APPENDIX 2

Warrington and Halton System Winter Plan 2020-2021

Contents

APPENDIX 2

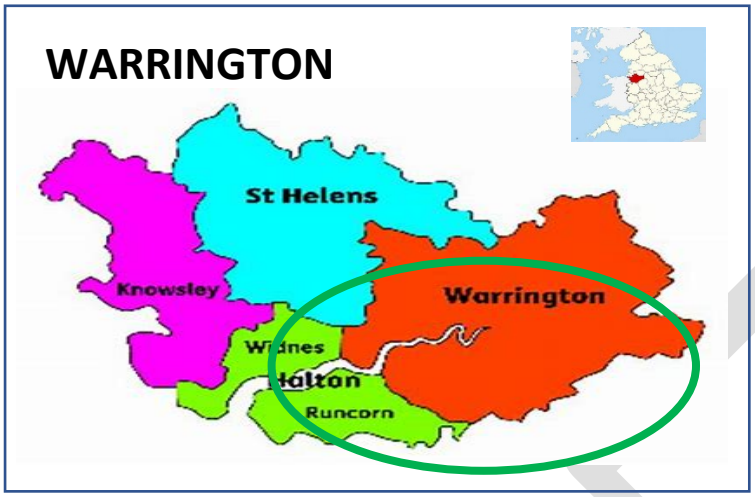
1.0 Version Control and Endorsement Information

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

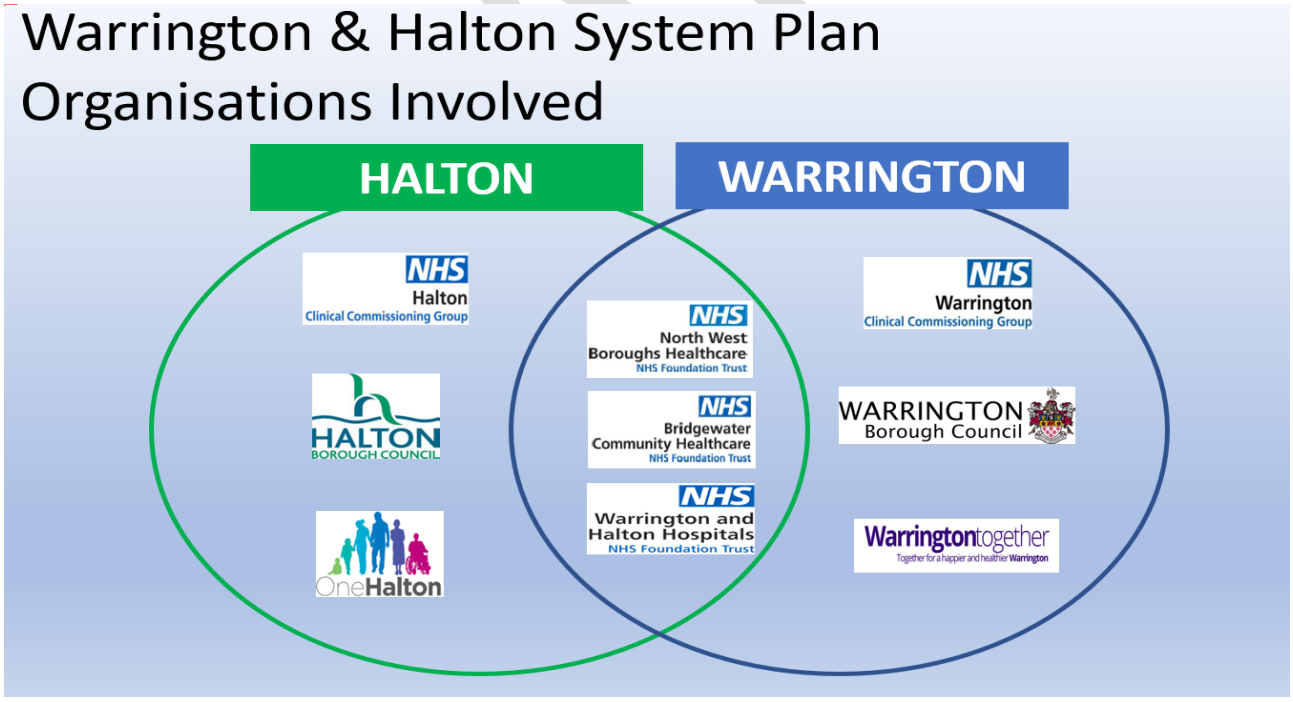
Endorsement		
Detail	**Date**	**Comments**
Governing Body	07.09.20	
Joint Urgent Issues Committee	29.07.20 26.08.20	Recommendations Noted TBC
NHSE/I check and challenge	TBC	
Health & Well-Being Board	TBC	
Warrington Health Forum	TBC	
Warrington Primary Care Oversight Group (PCOG)	TBC	
Bridgewater:- • 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.

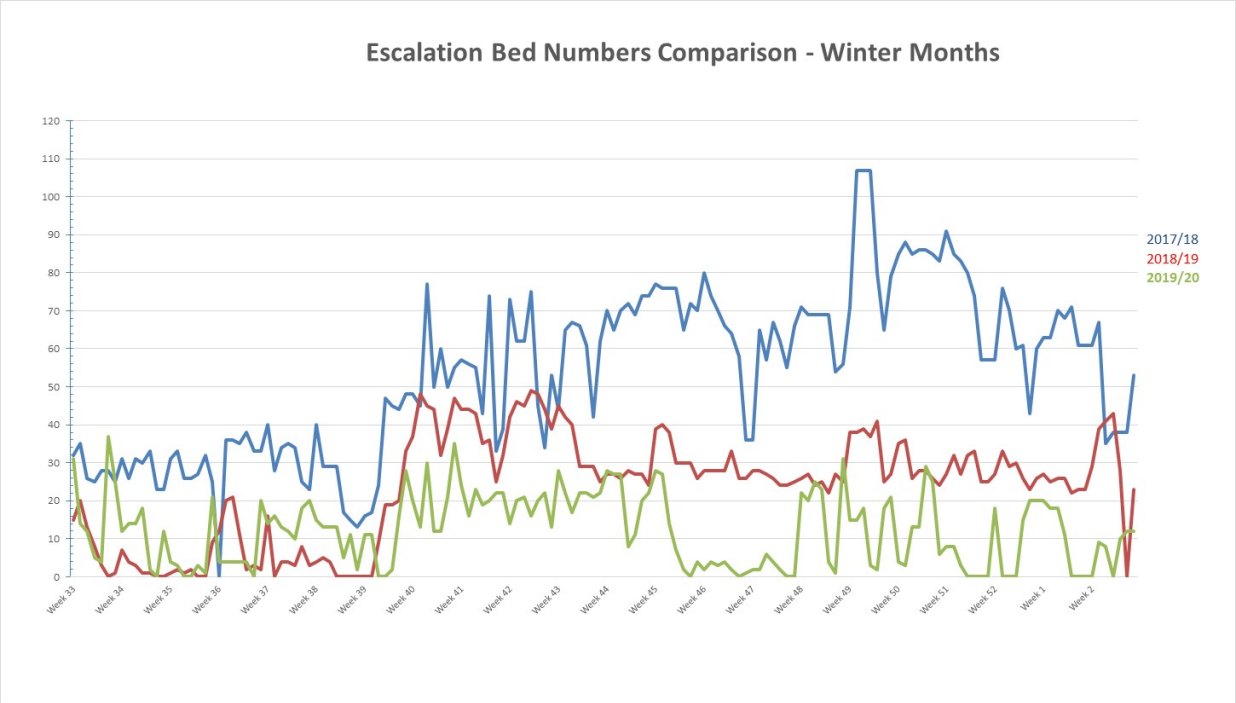
During the winter months of 2019/20 those actions were embedded. System working blossomed and we designed more key activities featured in our winter plan for 2019/20 that were also successfully implemented.

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

Escalation Capacity

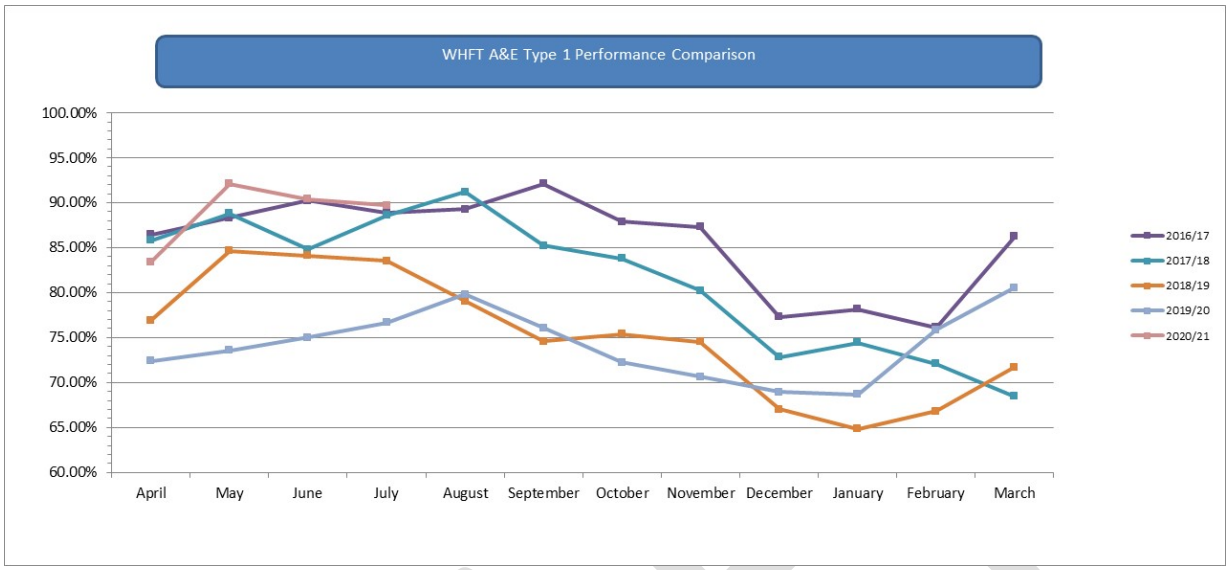
During the winter months (October – March) of 2017/18 we used c. 9338 escalation bed days. In 2018/19 that reduced to c. 3808.

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.



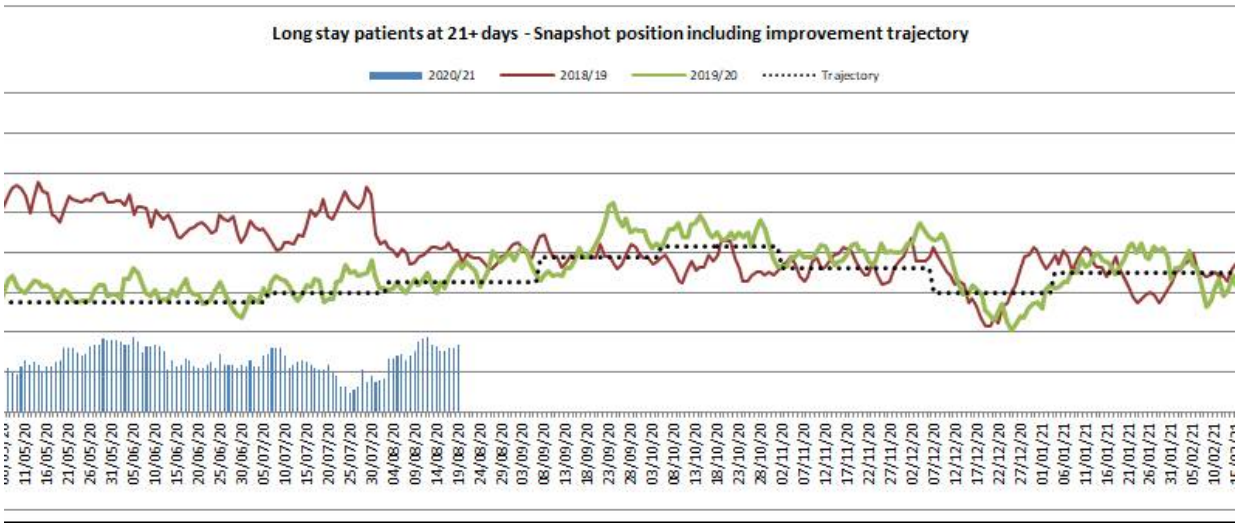
Improved Type 1 ED 4-hour performance standard

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



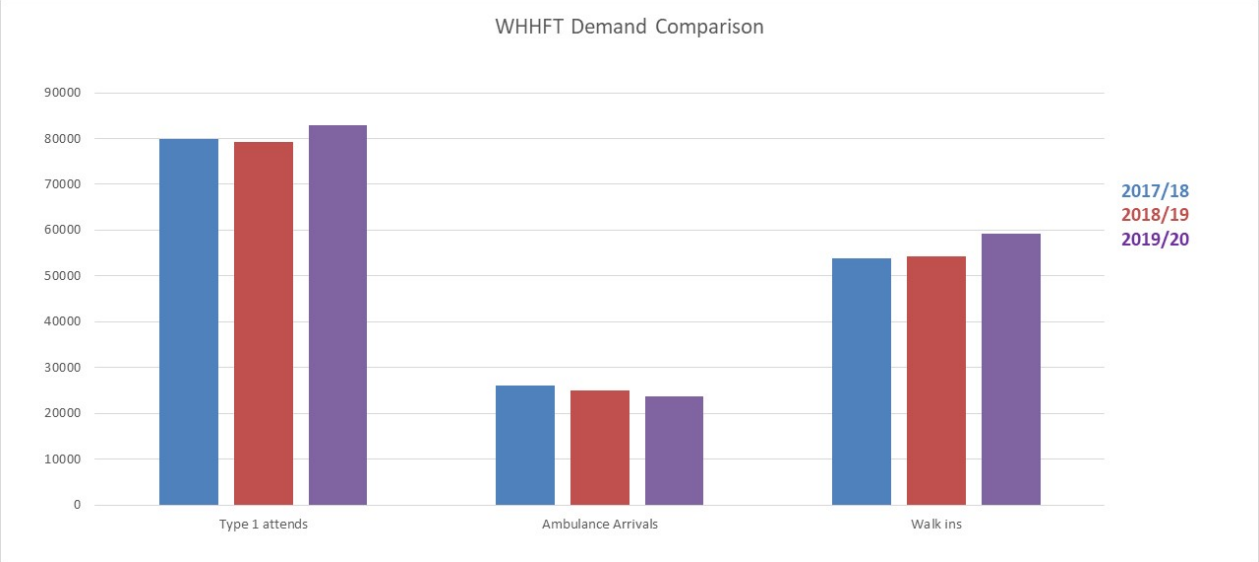
Reduced Super stranded compared to previous year

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

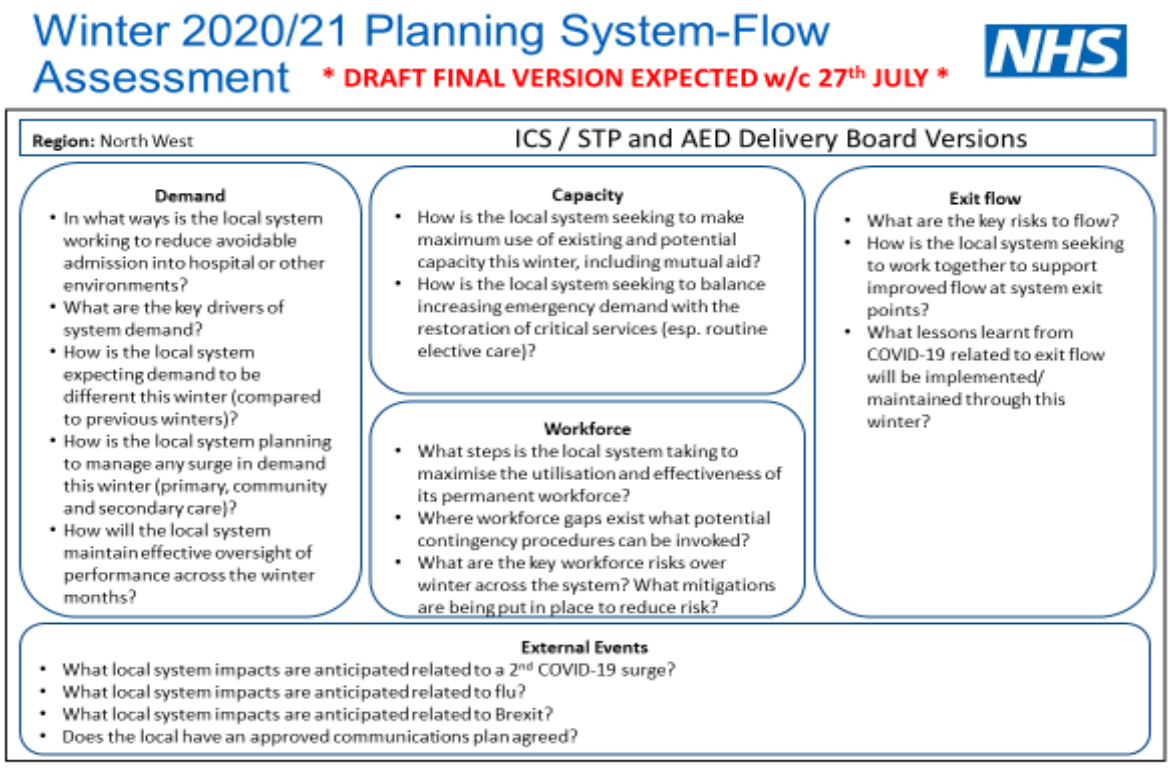
- Estimated 209,700 resident population (2017 MYE)
- Life expectancy (2015-17)
    - Males = 78.9 years
    - Females = 82.4 years
- Warrington Borough Council unitary local authority
- 26 GP practices, 5 Primary Care Networks (PCN's).
- Registered GP population 220,940
- Warrington Together is our Integrated 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.



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

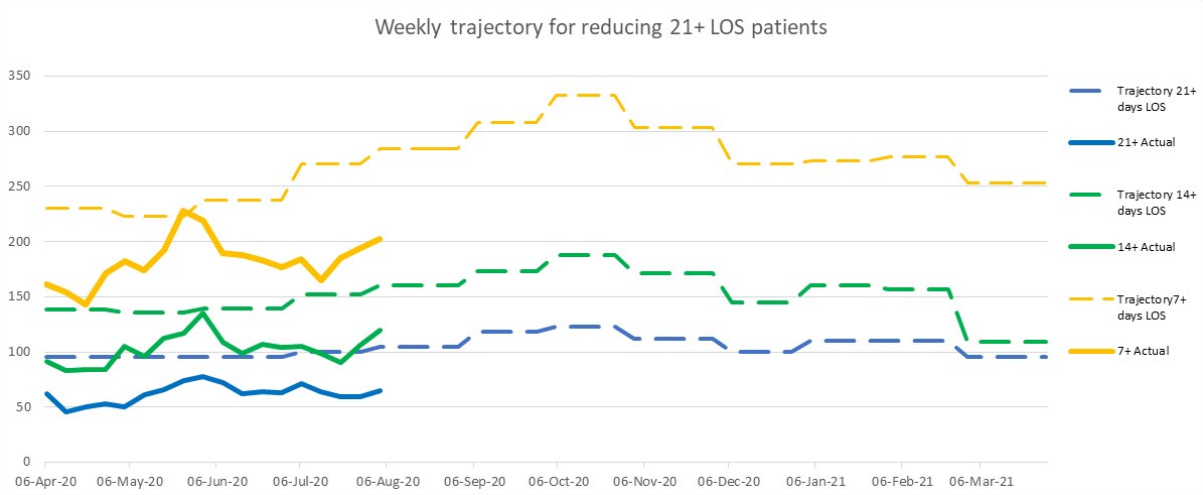
For winter 2020/21, delayed transfers of care will be further reduced which will contribute to the overarching LLOS measure by introducing additional capacity within:

- 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.

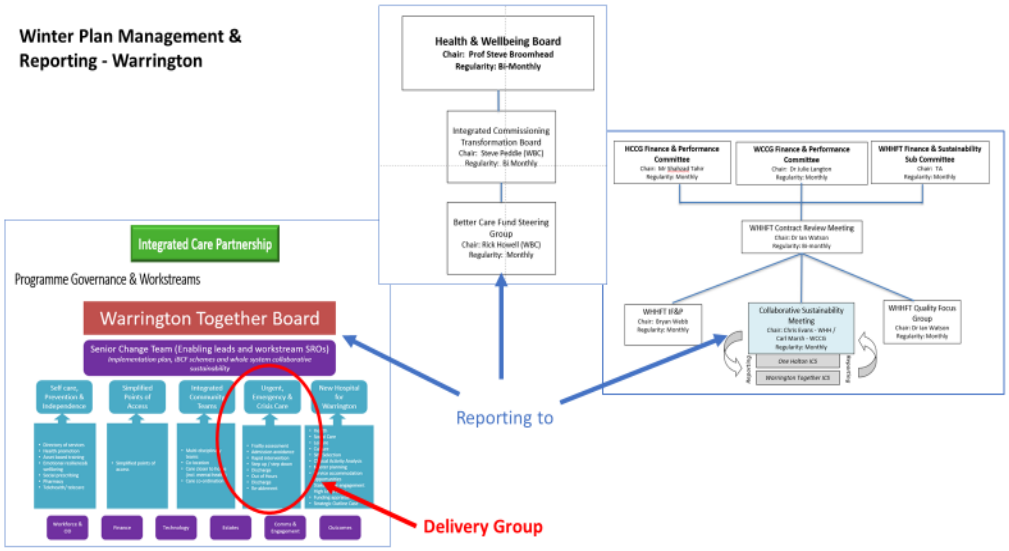
8.0 System Wide Communication Plan[37]

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.

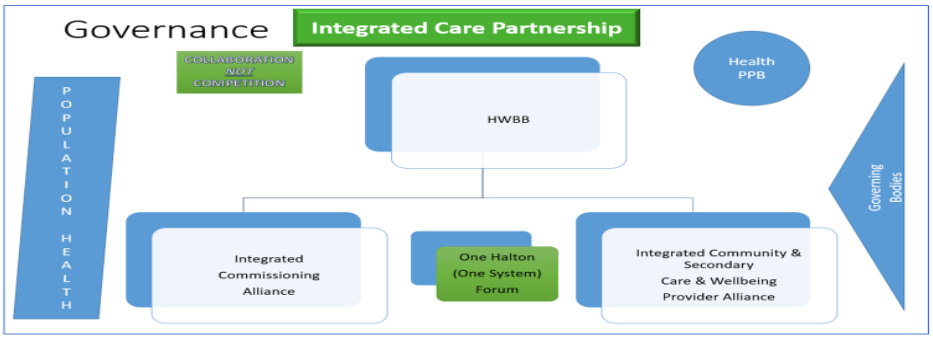
Discussions are being held with NHS E/I and the CMHCP regarding a C&M approach to the winter communication plan. Weekly meetings are taking place with a view to the development of a C&M wide plan, with a single approach in terms of the call to action, campaign materials, key messages etc. Whilst this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

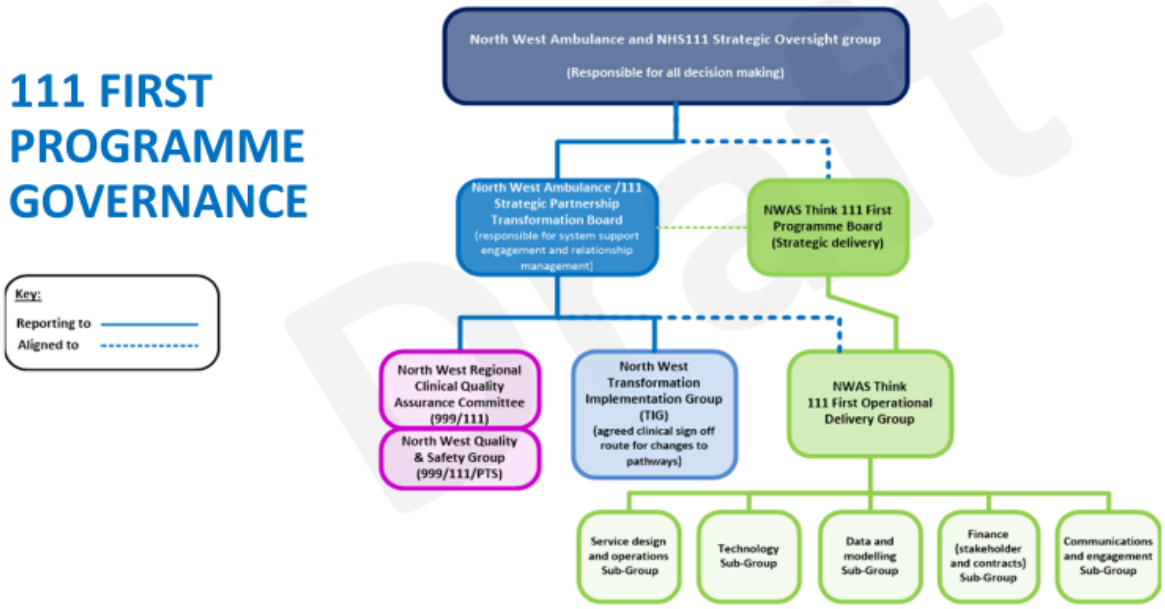
Appendices

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



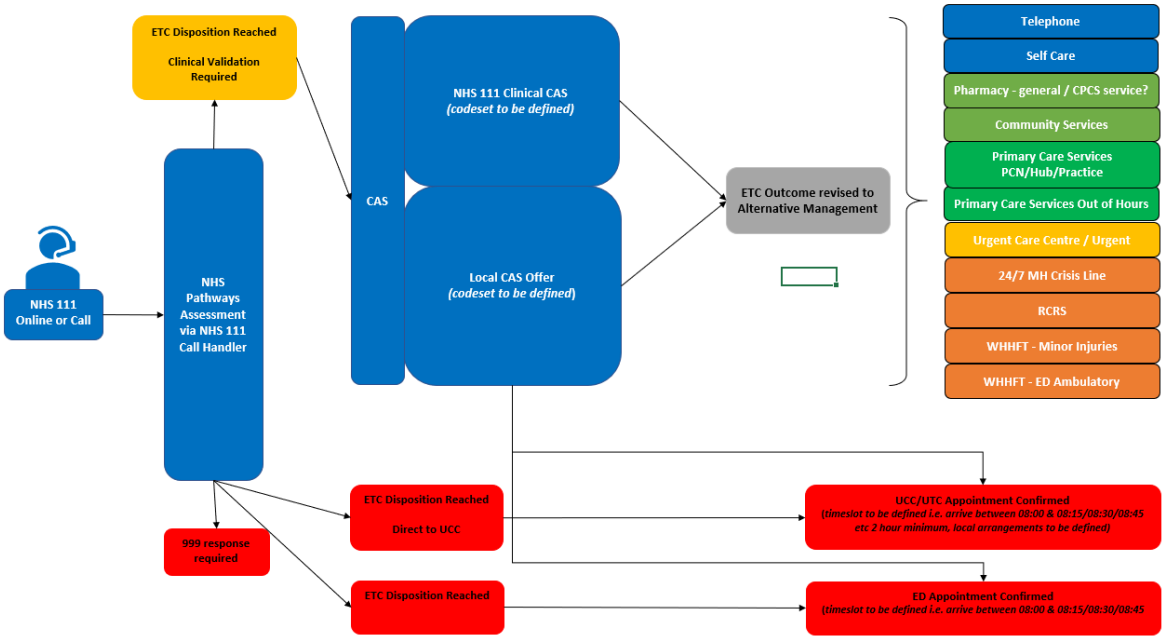
N.B. Contract management groups have been removed from the structure as have local engagement meetings further to NHS E & NHS I agreement

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.		

Appendix 4 – Intermediate Tier Services Escalation Plan

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

APPENDIX 2

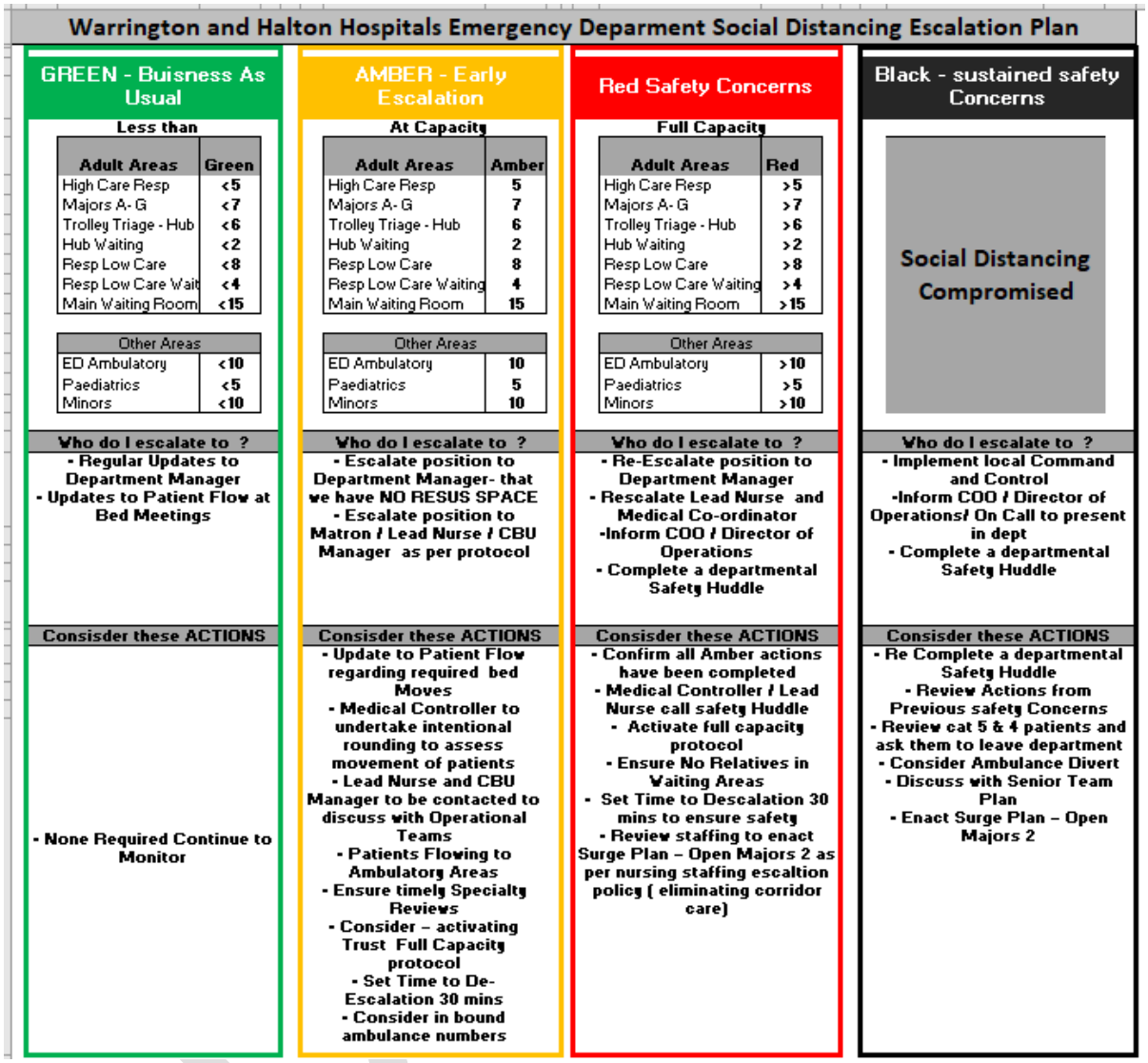
ESCALATION ACTIONS TO BE IMPLEMENTED- In addition to Green Day Amber Day: Actions to be implemented when there are 10 or more on the ICAHT list or 5 on the IMC bed waiting list, one person has been waiting more than 5 days for bed bas or Reablement have a caseload of 75+, Number of Super Stranded Patients > 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 ?

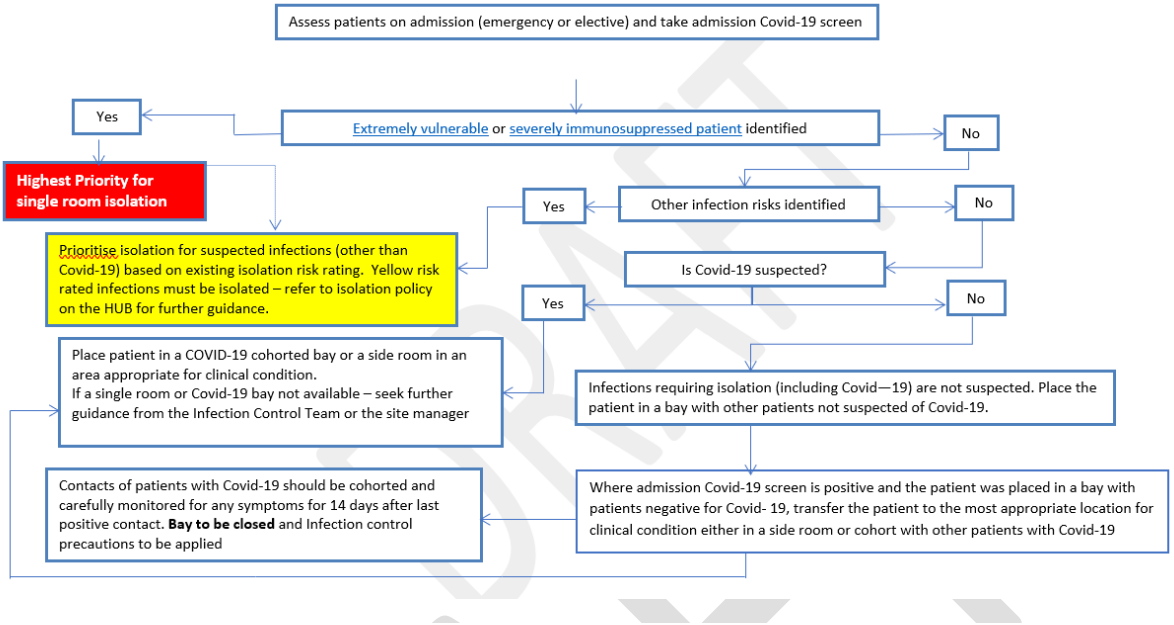
- Implement local Command and Control
- Inform COO / Director of Operations/ On Call to present in dept
- Complete a departmental Safety Huddle

Consisder these ACTIONS

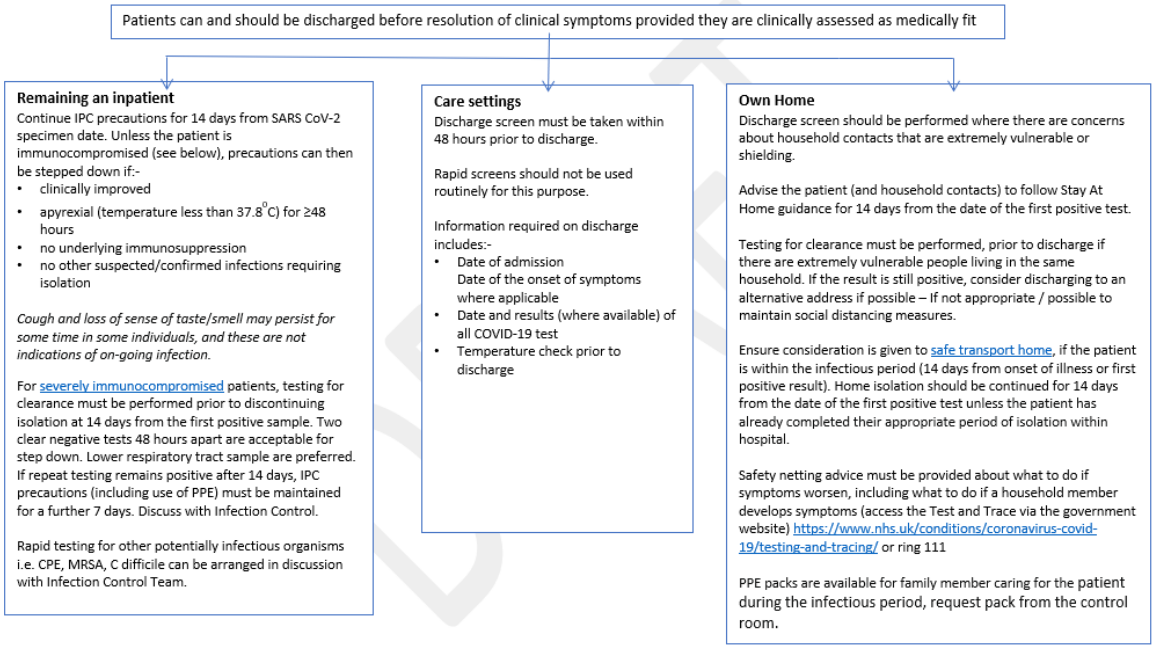
- Re Complete a departmental Safety Huddle
- Review Actions from Previous safety Concerns
- Review cat 5 & 4 patients and ask them to leave department
- Consider Ambulance Divert
- Discuss with Senior Team Plan
- Enact Surge Plan – Open Majors 2

APPENDIX 2

Appendix 6 – Patient Placement

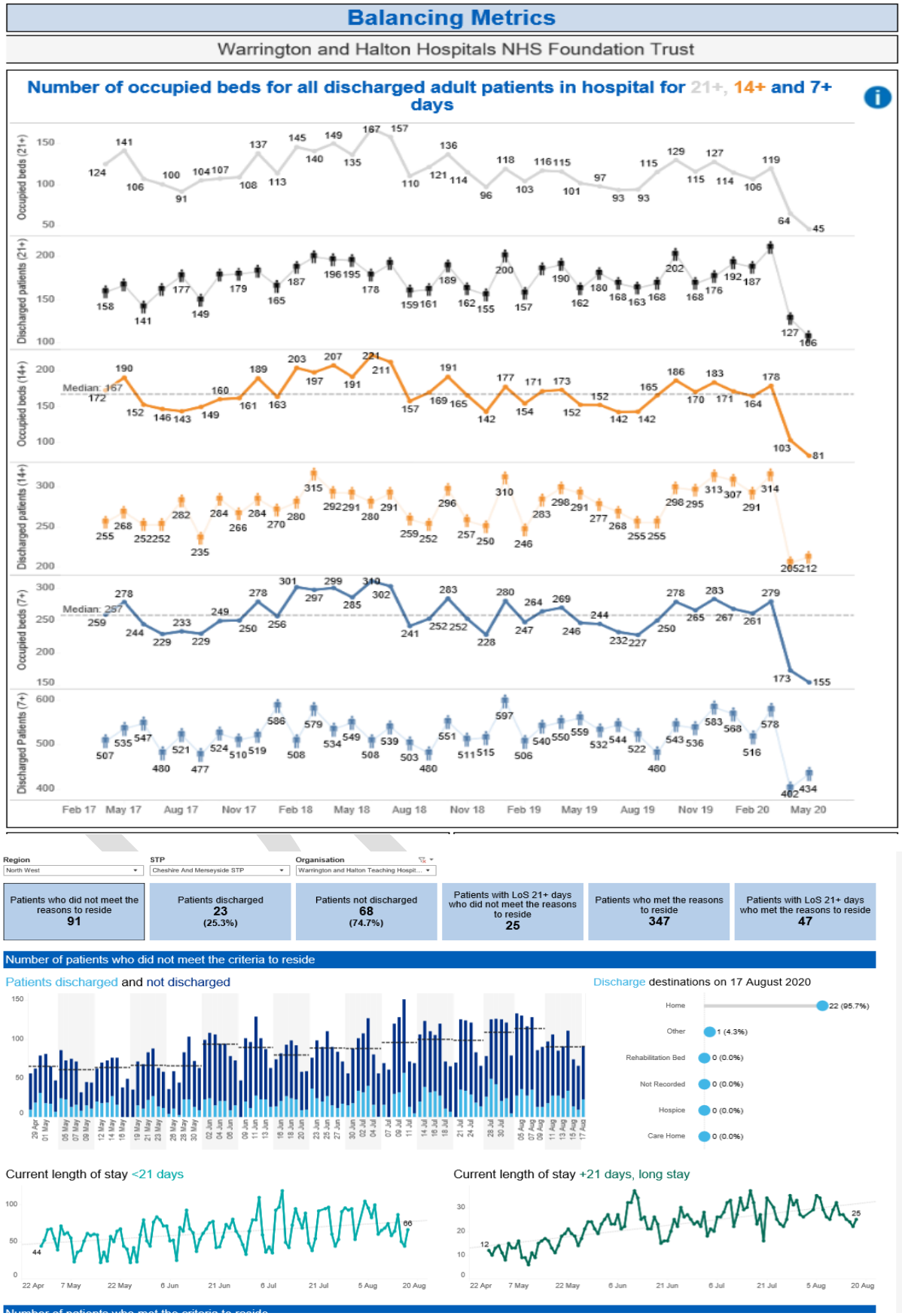


The flow chart below identifies the patient pathways related to a positive COVID-19 diagnosis.



APPENDIX 2

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



APPENDIX 2

Appendix 8 – Respiratory Driver Diagram