Healthier Futures
Black Country and West Birmingham

H2 Operational Planning - Winter Plan

20th October 2021

Building Healthier, Happier Communities

Contents

Executive Summary

Executive Summary (1)

The coming winter period looks to be extremely challenging as a consequence of the continued need to respond to the COVID-19 pandemic, alongside elective recovery and usual winter pressures.

The BCWB ICS has undertaken detailed demand and capacity modelling to support decision making and operational planning for the winter period using a common methodology across all Trusts. This has resulted in Best and Worst case bed scenario's based on the assumptions known at the time.

The worst case scenario has highlighted a potential for demand to exceed capacity for a protracted period over winter unless mitigating actions are taken. This plan sets out both the outcomes of our modelling and the mitigations which will provide us with the necessary resilience. Such mitigations include actions to be taken by Acute providers to manage in-hospital flow, effective IPC and SDEC. However, the plan is also dependent on active interventions from wider system partners at both Place and System to reduce demand on the acute sector. Actions include improving 999/111 services, increasing access to primary care activity, accelerating delivery of urgent community response and maintaining a focus on effective discharge arrangements, including within the care sector.

The best case scenario modelled indicates that whilst the system will be under extreme pressure, there is sufficient bed capacity, albeit with bed occupancy of over 95%. This is assumed to be the 'base case' as assumptions best reflect planning guidance expectations. A number of the mitigations described above have not been included in the base case, therefore additional modelling has been undertaken which has resulted in further reductions in expected bed requirements.

Executive Summary (2)

There are a number of assumptions, dependencies, and risks to this plan.

It is recognised that the Black Country and West Birmingham system was under significant pressure during previous waves of COVID. Currently, COVID case rates remain relatively stable across the BCWB system (XX per 100,000), with number of positive inpatients remaining similarly stable. COVID vaccination levels continue to increase but the rate of increase is slow. Adult critical care occupancy remains within core funded levels. However, demands on the 999/111 service remain high with call levels significantly exceeding forecasts and ambulance handover delays continue to be extremely challenging. We have reviewed the WMAS winter plan and will be considering it at the next UEC Board. The following slide includes extracts from COVID/Recovery Sitreps.

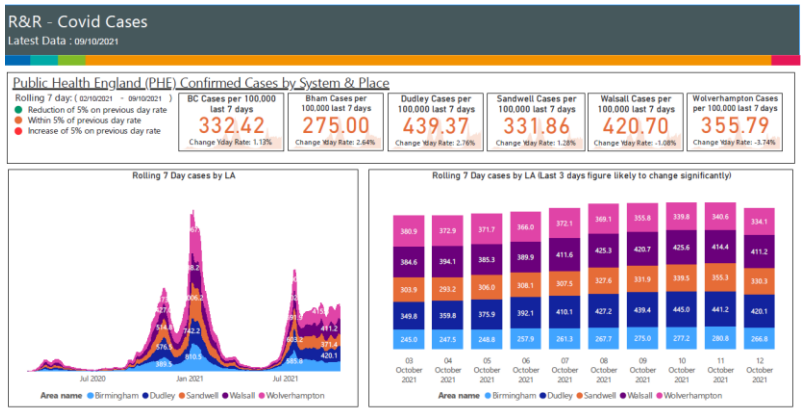
Our elective plan also assumes that ERF targets will be achieved and capacity will be protected by this winter planto aid elective recovery.

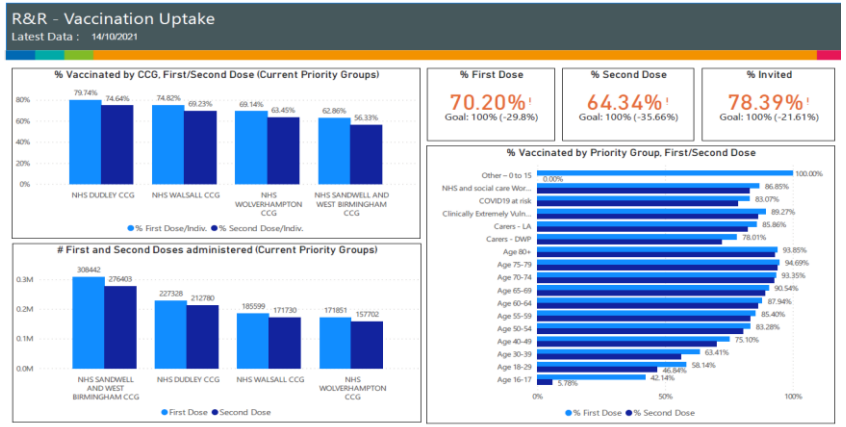
This plan will require investment. Such investment is being finalised as part of H2 financial planning. It also assumes workforce capacity and availability across the whole system will meet expectations, albeit some will be costed as temporary/supplementary staffing at premium rates..

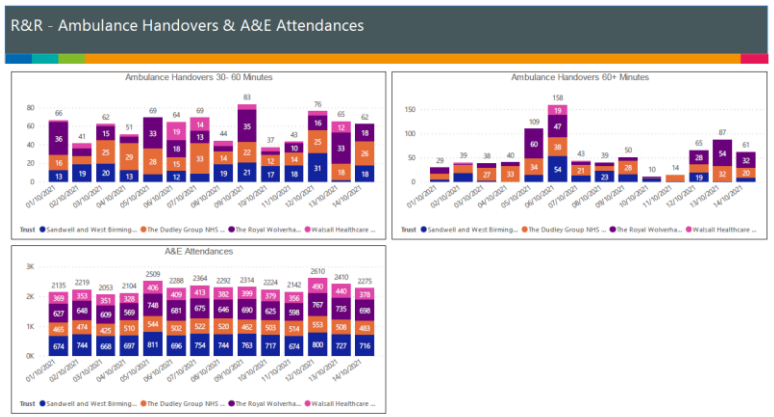
Finally, an assessment of health inequalities has been undertaken and used to inform our winter plan with specific actions being taken to support some of our most vulnerable residents like young people via the RSV plan, those in mental health crises and older people living in care homes.

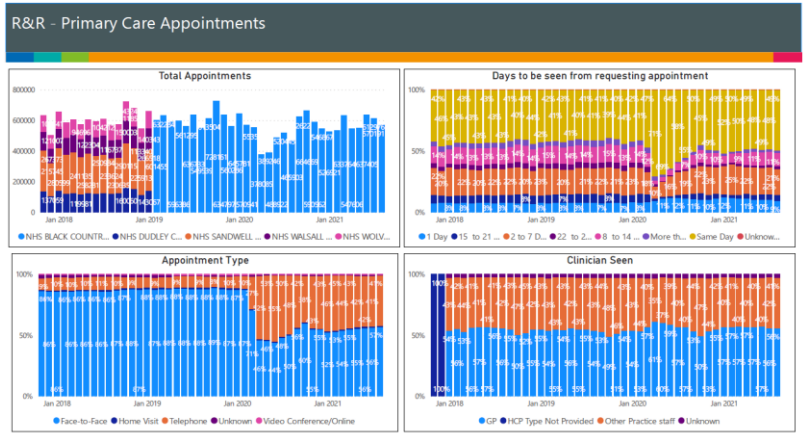
Appended to this plan is the response to the KLOEs associated with the UEC 10 Point Plan. This identifies specific actions and assurance in relation to expectations on the system. It identifies the greatest challenge being ambulance handovers and primary care capacity.

Extracts from COVID & Restoration & Recovery SitReps









Winter Bed Capacity

Approach

- All Trusts across the BCWB System have adopted a common approach to demand and capacity modelling for the winter period under the leadership of the BCWB UEC Board.
- A standard data set (HES) has been utilized within the modelling, a set of standard adjustments, and a standard methodology across all trusts along side any Trust Specific adjustments required
- This work has enabled forecasts to be produced for the BCWB system, individual Trusts, Medical, Surgical Elective a Surgical Non-Elective levels.
- All forecasts assume that existing improvements in LOS vs the baseline data (2018-20) are sustained
- All forecasts assume that improvements due to more consistent availability of staff and diagnostics through the festive period reducing peak bed demand in early Jan.
- At a system and Trust level both worst and best case scenarios have been modelled based on factors within the current control of Trusts such as improvement in hospital flow and increased use of SDEC pathways.
- Demand and capacity profiles for each Trust follow a common profile over the winter period reducing the potential to smooth the profile through mutual aid
- No ISP capacity has been factored into bed modelling forecasting

Outcome – modelling of bed capacity

The outcome of the demand and capacity modelling highlights the scale of the challenge faced by health services this coming winter.

As an outcome of the winter planning exercise a number of risks have been identified which if left unmitigated could result in demand exceeding capacity and baseline planning assumptions not being fulfilled. These risks relate to inefficiencies of flow both through the hospital and at the point of discharge and inadequate IPC controls to prevent the spread of COVID/flu.

All Trusts have developed plans to address these issues and bring them back to baseline.

An additional 297 escalation beds have also been confirmed to allow for some surge capacity to meet winter demands

The demand and capacity profiles for each Trust follow a common profile over the winter period reducing the potential to smooth the profile through mutual aid.

Whilst the Trust plans will bring us back to the baseline position a number of additional uncontrollable risks have been identified which could undermine delivery unless further mitigating actions are put in place. These include a further covid wave, a significant increase in staff absence and concerns about the resilience of the domiciliary care market. Given these additional risks a number of other mitigations are included in our winter plan which provide a level of head room.

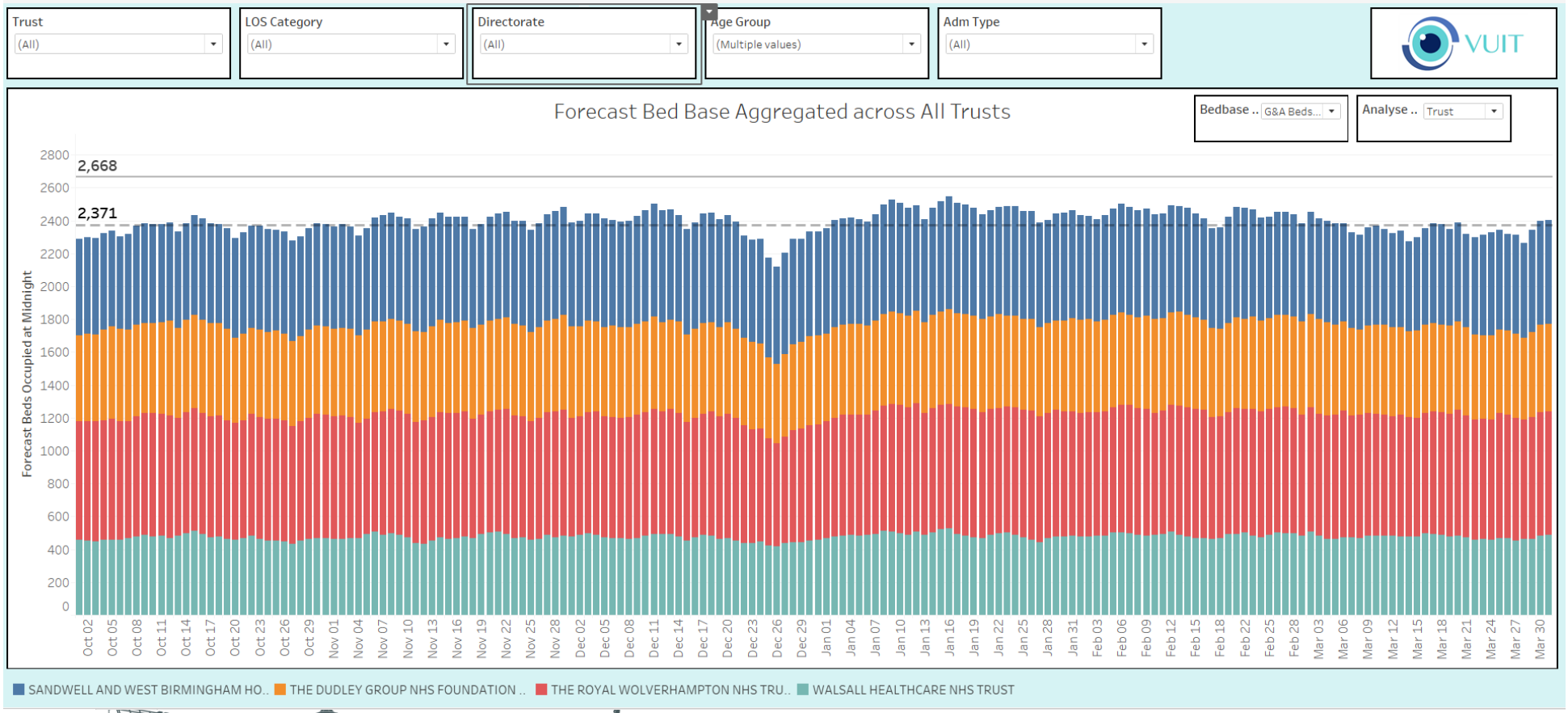
These mitigations are centred around

- ✓ Improving 999/111
- ✓ Increasing access to primary care and UTCs
- ✓ Accelerating delivery of UCR

A description of additional interventions is described in subsequent slides along with a quantification of impact which is shown in the waterfall diagram.

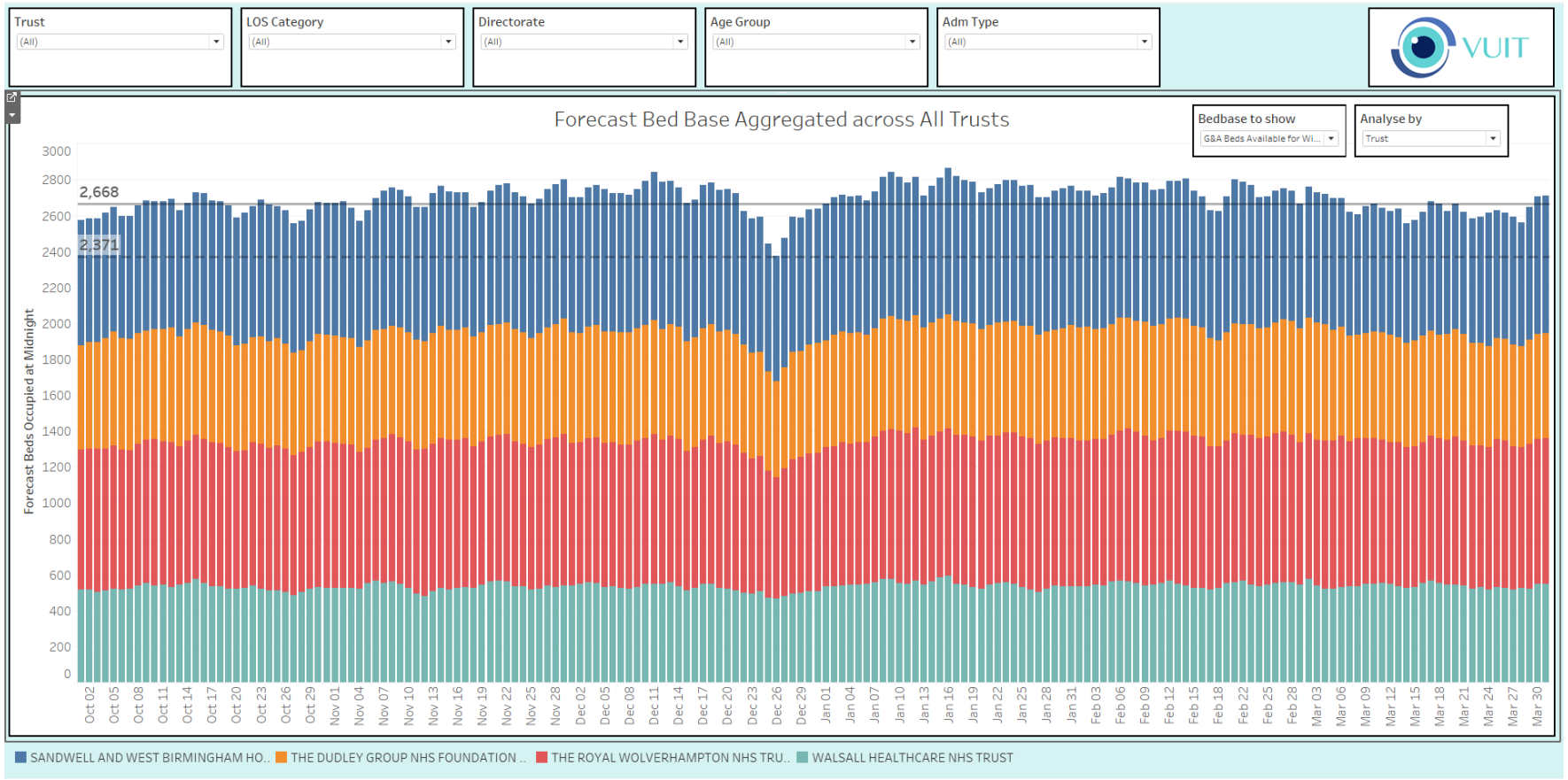
Reasonable Best Case Scenario

- Peak Demand 2547 Beds on 16th Jan 2022 – 176 Escalation Beds Open – Peak Occupancy 95.5%

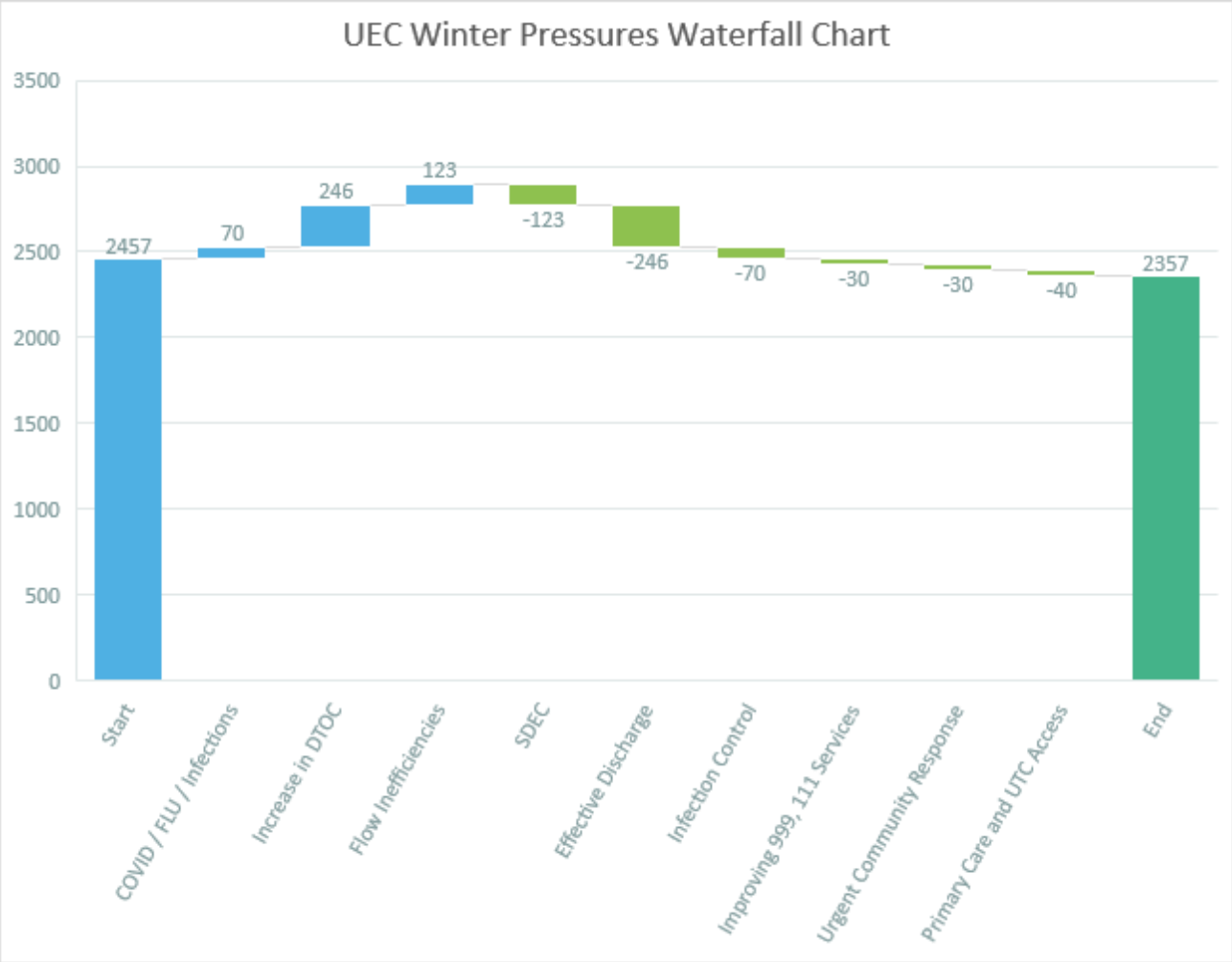


Reasonable Worst Case Scenario

- Peak Demand 2867 Beds on 16th Jan 2022 – 297 Escalation Beds Open – Peak Occupancy 107.4%



Waterfall Diagram



- The waterfall diagram show our best case scenario with peak demand at 2547 Beds & with 176 escalation beds being open
- A series of interventions are described in the next few slides that will bring these down to within baseline bed numbers.

SDEC/Effective Discharge

- All Trusts have plans in place to maximise Same Day Emergency Care through the development of new and extended SDEC pathways, extended hours and improvements in front door triaging to SDEC.
- Dudley Group have the opening of their new SDEC unit as part of this year's Winter Plan to further strengthen the SDEC offer.
- Trust level improvement plans have been developed in response to missed opportunities report findings will help maximise SDEC utilisation
- D2A pathways are in place and fully implemented across the system
- Multi agency discharge meetings taking place with Local Authorities & Community Services to ensure flow is not compromised
- Daily MDT meetings & ward rounds are taking place
- Patient Transfer Service – Arrangements are in place to enable the pre-booking of PTS to promote timely discharge of those who are assessed as medically fit with arrangements in place to promote discharges throughout the day.

Improving 999/111

- **Hear and Treat** – Significant improvements have already been secured in Hear and Treat Rates through the engagement of 70 Advanced Paramedics to undertake clinical validation of category 3 & 4 emergency calls, The financial year to date shows hear & treat rates at **8.2%** compared to **4.1%** for the same period last year. July & August have seen rates at **10%** & **15.4%** respectively.
- **Mental Health Response –** The Pre-hospital Mental Health Transformation Fund has been used to implement a street triage team to respond to those in crisis and additional mental health nurses are being employed to work within the NHS111 service
- **Reducing Handover Delays** - A review of HALO capacity has been completed across the system, additional capacity is to be provided to support handover during the winter period, staff to be deployed within November 2021, further details awaited from WMAS. Work continues alongside Trusts to ensure safe implementation of the national drop and go protocols
- **Increasing diversion rates** – A comprehensive review of the DoS is ongoing to promote increased diversion to community services, primary care and UTCs. Robust monitoring of diversion rates is in place to measure uptake and inform future commissioning.
- **Patient Transfer Service** – Arrangements are in place to enable the pre-booking of PTS to promote timely discharge of those who are assessed as medically fit with arrangements in place to promote discharges throughout the day.

Urgent Community Response

- UCR services in place across system which comply with national service specification requirements
- Mobilisation plans formed linked to each of our 5 places to accelerate delivery of increased capacity of UCR services throughout November utilising Ageing Well funding stream.
- Review of DoS completed to ensure clarity on diversion process to UCR. Monitoring of diversion in place with targets to increase rate over winter period via Black Country Collaboration meetings WMAS & system partners including provider & commissioner representation
- Care navigation processes strengthened across system to maximise diversion into community services to include co-location of care navigation staff into 111 team.
- Clear GP referral processes in place to UCR via local single point of access arrangements

Primary Care

Improving Access for patients & supporting general practice released 14th October 2021

Whilst we await requirements for submissions initial plans are:

- To consolidate and improve access at UEC
- To create RSV hubs in the community to provide some expert paediatric support
- To focus on 111 proactively clinically triage patients that the algorithm does not identify a disposition
- To focus work on proactive management of long term conditions to reduce multiple repeat visits to practices – reducing demand/but improving

  quality of the intervention
- To expediate early plans for health coaches to work with patients who are waiting for elective surgery. Proactive support & engagement –acting as the interface b between waiting list co-ordinators, reducing the calls to practice
- To work with practices to ensure access to their own private appointment dashboard – supporting to develop improvement plans at both practice & PCN level

Urgent Treatment Centre Access

A rapid review of UTC's across the Black Country and West Birmingham (BC&WB) has been undertaken to identify differentials in terms of opening hours and the potential to extend access to West Birmingham, Walsall and Sandwell UTC's to support systems winter resilience.

A review of arrival and discharge volumes by hour of the day for patients with the potential to be diverted to a UTC service has been undertaken. The analysis indicates additional demand for UTC services across the day and through the evening until midnight, with attendances dropping during the early hours of the morning.

As a result it has been agreed to expand the service offer for three UTC's, expanded service will run from 1st November to 31st March 2022.

Plans in place to extend opening hours at UTCs without 24 hr coverage from 1st November to 1.00pm. Arrangements in place across all Trust sites for triaging at the point of entry to UTC sites. Additional co-located UTC provision planned for SWBT City site to facilitate. DoS to be updated to reflect expanded provision.

Site	Current Opening Hrs	Hrs open each day	7 Days	Revised Opening Hrs
Dudley (includes GP OOH)	24 hr	24	Yes	24 hr
Wolverhampton (includes GP OOH)	24 hr	24	Yes	24 hr
Walsall	07:00 hrs – Midnight	17	Yes	8.00am – 3.00am
West Birmingham	08:00 hrs – 20:00 hrs	12	Yes	8.00am – midnight
Sandwell	09:00 hrs – 21:00 hrs	12	Yes	8.00am – 1:00am

Impact / Alignment

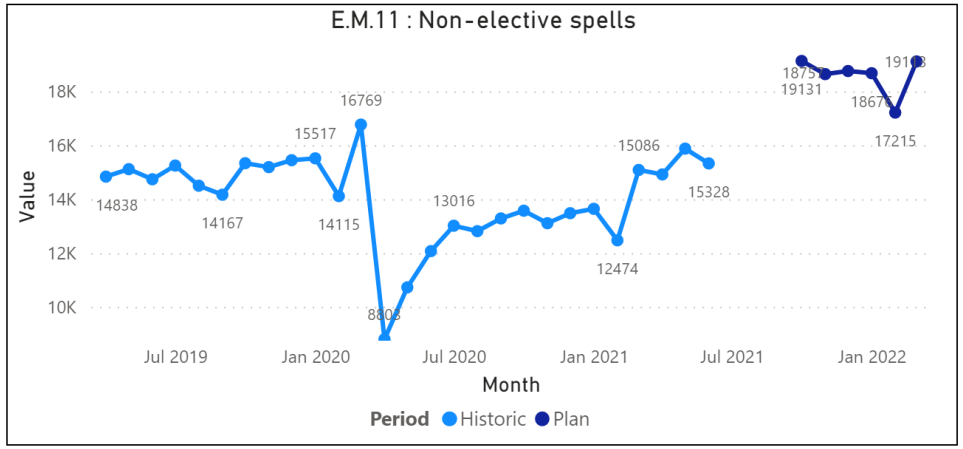
- The winter demand and modelling of bed numbers aligns with the NEL spells activity submission submitted on the 14th October 2021 & also triangulates with the elective plan submission.
- A summary of the key NEL indicator headlines submitted on the 14th October are provided on the next few slides
- We expect the series of interventions described earlier to have an improvement on improving ambulance handover delays. Further work is being undertaken to quantify the impact of this.

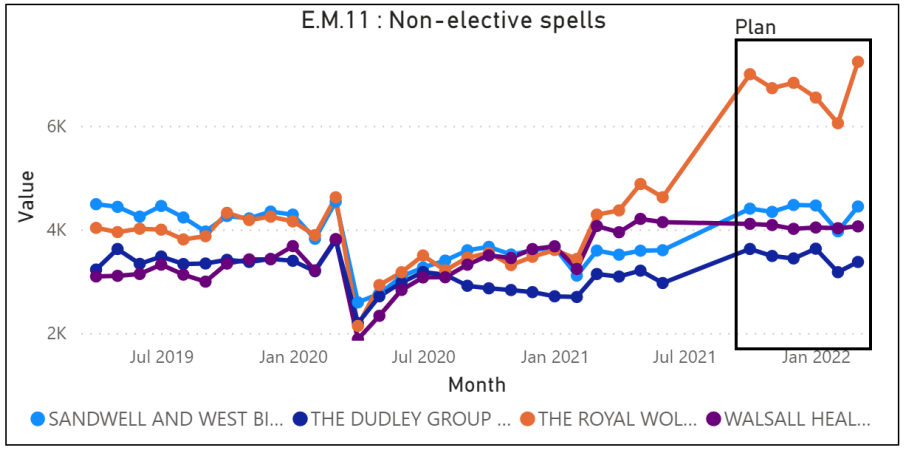
Impact / Alignment

Black Country and West Birmingham

H2 Planning : E.M.11 : Non-elective spells

NHS Black Country and West Birmingham Clinical Commissioning Group





ProviderName	SANDWELL AND WEST BIRMINGHAM HOSPITALS NHS TRUST			THE DUDLEY GROUP NHS FOUNDATION TRUST			THE ROYAL WOLVERHAMPTON NHS TRUST			WALSALL HEALTHCARE NHS TRUST			**Provider System Postion**		
MonthName	19/20 Value	Plan	Variance	19/20 Value	Plan	Variance	19/20 Value	Plan	Variance	19/20 Value	Plan	Variance	**19/20 Value**	**Plan**	**Variance**
October	4260	4402	103.33%	3414	3624	106.15%	4321	6997	161.93%	3341	4108	122.96%	**15336**	**19131**	**124.75%**
November	4214	4340	102.99%	3373	3488	103.41%	4182	6728	160.88%	3422	4086	119.40%	**15191**	**18642**	**122.72%**
December	4345	4473	102.95%	3431	3441	100.29%	4247	6831	160.84%	3425	4012	117.14%	**15448**	**18757**	**121.42%**
January	4287	4463	104.11%	3395	3629	106.89%	4156	6546	157.51%	3679	4038	109.76%	**15517**	**18676**	**120.36%**
February	3820	3965	103.80%	3194	3175	99.41%	3890	6051	155.55%	3211	4024	125.32%	**14115**	**17215**	**121.96%**
March	4538	4444	97.93%	3795	3373	88.88%	4621	7237	156.61%	3815	4059	106.40%	**16769**	**19113**	**113.98%**

Planning Guidance Expectation

Overall non-elective demand (from COVID and non-COVID) is at pre-pandemic (2019/20) levels, subject to the impact of any planned service developments

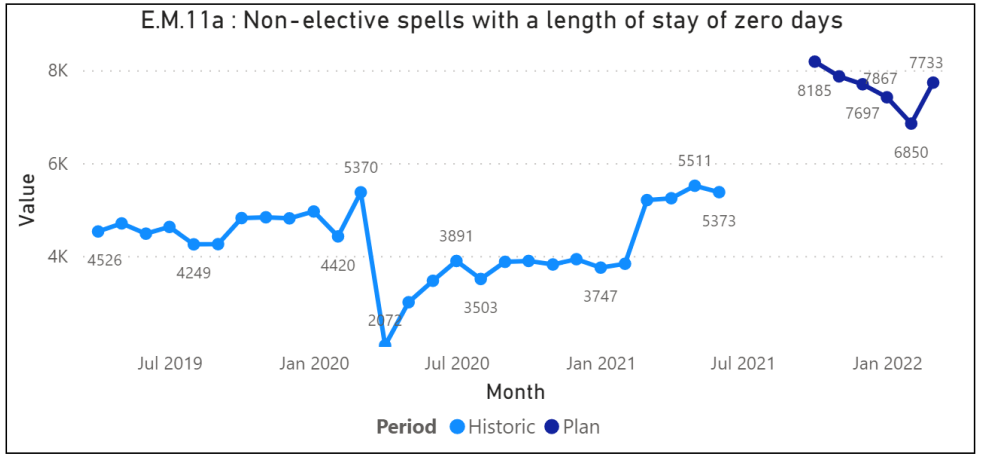
• COVID general and acute bed occupancy remains at the current level across the second half of the year.

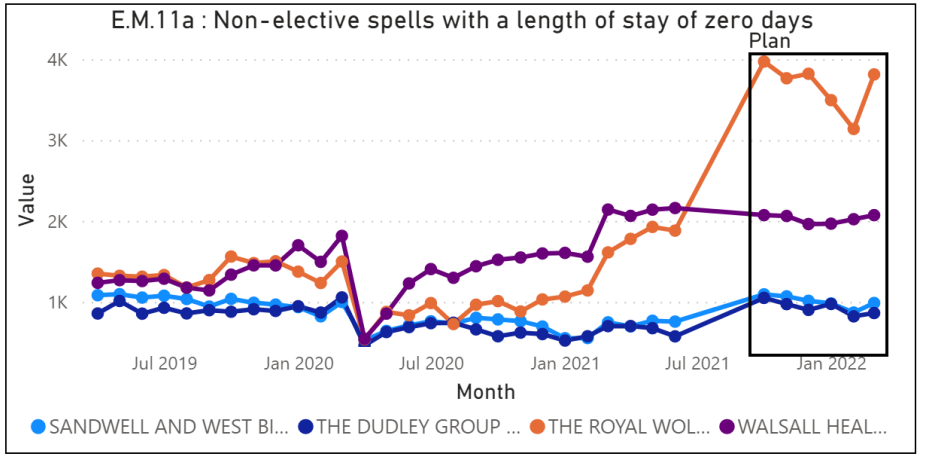
Impact / Alignment

Black Country and West Birmingham

H2 Planning : E.M.11a : Non-elective spells with a length of stay of zero days

NHS Black Country and West Birmingham Clinical Commissioning Group





ProviderName	SANDWELL AND WEST BIRMINGHAM HOSPITALS NHS TRUST			THE DUDLEY GROUP NHS FOUNDATION TRUST			THE ROYAL WOLVERHAMPTON NHS TRUST			WALSALL HEALTHCARE NHS TRUST			**Provider System Postion**		
MonthName	19/20 Value	Plan	Variance	19/20 Value	Plan	Variance	19/20 Value	Plan	Variance	19/20 Value	Plan	Variance	**19/20 Value**	**Plan**	**Variance**
October	1038	1094	105.39%	879	1050	119.45%	1561	3969	254.26%	1337	2072	154.97%	**4815**	**8185**	**169.99%**
November	990	1069	107.98%	910	973	106.92%	1480	3763	254.26%	1452	2062	142.01%	**4832**	**7867**	**162.81%**
December	967	1014	104.86%	889	902	101.46%	1502	3819	254.26%	1451	1962	135.22%	**4809**	**7697**	**160.05%**
January	936	982	104.91%	947	975	102.96%	1374	3493	254.22%	1700	1967	115.71%	**4957**	**7417**	**149.63%**
February	822	869	105.72%	869	822	94.59%	1234	3137	254.21%	1495	2022	135.25%	**4420**	**6850**	**154.98%**
March	999	987	98.80%	1056	863	81.72%	1499	3811	254.24%	1816	2072	114.10%	**5370**	**7733**	**144.00%**

Planning Guidance Expectation

Overall non-elective demand (from COVID and non-COVID) is at pre-pandemic (2019/20) levels, subject to the impact of any planned service developments

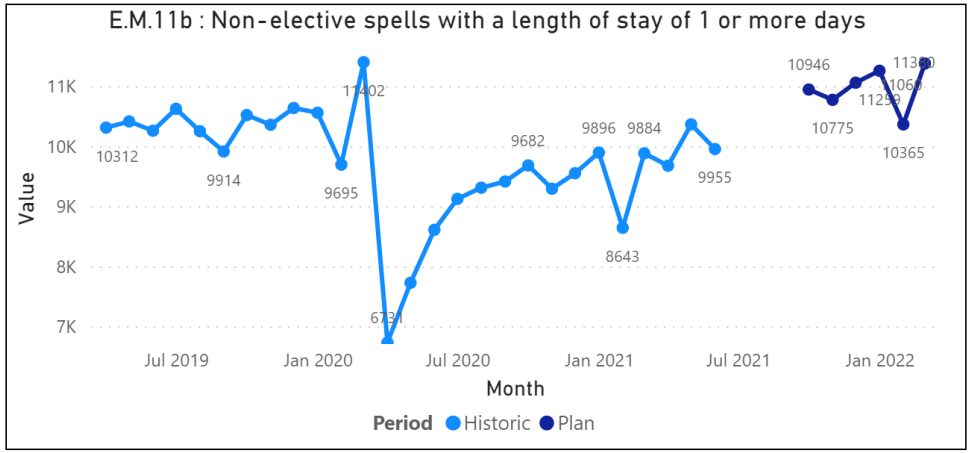
• COVID general and acute bed occupancy remains at the current level across the second half of the year.

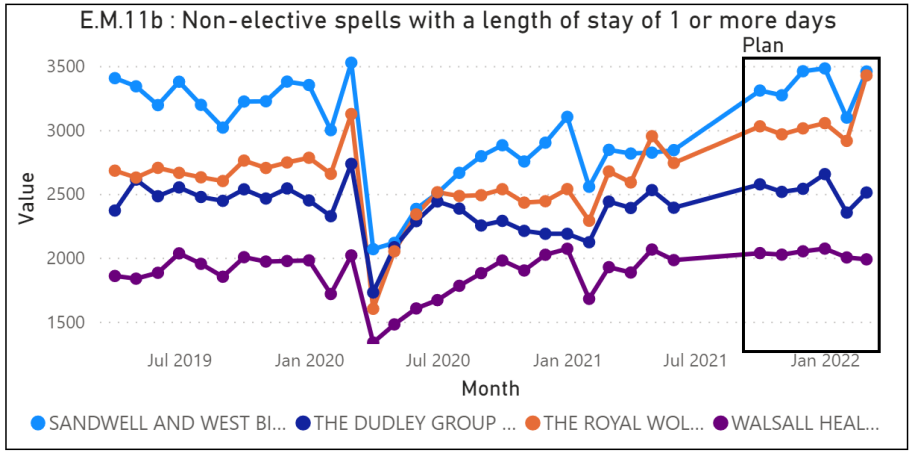
Impact / Alignment

Black Country and West Birmingham

H2 Planning : E.M.11b : Non-elective spells with a length of stay of 1 or more days

NHS Black Country and West Birmingham Clinical Commissioning Group





ProviderName	SANDWELL AND WEST BIRMINGHAM HOSPITALS NHS TRUST			THE DUDLEY GROUP NHS FOUNDATION TRUST			THE ROYAL WOLVERHAMPTON NHS TRUST			WALSALL HEALTHCARE NHS TRUST			**Provider System Postion**		
MonthName	19/20 Value	Plan	Variance	19/20 Value	Plan	Variance	19/20 Value	Plan	Variance	19/20 Value	Plan	Variance	**19/20 Value**	**Plan**	**Variance**
October	3222	3308	102.67%	2535	2574	101.54%	2760	3028	109.71%	2004	2036	101.60%	**10521**	**10946**	**104.04%**
November	3224	3271	101.46%	2463	2515	102.11%	2702	2965	109.73%	1970	2024	102.74%	**10359**	**10775**	**104.02%**
December	3378	3459	102.40%	2542	2539	99.88%	2745	3012	109.73%	1974	2050	103.85%	**10639**	**11060**	**103.96%**
January	3351	3481	103.88%	2448	2654	108.42%	2782	3053	109.74%	1979	2071	104.65%	**10560**	**11259**	**106.62%**
February	2998	3096	103.27%	2325	2353	101.20%	2656	2914	109.71%	1716	2002	116.67%	**9695**	**10365**	**106.91%**
March	3526	3457	98.04%	2734	2510	91.81%	3124	3426	109.67%	2018	1987	98.46%	**11402**	**11380**	**99.81%**

Planning Guidance Expectation

Overall non-elective demand (from COVID and non-COVID) is at pre-pandemic (2019/20) levels, subject to the impact of any planned service developments

• COVID general and acute bed occupancy remains at the current level across the second half of the year.

Oversight of System Demand & Capacity

Oversight of System Demand & Capacity

All system partners receive weekly predicted UEC activity levels for the forthcoming week from the Regional Capacity Management team to help inform service planning. A number of system measures are in place to manage demand and capacity across the system;

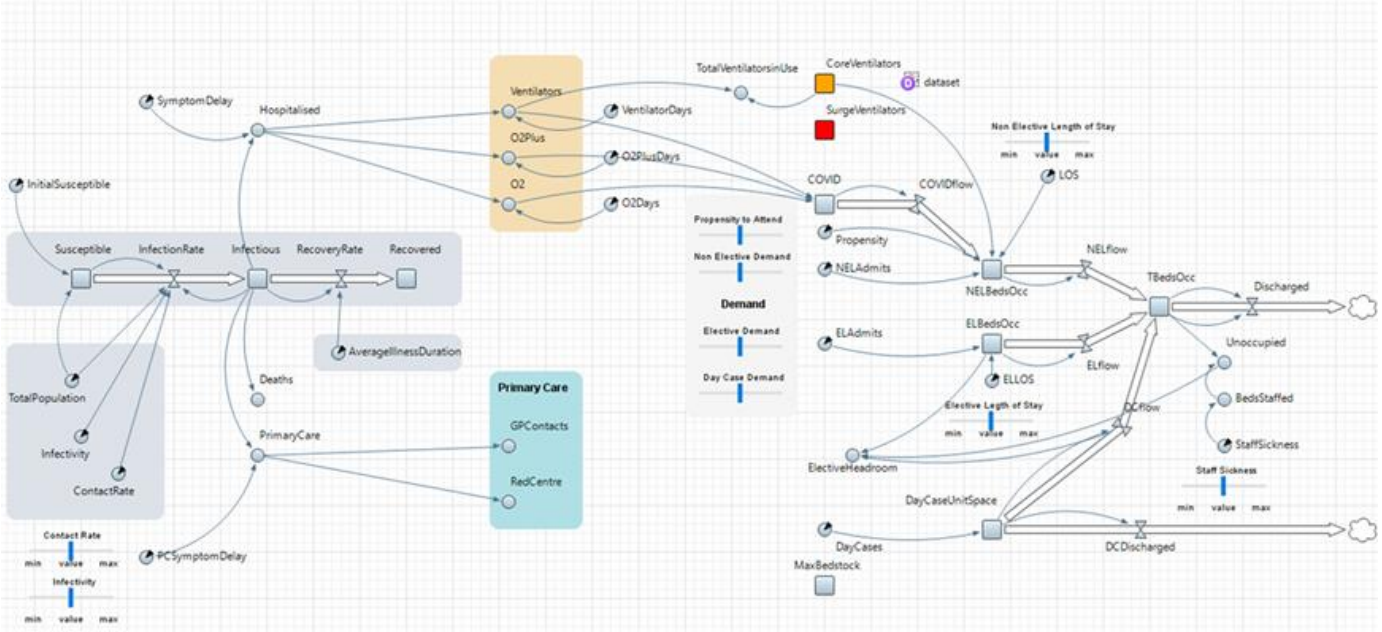
- Critical care and inpatient demand being monitored daily via the COVID Sitrep
- Fortnightly system calls with Birmingham Children's Hospital to discuss surge planning. Rotated with fortnightly BCWB ICS meetings with all four Trusts and the BC&WB Children & Young People System Lead to discuss surge planning and wider interventions to help with admission avoidance.
- System Gold Calls taking place three times a week
- Daily CCU capacity calls with CCU Consultants and COOs taking place, cross-site transfer of critical care patients across Black Country Network once existing physical capacity on the Critical Care Unit is full.
- Local place based calls are taking place with wider system partners (Local Authority, Primary care etc) at times of pressure to help resolve hospital flow issues.
- Daily in reach of nursing teams to support hospital discharge
- Additional surge capacity being utilised
- Continued use of independent sector utilisation to release capacity
- Workforce - skills mapping has been undertaken using the elfh skills matrix framework across the system to ensure appropriate levels of workforce are available and can be redeployed at times of surge if required

In addition to this the following measures are in place to manage demand across the system:

- When business as usual capacity is exceeded in any Trust a system call will be instigated to review and agree any potential mutual aid options for transfer of patients.
- If bed capacity across all Trusts is limited then this would trigger local Trust surge plans, daily system calls will be instigated to ensure mutual aid and bed capacity across the system is being managed collectively to avoid individual Trusts suspending or cancelling elective activity whilst others are operating at a lower levels of pressure.

BC&WB CCG have invested in the Anylogic platform which enables system dynamics, discrete event, agent based modelling to be built with stakeholders. This will enable a near time model of hospital activity flows and dynamic parameters in order to model interventions and changes. This will be a multiple element model that will be designed as linked components such as diagnostics, elective inpatient and outpatient flows along with non-elective flows with workforce, equipment/theatre outages and any other factor of influence. This model will dramatically reduce data mining and validation across the system and allow for much more sensitive and accurate modelling of change over time.

The prototype top level model has been constructed see below. AnyLogic specialists will be assisting this complex build during development.



The model will be used to oversee capacity and demand over the winter period.

Understanding Inequalities

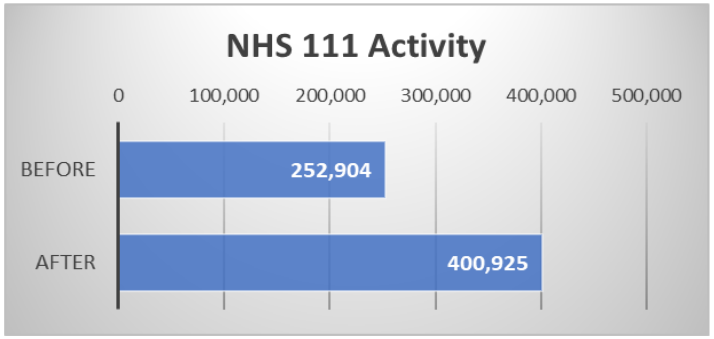
Inequalities

A review of available data was undertaken to understand the inequalities position within the UEC sector.

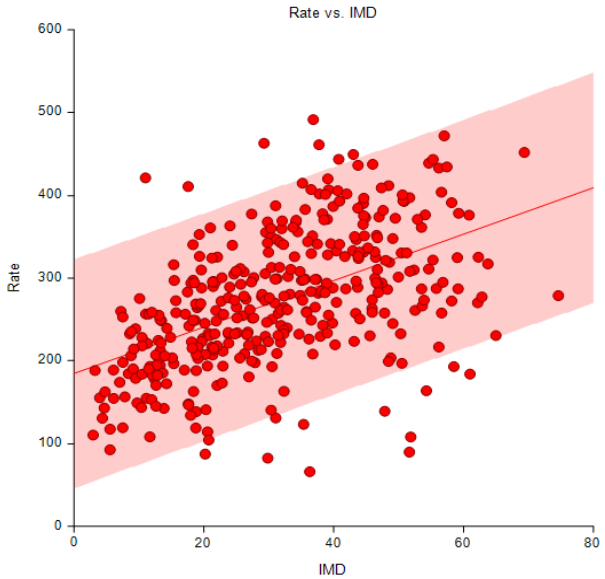
The following slides are an extract of the inequalities analysis presented to the UEC Board.

The analysis shows that although deprivation and ethnicity were factors of some influence in the model, these characteristics accounted for the minority of accountable variance. Recognising that such analysis is the beginning of a much larger review of inequalities with the system, it was agreed to initially develop a segmentation tool to better understand the wider factors of difference in service access and service user cohorts.

This will be reported to the UEC Board, and will be supplemented by regular reporting on inequalities as part of core assurance reporting.



The chart top left shows that NHS 111 activity increased from 253k in the pre COVID period to 401k in the post/during COVID period (a 58.5% increase).

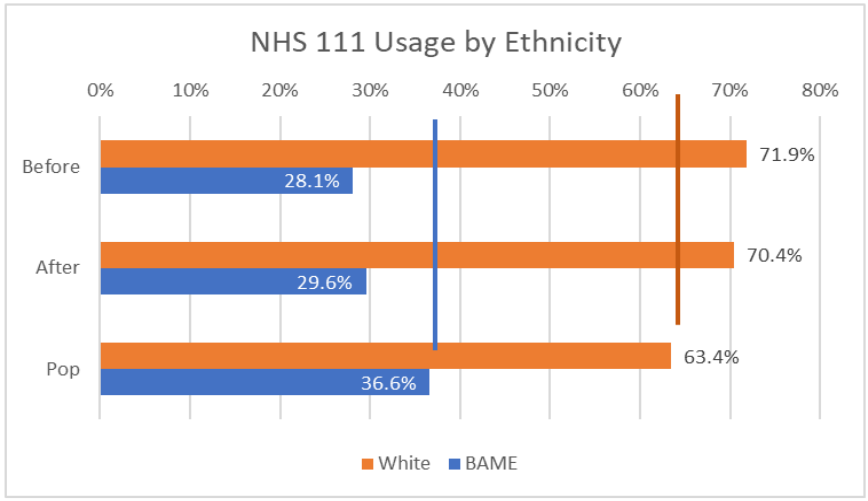


The plot directly above right shows the regression line for NHS 111 activity rates PKP and the Index of Multiple Deprivation Score (IMD) after/during COVID.

There is a significant relationship between these factors; correlation = 0.5512 p=0.000.

In a regression model, the following factors are significantly correlated with NHS 111 activity rates PKP. These factors are shown with the corresponding amount of accountable variance in activity rates at the LSOA level.

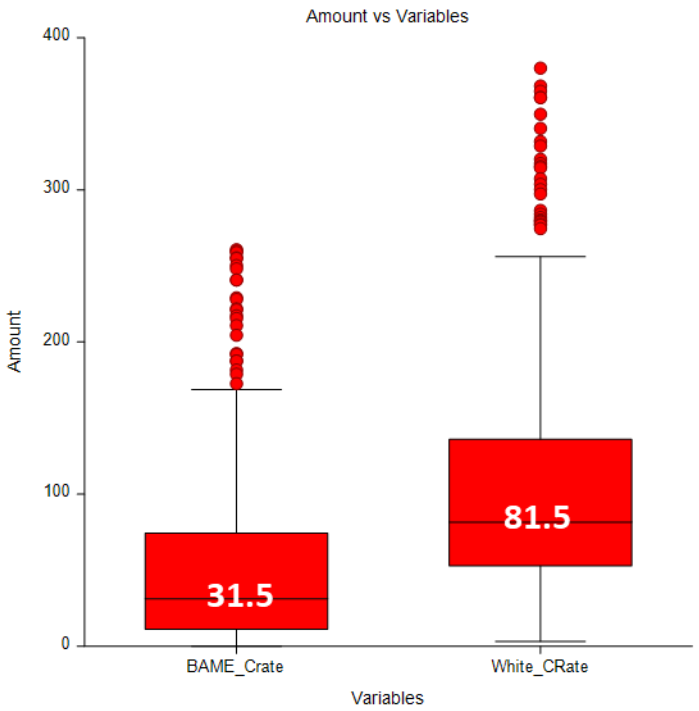
Factor	Accountable Variance	Note
IMD	27.6%	Despite margins of error, the relationship with activity rates and IMD strengthened in the post/during COVID period.
Ethnicity	3.4%	
Age	3.4%	

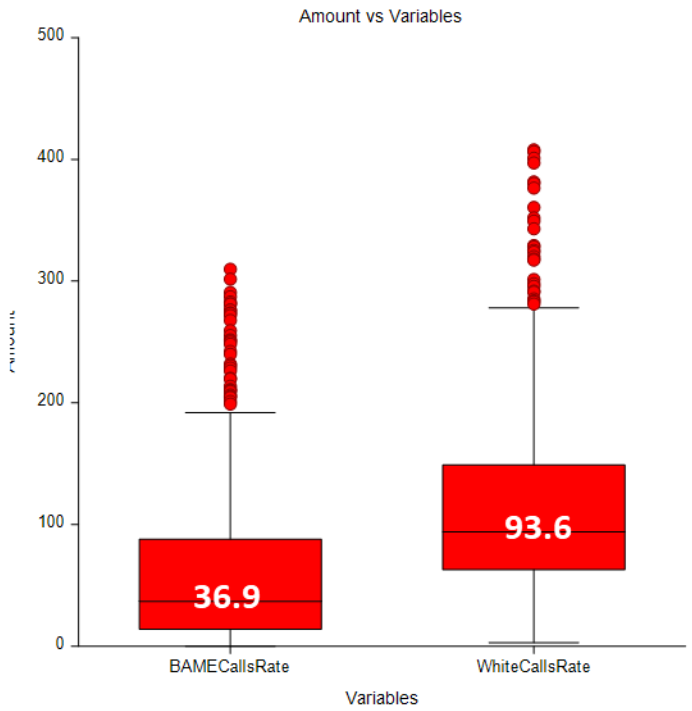


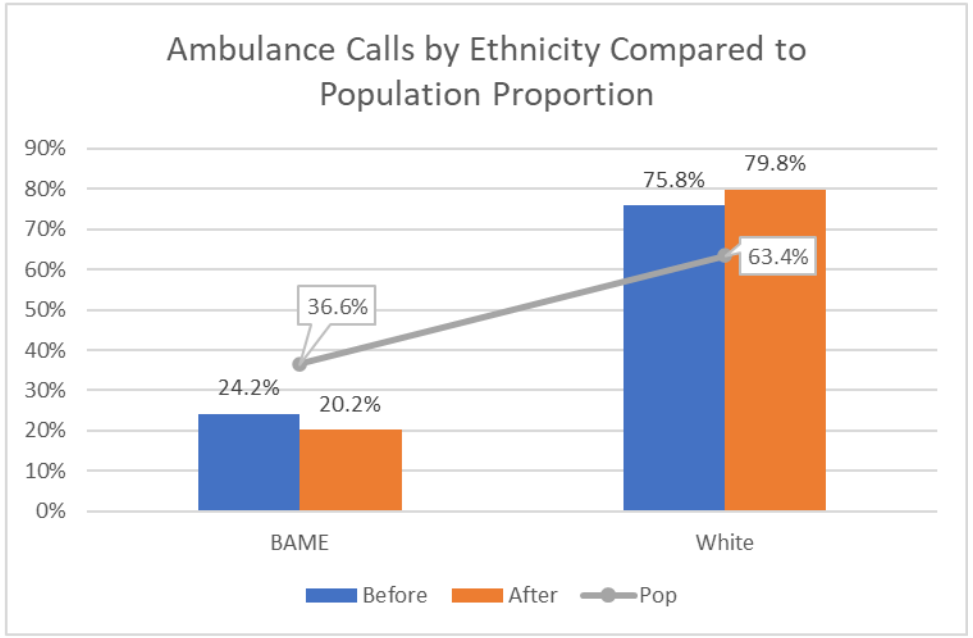
The bar chart bottom left shows the proportion of NHS 111 activity by Ethnic Group compared to the population percentage and across the before and after/during COVID periods.

The BAME group activity is less than the corresponding population percentage for both periods: the white group have the reverse of this profile.

Ambulance Calls by Ethnicity







The box plots above left and middle show 999 call rates by ethnic category at the LSOA level (before and after COVID).

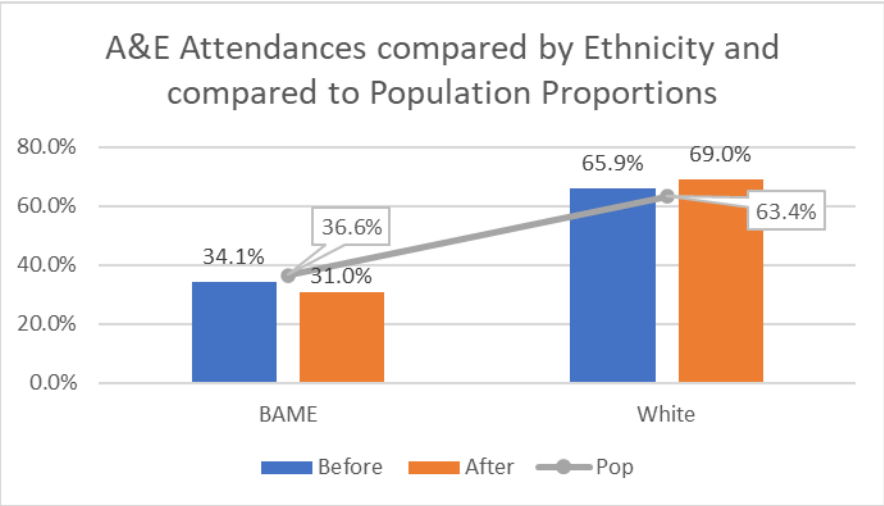
There is a statistically significant difference in call rates PKP between the White and BAME populations.

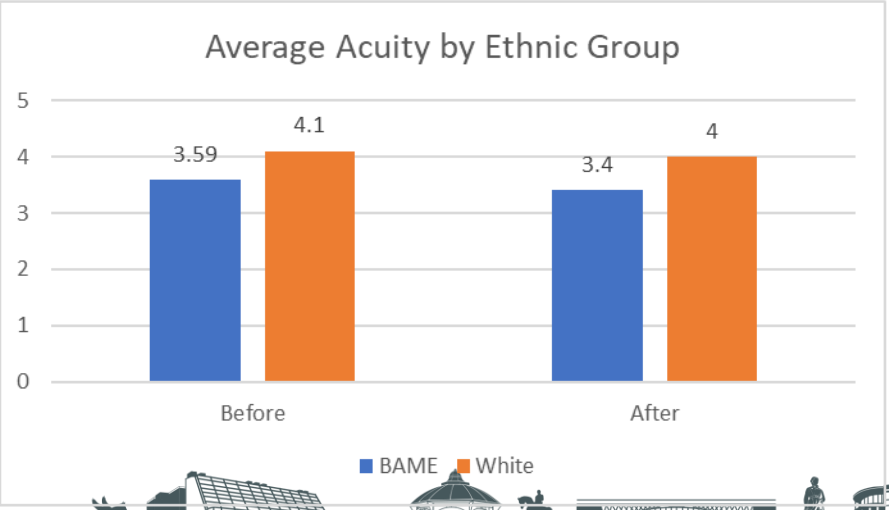
The chart above right shows the proportion of ambulance calls by Ethnic category compared to the population proportion for these groups across the two periods.
In both periods, the BAME group proportion of calls was well below their population proportion.

There is a significant correlation between ambulance calls and patient age although regression analysis shows that the this factor does not account for a large part of the variance in ambulance calls. This is a very similar feature for ambulance conveyances. Therefore this finding is difficult to interpret with clarity without further investigation.

Nonetheless, it is perhaps a plausible face value hypothesis that the BAME population is under represented in terms of ambulance service utilisation.

A&E attendances by ethnicity





The graph top left compares the A&E attendance proportions by Ethnic category across periods and compares these to the population proportions for those groups.

Across both periods people in the BAME category had lower attendance proportions compared to their population proportion. This gap increased in the post COVID period.

Across both periods people in the White category had higher attendance proportions compared to their population proportion. This gap increased in the post COVID period.

The bar chart bottom left shows the average Acuity levels recorded in A&E by ethnic category across the two periods.

In both periods people in the White category were coded with higher average acuity levels although acuity levels overall decreased slightly in the post COVID period.

A&E attendees from the BAME population also had a lower average age than White attendees.

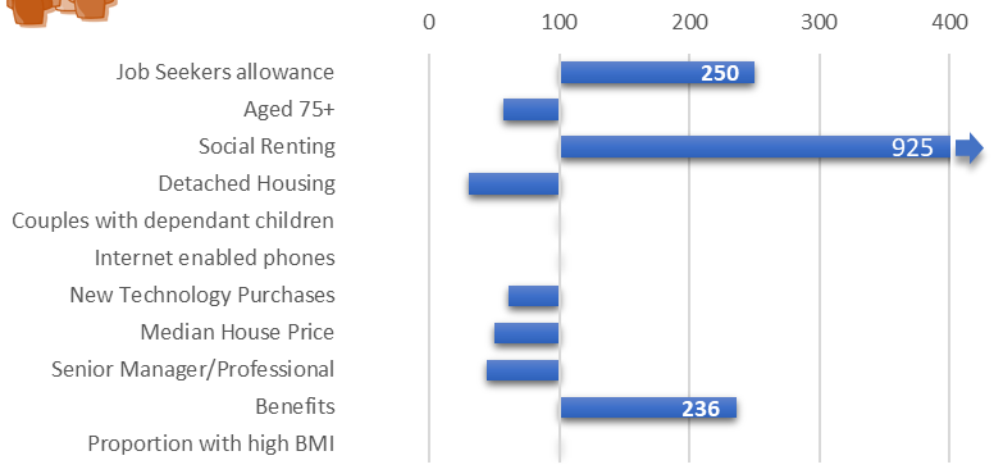
It is difficult to form concrete conclusions from these findings but key questions arise such as

- Is the BAME population better supported in Primary Care?
- Are the BAME communities underrepresented across healthcare (NHS 111 and Ambulance service contacts also show lower levels of activity for the BAME group)
- Do the BAME groups have stronger community support networks?
- Is lower service usage by the BAME population a product of a younger age profile with less acuity?

** Please note that Acuity is derived from the A&E HRG Investigation and Treatment level categories with a 1 point increase for each category. No investigation or treatment = zero and the highest level of investigation and treatment complexity = 9.*

A&E top ACORN profiles by volume

Profile 1

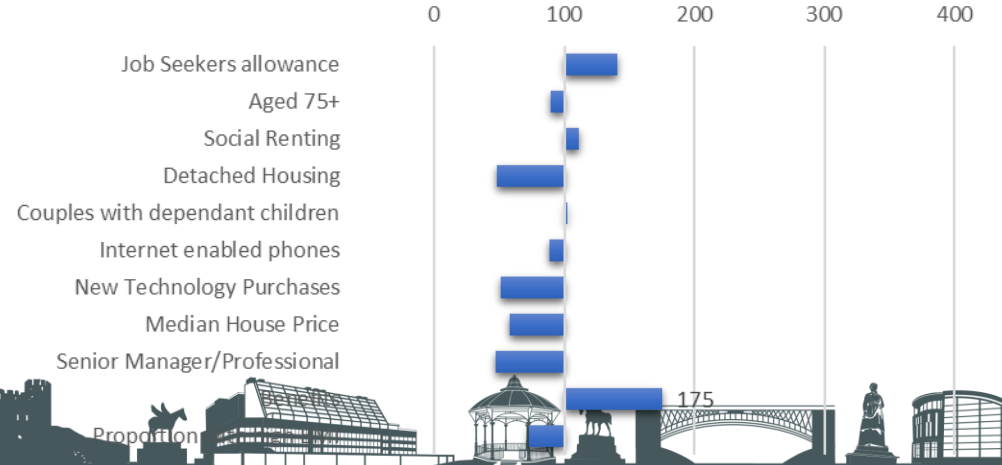


100 = the national average

Description

- People for this profile account for **7.5%** of all low acuity attendances at A&E
- 51% of the population are BAME background, 49% White.
- Unemployment is typically double the national average.
- Incomes often very low.
- Very high rates of job seekers allowance.
- Very high levels of social renting.
- Overall disease prevalence is lower than the average but specifically high levels of respiratory disease.
- Generally less responsive to all marketing channels.
- More likely to access social media.

Profile 2



100 = the national average

Description

- People for this profile account for **7.4%** of all low acuity attendances at A&E.
- 91% of the population are BAME background, 9% White.
- Many young, large families.
- Some of the more crowded housing in the country.
- Higher levels utilising job seekers allowance.
- Incomes are well below the average and qualification levels are low.
- Likely to have a large social online profile and likely to participate in discussion forums.
- Responsive to digital advertising, 3 times more likely to read promoted Tweets on Twitter.
- Higher levels of metal health conditions such as anxiety and depression.

Appendix 1. 10 Point UEC Plan

UEC 10 Point Plan

The next two slides provides an overview summary of our assessment against the 10 Point EUC Action Plan KLOES.

In summary there are overall 86 KLOES:

- 45 KLOES are rated as green/amber where system challenges are understood and plans to mitigate these are in place but need some further development/at risk of only being partially successful
- 35 KLOES are rated as green where system challenges are understood and plans to mitigate are in place & are appropriate
- 3 KLOES are rated as amber/red where system challenges are understood but mitigation plans are not in place or require significant development/unlikely to succeed:
  - Sit to Fit
  - Adherence to 24/7 Professional Care Standards for patients waiting ambulances
  - Patients within primary care self presenting to ED
- Detailed self assessment commentary and mitigating actions can be found in slides 36 - 63

UEC 10 Point Plan - RAG Summary

1. Supporting 999 and 111 services	RAG Rating (Select from drop down list)
Capacity and Demand - 111	
1. Is the system assured by the plans received from their 111 provider for the Winter period?	System challenges are understood and plans to mitigate these are in place but need some further development/at risk of only being partially successful
Maximising alternative pathways - 111 & 999 to include ambulance crews from scene	
2. Has the system ensured that the DoS that underpins the pathways has been both operationally and clinically reviewed alongside the benefits of a Single Point of Access in order to streamline and simplify access?	System challenges are understood and plans to mitigate these are in place but need some further development/at risk of only being partially successful
3. Has the system ensured that non ED pathways are fully accessible 7 days week?	System challenges are understood and plans to mitigate these are in place but need some further development/at risk of only being partially successful
4. Where appropriate has the system maximised the opportunity at the front door to stream and redirect patients using the Streaming and Redirection tool? What % of unheralded activity do you stream and redirect?	System challenges are understood and plans to mitigate these are in place but need some further development/at risk of only being partially successful
Workforce - 111	
5.What action has the system taken to address any identified gaps in staffing as a result of the capacity and demand modelling?	System challenges are understood and plans to mitigate these are in place but need some further development/at risk of only being partially successful
999 Ambulance Arrival and Handover Delays	
6. Is 'Fit to Sit' fully operationalised and utilised ?	System challenges are understood but mitigation plans are not in place or require significant development/or unlikely to succeed
7. Are ambulance clinicians, as trusted assessors, able to access to SDEC(s) directly?	System challenges are understood and plans to mitigate these are in place but need some further development/at risk of only being partially successful
8. Are you assured there is good adherence 24/7 to the 'Professional Care Standards for patients waiting in Ambulances'	System challenges are understood but mitigation plans are not in place or require significant development/or unlikely to succeed
9. Does the system have an explicit cohorting plan ?	System challenges are understood and plans to successfully mitigate are in place and are appropriate
10. Is the system assured by the plans received from their 999 provider for the Winter period?	System challenges are understood and plans to mitigate these are in place but need some further development/at risk of only being partially successful

2. Supporting primary care and community health services to help manage the demand for UEC services	RAG Rating (Select from drop down list)
Direct access	
1. What actions are being taken to improve direct bookings into general practice from 111 and to improve conversion rates in relation to calls into appointments? Are you able to evidence improvement?	System challenges are understood and plans to mitigate these are in place but need some further development/at risk of only being partially successful
2. How are you monitoring the amount of patients within primary care self presenting to emergency care, what is the plan to ensure these patients are ALWAYS seen by a PC practitioner and how are you assured your plan is working?	System challenges are understood but mitigation plans are not in place or require significant development/or unlikely to succeed
Digital	
3. What actions are being taken to improve the use of digital tools to access primary care services e.g. online consultations, online ordering of prescriptions / repeat dispensing etc?	System challenges are understood and plans to mitigate these are in place but need some further development/at risk of only being partially successful
Community Pharmacy Consultation Service	
4. How are the referral rates into CPCS (from both 111 and GPs) being monitored and what actions are being taken to increase and optimise referral numbers where required?	System challenges are understood and plans to mitigate these are in place but need some further development/at risk of only being partially successful
5. What actions are being taken to ensure PCNs will achieve the two IIF indicators aligned with GP CPCS?	System challenges are understood and plans to successfully mitigate are in place and are appropriate

Primary Care Workforce	
6. Are robust arrangements in place to ensure the recruitment within the Additional Roles Reimbursement Scheme fulfils the plans set out in the 31 August Workforce Plans and any underspend is considered for reinvestment in a timely way by the CCG using the provisions set out in the Unclaimed Funding section of the Network Contract DES ?	System challenges are understood and plans to mitigate these are in place but need some further development/at risk of only being partially successful
7. Are robust arrangements in place to ensure that PCNs are supported with workforce planning and that this is considered alongside wider system workforce planning with a shared understanding of the interdependencies and pressures on workforce supply (including specific considerations for Mental Health Practitioners, Paramedics, Clinical Pharmacists and Physician's Associates) ?	System challenges are understood and plans to successfully mitigate are in place and are appropriate
8. Are robust arrangements in place to ensure the delivery of the GP Retention Initiatives in line with the submitted ICS delivery plans, including appropriate governance reporting of progress through the H2 period?	System challenges are understood and plans to mitigate these are in place but need some further development/at risk of only being partially successful
9. Are robust arrangements in place to ensure that Training Hub funding investment delivers the training and retention of PCN workforce as locally determined ?	System challenges are understood and plans to successfully mitigate are in place and are appropriate
10. Are robust arrangements in place to ensure that the recording of primary care workforce continues to be updated in NWRS by PCNs and General Practice to ensure an understanding of capacity and the dynamics of the primary care workforce?	System challenges are understood and plans to successfully mitigate are in place and are appropriate
Community	
11. How are you ensuring community diagnostics to cope with the perceived Winter demand?	System challenges are understood and plans to mitigate these are in place but need some further development/at risk of only being partially successful
12. How are you coordinating palliative care support to manage care in the community and prevent admission?	System challenges are understood and plans to successfully mitigate are in place and are appropriate
13. Do you have plans to identify patients with a LTC who are at higher risk of admission and their care?	System challenges are understood and plans to mitigate these are in place but need some further development/at risk of only being partially successful

3. Supporting greater use of Urgent Treatment Centres (UTCs)	RAG Rating (Select from drop down list)
Capacity and Demand	
1. Has the system maximised the service offering of UTC's above and beyond the minimum specification?	System challenges are understood and plans to mitigate these are in place but need some further development/at risk of only being partially successful
2. Has the system reviewed lower acuity demand in ED that could be redirected / streamed to a UTC? What are the plans to ensure no patient with a primary or urgent care need is seen within an ED setting? How assured are you that your plan is working?	System challenges are understood and plans to mitigate these are in place but need some further development/at risk of only being partially successful
3. Does the UTC receive ambulance conveyed patients, supported by clear profiling on the DoS?	System challenges are understood and plans to successfully mitigate are in place and are appropriate
Workforce	
4. Has the system reviewed and mitigated against any gaps in staffing as a result of the capacity and demand modelling?	System challenges are understood and plans to mitigate these are in place but need some further development/at risk of only being partially successful

4. Increasing support for Children and Young People	RAG Rating (Select from drop down list)
1. Is there an RSV lead for the ICS? If so, please give contact details?	System challenges are understood and plans to successfully mitigate are in place and are appropriate
2. Is there an agreed surge plan and mitigations for RSV/seasonal demand in CYP services? Are you assured you have mitigated the feedback provided to you from the Regional RSV working group on your surge plans?	System challenges are understood and plans to successfully mitigate are in place and are appropriate
3. Is there a system pathway and support offer agreed for MH and social care support for CYP presenting at ED's?	System challenges are understood and plans to mitigate these are in place but need some further development/at risk of only being partially successful

5. Improving in-hospital flow and discharge (system wide)	RAG Rating (Select from drop down list)
SAFER	
1.Are multi-disciplinary Board and Ward rounds held daily starting by 09.00am and in the afternoon with allocated actions?	System challenges are understood and plans to successfully mitigate are in place and are appropriate
2.Do you have a systematic multi-disciplinary team review of patients with extended lengths of stay (>7 days – 'stranded patients', >21 days long stay patients) with a clear 'home first' mindset.	System challenges are understood and plans to successfully mitigate are in place and are appropriate
Hospital Discharge	
3. Do you have an integrated Discharge Hub and Operating Model?	System challenges are understood and plans to successfully mitigate are in place and are appropriate
4 Does the system have a plan for delivering weekend discharges on a par with weekday discharges?	System challenges are understood and plans to mitigate these are in place but need some further development/at risk of only being partially successful
5 .Does the system meet at least monthly to review key UEC care standards, quality and safety metrics?	System challenges are understood and plans to successfully mitigate are in place and are appropriate
6 .Are there robust arrangements in place for the daily management of flow into community beds and non-bedded services?	System challenges are understood and plans to successfully mitigate are in place and are appropriate
SDEC	
7. Does the system have plans for SDEC provision for medicine, surgery, frailty, paediatrics (and others - please list) which are 12hrs and 7 days as a minimum. Do these areas evidence they have direct (not through ED) referrals from ED nurses, streamers or triage /GP/111/999/Virtual Ward.	System challenges are understood and plans to mitigate these are in place but need some further development/at risk of only being partially successful
Discharge Lounge	
8.Does the Trust have a 7 day a week discharge lounge? If not, what is the plan to put in place for Winter?	System challenges are understood and plans to mitigate these are in place but need some further development/at risk of only being partially successful
Patient Transport	
9. What is the system's plan to provide PTS at any time the patient requires it so no patient remains in hospital overnight unnecessarily?	System challenges are understood and plans to successfully mitigate are in place and are appropriate
Virtual Wards	
10. Does the system have at least one non covid virtual ward in operation to use as a step down facility from acute hospital care?	System challenges are understood and plans to successfully mitigate are in place and are appropriate
CRS	
11.Has the system developed a process to implement 100% of patients have a time to initial assessment within 15 minutes of arrival? Can this be evidenced?	System challenges are understood and plans to mitigate these are in place but need some further development/at risk of only being partially successful
12.Does the system have a process for recognising and ensuring that the sickest patients (Type 1) are seen within 60 minutes of arrival to ED? How are you assured this is the case 24/7? What is the system plan to ensure this is the case throughout Winter?	System challenges are understood and plans to mitigate these are in place but need some further development/at risk of only being partially successful

UEC 10 Point Plan – RAG Summary

6. Protecting Elective Programmes + Elimination of 104wk waits by Mar-22	RAG Rating (Select from drop down list)
Elimination of 104wk waits	
1. What process will be put in place to ensure 104+ Week Waiter recovery and elimination is delivered during H2? Including the 104+ monitoring and oversight arrangements. Systems and providers are both expected to have a named Executive lead supporting the programme during H2.	System challenges are understood and plans to successfully mitigate are in place and are appropriate
2. Are there any additions to the provider and ICS Full Capacity Protocols that take into account the 104+ week waits and the H2 Elective objectives? If yes, please detail? Including the escalation process for cancellations.	System challenges are understood and plans to mitigate these are in place but need some further development/at risk of only being partially successful
Protecting Elective Programmes	
3. Please detail the protected capacity allocated to support long wait elective and cancer patients. Please include speciality and volumes and location of activity delivery (I,e within a "green" protected site)?	System challenges are understood and plans to mitigate these are in place but need some further development/at risk of only being partially successful
4. Please detail the approach taken to phasing elective activity in January and February. Are providers using "Smart Scheduling" to maximise capacity? Considering the pressures on In-patient beds and Ordinary Elective admission.	System challenges are understood and plans to mitigate these are in place but need some further development/at risk of only being partially successful

7. Using communications to support the public to choose services wisely	RAG Rating (Select from drop down list)
1.Does the system have a nominated comms lead? And are they linked to the UEC board/s?	System challenges are understood and plans to successfully mitigate are in place and are appropriate
2.Does the system have a comms / engagement plan that is signed-off by all ICS member organisations? Including a set of principles all comms leads will work to.	System challenges are understood and plans to successfully mitigate are in place and are appropriate
3.Does the comms / engagement plan cover: RSV NHSApp IPC Norovirus NHS111 first Staff flu and covid vaccinations Public flu and covid vaccinations Where's Best Next? or DTOC / ROLS messages GP access Antibiotics Pharmacy first Frailty Mental health - CYP / adults We are the NHS or recruitment / retention messaees	System challenges are understood and plans to successfully mitigate are in place and are appropriate
4. Does the comms plan have clinical spokespeople?	System challenges are understood and plans to successfully mitigate are in place and are appropriate
5. Does the comms / engagement plan outline how media will be managed reactively and proactively in and out of hours?	System challenges are understood and plans to mitigate these are in place but need some further development/at risk of only being partially successful
6. Does the comms / engagement plan explain how stakeholders will be engaged with?	System challenges are understood and plans to successfully mitigate are in place and are appropriate
7.Has a budget been identified?	System challenges are understood and plans to successfully mitigate are in place and are appropriate
8.Has the system committed to completing a monthly return on activity to region?	System challenges are understood and plans to successfully mitigate are in place and are appropriate
9.Has the system committed to adopting / adapting national campaigns where available?	System challenges are understood and plans to successfully mitigate are in place and are appropriate

8. Supporting adult and children's mental health needs	RAG Rating (Select from drop down list)
1. Significant transformation funding is available this year for adult crisis services. Please describe progress on the expansion of your Crisis Resolution Home Treatment Team in line with best practice. As well as the core service please describe progress with embedding crisis alternatives.	System challenges are understood and plans to successfully mitigate are in place and are appropriate
2. 24/7 crisis phone lines have been established across the country. Please detail how you ensure your phone line is well publicised, has appropriate triage arrangements in place, and has the right onward referral routes in order to meet patient need?	System challenges are understood and plans to successfully mitigate are in place and are appropriate
3. All acute sites in the Midlands with over 500 beds have received SDF funding as part of the LTP to establish a Psychiatric Liaison service that meets the Core 24 service standards. Does your system have a fully operational service which is meeting the service standards (a multidisciplinary 24/7 service that is meeting the target of 1 hour for emergencies and 24 hours for urgent ward referrals). If not, please detail timescales to achieve this.	System challenges are understood and plans to mitigate these are in place but need some further development/at risk of only being partially successful
4. The Midlands inpatient bed base is already under significant pressure. Please detail how the system is doing everything it can to maximise bed availability, including revisiting national IPC advice?	System challenges are understood and plans to mitigate these are in place but need some further development/at risk of only being partially successful
5. Work on purposeful admission and early discharge is well established as a means of reducing Length of Stay. There is significant SR money this year to support work on discharge. Can you please describe the work you are doing to reduce LoS (for example Red to Green or Perfect Day initiatives) and the impact on your overall LoS position.	System challenges are understood and plans to mitigate these are in place but need some further development/at risk of only being partially successful
6. A minority of systems chose to invest in the full LTP ambition around ambulance care this year. Please describe your work to reduce ambulance conveyances for people with mental health problems who do not need acute care. We are especially interested to know if the system is capturing data to support their work on reducing conveyance.	System challenges are understood and plans to mitigate these are in place but need some further development/at risk of only being partially successful
7. Thank you for the plans you submitted in April describing investment in (and expansion of) CYP crisis services and crisis alternatives. Can you please describe progress in implementing these plans.	System challenges are understood and plans to successfully mitigate are in place and are appropriate
8. As above for CYP Eating Disorder services. We are particularly interested to understand how children with Disordered Eating (ARFID) are being supported to avoid the need for inpatient care.	System challenges are understood and plans to mitigate these are in place but need some further development/at risk of only being partially successful
9. In August we asked you for s140 plans that described how you would work together as a system to deal with adults and children in crisis. Generally the collaborative arrangements (for example with Local Authority) for children were weaker than the arrangements for adults. Can you describe work you are doing to bolster your escalation processes for CYP.	System challenges are understood and plans to mitigate these are in place but need some further development/at risk of only being partially successful
Learning disabilities and/or Autism	
10.Has the system got clear plans to vaccinate people with a learning disability and / or autism as part of the booster/seasonal flu campaign in a way that makes reasonable adjustments to these groups?	System challenges are understood and plans to mitigate these are in place but need some further development/at risk of only being partially successful
11. Has the system got clear plans to ensure the continued delivery of high quality, preventative and effective annual health checks for people with a learning disability?	System challenges are understood and plans to successfully mitigate are in place and are appropriate
12.Does the system have enough capacity that is responsive to prevent adults and children with a learning disability entering crisis, EDs or inpatient care which can be avoided?	System challenges are understood and plans to successfully mitigate are in place and are appropriate
13. Does the system have robust plans to enable high quality physical health care to be delivered in MH/LDA settings to ensure that (where clinically appropriate) physical healthcare can be delivered safely and to a high standards?	System challenges are understood and plans to mitigate these are in place but need some further development/at risk of only being partially successful
14. Has the system got robust plans to ensure the safe continuation of discharges through the winter period for people with a learning disability, autism or both?	System challenges are understood and plans to successfully mitigate are in place and are appropriate

9. Reviewing Infection Prevention and Control (IPC) measures	RAG Rating (Select from drop down list)
1. How are you assured that the organisations within the system implemented the IPC guidance ?	System challenges are understood and plans to mitigate these are in place but need some further development/at risk of only being partially successful
2. Does the system have processes in place for monitoring healthcare associated infections and outbreaks ?	System challenges are understood and plans to successfully mitigate are in place and are appropriate
3. Do the providers have senior led outbreak meetings with engagement from the MDT ?	System challenges are understood and plans to successfully mitigate are in place and are appropriate
4. Is vaccination offered to all staff for vaccine preventable infections, including COVID19 boosters and influenza vaccination ? How assured are you that staff are adequately protected?	System challenges are understood and plans to successfully mitigate are in place and are appropriate
5. Do the providers have processes in place to offer all patients/service users/clients influenza vaccination and COVID19 vaccination and boosters?	System challenges are understood and plans to mitigate these are in place but need some further development/at risk of only being partially successful
6. Are contingency plans in place for safely managing any form of BOARDING (please note this means putting any patient in ANY space not specifically desgined for a patient – corridors, non-clinical rooms, trolleys in seating waiting areas) and this has been agreed by the Trust Boards with an incident being raised each time plans are enacted? How assured are you there is a clear process with escalation in place so that this risk is directly	System challenges are understood and plans to mitigate these are in place but need some further development/at risk of only being partially successful
7. Does the system have a heat map of risks related to low vaccination uptake and potential for impact on service provision ?	System challenges are understood and plans to mitigate these are in place but need some further development/at risk of only being partially successful
8. Does the system have a process in place to support IPC in care, nursing and residential homes?	System challenges are understood and plans to successfully mitigate are in place and are appropriate
9. Where IPC outbreaks are above expected numbers, have you established a ventilation committee to support your reduction plans?	System challenges are understood and plans to mitigate these are in place but need some further development/at risk of only being partially successful

10. Reviewing staff COVID isolation rules	RAG Rating (Select from drop down list)
1. Are there mechanisms in place to monitor the impact of the staff isolation guidance?	System challenges are understood and plans to successfully mitigate are in place and are appropriate

11. Ensuring a sustainable workforce	RAG Rating (Select from drop down list)
1. What workforce changes are expected as a result of winter pressure impact? For example: new ways of working , different team approaches etc, whilst ensuring safe staffing levels are maintained.	System challenges are understood and plans to mitigate these are in place but need some further development/at risk of only being partially successful
2.What is the gap between the current workforce and the workforce needed as a consequence of the anticipated winter pressure impact?	System challenges are understood and plans to mitigate these are in place but need some further development/at risk of only being partially successful
3.What are the workforce risks as a consequence of the additional winter pressure demand?	System challenges are understood and plans to mitigate these are in place but need some further development/at risk of only being partially successful
4. What are the actions being taken to mitigate the workforce risks ?	System challenges are understood and plans to mitigate these are in place but need some further development/at risk of only being partially successful
5. What can be built into the UEC program to support staff health and wellbeing and to retain staff?	System challenges are understood and plans to mitigate these are in place but need some further development/at risk of only being partially successful
6. Are Safer Nurse Staffing tools being utilised to safely plan the deployment of staff? (i.e. ED Safer Nurse Care Tool and royal college guidance / tools?	System challenges are understood and plans to successfully mitigate are in place and are appropriate

1. Supporting 111-999 Services

1. Supporting 999 and 111 services	Self assessment commentary	RAG Rating (Select from drop down list)	Evidence - Please attach appropriate document (i.e. Winter plan) with details of page where evidence can be found	Mitigating actions if not RAG rated GREEN
Capacity and Demand - 111				
1. Is the system assured by the plans received from their 111 provider for the Winter period?	The West Midlands Regional IUEC team have reviewed and distributed to all CCGs the WMAS 20201/22 Winter Plan and NHS 111 Q3 recovery plan.	System challenges are understood and plans to mitigate these are in place but need some further development/at risk of only being partially successful	WMAS 2021-22 Winter Plan (Enc) and 111 Q3 Recovery Plan (Enc) for information and assurance. Missed Opportunity Audit Results Black Country Summary (Enc)	WMAS Winter plan to be presented to ICS UEC Boards for assurance and local review on 5th November 2021.
Maximising alternative pathways - 111 & 999 to include ambulance crews from scene				
2. Has the system ensured that the DoS that underpins the pathways has been both operationally and clinically reviewed alongside the benefits of a Single Point of Access in order to streamline and simplify access?	Regular meetings taking place with WMAS DOS Lead & commissioners to ensure the DOS is kept under regular review and reflects current service provision. There are collaborative review meetinsg taking place with commissioners, providers and WMAS to ensure community pathways are working effectively . The West Midlands Regional IUEC commissioning Team supported by NHSX are undertaking a review of use of paramedic mobile search tools and UEC DOS. This process is ongoing and gaps highlighted.	System challenges are understood and plans to mitigate these are in place but need some further development/at risk of only being partially successful	NHSX National report on audit findings (Enc) and September Winter readiness return(Enc) enclosed for information and assurance.	The ICS is continuing to work with their local DOS leads to refine and review individual service requirements and changes. Black Country collaboration meetings taking place with DOS lead across the system with provider & commissioners to review UCR and alignment witH SDEC. There is recogniton that there is some variation with regards to naming conventions and profiling on the DOS and the ICS is reviewing & streamlining this.
3. Has the system ensured that non ED pathways are fully accessible 7 days week?	Non ED pathways are accessible seven days a week, this includes , UTC's, SDEC and SPA across the system. Comphrensive review of the SDEC opportunities have been undertaken with the support of the NHSE regional clinical lead. Reports and findings have been presented to Trust & System Boards. Action plans have been developed in response to findings. Improving primary care access includes: enhancing general practice websites to provide information, advice and signposting; recruiting/deploying ARRS to increase capacity; public engagement collaboration with LAs to enable multi-channel access to primary care and development of dashboard to inform targeted work with practices with greatest need to increase capacity including 111 directly bookable appointments to reduce ED attendance. Review of current UTC provision complete across BCWB system. Assessment of potential to divert completed with reference to group 4 and 5 attendances by ED department. Plans in place to extend opening hours at UTCs without 24 hr coverage from 1st November to 1.00pm. Arrangements in place across all Trust sites for triaging at the point of entry to UTC sites. Additional co-located UTC provision planned for SWBT City site to facilitate DoS to be updated to reflect expanded provision. UCR services in place across system which comply with national service specification requirements. Mobilisation plans formed linked to each of our 5 places to accelerate delivery of increased capacity of UCR services throughout November utilising Ageing Well funding stream. Review of DoS completed to ensure clarity on diversion process to UCR. Monitoring of diversion in place with targets to increase rate over winter period. Care navigation processes strengthened across system to maximise diversion into community services to include co-location of care navigation staff into 111 team. Clear GP referral processes in place to UCR via local single point of access arrangements	System challenges are understood and plans to mitigate these are in place but need some further development/at risk of only being partially successful		Whilst SDEC services are provided seven days a week there is some variation with opening hours that is currently being reviewed and will be addressed via the ICS UEC Board

4. Where appropriate has the system maximised the opportunity at the front door to stream and redirect patients using the Streaming and Redirection tool? What % of unheralded activity do you stream and redirect?	Missed opportunties report highlighted the potential for improvement in front door streaming, Trust and system level improvement plans have been developed and are in the process of being implemented.	System challenges are understood and plans to mitigate these are in place but need some further development/at risk of only being partially successful		Trust and system level improvement plans have been developed and are in the process of being implemented. Progress ie beign monitored through the ICS EUC Board.
Workforce - 111				
5.What action has the system taken to address any identified gaps in staffing as a result of the capacity and demand modelling?	The West Midlands Regional IUEC commissioning Team in partnership with WMAS & regional DoF's have undertaken extensive 999 & NHS 111 workforce capacity and financial mapping. The outcome of this work was presented at the AO IUEC Forum on the 13th October and papers from this meeting since circulated detailing the funding assumptions for H1, H2 and projections for 2022-23. These proposals are now with individual CCG for internal review. Circa 250 additional call handlers and clinicians have been recruited into NHS111. Further recruitment of call assessors also continuing through the national ambulance winter fund. Plans in place to increase the number of 'fleet ready' staff ahead of the festive season through both recruitment and the planned deployment of all employees, to include union reps and clinical managers, into operational delivery for the period 14th December 2021 – 12th January 2022. The merger of the 999 and NHS 111 call centres has increased the resilience of both services in the long term. Using NHS 111 staff to support 999 call taking during the unprecedented activity continues to ensure	System challenges are understood and plans to mitigate these are in place but need some further development/at risk of only being partially successful		
999 Ambulance Arrival and Handover Delays				
6. Is 'Fit to Sit' fully operationalised and utilised ?	Patients are streamed to appropriate ED area once Triaged however physical space in EDs is a limited factor with current system pressures.	System challenges are understood but mitigation plans are not in place or require significant development/or		Issue to be disussed at ICS UEC Board on 5th November 2021 for recommendations on implementation to be agreed.
7. Are ambulance clinicians, as trusted assessors, able to access to SDEC(s) directly?	As part of the NHS 111 First roll-out in December 2020 the functionality for this is now embedded in WMAS Paramedics ePRF's (toughbooks) & DOS profiling work has been completed so that SDEC(s) are being shown as alternatives to ED where appropriate.	System challenges are understood and plans to mitigate these are in place but need some further development/at risk of only being partially successful	IUC Service Specification (Enc)	ICS will continue to work with their DOS lead and Acutes providers to refine and review individual service requirements and encourage access to SDEC.
8. Are you assured there is good adherence 24/7 to the 'Professional Care Standards for patients waiting in Ambulances'	The NHSE/I Best practice guides and Professional Care Standards for patients waiting in Ambulance has been received by all providers.	System challenges are understood but mitigation plans are not in place or require significant development/or unlikely to succeed	Ambulance Professional Standards Letter (Enc) Professional Standards for Patients waiting for Ambulances (Enc)	Ongoing discussions taking place through the UEC ICS Board which includes WMAS as part of its membership.
9. Does the system have an explicit cohorting plan ?	The West Midlands Region does have a Managing Ambulance Conveyances to Hospital Plan, which includes guide for cohorting. This plan has recently (September 2021) been reviewed and amended by providers, commissioners and NHSE/I	System challenges are understood and plans to successfully mitigate are in place and are appropriate	NHSE/I Managing Ambulance Conveyances to Hospital Plan (Enc)	n/a

10. Is the system assured by the plans received from their 999 provider for the Winter period?	The West Midlands Regional IUEC team have reviewed and distributed to all CCGs the WMAS 20201/22 Winter Plan and NHS 111 Q3 recovery plan. Additional service delivery interventions to help manage demand and capacity include: Hear and Treat – Significant improvements have already been secured in Hear and Treat Rates through the engagement of 70 Advanced Paramedics to undertake clinical validation of category 3 & 4 emergency calls, The financial year to date shows hear & treat rates at 8.2% compared to 4.1% for the same period last year. July & August have seen rates at 10% & 15.4% respectively. Frailty Response – An enhanced service has been implemented for patients with frailty. Mental Health Response – The Pre-hospital Mental Health Transformation Fund has been used to implement a street triage team to respond to those in crisis and additional mental health nurses are being employed to work within the NHS111 service	System challenges are understood and plans to mitigate these are in place but need some further development/at risk of only being partially successful	WMAS 2021-22 Winter Plan (Enc) and 111 Q3 Recovery Plan (Enc) enclosed for information and assurance.	WMAS Winter plan to be presented to ICS UEC Board for assurance and local review on 5th November

2. Supporting Primary Care & Community

2. Supporting primary care and community health services to help manage the demand for UEC services	Self assessment commentary	RAG Rating (Select from drop down list)	Evidence - Please attach appropriate document (i.e. Winter plan) with details of page where evidence can be found	Mitigating actions if not RAG rated GREEN
Direct access				
1. What actions are being taken to improve direct bookings into general practice from 111 and to improve conversion rates in relation to calls into appointments? Are you able to evidence improvement?	Regular dialogue is taking place with the Director of Primarty Care and 111 Lead at WMAS to ensure that this area is well understood. Data on direct booking has been collected and reviewed. Data indicates that conversion rate across our system is higher at 37% than the national average (25%) There is however huge variation across practices.	System challenges are understood and plans to mitigate these are in place but need some further development/at risk of only being partially successful	80 practices were identified as not achieving the 25% conversion rate. Audit identified the practices that, at that time did not have appointments available. (shaded red) (Enc) Directly Bookable GP Appointments Letter 30/09/20 (Enc)	Work is underway to review the distribution of appointments across the working week, with targeted work with practices with the greatest potential to increase slots and conversion .A lprimary care UEC clinical lead has been appointed whol will be taking forward the work on improving direct bookings into general practice from 111.
2. How are you monitoring the amount of patients within primary care self presenting to emergency care, what is the plan to ensure these patients are ALWAYS seen by a PC practitioner and how are you assured your plan is working?	A comprehensive review of primary care access levels has been completed across the BCWB system drawing together the outcomes of a CCG snapshot survey, patient experience data, information on unheralded A&E attendances attracting vb11z tariff, z score data, 111 utilisation etc. The access review has considered : Number of appointments available, Level of face to face delivery vs virtual or telephone based delivery Time to consultation from initial request Ease of website navigation and accessibility of information Practices with low access levels have been prioritised for support from the primary care and place teams. Each of our 5 Places has received an allocation of £100k to develop local access improvement plans working alongside PCN CDs and practices. 5 Access and Engagement Officers recruited to work at Place level and support practices to put in place patient friendly access arrangements The level of extended access appointment utilisation is additionally underway. Primary care dashboards being developed and data will be being reviewed by practice level to target practices where high numbers of patients are presenting at ED. RSV searches are being completed that will help practices to prioritise children for their asthma reviews. We are working to support practices to consider ways of creating capacity to manage increased paediatric demands and to promote management in primary care. Clinical guidelines and new pathways have been shared with practices. Work has commenced with place teams to identify practices with significant registered children to prioritise roll out of pathways	System challenges are understood but mitigation plans are not in place or require significant development/or unlikely to succeed	Dashboards developed that aggregate data - Place teams using data to prioritise PCNs/practices for discussion and construction of improvement plans. Primary Care Pressures - Communications Plan (Enc)	Appointment of access and improvement officers work ongoing with patients and clinicians to co-produce access improvement plans. Key role in supporting the implementation of the communication plan. Following the publication of the improving access for patients and supporting general practice guidance being published on the 14th October 2021 we are developing reviewing our plans to improve same access to urgent same day primary care appointments. (Enc)
Digital				
3. What actions are being taken to improve the use of digital tools to access primary care services e.g. online consultations, online ordering of prescriptions / repeat dispensing etc?	Secure further improvement in the utilisation rates for online and video consultations via promotional work and re-launch of the online portal for practices to access promotional materials for on line/NHS APP etc. The CCG has good utilisation of EPS. with rates currently at 97.4%, well above the national average of 90.4% The CCG however lags behind the national trend of electronic repeat dispensing which will be an area of focus for the Medicines Management team as a key enabler of improved access to primary care services. Undertake a review of telephony with a view to procuring a cloud based service with additional functionalities. GP Connect - the CCG achieves a conversion rate of 34% - higher than the expected 25%. The CCG is looking to reduce the variation in performance by reviewing the distribution of available slots across the days of the week	System challenges are understood and plans to mitigate these are in place but need some further development/at risk of only being partially successful		Focused work to promote the use of online services to support triage, redirect patients to self-care advice and signpost to other services via practice websites. Work underway to find solutions to reduce digitally excluded cohorts in our population. Exploring further increase in availability and use of digital apps e.g. long term conditions management and patient communications. To integrate the reporting of utilisation into the emerging primary care dashboard to enable consistent review/monitoring.

Community Pharmacy Consultation Service				
4. How are the referral rates into CPCS (from both 111 and GPs) being monitored and what actions are being taken to increase and optimise referral numbers where required?	Referral rates are being monitored by BCWB CCG pharmacist lead for Community Pharmacy and disseminated to PCN lead pharmacists on a monthly basis. There is a current implementation plan for each place with engagement between practice and community pharmacy champions at a PCN level. CCG implementation group of key stakeholders including Local Pharmaceutical Committees convene monthly to review data, share best practices and troubleshoot local barriers/issues. CPCS implementation and uptake is a standing agenda item and subgroup of the ICS IPMO Pharmacy Leadership Group which reports to the ICS CLG. The IUEC Regional Commissioning Team monitor rates for both CPCS & Pharm+ and these are reported monthly to CCGs. A recent review of DOS profiles has been undertaken to ensure CPCS is ranked & presented appropriately to 111 call assessors & clinicians. The CCG continues to have a minor ailment scheme that is well utilised. The minor ailments scheme has been continued across our system with 7941 patients accessing the service in the last three months.	System challenges are understood and plans to mitigate these are in place but need some further development/at risk of only being partially successful	CPCS plans detailed in recent H2 submission. This data reporting is inclusive within the IUEC data resospiaty and accessible to all CCGs. See enclosed example of Aug 2020 (Enc) reporting Primary Care Pressures – Communications Plan (Enc)	Please see in mitigating actions described in self assessment commentary.
5. What actions are being taken to ensure PCNs will achieve the two IIF indicators aligned with GP CPCS?	Each PCN will have a CCG link pharmacist/technician who will keep them updated on target progress and likely achievement. Suggestions will be made to enhance uptake where required and issues escalated to PCN CDs and LPC representatives where required for resolution. Each place progress will be reported quarterly to Local Commissioning Boards for assurance.	System challenges are understood and plans to successfully mitigate are in place and are appropriate	National dashboard in development via NHSE	N/a
Primary Care Workforce				
6. Are robust arrangements in place to ensure the recruitment within the Additional Roles Reimbursement Scheme fulfils the plans set out in the 31 August Workforce Plans and any underspend is considered for reinvestment in a timely way by the CCG using the provisions set out in the Unclaimed Funding section of the Network Contract DES ?	Arrangements are in place to increase the number of ARRS roles. To date PCNs have appointed a total of 254 staff through the ARRS scheme. Highlights include the development of plans to increase the number of Physician Associates by 50% by promoting the offer of mentoring schemes and portfolio careers and PA the preceptorship offer as well as continuing to support and signpost practices that wish to recruit PA's. The Training Hub is also developing a number of Apprenticeships for (Health Care Assistants, Nursing Associates , Registered Nurse Degrees). Plans are also in place to introduce a number of new roles including Advanced Practitioners in Adult Mental Health and also Clinical Pharmacists. A review of PCN workforce plans will be taking place to confirm forward recruitment opportuntiies.	System challenges are understood and plans to mitigate these are in place but need some further development/at risk of only being partially successful		please see mitigation action under self assessment commentary. Recruitment to ARRS roles monitored and reported to Primary Care Commissioning Committee enabling any underspend to identified an reinvested in a timely way.
7. Are robust arrangements in place to ensure that PCNs are supported with workforce planning and that this is considered alongside wider system workforce planning with a shared understanding of the interdependencies and pressures on workforce supply (including specific considerations for Mental Health Practitioners, Paramedics, Clinical Pharmacists and Physician's Associates) ?	Activities include the recent development of a single flexible pool (digital solution) which will span the entire BCWB ICS footprint. This project aims to deliver a digital solution for Primary Care, enabling the pooling of resources to create greater resilience across the PCN's. This resource will initially focus on GPs but will expand to other staff groups with nursing being the next priority. Delivery plans are being developed with each of our 5 Places to ensure robust engagement and achievement of target uptake. We will continue to explore how digital pool can support future PCN workforce developments.	System challenges are understood and plans to successfully mitigate are in place and are appropriate		N/a
8. Are robust arrangements in place to ensure the delivery of the GP Retention Initiatives in line with the submitted ICS delivery plans, including appropriate governance reporting of progress through the H2 period?	The retention programmes being delivered via the Training Hub are resourced and routinely reported to the monthly HEE mandated Workforce Information Group. The TH is represented at the People Board and in its sub-groups according to the respective Terms of Reference. In addition NHSEI/HEE plans and progress submissions are made in accordance with the timetable as set, with participation in formal and informal review meetings	System challenges are understood and plans to mitigate these are in place but need some further development/at risk of only being partially successful		

9. Are robust arrangements in place to ensure that Training Hub funding investment delivers the training and retention of PCN workforce as locally determined ?	Regular progress meetings take place with NHS England and NHS Improvement to review milestones and targets. Regular meetings also take place with Primary Care Leads to understand and respond to training and development requirements. Furthermore, meetings are held with Finance leads to understand the budget trajectories, thus enabling plans to be put in place to respond to underspend and/or the reallocations of budgets.	System challenges are understood and plans to successfully mitigate are in place and are appropriate		N/a
10. Are robust arrangements in place to ensure that the recording of primary care workforce continues to be updated in NWRS by PCNs and General Practice to ensure an understanding of capacity and the dynamics of the primary care workforce?	Meetings are held with Primary Care Commissioning Leads to ensure that the recording of NWRS data capture is current. This in turn enables long term recruitment intentions particularly in relation to new and additional ARRS roles to be realised, as well as the vision of bespoke multi-disciplinary teams and how PCNs will build on existing primary care services to facilitate a more coordinated and integrated approach to improving population health.	System challenges are understood and plans to successfully mitigate are in place and are appropriate		N/a
Community				
11. How are you ensuring community diagnostics to cope with the perceived Winter demand?	Early adopter CDCs have opened in Dudley and Cannock which will increase capacity of H1 and allow delivery of key elective targets as this additional capacity had not been factored into original plans as a prudent approach of the CDC programme. Sandwell will be insourcing MRI capacity to manage the backlog, with mutual aid from the Dudley CDC	System challenges are understood and plans to mitigate these are in place but need some further development/at risk of only being partially successful	CDC early adopter business case approved by NHSE	outpatient transformation programme will create additional system capacity as it is implemented. This has not been factored into plans and therefore offers mitigation against any shortfall
12. How are you coordinating palliative care support to manage care in the community and prevent admission?	There good provision of community End of Life and Palliative care services across the system; with care coordinated through community nursing, AHP teams, specialist palliative and primary care. Community palliative care teams provide hands on care to all patients who are fast track funded and whose preferred place of care is in their own home. Rapid response teams are well established within the system with additional support and provision for emergency respite/end of life beds commissioned via hospices and nursing homes. In one of our localities the care coordination service will operate 7 days a week commencing from 01/10/2021 Advance Care Plans are promoted and ReSPECT (Recommended Summary Plan for Emergency Care and Treatment) process is being implemented across the system in conjuction with primary care Education, learning and raising awareness of services in place is ongoing across the system	System challenges are understood and plans to successfully mitigate are in place and are appropriate		N/a
13. Do you have plans to identify patients with a LTC who are at higher risk of admission and their care?	Practices will use UCL searches and risk stratification tools which are already embedded in primary care to identify those most at risk of admission. These patients will be reviewed by practice based MDTs and management plans agreed in conjunction with community services and specialist teams so that arrangements are in place to prevent admission should their condition deteriorate Blood pressure monitoring at home embedding.	System challenges are understood and plans to mitigate these are in place but need some further development/at risk of only being partially successful		General practice rescheduling reviews as part of the response to the constrained blood tube supply. ARRS continues to enhance proactive case management and personalised care planning. Monitoring of the impact of the BPM@home programme i.e. results submitted, ealry warning intervention
Dental				
14. How assured are you that urgent and routine dental capacity has been restored?				

3. Use of Urgent Treatment Centres

3. Supporting greater use of Urgent Treatment Centres (UTCs)	Self assessment commentary	RAG Rating (Select from drop down list)	Evidence - Please attach appropriate document (i.e. Winter plan) with details of page where evidence can be found	Mitigating actions if not RAG rated GREEN
Capacity and Demand				
1. Has the system maximised the service offering of UTC's above and beyond the minimum specification?	Review of current UTC provision has confirmed that it meets the specifications. Dialogue has started regarding opportunities for further development e.g. links to diagnostics. UTC review of provision complete across BCWB system. Assessment of potential to divert completed with reference to group 4 and 5 attendances by ED department. Plans in place to extend opening hours at UTCs without 24 hr coverage from 1st November to 1.00pm. Arrangements in place across all Trust sites for triaging at the point of entry to UTC sites. Additional co-located UTC provision planned for SWBT City site. DoS to be updated to reflect expanded provision	System challenges are understood and plans to mitigate these are in place but need some further development/at risk of only being partially successful		Dialogue has started regarding opportunities for further development e.eg. Link to diagnostics
2. Has the system reviewed lower acuity demand in ED that could be redirected / streamed to a UTC? What are the plans to ensure no patient with a primary or urgent care need is seen within an ED setting? How assured are you that your plan is working?	Detailed Analysis has established the appropriate patient demand within ED which has informed the decision making in extending the UTCs opening hours. Have also ensured UTC provision is co-located with ED departments which will result in a new service being available on the SWB City site.	System challenges are understood and plans to mitigate these are in place but need some further development/at risk of only being partially successful	FINAL BCWB UTCs - Options for Expansion	see narrative in self assessment commentary
3. Does the UTC receive ambulance conveyed patients, supported by clear profiling on the DoS?	All UTCs are able to receive ambulance conveyed patients and are profiled appropriately on the DOS. As service provision is extended the DOS will be updated.	System challenges are understood and plans to successfully mitigate are in place and are appropriate	Directory of Services	N/a
Workforce				
4. Has the system reviewed and mitigated against any gaps in staffing as a result of the capacity and demand modelling?	No immediate concerns identified for current service provision or for expansion plans. Any workforce issues are higlighted through contractual discussions with improvement plans put in place.	System challenges are understood and plans to mitigate these are in place but need some further development/at risk of only being partially successful		If there are worforce shortages agency and locum staff being utilised to help support winter resillence plans

4. Increasing Support for Children & Young People

4. Increasing support for Children and Young People	Self assessment commentary	RAG Rating (Select from drop down list)	Evidence - Please attach appropriate document (i.e Winter plan) with details of page where evidence can be found	Mitigating actions if not RAG rated GREEN
1. Is there an RSV lead for the ICS? If so, please give contact details?	Michelle Carolan BC&WB ICS CYP Lead - mcarolan@nhs.net	System challenges are understood and plans to successfully mitigate are in place and are appropriate	Confirmation sent to NHSE/I on 15th September 2021	n/a
2. Is there an agreed surge plan and mitigations for RSV/seasonal demand in CYP services? Are you assured you have mitigated the feedback provided to you from the Regional RSV working group on your surge plans?	RSV plan in place and submitted to NHSE/I. Includes details on system actions, trigger and esclation points for managing surge & capacity across the system. Feeback from regional working group been taken into account. Fortnightly system calls are in place with Birmingham Children's Hospital to discuss surge planning. Rotated with fortnightly BCWB ICS meetings with all four Trusts and the BC&WB Children & Young People System Lead to discuss surge planning and wider interventions to help with admission avoidance	System challenges are understood and plans to successfully mitigate are in place and are appropriate	RSV surge plan submitted (see attached)	n/a
3. Is there a system pathway and support offer agreed for MH and social care support for CYP presenting at ED's?	We have 50% coverage of CAMHS crisis 24/7 and are developing the remaining 50% across the Black Country. We have regular RSV meetings with acute hospitals and have a diversion pathway in place and joint triaging process in place with acute hospitals in which parity of safety is addressed throughout. We are also working with acute's to reduce any LOS if admission is required.	System challenges are understood and plans to mitigate these are in place but need some further development/at risk of only being partially successful	Service Summary / Identified Pressures / Mitigations (Enc)	We have regular MDT or daily operational calls with acute trusts to monitor the diverson pathways and ensure we are aware of current demands on acute trusts. There is an escalation process in place if required.

5. Communications

7. Using communications to support the public to choose services wisely	Self assessment commentary	RAG Rating (Select from drop down list)	Evidence - Please attach appropriate document (i.e. Winter plan) with details of page where evidence can be found	Mitigating actions if not RAG rated GREEN
1.Does the system have a nominated comms lead? And are they linked to the UEC board/s?	Yes - there is a provider lead and a CCG system lead identified for this. Laura Broster - laura.broster@nhs.net	System challenges are understood and plans to successfully mitigate are in place and are appropriate	BCWB UEC System Communications Plan - Autumn Winter 2021/22 (SLIDE 15)	n/a
2.Does the system have a comms / engagement plan that is signed-off by all ICS member organisations? Including a set of principles all comms leads will work to.	Yes - the plan went to UEC Board on the 1st October 2021	System challenges are understood and plans to successfully mitigate are in place and are appropriate	BCWB UEC System Communications Update October 2021 - (Highlights Board approval	n/a
3.Does the comms / engagement plan cover: RSV NHSApp IPC Norovirus NHS111 first Staff flu and covid vaccinations Public flu and covid vaccinations Where's Best Next? or DTOC / ROLS messages GP access Antibiotics Pharmacy first Frailty Mental health - CYP / adults We are the NHS or recruitment / retention messages	Yes- the plan includes these headline campaign areas and will be flexed throughout the winter period to ofocus on specific campaign areas. For example this month we are focussed on the areas identified regionally: • RSV - young children respiratory • NHSApp • NHS111 online • Staff flu and covid boosters • Public flu and covid boosters • GP Access - Multi-disciplinary team (MDT)	System challenges are understood and plans to successfully mitigate are in place and are appropriate	BCWB UEC System Communications Plan - Autumn Winter 2021/22 (SLIDES 11,12,21)	n/a
4. Does the comms plan have clinical spokespeople?	Yes - these details are held by the UEC lead but each provider has been tasked with not only identifying spokespeople for media but also those who speak community languages so that we can produce messages for our diverse communities	System challenges are understood and plans to successfully mitigate are in place and are appropriate	BCWB UEC System Communications Plan - Autumn Winter 2021/22 (SLIDE 24)	n/a
5. Does the comms / engagement plan outline how media will be managed reactively and proactively in and out of hours?	The plan doesn't specifically detail this approach in full, but we have a signed concordat for our system which we all practice within the comms community. Key NHS organisations have communications on call arrangements in place which are also	System challenges are understood and plans to mitigate these are in place but need some further development/at risk of only being partially successful	BCWB UEC System Communications Plan - Autumn Winter 2021/22 (SLIDES 14, 24) / on-call list / system concordat	n/a
6. Does the comms / engagement plan explain how stakeholders will be engaged with?	Yes - this will be led through place relationships	System challenges are understood and plans to successfully mitigate are in place and are appropriate	BCWB UEC System Communications Plan - Autumn Winter 2021/22 - (SLIDES 13-18, 22 23)	n/a
7.Has a budget been identified?	Yes - the CCG has identified funding of £20k for this plan	System challenges are understood and plans to successfully mitigate are in place and are appropriate	BCWB UEC System Communications Plan - Autumn Winter 2021/22 - (SLIDE 23)	n/a
8.Has the system committed to completing a monthly return on activity to region?	Yes - we have mechanisms in place to do this	System challenges are understood and plans to successfully mitigate are in place and are appropriate	BCWB UEC System Communications Plan - Autumn Winter 2021/22 - (SLIDE 15)	n/a
9.Has the system committed to adopting / adapting national campaigns where available?	Yes - detailed in our approach	System challenges are understood and plans to successfully mitigate are in place and are appropriate	BCWB UEC System Communications Plan - Autumn Winter 2021/22 - (SLIDE 13)	n/a

6. In hospital flow & discharge

5. Improving in-hospital flow and discharge (system wide)	Self assessment commentary	RAG Rating (Select from drop down list)	Evidence - Please attach appropriate document (i.e Winter plan) with details of page where evidence can be found	Mitigating actions if not RAG rated GREEN
SAFER				
1.Are multi-disciplinary Board and Ward rounds held daily starting by 09.00am and in the afternoon with allocated actions?	Yes in place across all Trusts	System challenges are understood and plans to successfully mitigate are in place and are appropriate		N/a
2.Do you have a systematic multi-disciplinary team review of patients with extended lengths of stay (>7 days – 'stranded patients', >21 days long stay patients) with a clear 'home first' mindset.	Yes in place across all Trusts and operating effectively	System challenges are understood and plans to successfully mitigate are in place and are appropriate		N/a
Hospital Discharge				
3. Do you have an integrated Discharge Hub and Operating Model?	Yes in place across all Trusts and operating effectively	System challenges are understood and plans to successfully mitigate are in place and are appropriate		N/a
4 Does the system have a plan for delivering weekend discharges on a par with weekday discharges?	Yes the providers have plans and any issues regarding discharge planning is escalated to the UEC Board. Trusts monitor weekday and weekend discharges regularly to ensure this is operating effectively. Local place based calls are taking place with wider system partners (Local Authority, Primary care etc) at times of pressure to help resolve hospital flow issues.	System challenges are understood and plans to mitigate these are in place but need some further development/at risk of only being partially successful		Trusts monitor weekday and weekend discharges regularly to ensure this is operating effectively & ensure corrrective action is taken if any issues arise
5 .Does the system meet at least monthly to review key UEC care standards, quality and safety metrics?	Yes monthly QSRM meetings take place and key information also reported through to the Quality, Safety & Performance Board & to the UEC Board.	System challenges are understood and plans to successfully mitigate are in place and are appropriate	CQRM Integrated Quality & Performance Report (Enc) Maternity Dashboard 2021 (Enc)	N/a
6 .Are there robust arrangements in place for the daily management of flow into community beds and non-bedded services?	Yes mulit agency discharge to assess discussions taking place on a daily basis. Utilisation of pathways regularly reviewed to enable any blockages or barriers to be addressed.	System challenges are understood and plans to successfully mitigate are in place and are appropriate		N/a
SDEC				
7. Does the system have plans for SDEC provision for medicine, surgery, frailty, paediatrics (and others - please list) which are 12hrs and 7 days as a minimum. Do these areas evidence they have direct (not through ED) referrals from ED nurses, streamers or triage /GP/111/999/Virtual Ward.	Review of SDEC has been completed in terms of SDEC pathways/provision. Trust level SDEC development plans in place linked to the missed opportunities work. SDEC dashboard in place to monitor uptake. SDEC pathways are included on DOS for direct referral. SPA available for GPs to enable direct access to SDEC services	System challenges are understood and plans to mitigate these are in place but need some further development/at risk of only being partially successful		Opportunity to improve SDEC direct referral rates & pathways, joint working ongoing with Trusts, WMAS and primary care.
Discharge Lounge				
8.Does the Trust have a 7 day a week discharge lounge? If not, what is the plan to put in place for Winter?	There is some variability across system in terms of provision of dedicted discharge lounge sevens days a week which is also due to estate challenges but all have effective arranegements in place	System challenges are understood and plans to mitigate these are in place but need some further development/at risk of only being partially successful		Where discharge lounges are not available alternative arrangements are in place to ensure patients have a place to sit and wait for their collection.
Patient Transport				
9. What is the system's plan to provide PTS at any time the patient requires it so no patient remains in hospital overnight unnecessarily?	Review of PTS has been completed, highlighting opportunities for prebookign and earlier dicharge planning. PTS service run by WMAS, contract	System challenges are understood and plans to successfully mitigate are in place and are appropriate		N/a

Virtual Wards				
10. Does the system have at least one non covid virtual ward in operation to use as a step down facility from acute hospital care?	Yes virtual wards in place across the system and operating effectively	System challenges are understood and plans to successfully mitigate are in place and are appropriate		N/a
CRS				
11.Has the system developed a process to implement 100% of patients have a time to initial assessment within 15 minutes of arrival? Can this be evidenced?	Processes are in place across the system, with some variability on compliance/peformance.	System challenges are understood and plans to mitigate these are in place but need some further development/at risk of only being partially successful	CQRM Integrated Quality & Performance Report (Enc) Maternity Dashboard 2021 (Enc)	Trusts monitor this via daily dashboards with escalation plans in place to ensure this is operating effectively & ensure corrrective action is taken if any issues arise, this is also reviewed via the QSRM.
12.Does the system have a process for recognising and ensuring that the sickest patients (Type 1) are seen within 60 minutes of arrival to ED? How are you assured this is the case 24/7? What is the system plan to ensure this is the case throughout Winter?	Yes clinically led triage processes in place with monitoring via daily dashboards with escalation plans in place.	System challenges are understood and plans to mitigate these are in place but need some further development/at risk of only being partially successful		Opportunity to improve system oversight
13. How are you assured that patient safety and risk is routinely monitored and mitigated against in your ambulance arrival area outside of ED and within ED as a whole? What evidence do you routinely have which evidences that patients are always safe inside and outside of your EDs?	All Trusts have clinical teams in place who undertake triage and manage/mitigate risk. A review of HALOs capacity has been completed across the system with the result that additional capacity is to be provided to sup[port handover during the winter period. Work continues alongside Trusts to ensure safe implementation of the national drop and go protocol Any patient safety incidents are investigated by the Quality & Safety Team	System challenges are understood and plans to successfully mitigate are in place and are appropriate		N/a

7. Adult & Children's Mental Health

8. Supporting adult and children's mental health needs	Self assessment commentary	RAG Rating (Select from drop down list)	Evidence - Please attach appropriate document (i.e Winter plan) with details of page where evidence can be found	Mitigating actions if not RAG rated GREEN
1. Significant transformation funding is available this year for adult crisis services. Please describe progress on the expansion of your Crisis Resolution Home Treatment Team in line with best practice. As well as the core service please describe progress with embedding crisis alternatives.	Achievement of the fidelity model across 2 boroughs with an increase in capapcity for all our patients. Improved patient flow and offer of alternative to hospital admission. All CRHTT's are staffed 24/7. Walsall and Dudley are staffed to meet national fidelity standards. Wolverhampton and Sandwell teams are expanding to meet the full staffing requirement of the standard. All four areas in the Black Country now have a Sanctuary Hub (crisis cafe) operating 7 days a week in each place. 24/7 helpline service is in place to meet both CYP and adult referrals, providing appropriate support and any sign posting.	System challenges are understood and plans to successfully mitigate are in place and are appropriate	https://www.rethink.org/help-in-your-area/services/advice-and-helplines/black-country-247-urgent-mental-health-helpline/ https://www.blackcountryhealthcare.nhs.uk/contact-us/help-crisis	**N/A**
2. 24/7 crisis phone lines have been established across the country. Please detail how you ensure your phone line is well publicised, has appropriate triage arrangements in place, and has the right onward referral routes in order to meet patient need?	24/7 Helpline is advertised on numerous websites of both statutory and non statutory providers. Various service promotions have taken place with stakeholders so partners are aware of the service and how to access it. Service is provided by 3rd sector provider who works closely with Black Country Healthcare Trust. Risk assessment and Triage protocols have been agreed. Performance monitoring captures information on calls and onward referral pathways. Community Development Workers also engage with BAME, LGBTQ+ and other hard to reach groups to ensure the wider community has information on services.	System challenges are understood and plans to successfully mitigate are in place and are appropriate		N/A
3. All acute sites in the Midlands with over 500 beds have received SDF funding as part of the LTP to establish a Psychiatric Liaison service that meets the Core 24 service standards. Does your system have a fully operational service which is meeting the service standards (a multidisciplinary 24/7 service that is meeting the target of 1 hour for emergencies and 24 hours for urgent ward referrals). If not, please detail timescales to achieve this.	Funding in place for staff to achieve this however recruitment to all posts has been slow and has created delay. Rceuritment has been repaeted in an attempt to achieve. Environmental factors around space within the acute trust remians a challenge	System challenges are understood and plans to mitigate these are in place but need some further development/at risk of only being partially successful		There is a 24/7 service being provided in all acute hospitals, we continue to utilise existing MDT local teams while recruitment continues to take place and we are awaiting start dates for appointments.
4. The Midlands inpatient bed base is already under significant pressure. Please detail how the system is doing everything it can to maximise bed availability, including revisiting national IPC advice?	7 day bed management team that will see an increase to cover 24 hours a day to manage flow • Escalation and oversight of bed usage twice a day • Discharge coordinators in place to assist with discharge planning at the point of admission and escalation and resolution of any delays • Clinical Directors aligned to each locality • Bed management meetings and Director oversight • IPC guidance embedded within admission procedures, including self-isolation and swabbing regime as part of controls for out break management • SOP in place to address additional capacity requirements within the acute bed provision	System challenges are understood and plans to mitigate these are in place but need some further development/at risk of only being partially successful		Daily & weekly oversight of bed demands and escalation of pressures and actions continue to be in place.

5. Work on purposeful admission and early discharge is well established as a means of reducing Length of Stay. There is significant SR money this year to support work on discharge. Can you please describe the work you are doing to reduce LoS (for example Red to Green or Perfect Day initiatives) and the impact on your overall LoS position.	Improvement and reduction in LOS supported by all clinical staff, bed management and discharge co-ordinators. Further investment for 24/7 bed management. We have amended processes from NICE guidance for self harm in CYP by assessing prior to acute hospital inpatient admission as much as is feasibly possible. This supports the reducing in bed usage. We have also amended processes from the NICE guidance if a YP is admitted in that we do not await for patient to be medically fit for MH assessment but we undertake individual assessments on suitablity for MH assessment asap when on the wards.	System challenges are understood and plans to mitigate these are in place but need some further development/at risk of only being partially successful		Daily & weekly oversight of bed demands and escalation of pressures and actions continue to be in place.
6. A minority of systems chose to invest in the full LTP ambition around ambulance care this year. Please describe your work to reduce ambulance conveyances for people with mental health problems who do not need acute care. We are especially interested to know if the system is capturing data to support their work on reducing conveyance.	The Black country has invested in 24/7 helpline and is working with WMAS to support 999/111 to divert calls and support those in crisis. Additionally we are investing in additional CRHTT workforce to meet national fidelity standards for this service and provide urgent community response. Furthermore the system has invested in additional Sanctuary hubs (crisis cafe models0 to divert presentations from A+E and 999.	System challenges are understood and plans to mitigate these are in place but need some further development/at risk of only being partially successful		Work is underway with NHSE support, to ensure WMAS have the support they require to divert calls and be supported to help those in crisis in the community. Work is underway to understand WMAS concerns and develop mitigation.
7. Thank you for the plans you submitted in April describing investment in (and expansion of) CYP crisis services and crisis alternatives. Can you please describe progress in implementing these plans.	Recruitment has commenced and policies and procedures are being updated to accommodate the whole of the CAMHS BC crisis teams. MoC paper commenced for moving to 24/7 on call rota. Working with acute hospitals to get seconded posts in place.	System challenges are understood and plans to successfully mitigate are in place and are appropriate		**n/a**
8. As above for CYP Eating Disorder services. We are particularly interested to understand how children with Disordered Eating (ARFID) are being supported to avoid the need for inpatient care.	We are participating in national training on ARFID for our eating disorder workforce and our dietitian offers training, advise and support to both community and acute hospital dietitians. We are engaging with a social care provider who are interested in developing their workforce to be able to better support people with ARFID. The TCP risk register is used to identify people with LD/A who may have ARFID and be at risk of admission, supporting effective planning, and also facilitating the identification of Keyworkers for those between 14-25.	System challenges are understood and plans to mitigate these are in place but need some further development/at risk of only being partially successful	Service Summary / Identified Pressures / Mitigations (Enc)	Regular reviews of TCP cohort on dynamic risk register and co working with core CAMHS with ARFID clients presenting
9. In August we asked you for s140 plans that described how you would work together as a system to deal with adults and children in crisis. Generally the collaborative arrangements (for example with Local Authority) for children were weaker than the arrangements for adults. Can you describe work you are doing to bolster your escalation processes for CYP.	Draft SOP has been developed around s140 process of escalation in collaboration with LA and CCG partners.	System challenges are understood and plans to mitigate these are in place but need some further development/at risk of only being partially successful	Extract BCHFT Winter Plan (Enc)	AMPs work with local authority and section 12 psychiatrists on a case by case basis.

Learning disabilities and/or Autism				
10.Has the system got clear plans to vaccinate people with a learning disability and / or autism as part of the booster/seasonal flu campaign in a way that makes reasonable adjustments to these groups?	In line with the approach taken each year to flu vaccination each practice/PCN will ensure that reasonabble ajustments are made for people with a LD and/or Autism to ensure high uptake of both the flu and booster campaigns amongst this group. Where possible vaccines will also be provided as part of the AHC process. 83.44% registerred LD population over 16 years have had either 1st or both doses of the COVID vaccination	System challenges are understood and plans to mitigate these are in place but need some further development/at risk of only being partially successful	LD vaccination status spreadsheet 11/10/21 (Enc)	GP surgeries ensuring people with learning disabilities, their family carers and paid supporters know they are entitled to a free flu vaccination and the benefits. We continue to work with practices to ensure LD registers are maintained, with coding indicating the patient needs flu immunisation. The sustained drive to ensure participation in annual health checks includes ensuring the opportunity is taken during these checks for discussions to take place regarding the importance of having the flu vaccination. Plans to ensure general practice understand the range of reasonable adjustments to increase uptake e.g. use of the nasal spray flu vaccine. Continued monitoring of uptake rates for this cohort to enable identification of any variation in uptake and appropriate mitigating actions to be put into place.
11. Has the system got clear plans to ensure the continued delivery of high quality, preventative and effective annual health checks for people with a learning disability?	Monthly monitoring is in place for LD AHCs which will convert to weekly in Q4 and performance is above plan to date. We have an ongoing programme of work around ensuring the quality of AHCs delivered including audits, training and development of a resource pack and LD Newsletter for primary care. We are also anlysing uptake data to look at targeting individuals who have not taken up the offer of an AHCs in the past 3 years.	System challenges are understood and plans to successfully mitigate are in place and are appropriate	LD Annual Health Checks 2021/22 (Enc) BCWB Learning Disability Annual Health Checks Work Plan 21/22 (Enc)	n/a
12.Does the system have enough capacity that is responsive to prevent adults and children with a learning disability entering crisis, EDs or inpatient care which can be avoided?	Intensive support team in place for LD citizens. On call commissioning and case management team in place out of hours to support hospital avoidance. Trust ow has a 24/7 helpline to support all adults and children with out of hourse support and signposting Additional capacity has been commissioned to support the response to crisis care. Pilots have been commissioned to respond to crisis. Crash Pad pilot has been developed to support 16-25 years old from entering acute trusts and inpatient care where inappropriate. Winter pressures monies has been allocated to fund additional staffing resource to support Acute trusts. Extension of previous out of hours response to ensure emergency response support is available till end of year	System challenges are understood and plans to successfully mitigate are in place and are appropriate	Extract BCHFT Winter Plan (Enc)	N/A
13. Does the system have robust plans to enable high quality physical health care to be delivered in MH/LDA settings to ensure that (where clinically appropriate) physical healthcare can be delivered safely and to a high standards?	The Trust has been working on a joint Physical health strategy since the merger of the two legacy Trusts in April 2021. A high level plan is being progressed to address physical health priority areas and risk mirtigation. The focus is around Physical health care assessment, documentation, training and management of deteriorating patients.NEWS 2 training is being mandated and an e-learning package is in place. Resus training and equipment across all Trust areas are in place and being monitored. A 3 year strategy is being supported from a Trust and Divisional perspective which includes a skill mix review to ensure skilled professionals in IPC and Physical Health are available to support clinical services. Joint pathways with Primary Care Networks and Acute Trusts.	System challenges are understood and plans to mitigate these are in place but need some further development/at risk of only being partially successful		There is Trust PH steering group in place and a high level plan being progressed. As part of the MH community transformation there is a dedicated workstream in relation to PH SMI which is a joint workstream between primary and secondary care.
14. Has the system got robust plans to ensure the safe continuation of discharges through the winter period for people with a learning disability, autism or both?	System holds Bi- weekly meeting to review all system dischargess part of the TCP. Escaltion is through TCP operational steering group and TCP board. Comissioning and case managers as part of the provider team support clinical teams with prompt and problamatic discharges. This process is business critical and will contiue thorughout winter. An emergency response team procured to support through Covid has been extended, providing wrap-around staff to support discharges / avoid admissions throughout 2021/2. Long term leaves continues to be supported by the system where clinically appropriate to facilitate / expedite discharge from hospital settings. Weekly review meetings led by childrens commisioners in place and fortnightly esclation calls across the system. Keyworker pilot implemented to support 0-25 discharges.	System challenges are understood and plans to successfully mitigate are in place and are appropriate	Extract BCHFT Winter Plan (Enc)	N/A

8 & 9. Infection Prevention & Reviewing Staff Isolation Rules

9. Reviewing Infection Prevention and Control (IPC) measures	Self assessment commentary	RAG Rating (Select from drop down list)	Evidence - Please attached appropriate document (i.e Winter plan) with details of page where evidence can be found	Mitigating actions if not RAG rated GREEN
1. How are you assured that the organisations within the system implemented the IPC guidance ?	This is an ongoing area where the CCG continues to seek assurance from all providers via the monthly CQRM. Assurance visits take place and discussions take place with IPC colleagues to offer support for full implementation of any new/ existing guidance.	System challenges are understood and plans to mitigate these are in place but need some further development/at risk of only being partially successful		Ongoing assurance will be received during CQRM. Audits will be reviewed. Meetings with wider partners to include Public Health and NHSE offer support to implement guidance
2. Does the system have processes in place for monitoring healthcare associated infections and outbreaks ?	There are regular meetings held with all acute and mental health providers, the CCG is invited to discuss actions being taken at monthly CQRM's, regular audits of ward areas are reported to the CCG. Reports are forwarded to Quality and Performance Committee to provide assurance and overview. CCG attendance to IPC Committee and outbreak meetings. COVID outbreaks reported in daily COVID SitRep	System challenges are understood and plans to successfully mitigate are in place and are appropriate		n/a
3. Do the providers have senior led outbreak meetings with engagement from the MDT ?	There are regular meetings held with both acute and mental health providers, the CCG is invited to discuss actions being taken. The outbreak meetings are Chaired by the Trust DIPC or Head of IPC.	System challenges are understood and plans to successfully mitigate are in place and are appropriate		n/a
4. Is vaccination offered to all staff for vaccine preventable infections, including COVID19 boosters and influenza vaccination ? How assured are you that staff are adequately protected?	Updates are provided at monthly CQRMs for all acute and mental health providers on vaccination uptake . Each provider will develop a covid 19, booster and flu vaccination plan which will be shared with the CCG. Where percentages have not met the target, details are requested to support efforts to increase/ improve uptake. Workforce and staffing issues are reviewed at monthly CQRMs. Details reported are taken to the monthly joint vaccination board for review.	System challenges are understood and plans to successfully mitigate are in place and are appropriate	BCWB ICS Flu and Covid Vaccination Programme – Project Board meeting notes (Enc)	n/a
5. Do the providers have processes in place to offer all patients/service users/clients influenza vaccination and COVID19 vaccination and boosters?	All Acute and mental health providers have developed a vaccination programme which allows access to Flu and Covid 19 vaccinations via a range of locations. These include Primary Care and local pharmacies and PCN's. Details will be updated as more options for access throughout the vaccination process rollout. All members of the population will be sighted on the methods available to access the vaccinations available.	System challenges are understood and plans to mitigate these are in place but need some further development/at risk of only being partially successful	BCWB ICS Flu and Covid Vaccination Programme – Project Board meeting notes (Enc)	Staff within providers are actively encouraged to take up the option of vaccinations available to ensure safety for staff and patients. erformance is monitored via CQRM.
6. Are contingency plans in place for safely managing any form of BOARDING (please note this means putting any patient in ANY space not specifically desgined for a patient – corridors, non-clinical rooms, trolleys in seating waiting areas) and this has been agreed by the Trust Boards with an incident being raised each time plans are enacted? How assured are you there is a clear process with escalation in place so that this risk is directly	It is likely that as winter pressures continue to increase that BOARDING will occur from time to time. The CCG will be asking our acute providers to update the CCG during CQRM about these instances and any mitigation / contingency. Assurance will be sought to ensure the safety of patients and any visits undertaken if any quality concerns arise.	System challenges are understood and plans to mitigate these are in place but need some further development/at risk of only being partially successful		The risks of BOARDING are likely to occurr as winter pressures increase. Providers will update the CCG around actions being taken to maintain patient safety
7. Does the system have a heat map of risks related to low vaccination uptake and potential for impact on service provision ?	Data is made available and reviewed during CQRM's for acute and mental health Providers and are supported to encourage staff to take up vaccinations available. The joint vaccination board meets monthly to review areas of low uptake for flu and Covid 19	System challenges are understood and plans to mitigate these are in place but need some further development/at risk of only being partially successful		Heat maps will be available as part of the monthly data collection. The CCG will review this data and take appropriate action to support providers
8. Does the system have a process in place to support IPC in care, nursing and residential homes?	IPC within care, nursing and residential homes is of paramount importance. Quality and Safety teams are working in partnership with local authority and health protection teams. PCN's are involved in delivering the vaccination programme in Care Homes.	System challenges are understood and plans to successfully mitigate are in place and are appropriate		n/a
9. Where IPC outbreaks are above expected numbers, have you established a ventilation committee to support your reduction plans?	The Quality and Safety team require additional detail around the development of Ventilaton Committees. We currently attend regular outbreak meetings for our Acute and Mental Health Providers. The monthly joint vaccination board provides an ongoing review of IPC matters.	System challenges are understood and plans to mitigate these are in place but need some further development/at risk of only being partially successful		n/a

10. Reviewing staff COVID isolation rules	Self assessment commentary	RAG Rating (Select from drop down list)	Evidence - Please attach appropriate document (i.e Winter plan) with details of page where evidence can be found	Mitigating actions if not RAG rated GREEN
1. Are there mechanisms in place to monitor the impact of the staff isolation guidance?	Yes mechanisms are in place to monitor impact of guidance, all partners have regular reporting in place which is reviewed and helps inform workforce planning.	System challenges are understood and plans to successfully mitigate are in place and are appropriate		N/a

10. Ensuring sustainable Workforce

11. Ensuring a sustainable workforce	Self assessment commentary	RAG Rating (Select from drop down list)	Evidence - Please attach appropriate document (i.e Winter plan) with details of page where evidence can be found	Mitigating actions if not RAG rated GREEN
1. What workforce changes are expected as a result of winter pressure impact? For example: new ways of working , different team approaches etc, whilst ensuring safe staffing levels are maintained.	As can been seen across the commentary on this return, the system will see a range of changes in ways for working.	System challenges are understood and plans to mitigate these are in place but need some further development/at risk of only being partially successful		Example the GP locum platform within Primary Care, mutal aid being given across the system by deploying staff; use of temporary COVID 19 workforce bureau workforce deployed into different roles; increases in lower banded roles to free up registered roles. The system and it's providers are also ensuring that their staff health and well being continues to be a priority by ensuring annual leave and rest breaks are taken; we continue to promote across the system and at provider level the well being offers which include access to the mental health hub and numerous online support mechanisms. The system is also rolling out the seasonal Flu vacs and CV19 Vaccine to prepare for Winter.
2.What is the gap between the current workforce and the workforce needed as a consequence of the anticipated winter pressure impact?	Providers all have developed recruitment campaigns along with a range of mitigations.	System challenges are understood and plans to mitigate these are in place but need some further development/at risk of only being partially successful		Include increasing bank usage, block booking of agency staff, deployment of individuals to address gaps. Providers have seen some movement in the decrease of gaps for example nursing due to the international nursing project within the system. We also continue to develop the widening participation agenda by working with Higher education to train staff, new role development for hard to recruit roles/supply shortage roles.
3.What are the workforce risks as a consequence of the additional winter pressure demand?	Overall, the system has a general shortage of staff with Anaesthetic skills and ODP's, we also have a number of shortages at band 5 and 6 nurses in a range specialities including theatre and critical care as well as medics in Anaesthetics, however some provider have had great success in recruiting to these areas. There are still some gaps within the system's junior doctors rota's and vacancies across the system with regards to the Diagnotics workforce. Further risks include the ability to recruit staff to meet the increased activity; sickness absence and their HWB; retention of staff. Added time lag in recruitment, ie jobs that go out now may not start until towards the end of winter	System challenges are understood and plans to mitigate these are in place but need some further development/at risk of only being partially successful		Provider risks are reported to various boards. At a system level we utilise and review workforce metrics highlight key risks to enable offers of support to be put in place at system level which include retention rates, sickness absence. Example of mitigation include joined up recruitment for HCSW; supporting social care with their recruitment; increasing the NHS branding and attraction package with Indeed; increasing pipelines for those "new to care" to have insight into the roles within the NHS. Providers are looking at new ways of working and new roles for the diagnostic workforce. Providers are looking at short term mitigations which include offering overtime; weekend working as well as increasing agency usage. Long term mitigation is to increase ODP student numbers and allocated funding for Nurses to achieve an Anaesthetic qualification, as well as supporting a cohort of healthcare support workers to gain with ODP qualifications. We also anticipate that several providers will also increase their bank establishment to support the extra shifts required. We are also working with partners like the Princes Trust, Homelessness, Thrive to work project to support the wider population who may not have thought about a career in health, this equally will support health inequalities across the system.

4. What are the actions being taken to mitigate the workforce risks ?	Providers all have developed recruitment campaigns to address the shortages.	System challenges are understood and plans to mitigate these are in place but need some further development/at risk of only being partially successful		A system level we are working in collaboration to recruit International Nurses, to date we have seen 324 arrivals (up to Aug 21) with further increased numbers by March 2022. We have a retention now in place which will focus on interventions for those who are over 55 plus and those who only 1/2 years employment within the health arena. The system has made closer links with the social care partners to try and support their vacancies by sign posting unsuccessful individuals from the acute providers. Some providers are looking to increase bank availability along with redeploying staff where possible and potential to use clinically trained managers. From November we will be working with the Princes Trust to form a pipeline of individuals who are looking to take up some of the lower roles initially, thus allowing other individuals to move into more profession roles. As already mentioned, we have our retention programme in place, one element of this is that we are part of the NHSEI flexible working programme "flex for the future" supporting clinicial colleagues in adapting their flexible working in operational areas.
5. What can be built into the UEC program to support staff health and wellbeing and to retain staff?	The system continues to support it's providers in supporting staff. We have a range of interventions at both system and provider level to ensure their safety as well as supporting them to recover. We are assured that all providers have identified and continue to promote a range of key messages to their staff.	System challenges are understood and plans to mitigate these are in place but need some further development/at risk of only being partially successful		Example include offering support for line manager in having health and wellbeing discussion around taking rest breaks and annual leave. At the same time, the system is continuing to support those staff who have carried forward leave to take this. Providers continue to give assurance, that they always offer the opportunity for their workforce to take the rest and recuperation option first. All ICS organisations continue to have assess to the Mental Health HUB offering support as and when needed. The system is now part of the HWB Trailblazer project and this will be developed across the system to further support staff during this difficult period.
6. Are Safer Nurse Staffing tools being utilised to safely plan the deployment of staff? (i.e. ED Safer Nurse Care Tool and royal college guidance / tools?	Yes, our providers use numerous tools / programme to safely plan the deployment of their staff to ensure transparency, they also report levels to various board at provider level as well as at CCG level via CSRM meetings.	System challenges are understood and plans to successfully mitigate are in place and are appropriate	Royal Wolverhampton NHS Trust Clinical Quality Review Meeting 30/09/21 - CQRM Integrated Quality & Performance Report (Enc)	

11. Protecting Electives

6. Protecting Elective Programmes + Elimination of 104wk waits by Mar-22	Self assessment commentary	RAG Rating (Select from drop down list)	Evidence - Please attach appropriate document (i.e. Winter plan) with details of page where evidence can be found	Mitigating actions if not RAG rated GREEN
Elimination of 104wk waits				
1. What process will be put in place to ensure 104+ Week Waiter recovery and elimination is delivered during H2? Including the 104+ monitoring and oversight arrangements. Systems and providers are both expected to have a named Executive lead supporting the programme during H2.	Our initial estimate at the end of March-22 based on September's projection data was 647 breaches of the 104+week standard. Key specialties of concern include; urology, general surgery, gynaecology and maxillo facial. Across H2 the acute sites will work together to share capacity in the challenged specialties which will enable us to treat all patients by March 22 that would otherwise have reached 104+weeks. The system will also focus capacity on the next group of patients likely to hit 104weeks to ensure that a system of zero tolerance on breaches is maintained.System will focus surgical capacity across the following elective case priorities; Due and overdue P2/P3 (including cancer), 104+week breaches & potential future slippage into 104+week breach. The following initiatives build on those being undertaken by providers: a) development of a new reporting set to identify futrure slippage across the system into 104ww. Will closely monitor plans and delivery for these. b) Mutual aid between providers and a shared prioritisation of the use of the independant sector. c) Recognising the backlog size we have commissioned a GP super clinic to support with demand reduction, recognising the use of secondary care Trust skills in those locations. d) moving forward the system has appointed clinical leadership in the specialties where redesign will be developed to maintain a balance between demand and capacity. Key Assumptions: H2 outpatient and surgical capacity supporting 104ww aligns with provision in recent months, low validation in to 104ww resultant from increased validation excercises, assumes that winter plan capacity aligns with plan profiles. Key Risks: There is a risk that to maintain zero 104+week breaches we will need to treat patients who are less clinically urgent than others on the waiting list. Covid surges will change the profile of treatment within the reduced capacity, the 104+week breach profile will change as mutual aid is employed, strategy has potential to increase waits at P3/P4. System and Provider named leads along with SRO.	System challenges are understood and plans to successfully mitigate are in place and are appropriate	Activity to achieve zero 104+ waits is included in the elective plan for H2 signed off by the stsem SRO for Elective recovery	N/a
2. Are there any additions to the provider and ICS Full Capacity Protocols that take into account the 104+ week waits and the H2 Elective objectives? If yes, please detail? Including the escalation process for cancellations.	Capacity is being procured in the independent sector and in GP superclinics to provide additional capacity to mitigate any loss of Trust capacity. Trust mutual aid plans across the system already mitigate for one provider requiring support from a neighbour. Trajectory for 104+ clearance is front loaded with low breaches in January and February	System challenges are understood and plans to mitigate these are in place but need some further development/at risk of only being partially successful	Activity to achieve zero 104+ waits is included in the elective plan for H2 signed off by the stsem SRO for Elective recovery	Negotiations are underway to extend independent sector provision to allow greater headroom to plans
Protecting Elective Programmes				
3. Please detail the protected capacity allocated to support long wait elective and cancer patients. Please include speciality and volumes and location of activity delivery (I,e within a "green" protected site)?	Protected capacity at Cannock Hospital for Wolverhampton (urology, orthopaedics, general surgery, dermatology) and Walsall Hospital (orthopaedics, urology, ophthalmology, oral, gynae, general surgery, ENT and dermatology). This capacity is being utilised as a system capacity rather than Trust specific and Trusts are agreeing the specialty mix based on both 104+ clearance and the challenged specialties for P2 breaches. There is also protected capacity at Birmingham Treatment Centre (orthopaedics, urology, vascular and ophthalmology)	System challenges are understood and plans to mitigate these are in place but need some further development/at risk of only being partially successful	Activity to achieve zero 104+ waits is included in the elective plan for H2 signed off by the stsem SRO for Elective recovery	Mutual aid capacity to be finalised, although system confident that the capacity is sufficient
4. Please detail the approach taken to phasing elective activity in January and February. Are providers using "Smart Scheduling" to maximise capacity? Considering the pressures on In-patient beds and Ordinary Elective admission.	We have taken a conservative approach to profiling January and February considering likely urgent care pressures. Green capacity is in place in Wolverhampton and Walsall, and Dudley have green pathways in place to protect activity. The use of the independent sector capacity will increase green sites and protect 104+ delivery Trusts have started to consider the use of smart scheduling but it will not be in place for Winter.	System challenges are understood and plans to mitigate these are in place but need some further development/at risk of only being partially successful	Activity to achieve zero 104+ waits is included in the elective plan for H2 signed off by the stsem SRO for Elective recovery	Negotiations are underway to extend independent sector provision to allow greater headroom to plans