/appointments	• 20% (c.400,00) of current "unheralded" ED attendances access remote assessment via 111; NW ambition higher • 10% reduction in ED attendances • Booking solution in all EDs by December: – Initially email referral, developing ITK – National expectation of a 2 hour timeslot; NW considering 30 minute • No predetermined method of CAS delivery, however 111 'ETC' outcomes must be clinically validated • Triage and streaming solution required at ED front-door • National and local communications campaigns • Reporting on progress and evaluation into NHSEI

111 FIRST NORTH WEST APPROACH

HOW WILL THIS BE DELIVERED? – *Whole system change with strong collaborative working across organisational boundaries*	
INCREASING CAPACITY	• **Recruiting** additional call handling and clinical capacity • **Harnessing capacity** across the urgent and emergency care system including; NHS 111, 999 and PTS, locality CASs, primary and community services, urgent treatment centres, EDs, including SDEC/AEC, and other secondary care services
TECHNOLOGY AND INTEROPERABILITY	• Increasing the use of **remote assessment** • **Direct appointment booking** into EDs and alternative services • Supporting **access to records** • Increasing **system interoperability**
CLINICAL PATHWAY DEVELOPMENT	• **Maximising the use of enhanced clinical assessment** via local CASs including increasing validation of C3/C4 and ED/ETC activity and targeted triage of high risk and/or vulnerable patients • **Enabling direct referrals to acute-based services** i.e. SDEC and AEC, Surgical/Medical/Paediatric/Early Pregnancy assessment units for primary care and other out of hospital clinicians, e.g. paramedics • **UEC DoS review** to support safe deflections into alternative services



Appendix 3 – Warrington & Halton Flu Action Plan 2020/21

Summary:

As Category 2 responders under the CCA (2004) and in line with arrangements for other major incidents and emergencies, Clinical Commissioning Groups (CCGs) have a role in supporting NHS England and providers of NHS funded care in planning for and responding to an influenza pandemic. The threat and potential impact of a pandemic influenza is such that it remains the top risk of the UK Cabinet Office National Risk Register of civil emergencies and continues to direct significant amount of emergency preparedness activity on a global basis. Lessons identified during the response to the 2009/10 pandemic caused by the A (H1N1) pdm09 virus and subsequent 2010/11 winter seasonal influenza outbreaks have informed ongoing preparedness activity.

Halton and Warrington seasonal flu action plan 2020/21

Flu is a key factor in NHS winter pressures. It impacts on both those who become ill, the NHS services that provide direct care, and on the wider health and social care system that supports people in "at-risk groups". Flu occurs every winter in the UK. The Flu Plan aims to reduce the impact of flu in the population through a series of complementary measures. These measures help to reduce illness in the community and unplanned hospital admissions, and therefore pressure on health services generally and ED.

The national flu immunisation programme is a key part of the plan. NHS Halton and NHS Warrington's Flu immunisation plan reflects the national plan.

This plan aligns to part one of the annual flu letter and will be updated when part two is produced.

This is a joint collaborative plan between Halton and Warrington localities due to a wider range of services working across both boroughs.

Covid-19 has caused major impacts on the Health and Social Care system, and this will need to be considered as we plan for winter pressures and seasonal flu.

The overall aims and objectives of this plan are:

- To outline NHS Halton and NHS Warrington CCGs roles and responsibilities during a pandemic influenza outbreak.
- To assist NHS Halton and NHS Warrington CCGs in minimising the potential health impacts caused by a future influenza pandemic on society and economy by:
    a) Supporting the continuity of essential services.
    b) Supporting the continuation of everyday activities as far as is practicable if an Influenza outbreak is declared throughout the 2020 / 21 period.
    c) Promoting a return to normality and the restoration of disrupted services at the earliest opportunity if Influenza outbreak occurs during 2020 / 21.
- Instil and maintain trust and confidence by ensuring that other health partners, the public and the media are engaged and well informed in advance of and throughout

the possible pandemic period and that health and other professionals receive information and guidance in a timely way so that they can respond to the public appropriately.

Planning:

Due to the uncertainty around the scale, severity, and pattern of development of any future flu pandemic, the following 3 key principles will underpin NHS Halton and NHS Warrington CCGs plan:

- *Precautionary:* This plan considers a new virus may carry the risk of being severe in nature. This plan therefore considers that any pandemic will have the potential to cause severe symptoms in individuals and widespread disruption to society.
- *Proportionality*: NHS Halton and NHS Warrington CCGs Flu Plan will be applicable for both potential high impact pandemics and milder scenarios with the ability to adapt as new evidence emerges.
- *Flexibility:* This plan will consider local patterns of spread of infection and be flexible and agile as required/ dictated by any possible pandemic.

	Action	**Lead/responsibility**	**Risk associated with covid-019**	**Completion date**	**Update / RAG**
Primary Care/GP	Guidance/information circulated recommending influenza vaccine orders	NHS England		February 2020	Completed.
	Vaccination orders placed – using guidance produced by NHSE  JCVI advice on Influenza Vaccines for	GP Practices	Possibility that more vaccines will need to be ordered if demand increases this winter due to covid-019	February 2020	Completed
	All Clinical and non-clinical immunisers are up to date with relevant training for delivering seasonal flu vaccination	GP Practices	Face to face training in line with Government social distancing guidance	July – September 2020	
	Meeting with Primary Care to clarify dilemmas and capabilities of delivering 2020 / 21 Flu programme.	GP Practices & CCG - SE	Shielding patients and social distancing issues regarding delivery.	July / August 2020.	

	Supporting Primary Care with the delivery of an extended programme following publication of nation flu letter part 2 (5.8.2020).	Primary Care	Workforce capacity issues. Social distancing restrictions with environments. Financial elements Accessing larger venues to accommodate extended cohort.	July – September 2020.	
	Circulation of Flu assurance template to Primary Care to allow CCGs assurance regarding robust, safe and high-quality delivery of Flu programme for identified eligible cohorts.	GP surgeries		August 2020.	
	Invite eligible individuals from identified groups as per PHE for vaccination: • 65+ • Under 65 with long term medical condition – including children. • Pregnant individuals • 2-year olds • 3-year olds • Carers • Shielded household individuals	GP Practices	Additional plans/risk assessments will have to be implemented to ensure social distancing is in place May need to review location of where vaccine is delivered Identify how they will vaccinate shielded cohort who may still be staying in their own homes	September 2020 for invites – programme to run September to November 2020	
	Attendance at joint monthly locality Flu group in collaboration with LA, Voluntary groups, Pharmacist / LPC, Providers to ensure	CCG – SE			Ongoing.

	robust and consistent offer as well as delivery regarding Flu – vaccine, communications and delivery Representation on C& M Influenza programme Board facilitated by PHE – report updates, initiatives and outcomes from meeting into locality Flu meetings.	CCG -SE			
	PPE – requirement of individual PPE when facilitating Immunisation clinics in accordance with IPC recommendations from PHE.	GP surgeries	May have restrictions on accessing and sourcing PPE for mass immunisation sessions. PHE guidance shared with Providers. Providers may choose not to follow PHE national guidance.		
	To encourage GP surgeries to deliver identified Flu programme to eligible cohorts by supporting and facilitating initiatives that will ensure patients are immunised timely and with the least disruption to usual contracted activities delivered.		Surgeries may decline to deliver to Flu immunisation programme due to competing workloads and due to constraints identified due to social distancing and national guidance.		

Intermediate Tier of Services Escalation Plan

ACTIONS TO BE IMPLEMENTED **Green Day: Daily actions to ensure optimum flow and capacity** **Daily Teleconference between ICaHT and IHDT** **Three times weekly Between ICaHT, IHDT and Dom Care**						
Bed Bases	Intermediate Care-Bridgewater	Hospital Discharge Team	ICAHT/ Reablement	Assisted Living/Telecare	Carecall	Rapid Community Response
Daily Huddles Daily information to be sent to all relevant personnel Regular contact with assessment team in the hospital Identify any patients who can be discharged within huddle and weekly handover Identify any reasons for delay – remove barriers Patients awaiting POC-ICAHT in community until POC available Routine utilisation of respite and transitional beds	Twice weekly formal MDT with all MDT present Assessment Team Manager (ATM) to review patients at MDT to ensure all care visits from ICAHT essential. Daily Huddles for Red cases Manager to attend morning teleconference Assess all service users for single handed care	Bed coordinator to chair twice daily teleconference with community and bed base colleagues. Review individuals on bed list to determine MOFD status. Complete / share with system sitrep. Face to face assessments / reviews to take place by bed assessor. Daily data to be circulated with the system. Daily huddle for all cases including SS and DTOC	To discuss patients on the ICAHT list on the daily teleconference to ensure number of visits initially recommended are still appropriate and ensure no medical change Capacity to be reviewed Daily Waiting list circulated to all interested stakeholders and interdependent services MDT's occur on Tuesday (full MDT) and Thursday (1:1). Deputy Manager to attend MDT's	Deputy Managers monitor desktops- First response, Assisted Living, MASH and Telecare. Each referral is screened by DM. Cases assessed on a priority basis. Staff allocated to geographical areas and work agilely. Monitor all special equipment panel requests weekly to identify	Incoming referrals are monitored throughout the day Mon-Fri by Admin staff. Incoming Telecare prescriptions are monitored and actioned daily. Carecall referrals and Telecare prescriptions are screened and prioritised by Admin staff with the support of TM. Carecall Installations/fault repairs are	Telephone referrals received from community and hospital are triaged via phone by qualified professionals. Referrals are prioritised with the support of the MDT according to level of risk and requirement for 2hr/2-day response. Strength based assessments ensure that care requirements are identified and provided on a needs led basis Daily communication with Intermediate Tier

		Daily LLoS exec de-brief. Daily allocation and authorisation of work. Daily where best next virtual huddle to confirm discharges, address delays, barriers and escalate to leads when needed. Twice weekly tele conferences between IHDT manager, ICAH manager and Care Arranger Manager to review capacity and demand, waiting lists. Identifying how best to support the system. Use of transitional beds for all patients that are MOFD and delays in discharge.	Geographical runs designed to enhance flow and capacity. Work closely with Dom Care to understand demand and capacity of both services.	priorities for discharge Monitor authorisation on Elms to ensure avoidance of admission is prioritised.	carried out 7 days per week, plus two evenings per week and will be completed within a week. Telecare installations are carried out Mon – Fri and will be completed within a week. Installations are arranged geographically wherever possible to maximise productivity. Capacity left within the working day for minimum of one urgent installation/fault repair. Equipment levels are monitored closely (Carecall & Telecare) to ensure continuity of service.	about capacity in bed base/ ICaHT. Daily check of equipment available onsite to ensure that urgent assessment and provision can take place. Holistic assessment will identify other services to provide support/intervention to enable effective seamless discharge to longer term services or community assets. Utilising the mobile App enables the staff to receive live updates about service users requiring face to face assessment. Staff are multi-skilled and can cross professional boundaries where trained appropriately

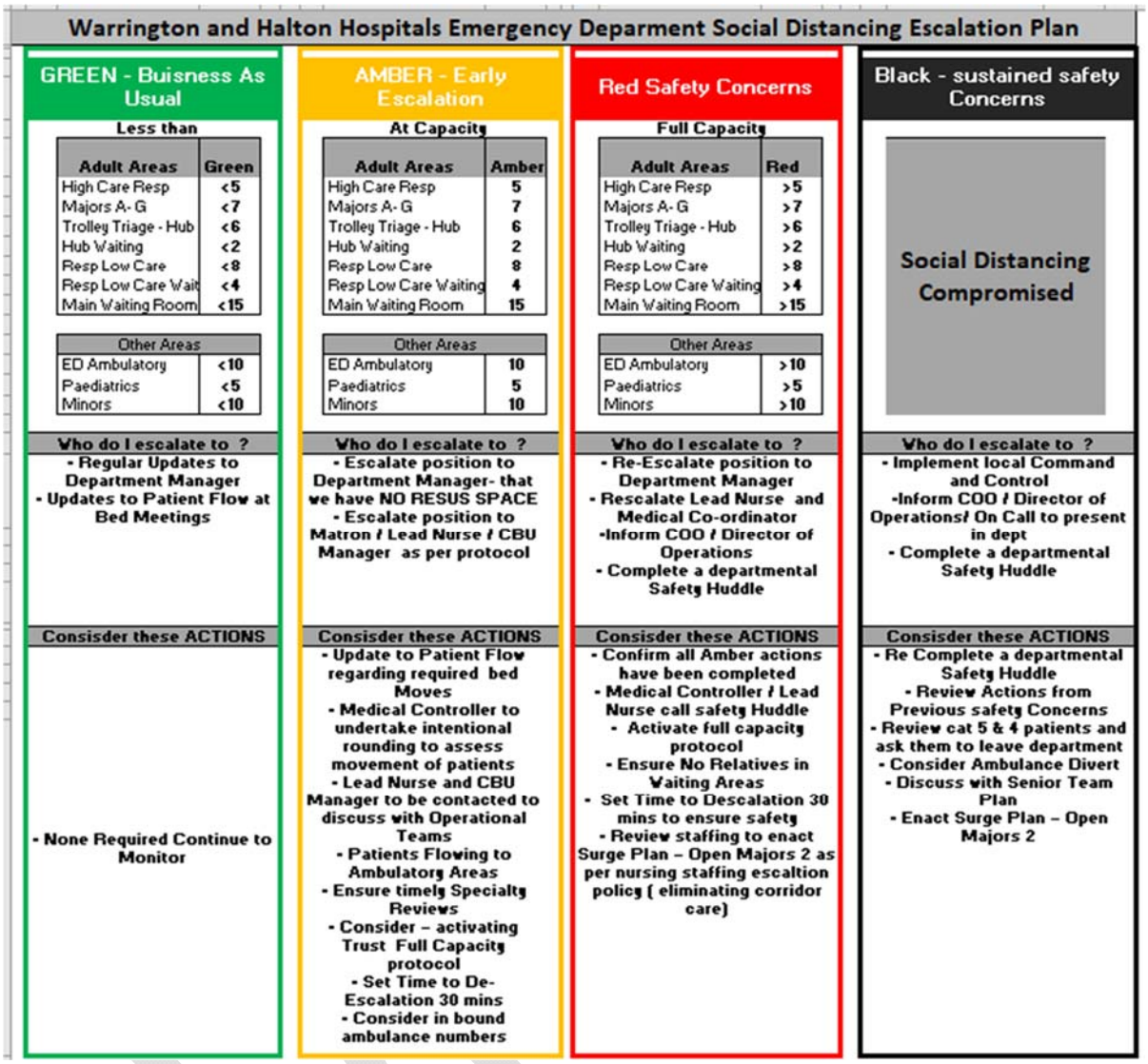
ESCALATION ACTIONS TO BE IMPLEMENTED- In addition to Green Day **Amber Day: Actions to be implemented when there are 10 or more on the ICAHT list or 5 on the IMC bed waiting list, one person has been waiting more than 5 days for bed bas or Reablement have a caseload of 75+, Number of Super Stranded Patients > 60** **Padgate & Brampton:** **Average LoS 35** **Longest LoS 40** **Woodleigh** **Average Los 25** **Longest Los 35 days** **Bed Bases link in with ICAHT, IDHT and Dom Care three times weekly tele-conference**						
Bed Bases	ICT Bridgewater	IHDT/Hospital Discharge Team	ICaHT /Reablement	Assisted Living/Telecare	Carecall	Rapid Response
Actions in Green day above Plus Three times weekly IHDT Management telephone review of all patients in all bed bases to expedite flow through the service Report to service manager on actions and timescales	Actions in Green above plus… Manager to review all patients on the boards and ensure resource is sufficient to manage increasing caseload Review all cases on community caseload collaboratively to identify opportunities for single handed care and a reduction in care Report to service manager on actions and timescales	Actions in Green above plus… Face to face assessment of patients on bed list. Report to service manager on actions and timescales. Daily management review of all SS and DTOC patients. Escalation of delays to health and social management.	Actions in Green above plus… Enhanced MDT discussion regarding intervention and discharge of those in service. ICAHT Team Manager/deputy to run a CM report to identify any visit taking less than 10 minutes or where patient is now independent. ICaHT/Reablement team to ensure visits are geographically optimised Open runs in areas where demand is greater and close runs in low demand areas.	Actions in Green plus…. Reprioritisation by DM if urgent cases are identified and require response. Telephone assessments where possible to enhance effective time management OT will be available in the First Response team at times of enhanced demand	Actions in green plus…. Urgent referrals/Telecare installations are prioritised/installations reprioritised to facilitate by TM Team Manager will review waiting list and ensure appropriate prioritisation. ICAHT/Rapid response staff will carry out	Actions in green plus…. Prioritisation by TM and DM on an hourly basis of those in service. AP's to be utilised to provide care where possible. Additional intensive therapy to be provided where possible to reduce POC required Anticipation of equipment requirements by senior OT/PT to ensure continuous replenishment of stock Additional huddles am and pm.

			Request support from Dom care where appropriate.		urgent installations, in addition of Carecall installers. Carecall Operators to carry out installations with the use of an ICaHT vehicle.	TM to prepare for additional resource requirements by monitoring referral types and communicating with referrers regarding demand i.e. FAU

ESCALATION ACTIONS TO BE IMPLEMENTED **Red Day: Actions to be implemented when ICAHT has a waiting list of 15+, bed base 8+ A waiting list of more than 8 days exists for bed base or Reablement have a caseload of 80+and the number of SS patients exceeds 80** **Padgate & Brampton:** **Average LoS 38** **Longest LoS 45** **Woodleigh:** **Average Los 32** **Longest 45** **Daily IMC tele-con chaired by AD Integrated Care**						
Bed Base	COMMUNITY	Hospital Discharge Team	ICaHT	Assisted Living/ Telecare	Carecall	Rapid Response
All actions in Green and Amber plus Service Manager to attend bed base weekly MDT and identify any barriers to discharge	All actions in Green and Amber plus… Service Manager to attend MDT and	All actions in Green and Amber plus… Senior support on LLoS ward rounds.	All actions in Green and Amber plus… Manager to attend team huddle and those of	All actions in Green and Amber plus…	All actions in Green and Amber plus…	All actions in Green and Amber plus…

Report to Associate Director Spot purchase respite or transitional beds	identify any barriers to discharge Report to Associate Director Joint service review of cases	Direct escalation to Silver Command and ADASS to overcome barriers. Twice daily review of SS and DTOC patients. Daily exec de-brief on SS patients. Escalate to First Response for assessment support. Management to undertake assessments to reduce delays.	assessment and reablement team Resource allocation to be reviewed with Service Manager to ensure optimal use of available staff Approach families to support care where possible Prioritise visits to P1 and Group A service users Consider additional runs and overtime Senior capacity review for assessments only Utilisation of Rapid Response AP's where appropriate	Service Manager to ensure optimal use of available staff and skill set within the service. Overtime to be offered to manage waiting lists on sessional basis. Enhance 1:1 with staff to ensure cases are managed effectively and flow is optimised	Service Manager to ensure optimal use of available staff and skill set within the service. Overtime to be offered to manage waiting lists on sessional basis. Enhance 1:1 with staff to ensure cases are managed effectively and flow is optimised	Service Manager to ensure optimal use of available staff and skill set within the service. Overtime to be offered to manage waiting lists. DM and TM to engage in the triage process to enable professional staff to assess.

Appendix 5 – Space within Warrington Hospital ED



Warrington and Halton Hospitals Emergency Deparment Social Distancing Escalation Plan

GREEN - Buisness As Usual

Less than

Adult Areas	Green
High Care Resp	<5
Majors A-G	<7
Trolley Triage - Hub	<6
Hub Waiting	<2
Resp Low Care	<8
Resp Low Care Wait	<4
Main Waiting Room	<15

Other Areas	
ED Ambulatory	<10
Paediatrics	<5
Minors	<10

Who do I escalate to ?

- Regular Updates to Department Manager
- Updates to Patient Flow at Bed Meetings

Consisder these ACTIONS

- None Required Continue to Monitor

AMBER - Early Escalation

At Capacity

Adult Areas	Amber
High Care Resp	5
Majors A-G	7
Trolley Triage - Hub	6
Hub Waiting	2
Resp Low Care	8
Resp Low Care Waiting	4
Main Waiting Room	15

Other Areas	
ED Ambulatory	10
Paediatrics	5
Minors	10

Who do I escalate to ?

- Escalate position to Department Manager- that we have NO RESUS SPACE
- Escalate position to Matron / Lead Nurse / CBU Manager as per protocol

Consisder these ACTIONS

- Update to Patient Flow regarding required bed Moves
- Medical Controller to undertake intentional rounding to assess movement of patients
- Lead Nurse and CBU Manager to be contacted to discuss with Operational Teams
- Patients Flowing to Ambulatory Areas
- Ensure timely Specialty Reviews
- Consider – activating Trust Full Capacity protocol
- Set Time to De-Escalation 30 mins
- Consider in bound ambulance numbers

Red Safety Concerns

Full Capacity

Adult Areas	Red
High Care Resp	>5
Majors A-G	>7
Trolley Triage - Hub	>6
Hub Waiting	>2
Resp Low Care	>8
Resp Low Care Waiting	>4
Main Waiting Room	>15

Other Areas	
ED Ambulatory	>10
Paediatrics	>5
Minors	>10

Who do I escalate to ?

- Re-Escalate position to Department Manager
- Rescalate Lead Nurse and Medical Co-ordinator
- Inform COO / Director of Operations
- Complete a departmental Safety Huddle

Consisder these ACTIONS

- Confirm all Amber actions have been completed
- Medical Controller / Lead Nurse call safety Huddle
- Activate full capacity protocol
- Ensure No Relatives in Waiting Areas
- Set Time to Descalation 30 mins to ensure safety
- Review staffing to enact Surge Plan – Open Majors 2 as per nursing staffing escaltion policy (eliminating corridor care)

Black - sustained safety Concerns

Social Distancing Compromised

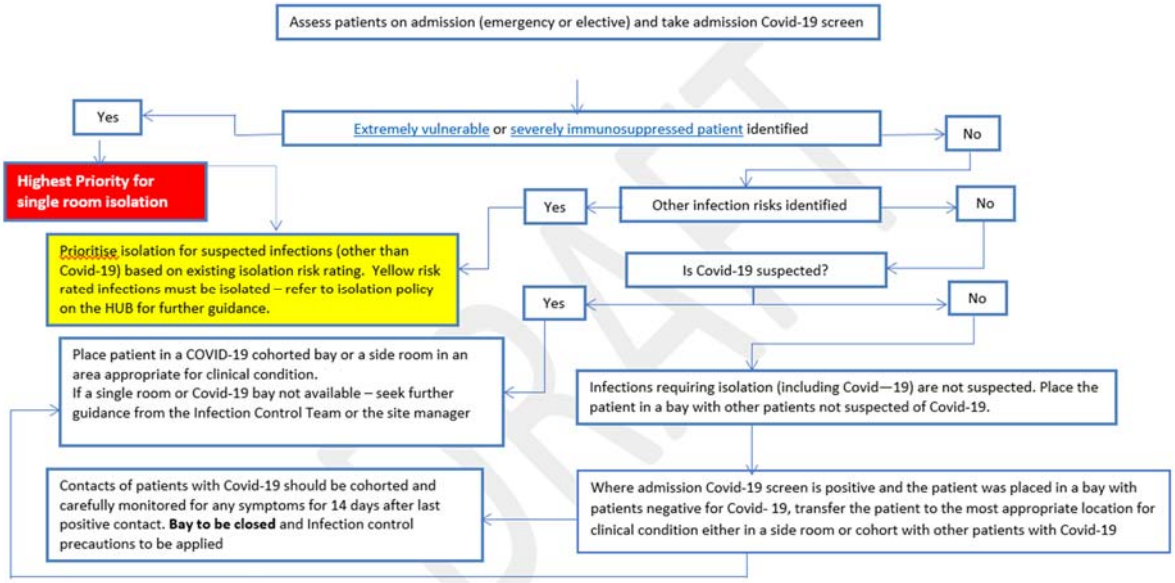
Who do I escalate to ?

- Implement local Command and Control
- Inform COO / Director of Operations/ On Call to present in dept
- Complete a departmental Safety Huddle

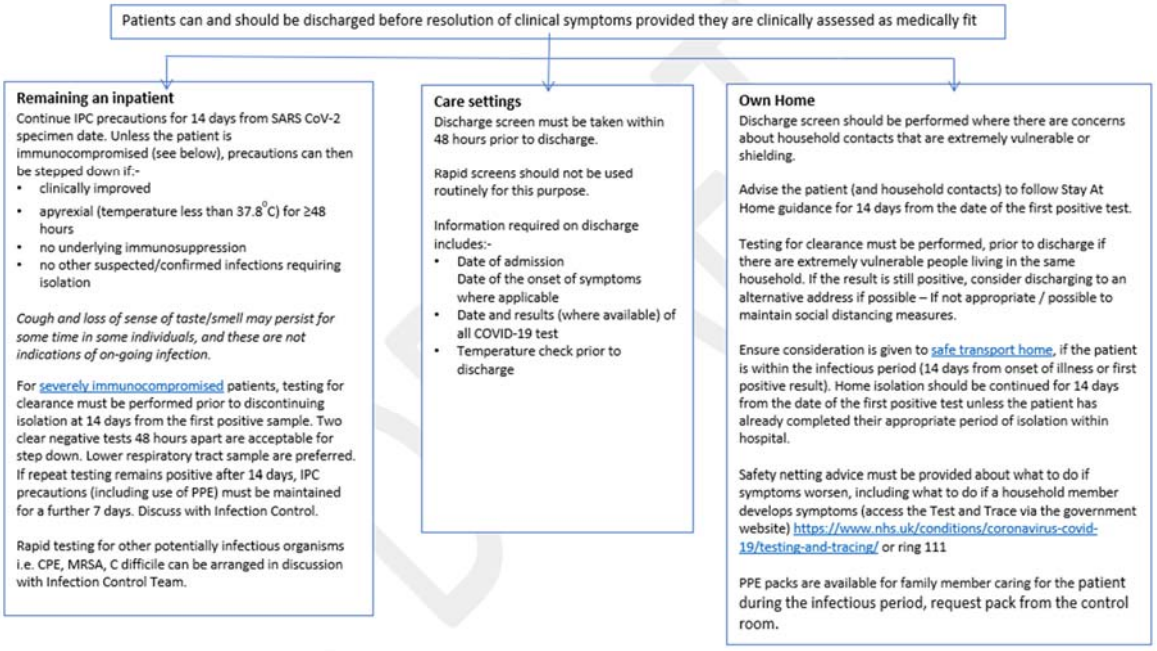
Consisder these ACTIONS

- Re Complete a departmental Safety Huddle
- Review Actions from Previous safety Concerns
- Review cat 5 & 4 patients and ask them to leave department
- Consider Ambulance Divert
- Discuss with Senior Team Plan
- Enact Surge Plan – Open Majors 2

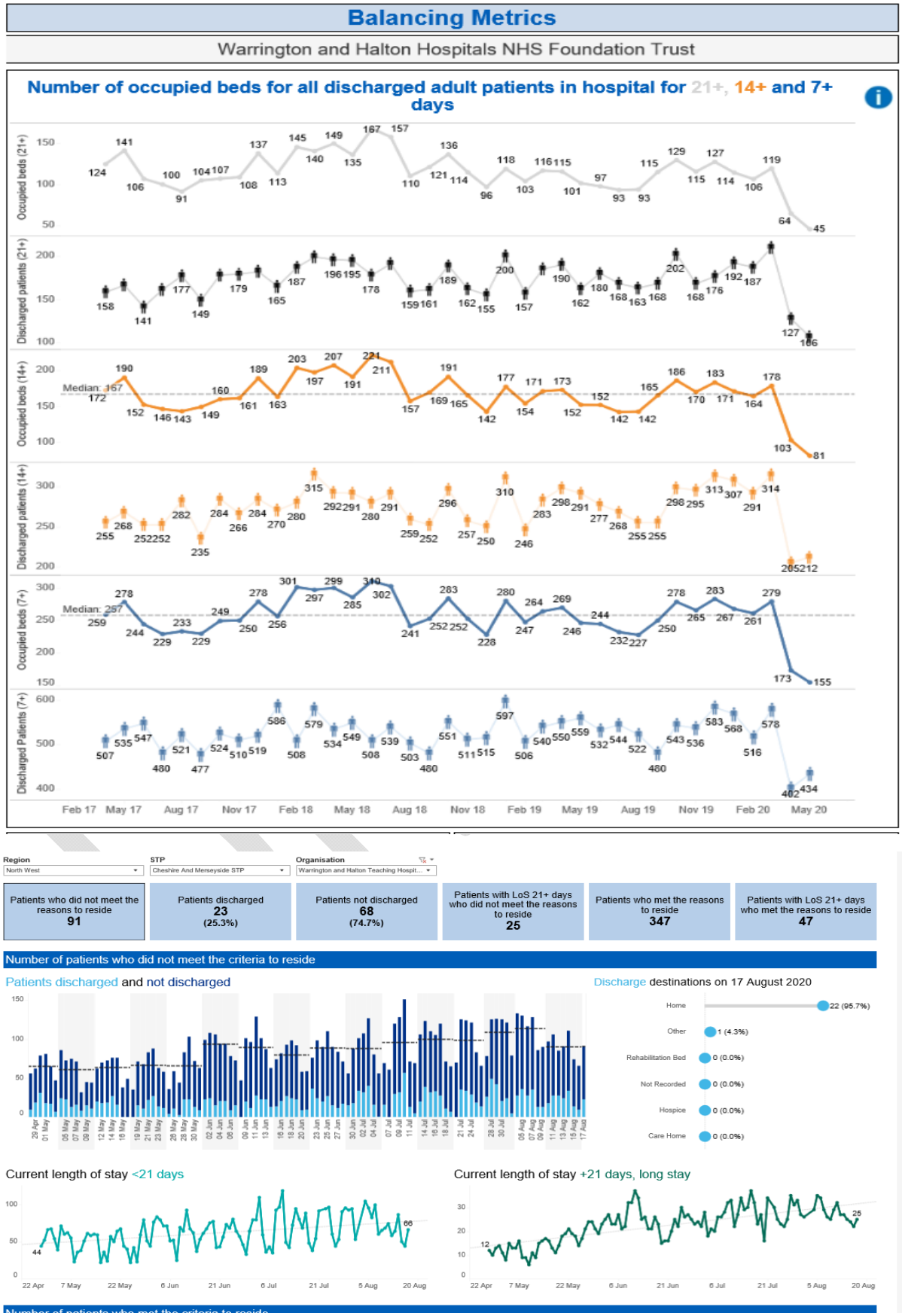
Appendix 6 – Patient Placement



The flow chart below identifies the patient pathways related to a positive COVID-19 diagnosis.



Appendix 7 – Long Length of Stay (LLOS) per CCG



Appendix 8 – Respiratory Driver Diagram