ROtherham System Wide Escalation Plan 2017/18
(Including Winter Planning)

NHS Rotherham Clinical Commissioning Group
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1. PURPOSE OF THE REPORT
This report sets out winter planning arrangements for health and social care in Rotherham including resources and capacity put in place to manage the impact of winter pressures. The plan incorporates Rotherham’s response to the National Cold Weather Plan updated in 2016 which helps prevent the major avoidable effects on health during periods of cold weather in England.

Rotherham CCG, along with other local CCGs, is required to provide assurance to NHS England regarding year-round and winter planning across the Rotherham health and social care community. This report, alongside the baseline assessment and ongoing highlight reporting from the Rotherham A&E Delivery Board aims to provide that assurance.

2. LEADERSHIP AND CO-ORDINATION OF WINTER PLANNING
2.1 Rotherham A&E Delivery Board
The Rotherham A&E Delivery Board is the forum for co-ordinating capacity planning and operational delivery across the local health and social care system for urgent and emergency care. This is done in co-ordination with an overall region wide urgent and emergency care strategy agreed through the Yorkshire and Humber Urgent and Emergency Care Network. The national expectation for the A&E Delivery Board is to focus entirely on A&E. Initially this is about the recovery of the 4 hour target and then to work within the South Yorkshire and Bassetlaw STP group on the longer term delivery of the Urgent and Emergency Care review.

The Next steps in NHSE’s NHS Five Year Forward View has a number of key deliverables for 2017-18 and 2018-19. Trusts and CCGs will be required to meet the Government’s 2017/18 mandate to the NHS that: 1) in or before September 2017 over 90% of emergency patients are treated, admitted or transferred within 4 hours – up from 85% currently; 2) the majority of trusts meet the 95% standard in March 2018; and 3) the NHS overall returns to the 95% standard within the course of 2018. In order to do so the key deliverables are:

- Every hospital must have comprehensive front-door clinical streaming by October 2017.
- By October 2017 every hospital and its local health and social care partners must have adopted good practice to enable appropriate patient flow.
- Hospitals, primary and community care and local councils should also work together to ensure people are not stuck in hospital while waiting for delayed community health and social care.
- Specialist mental health care in A&Es: 74 24-hour ‘core 24’ mental health teams.
- Enhance NHS 111 by increasing from 22% to 30%+ the proportion of 111 calls receiving clinical assessment by March 2018.
- NHS 111 online will start during 2017.
- Roll out evening and weekend GP appointments, to 50% of the public by March 2018 and 100% by March 2019.
- Strengthen support to care homes.
- Roll-out of standardised new ‘Urgent Treatment Centres’ which will open 12 hours a day, seven days a week, Integrated with local urgent care services.
- Implement the recommendations of the Ambulance Response Programme by October 2017.

The core responsibilities of the A&E Delivery Board are:
- Lead A&E recovery.
- Develop plans for winter resilience and ensure effective system wide surge and escalation processes exist.
- Support whole-system planning (including with RMBC) and ownership of the discharge process.
- Participate in the planning and operations for local ambulance services.
- Participate in the planning and operations of NHS 111 services including oversight of local DOS development.

• Agree deployment of any winter monies.
• Agree how money used via sanctions and incentives is deployed for maximum benefit of the system.
• Work within the STP footprint (& UEC Network) to deliver the local UEC Strategy with specific focus to:
  1. Expanded access to primary care
  2. Creating an out of hospital hub combining NHS 111 and OOH services
  3. Delivering on the 4 key UEC hospital standards
• Support Vanguard and New Care Models (where applicable) to ensure good outcomes and support spread.
• CCG / RMBC will lead BCF, the Rotherham A&E Delivery Board will help to implement action plans, particularly BCF DTOC plans where they help align the discharge elements of A&E plans and DTOC plans.

Attached as Appendix 1 is the Rotherham A&E Delivery Plan 2017-18 demonstrating our response to the key deliverables outlined in strategic documents such as NHSE Urgent and Emergency Care Delivery Plan April 2017 and the NHSI Good practice guide: Focus on improving patient July 2017.

2.2 Urgent and Emergency Care Network – Yorkshire and Humber
This network was recently established as part of the Bruce Keogh review into urgent and emergency care. It will operate strategically and its purpose is to improve the consistency and quality of urgent and emergency care by bringing together A&E Delivery Boards and other stakeholders to address challenges that are difficult for health and social care systems to address in isolation (eg 999 and 111 services). It will provide overall urgent and emergency care strategy from which the A&E Delivery Boards will retain the responsibility for ensuring the effective delivery of urgent care in the local area.

3. ROTHERHAM ESCALATION MANAGEMENT SYSTEM
Rotherham is the only community in Y&H to implement this best practice escalation tool. The expectation is that this is rolled out across the STP footprint this winter.

A&E Delivery Board agreed to adopt an Escalation Management System (EMS) which responds to and reflects pressures within the local health economy for last year’s winter planning (2016/17). It sets an escalation level for Rotherham Foundation Trust (Acute and Community, OOHs), YAS (local indicators), Social Care and Mental Health and provides visibility to partners on the pressures facing the organisations. The system is capable of alerting staff via email or text message when the escalation level changes. Figure 1 sets out the four escalation levels that will operate throughout the year, which have been aligned to the Opel Levels required by NHSE.

**Figure 1:** Summary of Escalation Levels

<table>
<thead>
<tr>
<th>Level 1</th>
<th>Normal Working</th>
</tr>
</thead>
<tbody>
<tr>
<td>Level 2</td>
<td>Moderate Pressure</td>
</tr>
<tr>
<td>Level 3</td>
<td>Severe Pressure</td>
</tr>
<tr>
<td>Level 4</td>
<td>Extreme Pressure</td>
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</tbody>
</table>

The A&E Delivery Board has approved the Operational Escalation Management System previously and maintains this stance moving into 2017-18. Appendix 3 sets out examples of the EMS triggers for some parts of the local health

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Economy. Each EMS level triggers a series of actions that is proportionate to the degree of pressure in the system. All areas of the system have triggers and actions that link to the escalation process. The online tool has the capability to produce reports which analysis trends in escalation (i.e. days, weeks, months of the year), it can also highlight particular triggers that are continually causing concern and provides a teleconference facility including the ability to disseminate actions agreed on the escalation calls to all partners.

Local telephone conferences take place every Monday morning during the winter period to share any issues affecting local services and to discuss and agree any actions to be taken throughout the week. The level of escalation will be monitored and actions (based on action cards/flash cards NHSE) agreed routinely to support the planning of increases in demand and mitigate further escalation. The calls include representation from YAS, Social Care, RDaSH, TRFT (including acute and community), RCCG and potentially VAR. When EMS hits Level 3, local telephone conferences will also be held with the same representation either on a daily or twice-daily basis, until any issues have de-escalated. This system is well established in Rotherham and is used in periods of high escalation throughout the year. If the system reaches high escalation (level 3 / 4) consideration will be taken to request support for diverts to alternative hospitals in the area.

Dashboard – Rotherham Care Record
For winter 2017-18 Rotherham partners will have access to the Trust’s Rotherham Care Record (SEPIA) on a daily basis. This dashboard provides clear visibility on activity within the Acute setting including performance against the 4 Hour Target. The data will be cleansed to ensure that no patient data is provided to the CCG and partners prior to go live and will be used to support all partners in assessing the escalation levels across the system at any point in time to ensure appropriate collective actions are taken.

4. DEVELOPING FLEXIBLE BED CAPACITY
The Rotherham A&E Delivery Board predicts that demand for beds will be as challenging as 2017-18, with an unknown element attached to the opening of the new Urgent and Emergency Care Centre in July 2017. The current acute bed base is not sufficient to manage the forecast demand alone; therefore a focus on early discharge home is essential. We know that the acuity of patients in winter is higher than in summer. We know that more patients are admitted to hospital beds in winter and that there are specific days when admissions are higher. These days tend to coincide with those when discharges are lower, usually a Monday. Extreme demand (80+ admissions a day) should be expected and planned for. 50% of days, were the daily admission rate is 80+, occur November to February and 40% occur on Mondays. The data suggests every 2 out of 4 Monday’s (at least) could be an 80+ admission day.

The A&E Delivery Board will ensure that there are clear strategies to reduce waiting times, maintain service and promote patient flow during these periods embedded in our plans across the system.

4.1 Establishment of a Fixed-Bed Base and Flex Beds
A&E Delivery Board is committed to ensuring that there is enough fixed bed capacity to meet demand. To meet the winter demand, projections suggest the need to increase bed capacity by 58 above summer baseline. Modelling suggests extreme pressure surges, could require up to 98 medical beds above summer base line.

To meet the 58 additional beds for winter capacity requirements, the local health economy requires additional capacity within the system. In 2017-18 TRFT, in collaboration with partners are working to provide a more flexible approach to demand management through the reconfiguration of the current bed base (acute) to flexibly meet demand across busy periods and in times of escalation (EMS Level 3 and Level 4). The current suggested approach to achieve the 58 additional winter beds is achieved through the implementation of a number of schemes, of which there are is as follows:
Bed Capacity Scheme | Downside | Working Capacity | Upside
--- | --- | --- | ---
Bed reconfiguration (internal medicine beds) | +4 | +12 | +12
A3 Winter Ward (with Discharge Lounge) | +12 | +12 | +12
Ackroyd Clinic (Nursing Home) | +6 | +8 | +11
Ferns | +6 | +9 | +12
DTC | +3 | +6 | +8
Elective Smoothing | +5 | +5 | +5
DST/CHC assessments off acute site | +3 | +6 | +8
LOS* | -16 | 0 | +8
TOTAL (vs 58 requirement) | 23 (-35 gap) | 58 (0 gap) | 76 (+18 gap)

*The rationale for a negative bed impact is in the event of LOS increasing more than anticipated over the winter period and therefore impacting on available bed capacity. LOS target is to remain in line with winter 15/16 levels (and overall LOS has fallen since this period).

The remaining gaps in beds to achieve surge pressures (up to 98 additional beds) will be achieved by a further deployment of capacity, for a specific period of time, and the options that are being worked up and developed are as per the table below. This also then provides an overall position across the system against the bed demand anticipated.

| Bed Capacity Scheme | Downside | Working Capacity | Upside
--- | --- | --- | ---
A3 Winter Ward (with no Dx Lounge on A3) | 0 | +6 | +12
Additional N/Home Capacity | +20 | +30 | +40
Surgical Capacity | +0 | +6 | +20
TOTAL (vs 40 requirement) | 20 (-20 gap) | 42 (+2 gap) | 72 (+32 gap)

OVERALL TOTAL (vs 98 requirement) | 43 (-55 gap) | 100 (+2 gap) | 148 (+50 gap)

The working principle around the bed stock to meet the surge demand, is that the specific timing and around the need for these beds is not known, although it is likely to be post the Xmas period, and therefore particular attention has been applied to the month of January. The scheme that is most notable within these options is the use of IBCF (£400k) to commission block and spot purchase beds from January 18 estimated at between 20 to 40 additional beds from January 2018 (see Additional N/Home Capacity above)**.

In line with the escalation plans developed over previous winters and through the deployment of more robust escalation management, other options will also be available depending on the nature of any mini-surges. These will be serviced through:

- Use of surgical outlying beds*.
- Availability of surge/spot purchase beds (particularly Monday am).
- Additional flexibility within Intermediate Care.
- Surge Plan to access Oakwood Community Unit, Breathing Space, Intermediate Care. –
- Use of IBCF to procure additional 1000 hours per week of additional re-ablement support.

The system will manage extreme pressure surges in demand by:

- Use of EMS across the network.
- Agreed action cards to support a response.
• Support to weekend discharge planning teams (social care, therapists, nurses).
• Monday morning Health Economy review (teleconference).

Further demand analysis will be undertaken at TRFT in September 2017 to ensure both the planned fixed and flex
bed bases can be utilised effectively to cope with fluctuations in demand.

*The use of surgical outlying beds is often factored in but this can be increased with further management of the
elective pathway and impact on RTT waiting times.

** A market exercise is currently being undertaken for completion by the end of October 2017. This section will be
fully updated with detailed plans of agreed hospital surge levels and community spot purchase and blocked capacity
to be signed off at the November A&E delivery meeting.

5. ANALYSIS OF OUT OF HOSPITAL SERVICES

Rotherham has access to a range of high quality Out of Hospital Services which actively support patients during the
winter period. Out of Hospital Services fit into 3 main categories:
1. Admission Prevention and Supported Discharge Care Pathways
2. The Care Coordination Centre
3. Locality Based Community Nursing Teams

During winter these services can flex to support reduction of avoidable non-elective hospital admissions and re-
admissions. They promote 7 day working, facilitate timely hospital discharge and improve patient experience.

5.1 Admission Prevention and Supported Discharge Pathways

Pathway 1: Hospital to Home
Pathway 1 supports patients who are medically stable, but cannot be supported at home with generic health and
social care services. Rotherham CCG and Rotherham MBC jointly commission an Integrated Rapid Response Service
to support discharge and prevent admission for this cohort of patients. The Integrated Rapid Response Service
operates 24/7, 7 days/week, providing short term therapy, nursing and social care support.

In 2017-18 additional capacity will be commissioned in reablement services to reduce Delayed Transfers of Care
(DTOC), as part of the action plan developed to reduce the DTOC levels in line with National Condition 4 of the Better
Care Funds (BCF) Policy Framework and Planning Guidance 2017-19. The Local Authority is planning to procure the
reablement service from the independent sector and secure services for up to 2,000 hours per week for a time as yet
undetermined. This will increase capacity and provide an alternative model capable of achieving reduction in
dependency, timely reviews and increased integration with the health community, the voluntary and community
sector and utilise assistive technology.

Pathway 2: Intermediate Care
Pathway 2 provides residential rehabilitation to patients who cannot return home. The aim is to maximise
independence and optimise patients who do not have nursing needs. The Intermediate Care Residential service
supports all patients on Pathway 2.

Intervention focuses on active enablement with view to maximising independence and returning home. The service
is provided on the basis of a comprehensive assessment, resulting in a structured individual care plan that involves
active therapy and treatment.
The care plan sets out agreed rehabilitation goals and milestones. The service is time-limited, normally no longer than six weeks with average stay of 18 days. There are currently 50 beds across the borough, commissioned jointly by RCCG and RMBC. The Intermediate Care Residential Service accepts admissions 7 days/week.

**Pathway 3: Discharge to Assess**
Pathway 3 provides 24/7 nurse-led care for adults with complex care needs who are medically stable. The pathway is for patients who need a place to recover from an acute illness before an assessment can be made about their long-term care needs. Pathway 3 provides residential assessment and rehabilitation for patients with nursing needs. It also supports patients who trigger positive for the CHC checklist but have not yet had an assessment.

Pathway 3 services are delivered by The Oakwood Community Unit, Breathing Space Inpatient Beds and Waterside Grange Residential and Nursing Home. Oakwood is a 20 bed nurse-led unit situated in the grounds of Rotherham District General Hospital. Work is currently underway to reconfigure the unit so that it is better able to meet the needs of Pathway 3 patients.

Rotherham CCG and Rotherham MBC also jointly commission, through BCF, 6 independent sector nursing home beds at Waterside Grange Residential and Nursing Home to support Pathway 3 patients.

The Community Unit, Breathing Space and Waterside Grange play a pivotal role in facilitating timely discharge from hospital for those patients who no longer require specialist acute care. All Pathway 3 services will receive admissions 7 days/week.

Discharge to Assess at Home is one of the key priorities for Rotherham in the coming months. Our key actions to improve patient flow (DTOC) are outlined in our Better Care Fund Plan 2017-19 which is currently in draft form awaiting NHS Assurance (September 2017). The plan articulates our vision for Discharge to Assess including:

- The proposals outlined in Pathway 1 above.
- The reconfiguration of the current Discharge to Assess bed base at Waterside Grange.

Appendix 1 – Rotherham A&E Delivery Plan 2017-18 provides further detail.

Figure 3 summarises the pathways that Rotherham currently operates for admission prevention and supported discharge.

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3 Breathing Space is a 20 bed nurse-led unit focusing on patients who have COPD and other respiratory conditions. It is both a step-up and step-down facility for this cohort of patients.
Pathway 1: Hospital to Home
Integrated Rapid Response Service provides early supported discharge at home. Active in-reach into hospital, identifying patients who are medically stable and can be cared for at home. Delivered by an MDT for up to 6 weeks. Supported by specialist home care provider. Incorporates community rehabilitation.

Pathway 2: Intermediate Care
Intermediate Care provides residential rehabilitation to patients who can not return home. Aim is to maximise independence. Patients do not have nursing needs. Delivered by an MDT for up to 6 weeks. 50 community based beds

Pathway 3: Discharge to Assess
24/7 nurse-led care for adults with complex care needs who are medically stable. Delivered from The Community Unit and Breathing Space. Residential assessment and rehabilitation for patients with nursing needs. Supports patients who are preparing to undergo Continuing Health Care assessments.

5.2 Community Bed Base
Table 1 (below) describes the community bed-base available, by care pathway. The escalation framework set out in Section 2 enables thresholds for entry to these beds to be adjusted so that they can be used to support patient flow. Through reconfiguration of intermediate care services, Rotherham was able to introduce additional capacity within the same cost envelope in 2016-17 which will remain in place this winter. The community bed base has increased from 106 to 122 (+15%).

<table>
<thead>
<tr>
<th>Pathway</th>
<th>Unit Name</th>
<th>No. of beds</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>2016/17</td>
</tr>
<tr>
<td>2</td>
<td>Lord Hardy Court (LA Facility)</td>
<td>25</td>
</tr>
<tr>
<td>2</td>
<td>Davies Court (LA Facility)</td>
<td>25</td>
</tr>
<tr>
<td>3</td>
<td>Waterside Grange (Independent Sector)</td>
<td>6</td>
</tr>
<tr>
<td>3</td>
<td>Community Unit (TRFT)</td>
<td>20</td>
</tr>
<tr>
<td></td>
<td>Breathing Space (TRFT)</td>
<td>20</td>
</tr>
<tr>
<td>2/3</td>
<td>Ackroyd (Independent Sector) TRFT commissioned</td>
<td>10</td>
</tr>
<tr>
<td></td>
<td>‘Ferns’ Dementia Facility (RDaSH)</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>Total Bed Capacity</td>
<td>106</td>
</tr>
</tbody>
</table>

There are also 5 beds at Oakwood Community Unit for adults with neurological conditions who are medically stable but who need rehabilitation.

The 12 beds commissioned by the CCG on the Ferns Ward at Woodlands (RDaSH) are for people with dementia/cognitive impairment who no longer require an acute inpatient bed at TRFT.
There are 3 social care assessment beds available at Lord Hardy Court which were available in 2016-17 and 4 short stay housing units at Shaftesbury House (LA facility) which provide support through enablement and housing for a maximum of up to six weeks.

TRFT has commissioned 11 care home beds at Ackroyd House for people who are MFFD and no longer requiring consultant-led medical care; patients awaiting non-acute health and social care support will be transferred from TRFT to Ackroyd House.

5.3 Care Coordination Centre

The Care Coordination Centre (CCC) acts as a key vehicle for identifying the most appropriate care pathway for patients during the winter period. It acts as an access hub for community health services. On supported discharge the CCC holds a register of patients in an acute bed, whose medical episode is complete. It actively engages with the relevant community services to ensure that patients are placed on the right discharge pathway.

The CCC coordinates transfer to the relevant service. It monitors outcomes and identifies where there are capacity issues within each care pathway. The CCC supports the commissioning process by identifying where there is under and over-utilisation of services on each care pathway. The CCC also receives all hospital based referrals for community nursing services. Transferring responsibility to the CCC for these calls will ensure that health professionals and patients are able to speak to a clinician about the most appropriate level of service. Figure 4 summarises the current functionality of the Care Coordination Centre.

As part of the Rotherham Place Plan priorities there is an ambition to provide a Rotherham wide coordinated approach to immediately presenting health and social care needs in adults, where the presentation requires a service level response (enhancing the Care Co-ordination Centre). This is a second tier approach that sits behind the prevention agenda but that contributes to a reduction and delay in needs for adults who are already at a point in which provision of services is unavoidable. The primarily actions are the expansion of two key services:

i. The Care Coordination Centre which is commissioned to provide a telephone based nurse led approach to directing customers to appropriate levels of care and

ii. The Integrated Rapid Response Service which is commissioned to provide an immediate short term response to meeting community based health and social care needs.

Phase one of the project focusses on:

- An integrated 24/7 access point for physical health, mental health and learning disabilities
- Formal absorption of social care out of hours calls between 10pm and 8am (currently managed on an informal arrangement with integrated rapid response)
- Scoping and comparative exercise for the interdependencies, duplications and remit of care coordination centre compared with Rotherham Council Single Point of Access (formerly assessment direct).

Phase one will be completed by December 2017.

Phase Two will focus on:

- Achieving a make safe function across the whole system on an out of hours basis by bringing the existing out of hours (10pm to 8:30am) functions across each of the partners closer together.

Further phases will consider:

- A more holistic joining up of health and social care services to provide an immediate service response to adults, who require care or support with an aim of ensuring this is provided at the right level, in the right place at the right time.
- The link between care coordination and a wider prevention offer of a single point of access for Rotherham.
**Figure 4: Key Functions of the Care Coordination Centre**

**GP Support Service**
Access point for GPs require an alternative level of care for a patient. Advises on available range of services. Makes referrals, arranges placements and co-ordinates transport. Includes community pathway for suspected DVT.

**Urgent Response Service**
Single point of access for NHS 111 and the 999 ambulance service into alternative levels of care. CCC forms part of the YAS Pathfinder Project which supports ambulance crews when patients do not require A&E services.

**24/7 Service**
Service will receive out-of-hours calls from patients and health professionals who require access to community health services or who have an urgent health need.

**Supported Discharge**
Service holds a register of patients in an acute bed, whose medical episode is complete. The CCC will actively engage with relevant services to ensure that patients are place on the right discharge pathway.

**Single Point of Access for Community Nursing Referrals**
Receive all hospital based referrals for community nursing services. The CCC carries out task allocation for all community nursing teams. Primary care referrals can be submitted to the CCC or direct to teams.

### 5.4 Mental Health Liaison Service
The Rotherham Mental Health Liaison Service provides round the clock mental health care to people who attend Rotherham Hospital to provide assessment, treatment and management of mental health problems to adults aged over 18.

The aims of the service are to:
- Reduce the number of admissions from Accident and Emergency
- Reduce length of stay
- Improve access to assessment and appropriate services during Mental Health crisis
- Reduce re-admission.

The service is clinically led, with medical expertise and operates from Urgent and Emergency Care centre at the Rotherham Acute Hospital.

The service provides:
- Mental health expertise to the Emergency Department (ED) 24 hours a day, 7 days a week for admission avoidance for those 18 and over
- Specialist adult and older people liaison in-reach activity to wards 8.00am – 8.00pm 7 days a week
- Support for 16 – 18 year olds overnight and at weekends.
5.5 **Locality Based Community Nursing Teams**

In Rotherham, our newly reconfigured, locality based community nursing teams support the transition from hospital to community. They are a key service for supporting vulnerable patients at home during the winter period. The current service model incorporates 7 community nursing teams serving GP practice populations. The teams service geographical clusters of GP practices.

The focus on practice populations has supported partnership working between community and primary care. The service model uses an allocation formula which ensures equitable distribution of community nursing resources across the borough. Finally the service is now underpinned by a comprehensive service specification, a coherent system of governance and a robust performance management framework.

Finally, the work in 2016-17 to pilot an integrated locality which links to the Better Care Fund commissioned services is providing insight into the opportunities and challenges for roll out across the health and social care system. This work will take place throughout 2017-18.

6. **CAPACITY AND CAPABILITY OF LOCAL SERVICES**

The JSNA predicts a substantial increase in the number of adults with additional health and social care needs over the next five years. The Rotherham BCF plan and Integrated Health and Social Care Place Plan are aligned with all of the emerging population needs and all the local priorities focus on addressing the impact of the ageing population. Through a combination of integration, prevention and case management the Rotherham can deliver better outcomes for the growing population of older people and reduce pressure on the local health and social care economy.

The Joint Strategic Needs Assessment can be found at the following website address:

http://www.rotherham.gov.uk/jsna/

**Market Sustainability**

RMBC has produced a Market Sustainability report which uses the Cordis Bright framework to understand the risks associated with the current diminishing market place for adult’s social care. This looks at the local, sub-regional and regional market place and carries out benchmarking exercise around Residential, Nursing and EMI beds within the market place.

There are on average 1,282 people at any one time receiving Domiciliary Care packages and this is provided by 8 contracted domiciliary providers and 7 spot purchase providers.

6.1 **A&E Delivery Board Baseline Assessment**

Appendices 4 and 5 provide the current baseline assessments for acute services, NHS 111 and the ambulance service.

6.2 **Rotherham Clinical Commissioning Group**

Rotherham CCG collates plans from Provider organisations in the health and social care community regarding arrangements over the bank holiday periods. A winter contacts and information pack for staff will be circulated to partner organisations in December and will include details of service opening times over the bank holiday period and emergency contact details for all partner organisations.

Rotherham CCG will also participate in NHSE winter telephone conferences to provide an update on any local pressures in the system and to share good practice. The calls are led by NHSE and last year were held weekly. They included representation from all South Yorkshire and Bassetlaw CCGs, together with YAS (999 and 111).
TRFT has a winter plan in place which incorporates both acute and community services. The principle objectives of the plan are to:-

- Protect patients, staff and visitors against the potential adverse effects of increased winter demand where possible.
- Ensure a pro-active response is maintained to deal with increasing pressures, in order that the Trust is able to meet key performance commitments including the ED 4 hour emergency care access standard, the 18 week elective care pathway standards and the cancer treatment targets.
- Ensure that an effective escalation process is in place when emergency activity exceeds anticipated capacity requirements. This enables business continuity plans to be implemented to protect essential levels of service provision within the organisation. When indicated by the most severe pressure on Trust resources and services, the escalation process also ensures a Trust Command and Control Team will be invoked. The overall Trust Command and Control Team aims to enable strategic decision – making for the protection of Trust Critical Services.
- Provide cover for the full 24 hour period, 7 days a week within the Trust.
- Be prepared in relation to risks identified.
- Support the continuity of essential services and everyday activities for as long as possible.
- Provide forward planning for the Christmas and New Year Bank Holiday period.
- The Trust will be profiling its elective work over the winter period; in particular it will be significantly reducing elective in-patient work over the 2 week festive period and doing more day-case elective work.

The TRFT Winter Plan continues to be reviewed and revised to provide increased clarity on roles, responsibilities and accountability.

Site Management
Site management meetings have developed, with increased attention to detail, action planning and capacity management. The Trust IT system SEPIA is used to support the site management function for both hospital and community based services. The dedicated 24 hour Site Management Team function is well embedded and works closely with the Care Co-ordination Centre, which has been co-located adjacent to the Site Management Room.

4Hour Access Meetings
The Trust has implemented a weekly 4 hour access meeting to review both retrospective performance and agree strategies to improve the day to day operational delivery of urgent and emergency care – this includes consideration of likely impact on the elective care pathways. The Trust and CCG have incorporated A&E Extraordinary Performance Meetings into the contract performance framework, these meetings take focus on performance and the 4 hour access recovery plan to escalate issues and ensure appropriate action is taken. The last of these meetings was on the 24\textsuperscript{th} August and the next meeting is scheduled for the 20\textsuperscript{th} October 2017.

Patient Flow
There is continued work with partners in order to ensure that discharge processes are effective and efficient and delayed transfers of care are minimised. The Trust has established a Transfer of Care Team, who specialise in supporting complex discharges. Working with partners, there is a weekly health and social care economy that also focusses on supporting and unblocking complex discharge issues. This group supports the identification of actions to reduce Delayed Transfers of Care (DTOC) and monitors effective patient flow. If the Trust faces prolonged periods of pressure, this meeting may be required more frequently.
The Trust aims to achieve 30% of patients for discharge vacating their bed before 12.00noon. Where clinically appropriate all discharge patients should be transferred to the Discharge Lounge at the earliest opportunity. If the Discharge Lounge is unavailable or full then Wards should consider sitting patients out in their day room.

All patients will be allocated an Estimated Date of Discharge (EDD) by the Consultant before (planned) or within 24hrs (unscheduled) admission. This may be based on the predicted length of stay for the patient’s condition and should be reevaluated at every Ward Round.

The Trust will be adopting the Red to Green Day best practise advocated by the National Emergency Care Improvement Team (ECIP), whereby every day a patient spends in hospital, interventions are undertaken that contribute to the discharge pathway home.

**Bed Capacity – Acute Care**
The Trust will be trying to ensure that there is sufficient bed or care capacity outside of the acute hospital setting. This may be alternative step-down beds, additional enablement, social care packages, and access to urgent appointments. Rotherham FT will be ensuring that there is flex capacity in the system, but this will be limited to a finite amount of resource capacity, which will not exceed the bed capacity provided in 2016/17.

**Community Services**
There are at least twice weekly huddles (Monday & Fridays) to discuss capacity & demand across community services including the 7 localities (incorporating integrated locality team). Demand is also managed through the use of SEIPA (Rotherham Care Record). At times of pressure consideration is taken to moving resource (staff) from one locality to another to support effective and flexible working. The benefit of the reconfiguration of the Rapid Response service to form an integrated team (including the Care Home Advanced Nurse Practitioners and Night Visiting District Nurses) is that workers can respond more flexibly to demand. Staffs provide a more hybrid approach to enhance service delivery to patients i.e. hours of support to Care Homes can increase at times of demand as the service is now part of a 24 hour provision.

**GP OOHs**
Activity and dispositions are monitored daily and weekly against predicted demand and the clinical and non-clinical workforce is adjusted to respond to demand including redeployment of workforce across OOHs and the Urgent and Emergency Care Centre. For example if face to face activity increases and telephone triage in OOhs reduced, clinicians will be redeployed to meet the face to face demand. The service also utilised ANPs to support GPs. The service links into local intelligence provided by CCGs, NHS 111 and the Department of Health and any breaking news stories which could result in increased demand on services.

Staff rotas for predictable changes in demand are populated in accordance with predicted seasonal demand. Bank holiday staffing will be based on previous years combined with recent trend analysis. Processes are in place to review staffing levels and hold planning meetings with other agencies as and when required to cope with exceptional variation in demand. The service supports NHS 111 in times of demand by providing triage for additional patients.

**Outliers**
Fluctuations in emergency admissions leads to a need to accommodate patients in beds outside their specialty ward, this is referred to as ‘outlying’. Patients will only be moved from their specialty ward where it is safe and appropriate to do so. A formal assessment should be made of each patient that it is proposed to outlier.

**Infection Prevention and Control**
The Trust has an Infection Prevention and Control Team which provides cover across the Trust hospital and community services. There are robust infection prevention and control policies and procedures in place and the
Trust holds formal Outbreak meetings when indicated and internal operational meetings for localised clusters of infection. The Trust IPC team work closely with the Rotherham CCG lead Lead Infection Prevention and Control Nurse and both the Trust and CCG works closely Public Health England, RMBC and other Providers as indicated. The Consultant Medical Microbiologists provide 24 hour on call cross cover between Rotherham and Barnsley as part of the Partnership between the two Trust Pathology Laboratories and this includes urgent out of hours Infection Prevention and Control advice. The Trust Infection Prevention and Control Nurses work additional hours to cover outbreaks as part of internal team management plans.

Key Risks
The key risks to winter planning for 2017/18 will be the ability of the A&E Delivery Board to manage demand. The new Urgent and Emergency Care Centre (UECC) became fully operational on 6 July 2017. The UECC will provide a fully integrated service for all urgent and emergency care, offering co-located urgent primary care streaming and the ability to flex the clinical workforce, where appropriate, to meet demand. This includes the development of alternatives to workforce to support medical staffing challenges through ANPs and ENPs. Whilst the service will still be very new over the 2017/18 winter period, it is anticipated that the new ways of working will support effective management of significant surges in demand. However, this will be continuously monitored and closely managed as the system moves into the winter period.

Whilst the recruitment of ED middle grade doctors remains challenging, the Trust is developing a CESR Training Programme for the middle grade doctor workforce, which will be attractive to potential recruits and, therefore, attract those wishing to undertake further training towards achieving consultant level, this includes recruitment to the OOH GP service. In addition, the Trust has started to have success in the recruitment to the consultant workforce. All of this, together with increased GP input as a result of the new integrated model of working in the UECC, will add to the Trust’s resilience over the coming winter. However, should demand significantly rise beyond expected levels, challenges will remain in relation to operational delivery over the winter months.

Testing of the ability to meet demand across the system is twofold and continues to be an ongoing action. In terms of the UECC a significant amount of analysis has taken place to predict the demand once the Walk in Centre (WIC) closed and all services moved to the new model. Actual demand is monitored on a frequent basis and is in line with expected demand. The EMS system in place in Rotherham alongside the SEPIA portal (Rotherham Care Record) allows for continuous testing of how the local health and social care system will manage peaks in demand. Our actions for escalation are well embedded across the system and include increase in multi-agency conference calls (strategic and operational), flexibility in use of community bed bases, increased resource into services that are struggling to meet demand, support for commissioners to unblock issues i.e. equipment, domiciliary care packages.

A full capacity and demand analysis is to be done by the Trust by the end of September 2017 which will be presented to A&E Delivery Board.

Sitrep Reporting
The TRFT winter plan includes daily sitrep reporting to NHS England, as required, and has daily escalation processes for each of the elements within the NHS England guidance. If services are no longer able to ensure essential services within their area the Battle Rhythm process within the Trust Pandemic Influenza Plan and Command and Control process will be followed.

Estates and Facilities Management
The Estates and Facilities Team has business continuity plans in place in order to ensure critical functions are maintained and continue to be delivered for as long as is reasonably possible in the face of adverse weather conditions. This includes maintenance of electricity and heat supplies and tractors/gritting equipment. A plan is in place to ensure the site remains open during inclement weather for salt gritting and snow clearance.
Urgent and Emergency Care Transformation

A number of new additional plans are being developed to support the Trust over the winter period which are being managed through the Trust’s Transformation Programme and focus on:

- Emergency Access and Admissions – Enhanced Ambulatory Care provision.
- Inpatient Management – continuing to embed the SAFER care bundle and working to the Red to Green Day principles.
- Reconfiguration of the Trust’s bed base – both for surge ability and to support streaming pathways from the UECC.
- Development of the Frailty Service (detail can be found in the A&E Delivery Plan 2017-18 attached at Appendix 1).
- Transformation of Children’s Services.
- Review of the Delayed Transfer of Care processes, including the development of a fully Integrated Discharge Team and agreeing a review of the Discharge to Assess model and the Trusted Assessor process.
- Community and Locality Working Trust/Site Management and Daily Operational Delivery.

This programme of work has been shared with partners through the A&E Delivery Board.

Rotherham FT has recently developed an Urgent and Emergency Care 4 Hour Action Plan which Within TRFT describes the operational improvements aimed at improving A&E performance (Appendix 2).

6.4 Rotherham Metropolitan Borough Council

RMBC is reviewing its level of response to winter for 2017-18 and is expecting that there will be only minor changes from plans for 2016-17. 2016-17 plans are summarised below:

Seasonal Flu Vaccination Programme

In partnership with TRFT Occupational Health Team, flu vaccinations are offered to employees of RMBC within eligible groups involved in the delivery of health & social care and/or support of service users. Moreover, RMBC are encouraging external care providers to protect their workforce and service users by offering vaccination opportunities to staff and promoting uptake within the community as well as supporting national keep well health messages.

Severe Winter Weather Framework

RMBC has a Severe Winter Weather Framework which is an overarching document designed to deal with an extreme winter weather event at an authority level. It contains what is expected of Directorates, how this links in with Local Resilience Forum and national structures, and reporting routes. It has a series of trigger points based on the Cold Weather Alert Levels issued by the Met Office. It is reviewed annually to coincide with the annual publication of the PHE Cold Weather Plan, which historically is issued at the end of October. In particular there is a section on winter maintenance and transport.

Salting

Community Safety and Streetscene conducts precautionary salting throughout the borough on 508km of roads. Precautionary salting is carried out when ice formation on the highway can be reasonably anticipated from the daily weather forecasts and data from the Icelert stations. The network of roads to be treated only includes roads important to the free flow of traffic i.e. principal roads, other well used classified roads, bus routes, and access roads to hospitals and fire stations. Salting also takes place in the Town Centre on pedestrianised areas and footways. Details of the routes that are salted can be found in the Winter Service Manual. If weather conditions deteriorate and it is not possible to keep open all of the roads that are on the precautionary salting routes, then priority will be
given to a reduced number of roads known as the ‘Strategic Network’. These routes will only include principal roads and non-principal roads as specified in the South Yorkshire LTP3 strategic network.

The council maintains a stock of salt which is replenished at regular intervals. Salt may be supplied to the Fire and Rescue Service and Ambulance Service, and to other departments of Rotherham Metropolitan Borough Council following the receipt of a purchase order which is approved by the Highway Network Manager. The provision of this salt is not guaranteed and is subject to there being enough to treat the road network as a priority. Any salt provided to external bodies or departments must be collected.

When conditions of laying snow pertain, snow ploughing and associated salting will be undertaken with routes being cleared in the order of their traffic importance. Once the Priority Network of roads is clear then secondary action will be undertaken on more minor routes with the priorities for action being those areas where people are most at risk, e.g. sheltered housing, footways near hospitals, schools, etc.

Because of the geographical nature of the borough the busier pedestrian routes are widely spread in the outlying townships. Because of this it is not practicable to pre-treat these footways. Where appropriate salt bins are provided in these areas and the footways will be treated as a priority during secondary action. Details of locations of over 300 salt bins can also be found in the Winter Service Manual. This salt may be used by the public on roads and footways; however it should not be used on private drives and paths. Some Parish Councils provide their own salt bins.

**Snow Wardens**

Snow wardens are volunteers who undertake snow clearing duties on footways within their own community. The areas to be targeted for snow clearance would be prioritised to areas that are frequented by vulnerable people such as access to community centres, schools, health centres, doctors’ surgeries and hospitals. Volunteer snow wardens receive their equipment and induction safety training by RMBC and they are required to sign a ‘Fit to Participate’ declaration.

**Parish and Town Councils**

Training is offered to Parish and Town Councils from the Network Management Group and those who participate are supplied with snow clearing equipment and rock salt by RMBC so that they can clear their own identified ‘winter trouble spots’. These councils co-ordinate the snow clearing operations within their own communities whilst keeping Community Safety and Streetscene informed of their progress.

**Priority Patients**

A number of NHS patients require life-saving treatment at regular intervals; these include chemotherapy and renal dialysis patients. Because patients requiring treatment changes on a daily basis the NHS and Yorkshire Ambulance Service speak directly to Community Safety and Streetscene in order to prioritise clearing/salting of roads that patients live on. This service can only be offered after the principal roads have been cleared/salted and does not include clearing/salting of footways and on the patient’s own property.

**6.5 Yorkshire Ambulance Service – 999, NHS 111 and Patient Transport Services**

The YAS Winter ConOps (concept of operations) has been updated and shared with health and social care partners. Escalation measures are firmly embedded and very much business as usual. The 2017-18 ConOps plan will remain is summarised below.

The YAS Winter Concept of Operations Plan covers the 999, 111 and patient transport services. The plan describes how YAS will anticipate control and coordinate its organisational activities in response to the additional impact of winter pressures on our service delivery.
The purpose of Con-Ops Winter is to provide a structure within which operational pressures will be anticipated and managed. It provides a framework for managers and clinicians in the trust to work together and with other organisations. The Top Ten Winter Tasks will be to:

1. Protect and maintain operational performance plans in line with agreed performance trajectories for patient critical services ie 999, Patient Transport Services and NHS 111 Service.
2. Keep patients out of hospital by improving non conveyance and referral to alternative pathways.
3. Take all reasonable steps to ensure no patient, member of the public or member of YAS staff is put at risk.
4. Maintain optimum resource levels for critical operational and clinical services.
5. Increase manager availability, visibility and support over the critical period.
6. Work with NHS partners to manage any demand increases effectively and efficiently.
7. Task as appropriate the voluntary services and in particular the St John Ambulance Brigade for additional capacity and capability. Consider Private Ambulance Service Providers.
8. Invoke major incident plan, business continuity plans and/or other plans as required to maintain service delivery.
9. Maximise fleet availability for frontline services and supply chain for critical services e.g. medical gases.
10. Warn and inform stakeholders of any issues that impact on NHS services relating to winter.

The Plan includes YAS's Resource Escalation Action Plan (REAP) which provides a framework to enable individual ambulance services to deliver a clinically-safe service to patients when they are under pressure. REAP is activated when internal escalation plans for NHS 111, PTS and A&E services fail to control operational pressures. It is assumed that ambulance services will not all face the same level of pressure at the same time. There are clear triggers for 6 levels of REAP depending on severity and these are primarily linked to performance outcomes. NHS partners and other organisations will be made aware of escalation to REAP and the reasons for it. Throughout the year the REAP levels are assessed once a week by members of the resilience team and the regional operations centre.

Day to day oversight of the delivery of the YAS winter planning arrangement will be the responsibility of the Winter Assurance Team which will be made up of Associate Directors with responsibility for Mission Critical Services and it will be led by the Associate Director of Resilience and Special Services. It will review winter planning implementation and delivery at its weekly meetings.

From November 1st onwards YAS will convene a winter assurance team to ensure:

- The tactical and operational plans are delivered and adjustments made where events and intelligence deem it necessary.
- That through information and intelligence gathering/monitoring the appropriate escalation plans are implemented.
- Delivery of the YAS Communications Plan for ambulance and 111 services.
- Conduct teleconferences with YAS NHS partners as business delivery dictates.
- Maintain information updates on ResWeb for internal and external partners.

Appropriate Rotherham health and social care services are profiled on the NHS 111 Directory of Services for callers to NHS 111 to be signposted to. This is regularly reviewed and updated by eMBED Health Consortium on behalf of Rotherham CCG. Any changes are reviewed and agreed between commissioner and provider leads.

**6.6 RDASH – Mental Health and Learning Disabilities**

Rotherham Doncaster and South Humber NHS Foundation Trust has a Severe Weather and Winter plan that provides guidance and information to enable the Trust to provide a response to an episode of severe weather where an emergency response is required. The plan is activated when certain triggers are reached. These relate to the following alert systems through which severe weather is measured by the Met Office and Environment Agency.
- Cold Weather Alerts.
- Severe Weather Warnings and Flash Weather Warnings.
- Environment Agency Flood and Severe Flood Warnings.

The plan sets out the response when the above alerts are received. All teams in the Trust have Business Continuity Plans, which identify the actions required for the service to continue to maintain essential services during severe weather. This includes plans for disruption to staffing to ensure sufficient numbers of staff are available.

Flu vaccination programmes will be undertaken in line with the Department of Health guidance and there will be a flu vaccination programme with all staff being offered the flu vaccination. This will be monitored to understand staff uptake with communications being made to encourage a greater level of uptake by staff.

### 6.7 Primary Care – GP Services

All GP practices will be sent a copy of the covering letter and action cards for the Cold Weather Plan when the 2017 version is produced which relate to commissioners/providers and RCCG will be reviewing this to capture all recommended action into the winter/surge plan actions. Action cards are now in place following the publication of flash cards and have been localised to Rotherham. This involves an arrangement for non-patient facing clinicians to commence patient facing duties if the system is on OPEL 3/4. Public Health has put in place arrangements for 2017 influenza vaccinations.

Extended access for patients ie appointments outside 8.00am to 6.30pm core hours will be in place for the whole Rotherham population from October 2017. 24 practices are providing extended access and the Rotherham ‘Hub’ will support the remaining Rotherham population. Saturday provision has been in place since January 2017 with three hubs in North, Central and South. Sunday provision will be in place via one hub centrally from December 2017. Rotherham has implemented a new Quality Contract to more clearly define the requirements and expectations of primary care. This includes the following requirements:

1. Practices will offer sufficient capacity to achieve
   a. Urgent access within 1 working day
   b. An appointment for patients within 5 days when their condition is routine.
   c. Follow-up appointments within a working week of when the clinician identified i.e. if a 1 month follow-up, the appointment offered will be no more than 1 month and 5 working days.
2. It is a requirement that there is a minimum of 75 contacts per 1000 patients per week. Contacts may be provided by a GP (or training GP) and/or Nurse Practitioner (who is qualified to diagnose) and may be face to face or by telephone (triage followed by face to face consultation will be deemed as one episode).
3. Practices are required to have reviewed their capacity and demand and to ensure they are resourcing to meet this demand. This includes:
   - provision of capacity in alternative ways e.g. virtual (telephone) and using alternative roles.
   - 10 bookable sessions (am/pm)
   - offer access to both male and female clinicians.
4. Ensure acutely ill children under 12 are assessed by a clinician on the same day
5. Accept deflections from Yorkshire Ambulance Service (YAS).
6. Provide an in hours home visiting service for those patients presenting with an urgent clinical need requiring a home visit who live within the practice boundary but are registered with a practice outside of Rotherham CCG Boundary in accordance with GP choice requirements with associated payments (currently £60 per home visit). It is not anticipated that demands for such visits will exceed one per month.
   http://intranet.rotherhamccg.nhs.uk/standards.htm
7. Improve on patient survey measures.
Care navigation is in operation in 10 practices with a further 10 going live before the end of the financial year. We are anticipating approximately 25% of workload being navigated away from these practices freeing up more capacity from general practice teams to support winter.

RCCG continues to commission social prescribing arrangements with the voluntary services to ensure patients are better informed and supported with their conditions. This has now been extended to include mental health patients. RCCG is also supporting practices to ensure they have sufficient capacity in place to manage the increased demand over the winter period. All Rotherham practices have undertaken productive general practice which has a core module which looks at capacity and demand along with how alternative roles can support the practice. Rotherham already has Clinical Pharmacists working with a number of practices with the plan to extend this if additional funding is granted. RCCG has also implemented a ‘Quality Contract’ with practices where access requirements are more defined than within the national contract e.g. urgent access within 1 working day, routine access within 5 working days and patients having the ability to book a follow-up as per the clinician defined time.

Medical documentation training has now been provided for all practices to free up clinician time within practices and provide this for front line services.

Care homes across Rotherham are now aligned with a GP practice (more than one where the numbers of patients are very high), the intention of these arrangements is to provide improved continuity for care home teams, improved care planning and reduce hospital admissions. RCCG has also implemented an Advanced Nurse Practitioner/Rapid Response service for care homes to support patients to remain within the care home and not default into secondary care.

All GP practices have marketing literature on display in relation to ‘Right care first time’ to educate and support patients in relation to the range of services available.

6.8 Primary Care – Pharmacy Services

The CCG has commissioned 2 Local Enhanced Services with Rotherham pharmacies. These are the Pharmacy First (Minor Ailments Scheme) and the Palliative Care Service.

The Pharmacy First Scheme enables patients to receive medication(s), to treat a range of common conditions, direct from the pharmacist without a GP prescription. If a patient does not usually pay NHS prescription charges, then they can receive medicine supplied under the Pharmacy First scheme free of charge. The conditions covered by the scheme are; acute cough, allergic conjunctivitis, allergic rhinitis (hay fever), common warts and verruca, constipation, diarrhoea, fever in children, head lice, infantile colic, infective conjunctivitis, scabies, threadworm and vaginal thrush. The Palliative Care Community Pharmacy Service ensures the availability of palliative care drugs across all participating community pharmacies in Rotherham. The service is designed to improve access to palliative care medicines (from a locally agreed list) for patients, carers and healthcare professionals when they are required, in order to ensure that there is no delay to treatment whilst also providing access and choice. The scheme is available every day of the year when participating pharmacies are open and pharmacies have a set list of palliative care drugs that they are expected to hold at their pharmacy for the scheme.

The Rotherham Emergency Prescription Service is no longer commissioned by RCCG. From October 2016, NHSE has commissioned a pilot scheme – NHS Urgent Medicine Supply Advanced Service (NUMSAS). The service is being commissioned as an Advanced Service and will run from 1st December 2016 to 31st March 2018 with a review point to consider progress in September 2017. The objectives of the service are to:

- manage appropriately NHS 111 requests for urgent medicine supply;
- reduce demand on the rest of the urgent care system;
- resolve problems leading to patients running out of their medicines; and
- increase patients’ awareness of electronic repeat dispensing.
6.9 Care Homes
The 5YFV emphasises the importance of Enhancing Health in Care Homes to ensure that they have direct access to clinical advice, including appropriate on-site assessment. This work is furthered developed within the Framework for Enhanced Health in Care Homes. See Appendix 1 for further detail.

6.10 Voluntary Sector
Voluntary Action Rotherham
Voluntary Action Rotherham (VAR) has a membership base of approx. 800 voluntary and community groups and organisations. VAR issues regular email bulletins and newsletters to its members; which contains useful information and updates. The VAR communications includes key voluntary organisations with whom it shares:
- Information about planning for cold weather/keeping vulnerable people warm.
- Cold Weather Alerts.

These details are also shared with the VAR Social Prescribing Team and linked services. The Social Prescribing Team have incorporated questions to service users to remind them about flu vaccination as recommended by a risk assessment tool being promoted by Rotherham Public Health, as well as questions around keeping warm and heating. In addition VAR’s Health Ambassador Project supports the ‘winter’ messages and information by continuing to take the ‘Right Care, First Time’ message out to members of the public and VCS groups via a programme of events, talks and other public engagement activities.

Age UK
Age UK will be providing an emergency service during severe weather to assist vulnerable older people in the community and full details will be shared with partner organisations once confirmed.

The Linkline service will also be available throughout Christmas and New Year. This service involves volunteers telephoning vulnerable over 55 year olds each morning to check they are alright. It can be on a permanent basis, up to seven days a week, or on a temporary basis such as when a carer is away.

The Hospital After Care Service will also support discharge planning over the winter period and is available 365 days a year.

7. LESSONS LEARNT
Summary of Performance Winter 2015-16
There were significant pressures over the winter period for 2016-17 with high numbers of attendances at A&E and a high number of emergency admissions. There were significant bed pressures at TRFT with bed occupancy above 95% and escalation beds open throughout the winter period. Community beds including Breathing Space, Intermediate Care, Discharge to Assess beds and the Community Unit were fully utilised.

TRFT did not meet the 95% 4 hour A&E target over the winter period and YAS also did not meet the 75% target for Category 1 calls (8 minutes). NHS 111 received a higher number of calls than for winter 2016/17 and did not meet its targets for clinical calls back and warm transfers. Overall services coped well despite these significant demands.

Sitrep data indicated that the main areas of concern from the reports were A&E performance, bed occupancy and number of escalation beds open. Bed occupancy had a mean average of 96.1% and was above 95% throughout a high

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proportion of the winter period, reaching 100% on 2 occasions. The mean average number of escalation beds was 26.7 beds per day throughout the reporting period and this was particularly high during early February 2017 peaking at 44 and 43 beds for a number of days. The number of core (general and acute) beds open was slightly higher for 2016/17 at 403 compared to 2016/17 at 377. Despite pressures on the hospital, there were no ED closures and 1 divert was reported on 5 December 2016. There were a small number of ambulance handover delays and minimal disruption due to bed closures linked to infection control. There were a small number of cancelled elective and urgent operations which were all reappointed within Department of Health guidelines.

There were a total of 1,571 bed days unavailable from November 2016 to February 2017 due to delayed transfers of care at TRFT, the majority of these were due to patients Awaiting Further NHS Acute Care. RDaSH also reported 2,092 delayed days during the same period, the majority of which were due to Completion of Assessment. The 4 hour A&E target remained a challenge for TRFT and performance dropped significantly during the winter period – see figure 4 below. Performance was a challenge across acute trusts nationally. Due to a change in IT system, TRFT did not report against the 4 hour target in November 2016.

Figure 5 TRFT 4 Hour Performance – National comparison covering February 2016 to February 2017.

<table>
<thead>
<tr>
<th>Month</th>
<th>TRFT Performance</th>
<th>England Avg (Type 1)</th>
<th>Standard</th>
<th>TRFT Rank (of 140)</th>
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<tbody>
<tr>
<td>Apr-16</td>
<td>85.8%</td>
<td>81.6%</td>
<td>95.0%</td>
<td>49</td>
</tr>
<tr>
<td>May-16</td>
<td>77.4%</td>
<td>80.9%</td>
<td>95.0%</td>
<td>91</td>
</tr>
<tr>
<td>Jun-16</td>
<td>92.9%</td>
<td>85.0%</td>
<td>95.0%</td>
<td>27</td>
</tr>
<tr>
<td>Jul-16</td>
<td>90.1%</td>
<td>85.4%</td>
<td>95.0%</td>
<td>50</td>
</tr>
<tr>
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<td>91.9%</td>
<td>85.8%</td>
<td>95.0%</td>
<td>41</td>
</tr>
<tr>
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<td>89.1%</td>
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<td>95.0%</td>
<td>55</td>
</tr>
<tr>
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<td>95.0%</td>
<td>86.4%</td>
<td>95.0%</td>
<td>16</td>
</tr>
<tr>
<td>Nov-16</td>
<td>92.8%</td>
<td>86.0%</td>
<td>95.0%</td>
<td>28</td>
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<tr>
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<td>85.2%</td>
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<td>95.0%</td>
<td>76</td>
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<tr>
<td>Feb-17</td>
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<td>Feb-17</td>
<td>74.50%</td>
<td>81.20%</td>
<td>95%</td>
<td>112</td>
</tr>
</tbody>
</table>

A&E activity decreased overall during 2016-17 compared to 2015-16, particularly during the winter months – see figure 5 below. There was a high acuity of patients attending A&E throughout the winter period with a high number of ambulances; the mean average from 19 December 2016 to 28 February 2017 was 69.8 ambulances per day with a number of days having 80+ patients arriving by ambulance. The mean average for conversion rates during the same period was 24.07% with admissions reaching above 30% on a number of occasions.

Figure 6 A&E attendances at TRFT 2015-16 and 2016-17.

<table>
<thead>
<tr>
<th>Month</th>
<th>TrustCode</th>
<th>Sum of Activity Actual</th>
<th>% Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Grand Total</td>
<td></td>
<td>5,198</td>
<td>-114</td>
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<tr>
<td>2016/17</td>
<td>RFR</td>
<td>5,823</td>
<td>10.3%</td>
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<tr>
<td>2015/16</td>
<td>RFR</td>
<td>5,413</td>
<td>299</td>
</tr>
<tr>
<td>Year on Year Increase/Decrease</td>
<td>-114</td>
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<td>299</td>
</tr>
<tr>
<td>% Change</td>
<td>2016/17</td>
<td>5,119</td>
<td>-2.1%</td>
</tr>
<tr>
<td>2015/16</td>
<td>5,272</td>
<td>5,387</td>
<td>10.3%</td>
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</tbody>
</table>

Walk in Centre activity over the winter period for 2016-17 was higher than for the previous year with 16,546 attendances between November 2016 and February 2017 compared to 14,957 for the same period during 2015/16. The WIC performed well against the 95% target during the winter period of patients seen by a clinician, treated and then discharged within 4 hours.

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6 TRFT (2017) Operational Update Report for TRFT Board Meeting 25 April 2017  
7 TRFT (2017) Daily ED Performance Reports  
8 RCCG (2017) TRFT Contract Monitoring Reports  
9 Care UK (2017) Monthly Performance Reports to RCCG
Ambulance 999 activity for all calls across Yorkshire and Humber were above plan in month for November (+9.2%) and December 2016 (+10.6%) and January 2017 (+6%), and slightly below plan for February 2017 (-0.6%). YAS did not achieve the 75% target for arrival to Category 1 patients within 8 minutes throughout the winter period. NHS 111 activity across Yorkshire and Humber has increased year on year over the last 3 years including over the winter period. Activity was at its highest in December 2016 with 157,502 calls answered. YAS did not meet the performance targets for clinical call back and warm transfer across the winter period. This is not a local issue and performance against these targets is not being met nationally by other 111 providers.

Weather and Flu Vaccination Uptake

There were no significant cold and prolonged periods of weather during winter 2016/2017 with a small number of cold weather warnings issued by PHE from the end of December 2016 to the beginning of February 2017. There were no major disruptions due to snow.

Uptake for seasonal influenza vaccination had above the average uptake for all the target groups when compared to the England figures with the exception of pregnant women which were slightly below at 44.2% compared to 44.8%. Frontline HCWs involved in direct patient care are encouraged to receive seasonal influenza vaccination annually to protect themselves and their patients from influenza. Uptake of the vaccine amongst Frontline Healthcare Workers (HCWs) in England for last winter (from 1 September 2016 to 28 February 2017) for Local Trusts was 80.2% at RFT, 61.4% at RDaSH and 18.4% at YAS. The England average uptake for HCWs was 63.4%.

Areas for Improvement

At its March 2017 meeting, A&E Delivery Board discussed Winter 2016-17. The Board agreed to produce a Strategic Winter Plan and to recommence a Winter Planning Group to lead on its development. It was agreed that the work of the sub-group would be to focus on the development of EMS to include acute and community services, social care, mental health services, GP OOHs, the ambulance service and primary care; this is being taken forward as part of this System Wide Escalation Plan (see Section 3. Rotherham EMS).

With regards to performance, TRFT has an action plan to improve performance against the 4 hour A&E target (attached at Appendix 2). TRFT also has a plan to establish a fixed bed-base and flex beds to address additional winter demand for beds and bed occupancy (see Section 4. Developing Flexible Bed Capacity). There is also a focus on supporting patients at home where appropriate, including 3 pathways to prevent admission and support discharge (see Section 5. Analysis of Out of Hospital Services). Plans are in place to improve patient flow and improve the discharge process; an action plan is in place following a review of the discharge pathway undertaken by TRFT, RMBC and an third party provider (see the Rotherham A&E Delivery Plan at Appendix 1 for further detail).

8. SUMMARY OF KEY RISKS

The Rotherham A&E Delivery Board has a risk register which is reviewed and updated at each meeting. The risk register is rag rated and identifies where issues are being managed. The following key risks to the local health economy have been identified as we approach the winter.

- Achievement of A&E 4 Hour Target 2017-18:
  - medical workforce (Consultants and Middle Grade)
  - embedding the new UECC model and utilising the new estate.
  - impact of IR35 on locum GPs.
- Achievement of YAS targets 2017-18.

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11 Embed (2017) NHS 111 Monthly Performance Dashboards
- Achievement of non-elective trajectories 2017-18.
- Delayed Transfers of Care:
  - quality and access to care homes and domiciliary care packages.
- Social Care funding pressures.

These risks are all being mitigated through interventions identified within this plan and the A&E Delivery Plan (Appendix 1).

9. **FLU IMMUNISATION PROGRAMME**

The Department of Health and NHS England has published its National flu immunisation programme plan for 2017-18\(^{14}\). The plan provides the public and healthcare professionals with an overview of the coordination and the preparation for the flu season and signposting to further guidance and information.

In 2017-18 the following groups are eligible for flu vaccination:

- those aged 65 years and over
- those aged six months to under 65 in clinical risk groups
- pregnant women
- all children aged 2 to 8 on 30 August 2017 all primary school-aged children in former primary school pilot area
- healthcare workers with direct patient contact
- those in long-stay residential care homes
- carers

Delivery through the Community Pharmacy Seasonal Influenza Vaccination Advanced Service will continue in 2017-18. Eligible adults aged 18 years and over will have the choice of getting their flu vaccine at a pharmacy.

It is expected that frontline health and social care workers to be offered flu vaccination by their employer. This includes general practice staff. Locally, plans are in place for vaccination programmes for health and social care staff across all partner organisations.

10. **THE NHS COLD WEATHER PLAN FOR ENGLAND**

This report incorporates Rotherham’s response to the National Cold Weather Plan updated in 2016\(^{15}\). The plan is a framework intended to protect the population from harm to health from cold weather. It aims to prevent the major avoidable effects on health during periods of cold weather in England by alerting people to the negative health effects of cold weather, and enabling them to respond appropriately. The NHS Cold Weather Plan for England sets out what should happen before and during severe winter weather in England. It describes what individuals and organisations can do to reduce health risks and includes specific measures to protect at risk groups.

The cold weather plan relies on well co-ordinated plans being in place for how to deal with severe cold weather before it strikes, including the following essential elements:

- Strategic planning across partner organisations and at a national and local level.
- Advance warning and advice during the winter months.
- Communicating with the public.
- Communicating with service providers.
- Engaging the community.


Outlines responsibilities and actions for healthcare organisations, the Local Authority and care professionals in the event of cold weather.

The A&E Board wants to avoid two separate systems of escalation, responding to spikes in demand and severe weather events. Therefore the Escalation management System set out in Section 3 of this report covers the triggers and actions for both these scenarios.

11. WINTER COMMUNICATIONS

A continuation of the Rotherham Right Care, First Time campaign will be used throughout winter, with a focus on older people, 25-40 year old adults, people with long-term conditions, carers and parents of children under 5. This multi-agency campaign, aligned to the national Stay Well This Winter campaign, will ensure that winter messages to staff, patients and carers are consistent and activity is joined up.

NHS England and Public Health England lead on the national Stay Well This Winter campaign, which has been running for two years, using learning from the evaluation. Locally we will share messages and materials, in a timely manner. These messages including keep warm, keep well and flu vaccination, will help people to self-manage their condition/illness and prevent avoidable use of busy health services. Rotherham residents will be encouraged to access approved online information such as www.nhs.uk/staywell to help themselves over the winter months.

Throughout winter, our communications activity will be based on local insight to encourage a reduction in unnecessary attendances at A&E and an increase in use of community/primary care services and support services such as GP out-of-hours and NHS 111. Key messages will be developed to be used by all partners, using positive language about services that people can and should use rather than telling them not to use services such as A&E. A local winter communication activity plan will be implemented from October 2017 onwards.

11.1 Severe Weather

Weather alerts form part of system wide communication across the borough, adverse weather warnings are included in this communication. All organisations have a winter plan in place (See section 6), the identification of vulnerable groups and people at risk in severe weather forms part of this winter planning.

The Health and Social Care System follow EMS action cards as part of any response to extreme cold weather / snow. For example; where there are problems in the community with staff reaching their base, cases work is re-allocated & moved to geographical working.

Breathing Space provides a bespoke respiratory pathway, focusing on COPD as well as other respiratory conditions involving out-patient care and pulmonary rehabilitation. The team consists of special respiratory practitioners including nurses and therapists. During periods of high need, including during periods of cold weather, practitioners provide home visits.

12. INFECTION PREVENTION AND CONTROL

A Rotherham multi-agency outbreak plan, which provides a system wide approach to outbreaks of a healthcare associated infections or communicable diseases, has been developed and is going through the appropriate approval processes for final ratification. In addition, all Providers have their own outbreak plans in place.
<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
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<tr>
<td>A&amp;E</td>
<td>Accident and Emergency</td>
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<td>BCF</td>
<td>Better Care Fund</td>
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<td>DH</td>
<td>Department of Health</td>
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<td>DTOC</td>
<td>Delayed Transfers of Care</td>
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<td>Emergency Department</td>
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<td>GP OOHs</td>
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<td>IBCF</td>
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<td>PHE</td>
<td>Public Health England</td>
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<td>RDaSH</td>
<td>Rotherham, Doncaster and South Humber NHS Foundation Trust</td>
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<td>Rotherham Metropolitan Borough Council</td>
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<td>NHS Rotherham Clinical Commissioning Group</td>
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<td>Urgent and Emergency Care Centre</td>
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<td>Walk in Centre</td>
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<td>Yorkshire Ambulance Service</td>
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ROtherham
A&E Delivery Board Plan 2017-18

2017-18
Final Version 8 September 2017
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1. PURPOSE OF THE REPORT

This document sets out the actions for the Rotherham A&E Delivery Board in relation to the key deliverables for Urgent and Emergency Care set out in NHS England’s ‘Next Steps on the NHS Five Year Forward View’ published on 31 March 2017. Urgent and Emergency Care (UEC) is one of the NHS’ main national service improvement priorities.

The key deliverables incorporate:
- Front door clinical streaming in A&E by October 2017.
- Good practice to enable appropriate patient flow.
- Joint work to ensure people are not stuck in hospital while waiting for delayed community health and social care.
- Specialist mental health care in A&E.
- Enhancement of NHS 111.
- Roll out of extended access to GP appointments.
- Strengthening support to care homes.
- Roll out of standardised Urgent Treatment Centres.

Trusts and CCGs are also required to meet the Government’s 2017/18 mandate to the NHS that: 1) in or before September 2017 over 90% of emergency patients are treated, admitted or transferred within 4 hours – up from 85% currently; 2) the majority of trusts meet the 95% standard in March 2018; and 3) the NHS overall returns to the 95% standard within the course of 2018.

Further detail is included in NHSE’s Urgent and Emergency Care Delivery Plan April 2017 and this has been reflected in this plan. A South Yorkshire and Bassetlaw Urgent and Emergency Care Plan has also been developed and actions from this plan have been included.

2. A&E STREAMING AT THE FRONT DOOR/URGENT TREATMENT CENTRE

Strategic Vision and Key Deliverables

The need to redesign urgent and emergency care services in England and the new models of care which propose to do this are set out in the NHS Five Year Forward View (SYFV) and ‘Next Steps on the NHS Five Year Forward View (March 2017). The Urgent and Emergency Care Review proposes a fundamental shift in the way urgent and emergency care services are provided, improving out of hospital services so that we deliver more care closer to home and reducing hospital attendances and admissions. We need a system which is safe, sustainable and that provides consistently high quality. The vision of the Review is:

- For those people with urgent care needs we should provide a highly responsive service that delivers care as close to home as possible, minimising disruption and inconvenience for patients and their families.
- For those people with more serious or life threatening emergency care needs, we should ensure they are treated in centres with the very best expertise and facilities in order to maximise the chances of survival and a good recovery.

2.1 Urgent and Emergency Care Centre and GP Streaming

The Urgent and Emergency Care Centre (UECC) opened its doors on the 6th July 2017 providing a single urgent and emergency care system for the people of Rotherham. It is supported by a diverse clinical team to provide responsive, quality care, ensuring the patient receives the right care first time 24/7 365 days a year.

The emphasis within the new model is to integrate staff as much as possible across artificial clinical streams so all patients are seen as ‘theirs’ and not someone else’s patient. This follows the latest thinking around processing of patients to the most effective clinician and is the most innovative element of the model. This ensures that the clinician with the relevant skills sees the patient first time, reducing unnecessary handover across clinicians reducing clinical risk and the potential for patients to be overlooked and forgotten.

The UEC Centre will also house the MHS liaison team, social care and the GP OOH service, co-locating all unscheduled care services.

The diagram below shows the overarching service model which is effective with the UEC Centre.

Primary Care streaming – for urgent conditions

At initial assessment, the ED triage nurse will be directly stream primary care conditions into primary care, in line with protocols, to be seen within the urgent and emergency are centre by primary care staff.

Minors streaming

At initial assessment the ED triage nurse will directly stream into the minors stream in line with streaming protocols to be seen by the ENP, GP, or ED Doctor as appropriate.

Majors streaming

At initial assessment the ED triage nurse will directly stream majors conditions into the majors stream in line with protocols to be seen by the wider ED team.

Redirection to GP/Pharmacist.

For patients who have chronic conditions that do not require urgent interventions, patients can be best cared for by their own GP who has knowledge of the history of the patient and who is able to take time discussing care options/medications.
For some patients the most appropriate clinician may be the pharmacist, such as minor ailments (e.g. insect bites). In this instance the patient will be asked to visit the nearest pharmacist, of which one will be on site at the hospital.

**Advice and Guidance for Self-care**

Following assessment, some patients who access the UEC Centre will only require advice and guidance for self-care. In this instance the rapid assessment team will issue advice and guidance and discharge the patient home without referring to into zone 3.

**Direct referral to specialty**

In some instances the most appropriate clinician to treat the patient may not be within the Emergency Centre, but elsewhere within the hospital, such as the stroke, services. In this instance, following rapid assessment, the patient will be referred direct the specialty, following standard operating procedures already in existence across TRFT

**GP OOH Booked appointments**

Some patients who ring the out of hours (Out of Hours) service will still need to be able to be seen by a GP in a pre-booked manner. The service model will support this by co-locating the Out of Hours service within the Urgent and Emergency Care Centre. Patients who ring 111 will be redirected to Out of Hours service which will be situated on the upper floor of the Urgent and Emergency Care Centre. The triage GP will then be able to make a decision if the patient needs to be seen at home or within the Urgent and Emergency Care Centre.

Figure 1 below illustrates the streaming process and who is working in which stream in the UEC Centre. P1 – P5 relate to level of acuity in line with Manchester triage.

2.2 Specialist Mental Health Services in A&E

Staff from the TRFT’s Mental Health Liaison service are based in the Urgent and Emergency Care Centre and patients are referred on to this service when appropriate to provide specialist mental health care for adults. Out of hours, pathways are in place to refer patients to the Mental Health Crisis service.
3. OTHER HOSPITAL SERVICES

There are a number of key actions over the next 6 months to ensure that the pathways from our new Urgent and Emergency Centre are effective including the development of robust frailty and ambulatory pathways.

3.1 Frailty Unit and Ambulatory Care

Rotherham Foundation Trust is intending to develop a frailty and ambulatory care pathways as part of its 2017-18 Operational Plan. The intention is to establish a multi-disciplinary Frailty Service before the winter period. The integrated team is currently being piloted. The service will carry out holistic assessments of patients with complex needs who come to the hospital. It will stratify patients in terms of urgency and develop appropriate care plans. The Frailty Service will receive direct referrals from the new Urgent and Emergency Care Centre, Assessment Units and acute wards. The ambulatory care pathways will ensure that, where appropriate, patients who do not require a bed receive the appropriate care within an ambulatory care setting. This pathway will also be in place before the winter period.

Key objectives of the new frailty and ambulatory pathways include;

- Contribution to delivering the 4 hour emergency access standard.
- Delivery of comprehensive needs assessment on point of entry to the hospital.
- Rapid diagnosis, observation, treatment and rehabilitation.
- Reducing delayed discharges.
- Reducing the number of readmissions within 30 days.

Initial outcomes from the new frailty pathway have been positive and a comparison of bed days from March-June last year to March-June this year, whilst the frailty pilot has been running demonstrates a saving of over 1,000 bed days. Average length of stay for the same period has also reduced from 5.43 to 4.04 days.

3.2 Hyper Acute Stroke Services

The commissioning of Hyper Acute Stroke Units is included in the South Yorkshire and Bassetlaw Urgent and Emergency Care Delivery plan. The business case for hyper acute stroke services is still underway, once a decision is made regarding the future commissioning arrangements for this service RCGG will take appropriate action.

4. PATIENT FLOW AND IMPROVING DISCHARGE PROCESS

Strategic Vision and Key Deliverables

The SYFV builds on guidance such the High Impact Change Model (a self-assessment tool for areas assess the effectiveness of discharge processes/pathways) in focusing on the importance of efficient patient flow.

4.1 Board rounds

Each identified ward holds a clinically led Board Round between 08:00 – 09:30. This will be led by a Senior Clinician. The Board Round introduces structure to the daily running of the ward and helps teams to coordinate activities to proactivity manage each patient safely and effectively.

4.2 Ward rounds

Each identified ward undertakes an MDT Round between 12:00 – 13:00. The MDT team consists of Doctors, Nurses, Social Workers, Occupational Therapists and the Transfer of Care Team required to support effective review of the patients.

N.B this process is currently under review as part of the DTOC action plan priority to integrate the discharge teams (Hospital Social Work Team, Transfer of Care Team (TOC) and Therapists). See Section 4.6 for detail.
4.3 Estimated date of discharge
Patients on identified wards have an Estimated Date of Discharge (EDD) based on the medically suitable discharge status agreed by clinical teams and this is recorded in the patient’s notes within 24 hours. Percentage of delays in patient discharges should not exceed 3.5% of all discharges on any given day. This work is supported throughout this A&E Delivery Plan i.e. sections 4.5 – 4.12.

4.4 Monitoring Implementation of the SAFER Care Bundle
The delivery of the Safer Care Bundle remains a key priority for the Trust. The CCG has previously incentivised this through the local CQUIN, however for 2017-19 the ability to influence the CQUIN indicators from a local perspective has been removed nationally. The Safer Care Bundle has become ’business as usual’ within the Trust and whilst there remain challenges and improvements to be made, significant progress has been made to ensure that this has been embedded across the identified wards within the Trust.

4.5 Seven Day Discharge Capabilities
Acute and Community
RCCG monitors the delivery of the seven day clinical standards as per the requirements of the 2017-19 NHS Standard Contract and in line with RCCG’s local reporting requirements to support seven day discharge capabilities from the acute Trust. The standards are as follows:

- Standard 2: Time to first consultant review
- Standard 5: Diagnostics
- Standard 6: Intervention / key services
- Standard 8: On-going review.

Social Care
7 day social care working is now in place and embedded at the hospital with on-site social care assessment available to support patients. The hospital and Hospital Social Work Team (now known as Supported Discharge Pathways team) now provide a joint approach to assessments and care planning on a 7 days a week basis. This new pathway also reduces length of stay in hospital medical wards and continues to support discharge and admission prevention. Additional support over and above the dedicated resources identified can be accessed through the out of hour’s service on an as needed basis. Over the winter period to support pressures the OOH social care service has also been based within the Supported Discharge Pathways Team, this will continue in 2017-18.

Domiciliary care providers are also now (new this year) contracted to respond to urgent referrals on a 7 day a week basis, delivering urgent packages of care and night visiting packages.

Intermediate Care Services receive referrals 7 days a week. Historically hospital discharges could only take place during the working week. Extending the time frame for referrals supports timely discharge and can prevent admissions during the weekend. There is a specialist Mental Health OT and CPN which carry out assessments and management of mental health for individuals whose needs affect their function and ability to undertake rehabilitation. This service also covers the Integrated Rapid Response service.

Integrated Community Equipment Service (ICES) has a range of satellite offices in the community to enable access to community equipment on a 7 day basis.

Mental Health
Home treatment services can support people being discharged from wards within an early discharge pathway. The Rotherham Mental Health Liaison Service also supports 7 day discharge and provides round the clock mental health care to people who attend Rotherham Hospital to provide assessment, treatment and management of mental health
problems to adults aged over 18. The aims of the service include reducing the number of admissions from A&E, reducing length of stay and reducing re-admissions.

4.6 High Impact Change Model

National Condition 4: Managing transfers of care (new national condition) of the Better Care Fund (BCF) sets out the requirement to ensure people’s care transfers smoothly between services and settings. This requires all local areas to implement the high impact change model which is also a condition of the Improved Better Care Fund (IBCF).

Rotherham used the High Impact Change Model to self-assess the local position in 2016-17 and developed a Delayed Transfer of Care (DTOC) action plan. This self-assessment was completed by the multi-agency effective patient flow group and was reported through to our local A&E Delivery Board prior to winter 2016-17. As a system we have recently commissioned an external review of the discharge processes and pathways by the LGA and NHSE. The outcome of which is as follows;

- Rotherham’s Delayed Transfers of Care are comparatively low. However there is an upward trajectory in recent months
- There is an energy, commitment and enthusiasm from staff to make improvements
- There are some examples of good practice on wards i.e. MDT approaches – but this is not consistent
- IT system Rotherham Care Record is best practice model
- Pathways out of hospital are confusing
- Planning around the individual was strong
- Lack of process for agreeing and signing off DTOCs

We have already developed a Memorandum of Understanding around better integrated discharge planning and have piloted ‘Trusted Assessor’ models in our services i.e. Ackroyd Care Home. We plan to further develop a ‘Trusted Assessor’ model to streamline the assessment – defined as one person/team appointed to undertake health and social care assessments on behalf of multiple teams, using agreed criteria and protocols in 2017-18).

A set of agreed actions have been developed that form part of the DTOC action plan for 2017-19 included in the BCF Plan 2017-18 as follows;

1) Implement an Integrated Discharge Team:
   - Would help with roles, responsibilities, clarity of teams.
   - Would help structure MDT’s better, referral processes, working relationships

2) Agree Joint reporting and Data Set
   - System to have standard, single version of the truth
   - Some things get reported, some things unclear (non-acute delays)

3) Simplify Pathways (including Home First and DST’s)
   - Too many pathways and need greater clarity
   - DST’s need a better pathway and need to get them home where safe to do so

4) Awareness and Training
   - Understanding of DTOC’s, Care act needs improving
   - Training for teams and awareness sessions

The action plan includes specific tasks to support the winter period and alleviate pressure;

1. Integration of discharge functions within the hospital with close links to community – the hospital social work team already work closely with the transfer of care team (TOC) and the therapist however, the teams are not fully integrated, do not use the same assessment process and frequently duplicate work. Work is
underway to identify short to medium term actions to support better integration including initial co-location and streamlining of processes prior to full integration (one assessment/trusted assessor).

2. Commissioning of reablement to support ‘Discharge Home’ pathway and assessment in the home rather than in our bed based community provision – it is our intention through the IBCF to commission additional reablement capacity on a test basis to work alongside our Integrated Rapid Response Service. This provision will elevate some of the delays created by patients awaiting packages of care at home, create opportunities for appropriate reablement prior to assessment for a package of care and increase independence and resilience.

3. Reporting and analysis of data - agreement on an appropriate collection method for reporting DTOCs is essential to ensure that accurate data is submitted to NHSE and that local analysis of delays is accurate.

Improved Better Care Fund
The IBCF has now been agreed by all partners and will form part of the BCF Plan 2017-19 submitted on the 11th September to NHSE. The plan includes an identified fund of £400,000 to support winter pressures. This money will be used throughout the remainder of the year to respond to bed pressures following the anticipated winter demand surge. The specific investment has not yet been defined as the aim is that this budget can be used by system partners to respond flexibly to where it is required.

4.7 Continuing Health Care Processes
RCCG’s NHS Continuing Health Care (CHC) service and RMBC’s NHS Continuing Health Care social care service have implemented a CHC trusted assessor initiative. The CHC trusted assessor initiative will mean that where the MDT at the DST visit is in agreement of an eligibility recommendation, this will be confirmed as approved at the time of the DST, the initiative will be in practice across the borough, and will benefit patients in any setting with the aim of providing timely outcomes that will improve patient flow.

RCCG CHC service also offer to commission a standard package of care, for individual patients in the acute setting that are eligible for a DST and are medically fit for discharge. This means that RCCG will commission a package of domiciliary or residential care that meets the patients’ needs, and allows the patient to be discharged from hospital without delay to a preferred placement and the DST completed in the preferred placement.

RCCG and RMBC CHC services now provide the regular availability of 5 DST visits a week, to D2A and where necessary acute hospital patients that are eligible for completion of a DST, with the option of increasing to 10 a week if the need arises.

4.8 ‘Home first: discharge to assess’ ways of working
As discussed in 4.6 High Impact Change Model the self-assessment process has identified the need for additional reablement capacity in Rotherham. The main areas of concern are;

- The current reablement service is not meeting current demand and will not meet future demand given the requirement for assessment and reviews to be undertaken. The service model of the in house service is not effective in optimising the reablement potential of service users. The DTOC is causing negative impact on the Rotherham Foundation Trust in terms of patient flow through the service.

- There is an immediate requirement for additional capacity and an alternative model capable of achieving reduction in dependency, timely reviews and increased integration with the health community, the voluntary and community sector and utilise assistive technology.

A trusted assessor approach where service users who have reached their optimum level of reablement are promptly discharged from the service if they have no further need for paid care is required. This is achieved through offering
intense support at the commencement of the service (including therapy), a model that is not currently provided through the rehalement provision in place.

The commissioning of this provision on a pilot basis is expected to be delivered prior to winter 2017, through the IBCF.

Discharge to Assess; Community Beds

Rotherham Clinical Commissioning Group (RCCG) commission 14 Discharge to Assess beds (D2A) across 2 placements:

- Waterside Grange Nursing Home
- Oakwood Community Unit

It is believed that patient flow within these beds may not be optimised and therefore in preparation for winter a new process for accessing beds at Waterside Grange will be tested as a pilot. This will be an alternative way of working to improve patient flow.

Waterside Grange Nursing Home D2A team with support from the Rotherham Foundation Trust (RFT) Transfer of Care (TOC) Team will identify 3 beds within the existing provision of 6 D2A beds. These beds will be called CHC D2A Bed 1, 2 and 3 and will be utilised to reduce length of stay in hospital by transferring patients who are medically fit for discharge but require an NHS Continuing Health Care (CHC) Assessment. A copy of the draft report outlining the pathway for the Discharge to Assess Pilot is attached at Appendix 2.

4.9 ‘Trusted assessor” ways of working

As discussed in 4.6 High Impact Change Model the self-assessment process has identified the need to review and reconfigure the discharge teams within the hospital (Hospital Social Work, TOC and Therapists in particular) to form an integrated team. Significant focus will be taken to ensure that the Trusted Assessor model outlined in the Memorandum of Understanding (signed in 2016-17) is implemented across all pathways.

This model is implemented arbitrarily by teams; in terms of intermediate care progress has been made to implement the trusted assessor approach with some success and it is also working well within the Ackroyd (Independent Sector Home commissioned by TRFT). However, there is much work to be done to ensure a single assessment process across Health and Social Care that meets all requirements including Care Act 2014 compliancy.

It is also recognised that the trusted assessor model should be rolled out across all Care Homes (Recommendation in Enhanced Health in Care Homes). This is discussed in the BCF plan 2017-19 and will include scoping the potential roll out across Domiciliary Care as well.

4.10 Supporting patients’ choices to avoid long hospital stays

Rotherham does not have a standard operating procedure for supporting patient choice on discharge. However Friends and Family surveys indicate that communication with patients and families is good.

4.11 Supported Discharge Care Pathways

See System Wide Escalation Plan for details of the 3 Discharge Pathways available in Rotherham.

4.12 Bed Capacity

The Rotherham A&E Delivery Board predicts that demand for beds will be as challenging as 2017/18, with an unknown element attached to the opening of the new Urgent and Emergency Care Centre in July 2017.

Initial findings in the first weeks of opening are as follows;
The current acute bed base is not sufficient to manage the forecast demand alone; therefore a focus on early discharge home is essential. We know that the acuity of patients in winter is higher than in summer. We know that more patients are admitted to hospital beds in winter and that there are specific days when admissions are higher. These days tend to coincide with those when discharges are lower, usually a Monday.

Extreme demand (80+ admissions a day) should be expected and planned for. 50% of days, were the daily admission rate is 80+, occur November to February and 40% occur on Mondays. The data suggests every 2 out of 4 Monday’s (at least) could be an 80+ admission day.

The A&E Delivery Board will ensure that there are clear strategies to reduce waiting times, maintain service and promote patient flow during these periods embedded in our plans across the system.

4.13 Establishment of a Fixed-Bed Base and Flex Beds
Rotherham A&E Delivery Board is committed to ensuring that there is enough fixed bed capacity to meet demand. See The Rotherham System Wide Escalation Plan 2017-18 (Including Winter Planning) for more detail.

5. INCREASING THE PROPORTION OF NHS 111 CALLS TRANSFERRED TO A CLINICAL ADVISER
The SYFV outlines the following key deliverables for increasing the proportion of NHS 111 calls transferred to a clinical advisor. By 2019, NHS 111 will be able to book people into urgent face to face appointments where this is needed. NHS 111 online will start during 2017, allowing people to enter specific symptoms and receive tailored advice on management.

5.1 More People Receiving Clinical Assessment
NHS Greater Huddersfield CCG is the lead commissioner for the Yorkshire and Humber NHS 111 service. YAS is already achieving 30% of 111 calls transferred to a clinician by March 2017. Plans are being developed for achievement of 40% of 111 calls transferred to a clinician by December 2017, and 50% by March 2018. Further guidance is awaited on how performance is to be calculated and whether additional resource will be required. This will form part of commissioners’ commissioning intentions with YAS once further guidance has been received.

Regarding NHS 111 booking OOH GP appointments, action plans have been developed in partnership with OOH provider and NHS 111. The plans are based around a phased introduction. Initial actions will see the direct booking of a limited number of specific DX Codes with an outcome of GP appointment within 1-2 hours on weekdays from 2 October 2017. This will develop confidence in the new referral system and OOH to ensure clinical staffing levels are appropriate for the change in practice before undertaking a full roll out of the service during November and December. Work is taking place within Rotherham to enable 111 to book directly into practices for telephone triage.

5.2 NHS 111 Online
NHS 111 on-line is live as a pilot scheme in Leeds and is expected to be rolled out across Yorkshire and Humber in December 2017.

6. AMBULANCE SERVICES
The SYFV outlines the following key deliverables for ambulance services to work closely with the Association of Ambulance Chief Executives and the College of Paramedics, to implement the recommendations of the Ambulance Response Programme by October 2017.

6.1 Recommendations of Ambulance Response Programme
YAS was chosen as a pilot site for the APR and have been instrumental in developing and evaluating the program. APR 2.2 is firmly embedded within YAS and delivering a clinically focused service.

7. PRIMARY CARE
The SYFV and the NHSE Final UEC Delivery Plan April 2017 set out priorities to improve urgent GP access and to increase access to pre-bookable evening and weekend appointments with general practice.
7.1 Extended GP Appointments

23 practices continue to provide extended hours in Rotherham and from October 2017, Broom Lane practice will provide extended access for the remaining 8 practices to ensure all Rotherham population have the ability to have appointments outside of the normal working day.

There are two operational hubs in Rotherham providing full population coverage on Saturdays. Preparations are being made for a third hub to provide this closer to the patients in the South of Rotherham and this will be in place from October 2017. Broom Lane will be providing Sunday access from December 2017 for the whole population of Rotherham.

7.2 Technology

Telehealth is now embedded in all GP practices with an additional benefit of the practices being able to utilise the system to message patients with mobile phones with campaign and key messages. All practices have been provided with equipment to undertake remote consultation to provide improved access for patients and reduce travel time for GPs. All GPs have laptops to enable them to work on an agile basis.

7.3 Care Navigation and medical documentation

Rotherham is rolling out care navigation across GP practices and anticipates 20 practices will have implemented navigation to 6 services, physiotherapy, pharmacy, IAPT, midwifery, smoking cessation and sexual health by this winter. Care navigation has been proven, in other areas to reduce dependency on practice staff and therefore improving capacity within general practices. All practices have also been trained to support GPs with medical documentation and again free up capacity for patient facing tasks.

7.4 Capacity and demand

Rotherham has implemented a new Quality Contract to more clearly define the requirements and expectations of primary care. This includes the following requirements:

1. Practices will offer sufficient capacity to achieve
   a. Urgent access within 1 working day
   b. An appointment for patients within 5 days when their condition is routine.
   c. Follow-up appointments within a working week of when the clinician identified i.e. if a 1 month follow-up, the appointment offered will be no more than 1 month and 5 working days.

2. It is a requirement that there is a minimum of 75 contacts per 1000 patients per week. Contacts may be provided by a GP (or training GP) and/or Nurse Practitioner (who is qualified to diagnose) and may be face to face or by telephone (triage followed by face to face consultation will be deemed as one episode).

3. Practices are required to have reviewed their capacity and demand and to ensure they are resourcing to meet this demand. This includes:
   - provision of capacity in alternative ways e.g. virtual (telephone) and using alternative roles.
   - 10 bookable sessions (am/pm)
   - offer access to both male and female clinicians.

4. Ensure acutely ill children under 12 are assessed by a clinician on the same day

5. Accept deflections from Yorkshire Ambulance Service (YAS).

6. Provide an in hours home visiting service for those patients presenting with an urgent clinical need requiring a home visit who live within the practice boundary but are registered with a practice outside of Rotherham CCG Boundary in accordance with GP choice requirements with associated payments (currently £60 per home visit). It is not anticipated that demands for such visits will exceed one per month.

   http://intranet.rotherhamccg.nhs.uk/standards.htm

7. Improve on patient survey measures.

In addition to this, if the system escalates to Opel 3/4, an arrangement is in place to request that where any clinicians are non-patient facing they commence patient facing duties to support the system.
B. CARE HOMES

The SYFV emphasises the importance of Enhancing Health in Care Homes to ensure that they have direct access to clinical advice, including appropriate on-site assessment. This work is furthered developed within the Framework for Enhanced Health in Care Homes\(^2\). The elements of this framework include:

1. Enhanced primary care support
2. Multi-disciplinary team (MDT) support including coordinated health and social care
3. Reablement and rehabilitation
4. High quality end-of-life care and dementia care
5. Joined-up commissioning and collaboration between health and social care
6. Workforce development
7. Data, IT and technology

Rotherham has already assessed itself against this framework and have identified actions to improve the local offer through the BCF Plan 2017-19.

Achievements to Date

The Better Care Fund has supported the recruitment of a Clinical Quality Advisor within the Care Home Support Service from February 2017. This post is integral in ensuring that health issues are addressed when monitoring contract quality and performance. The post will work flexibly across health and social care and will improve the standard of care for residents. The Advisor will monitor quality standards of care and will undertake audits, reviews, assessments and provide advice, training and support to care homes. The Advisor will also work with the Local Authority contracting team and will contribute to co-ordinated patient pathways.

The Rotherham Care Home Support Service will carry out targeted interventions on residential and nursing homes who are outliers on emergency admissions. The service will support GPs in the case management of people who are at high risk of hospital admission. The team supports residential and nursing homes in meeting the needs of residents with organic and functional mental health problems, including annual mental health assessments. The assessment will identify residents with depression and dementia who will be monitored sign-posted to appropriate health and adult social care services for support. We will identify residents who have memory problems and ensure that they are referred to the Rotherham Memory Service for a comprehensive dementia assessment. The team will also deliver an extensive and comprehensive training programme agreed with RCCG and RMBC commissioners including safeguarding, infection control, continence, tissue viability, falls and equipment assessment.

The Integrated Rapid Response Service incorporates an Advanced Nurse Practitioner service to people living in care homes that are registered by the CQC and are within the boundaries of the Rotherham Local Authority. The service is the first point of contact following minor injury or acute minor illness (non-life threatening). ANPs can independently assess, diagnose, treat minor illnesses and injuries, and prescribe medication. They also provide a care co-ordinating role for people who are at high risk of admission.

All Rotherham care homes (elderly and EMI residential and nursing homes) are now aligned to a GP practice to improve the overall care for Rotherham people living in care homes. The service is delivered by practices through a Local Enhanced Service and consists of regular planned clinics (minimum fortnightly), 6 monthly reviews (physical review and review of care plan), bi-monthly meetings with the care home manager to discuss unplanned admissions, a practice register for all care homes residents, care plans for all residents, 6 monthly medical reviews and assessment of residents within 2 weeks of admission to the care home.

The Rotherham GP OOHs service provides an advice line for care home staff so that they can contact a clinician for a direct discussion. This helps to reduce calls to 999 and in turn reduce admissions to hospital ensuring better use of

resources and better patient experience. The OOHs service can offer advice over the telephone or a home visit if appropriate. It can also refer patients directly to specialties, bypassing A&E.

NHSI has issued requirements for winter plans which should include a focus on supporting care homes through the Red Bag Scheme. This was implemented in Rotherham in 2007 with limited effectiveness. RCCG is now leading a re-invigoration of the scheme and developing a local implementation plan.

RCCG is also leading on developing a local implementation group with RMBC and independent care home providers, to implement the Care Home Bed State system. This will provide live information on current bed vacancies across the North of England.

See the Rotherham System Wide Escalation Plan 2017-18 for further detail.

9. PREVENTION AND SELF CARE

9.1 Social Prescribing

The Rotherham Social Prescribing Programme is funded through the Better Care Fund. Social prescribing is an approach that links patients in primary care with non-medical support in the community. The Rotherham social prescribing model particularly focuses on secondary prevention, commissioning services that will prevent worsening health for those people with existing long term conditions, and thus reduce costly interventions in specialist care. Voluntary Action Rotherham (VAR) have been commissioned to employ a social prescribing team which maps voluntary and community services across the borough. The team will attend case management MDTs and link patients into services that promote community integration and re-ablement. VAR provide a one-to-one service to people on the GP Case Management Programme, motivating, signposting and supporting them to access services in the voluntary and community sector.

Rotherham CCG is also running a pilot within Mental Health. This has supported people to move away from traditional secondary care services and to become more independent and integrated within their local communities.

Voluntary Action Rotherham, on behalf of NHS Rotherham CCG, co-ordinates both social care prescribing schemes By connecting people with a range of voluntary and community sector-led interventions, such as exercise/mobility activities, community transport, befriending and peer mentoring, art and craft sessions, carer’s respite, (to name a few), the scheme aims to lead to improved social and clinical outcomes for people and their carers; more cost-effective use of NHS and social care resources and to the development of a wider, more diverse range of local community services.

Both services have been independently evaluated by the Centre for Regional Economic and Social Research (CRESR) at Sheffield Hallam University and are well regarded.

This initiative has recently been recognized nationally and is being recommended for inclusion in Sustainability and Transformational Plans (STPs).

9.2 Prevention – Cardiology Services

The South Yorkshire and Bassetlaw Urgent and Emergency Care Delivery Plan aims to radically upgrade prevention programmes with targeted interventions around smoking cessation, weight loss, alcohol consumption and CVD clinical risk management. The target is a 5% reduction in demand for cardiology services by 2021.

9.3 Long Term Conditions

Strategic Vision and Key Deliverables

The South Yorkshire and Bassetlaw Urgent and Emergency Care Delivery Plan aims to improve how individuals with long term conditions self-manage to reduce non-elective admissions. It has a target of 2.07% reduction in non-elective admissions by 2021.
Local Planning

When done well, care planning can be effective in improving the quality of life of people with long term conditions. Over the next two decades, shifts in demographics and disease management will result in a greater proportion of people than ever before, living well into their eighth and ninth decades of life. The majority of these people will also be living with at least one long term condition. Ensuring their care is well managed over the long term, including the approach to the end of their lives, will become an increasing challenge for the CCG and the local authority.

One major barrier to supporting this cohort of is the fragmented approach to care planning. Health and social care still have separate systems for preparing care plans. Although communication and connectivity has improved between health and social care professionals, they are hampered by a requirement to have separate care plans.

The Cochrane Review on integrated care planning found that it leads to improvements in physical, psychological and subjective health. Integrated care planning also affects people’s capability to self-manage their condition. The studies showed that the effects were greater when it incorporated a single health and social care plan.

In Rotherham through the BCF Plan 2017-19 we will develop integrated health and social care plans for people on the long term case management programme. Now that social care and health records can be matched using the NHS number there is an opportunity to develop single care records and care plans. Using integrated care planning we can avoid duplication and multiple monitoring regimes. This work is already starting to take place within the integrated locality pilot and will be a consideration on commencement of roll out across the borough.

10. CARE CO-ORDINATION

Strategic Vision and Key Deliverables

The South Yorkshire and Bassetlaw Urgent and Emergency Care Delivery Plan aim to deliver an enhanced model of care co-ordination in each CCG area, to reduce non-elective admissions via A&E. It has a target of a 2.6% reduction in non-elective admissions, 3% reduction in A&E attendances and 0.9% reduction in out-patient attendances.

10.1 Development of Rotherham 24/7 Care Coordination Centre (CCC)

The aim of the CCC is to act as a central point of access for health professionals and people into community and hospital based urgent care services. This will expand the scope of the CCC to include mental health, voluntary and social care sector services, improving access through a comprehensive directory of services, driving efficiency and cutting down waste.

Through managing system capacity, carrying out an initial assessment on the most appropriate level of care needed, and deploying the right teams (e.g. integrated rapid response team), the CCC has assisted in meeting targets for emergency admissions, reducing the number of avoidable admissions and ensuring full and appropriate utilisation of community services. It also relieves pressure on GPs by streamlining the referral process into urgent care services and ensuring that GPs are able to make informed choices about the most appropriate level of care for people. The CCC is crucial to The Rotherham Foundation Trust (TRFT) vision of developing a whole system integrated service approach where people receive the appropriate care at the appropriate time in the appropriate place provided by the appropriate professional.

Over the next two or three years we expect our CCC to allow our health and social care services to:

- Develop information sharing among all health and social care professionals to quickly identify individuals at risk and where a needs assessment can be made
- Develop and maintain a register of patients who are medically fit for discharge and ensure that they are placed on the correct care pathway

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In addition to being the single point of access for community nursing referrals, the CCC will also start to support 
GPs in the case management of people with long term conditions.

New technology will also be deployed which will provide access to single care records and also allow the CCC to see 
people in the various care settings throughout the health and social care community. The CCC will also help support 
the integrated locality teams in providing advice and support around pathways and to also act as a trigger when 
people from the locality (case managed by the locality team) access hospital services.
### 11. ACTION PLAN

Table 1 sets out the key actions that need to be undertaken to support A&E delivery.

**Table 1: A&E Delivery Plan**

<table>
<thead>
<tr>
<th>Priority 1 – A&amp;E Streaming/Urgent Care Centre</th>
<th>Objective</th>
<th>Tasks</th>
<th>Timescale</th>
<th>Lead(s)</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1.1 Urgent Treatment Centre – to meet national specification for UTCs.</td>
<td>Pre-bookable and same day appointments to be available in the centre.</td>
<td>Ongoing</td>
<td>Sarah Lever, Head of Contracts and Service Improvement, RCCG</td>
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<thead>
<tr>
<th>Priority 2 – Patient Flow and Hospital Discharge</th>
<th>Objective</th>
<th>Tasks</th>
<th>Timescale</th>
<th>Lead(s)</th>
<th>Comments</th>
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<tbody>
<tr>
<td></td>
<td>2.1 Reduce delayed transfers of care by 3.5% by September 2017</td>
<td>A full action plan in place and agreed through A&amp;E Delivery Board. It forms part of the BCF plan for 2017-19.</td>
<td>March 2018</td>
<td>Claire Smith, Head of Adult Commissioning, RCCG/RMBC</td>
<td>IBCF monies identified for a lead to cover DTOC action plan.</td>
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<tr>
<td></td>
<td>2.2 CHC full assessments in acute settings &lt;15% by March 2018</td>
<td>Action in DTOC plan to support hospital discharge.</td>
<td>March 2018</td>
<td>Claire Smith, Head of Adult Commissioning, RCCG/RMBC</td>
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<td></td>
<td>2.3 95% A&amp;E 4 hour standard – 95% by March 2018</td>
<td>The Trust has a detailed Action Plan for recovery of performance A&amp;E Extraordinary Performance Meetings focusing on the 4 hour access recovery plan to escalate issues and ensure appropriate action take place regularly.</td>
<td>March 2018</td>
<td>Sarah Lever, Head of Contracts &amp; Service Improvement, RCCG</td>
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<td></td>
<td>2.4 Provision of ambulatory emergency care at least 14 hours a day, 7 days a week</td>
<td>2.4.1 Ambulatory care pathways developed and being developed. 2.4.2 Priority action through the Trust Transformation Board.</td>
<td>October 2017</td>
<td>Sarah Lever, Head of Contracts &amp; Service Improvement, RCCG</td>
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<td>Objective</td>
<td>Task</td>
<td>Timescale</td>
<td>Lead(s)</td>
<td>Comments</td>
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<td>2.4.3 Action as part of developing 7-day services.</td>
<td>October 2017</td>
<td>Sarah Lever, Head of Contracts &amp; Service Improvement, RCCG</td>
<td></td>
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<tr>
<td>2.5 Clear frailty pathway in place which includes an early comprehensive geriatric assessment</td>
<td></td>
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<tr>
<td>2.5.1 Trust is currently piloting a Frailty Team model.</td>
<td>October 2017</td>
<td>Sarah Lever, Head of Contracts &amp; Service Improvement, RCCG</td>
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<tr>
<td>2.5.2 Business Case developed to fully implement the Frailty Team model.</td>
<td>October 2017</td>
<td>Sarah Lever, Head of Contracts &amp; Service Improvement, RCCG</td>
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<tr>
<td>2.5.3 Priority action through the Trust Transformation Board.</td>
<td>October 2017</td>
<td>Sarah Lever, Head of Contracts &amp; Service Improvement, RCCG</td>
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<tr>
<td>2.6 Mental Health % of acute hospitals that meet the 'core 24' service standard for adults - 13%+ by March 2018</td>
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<tr>
<td>2.6.1 Core 24 Task and Finish Delivery Group established.</td>
<td>Ongoing</td>
<td>Kate Tufnell, Head of Mental Health Commissioning, RCCG</td>
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<tr>
<td>2.6.2 Expansion of the current ADMHL team to achieve Core 24 standards (during funding period).</td>
<td>April 2018 to March 2019</td>
<td>Kate Tufnell, Head of Mental Health Commissioning, RCCG</td>
<td></td>
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<tr>
<td>2.6.3 Delivery / sustainability of the Core 24 service post NHS England funding period.</td>
<td>Ongoing</td>
<td>Kate Tufnell, Head of Mental Health Commissioning, RCCG</td>
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</table>

**Priority 3 – NHS 111**

<table>
<thead>
<tr>
<th>Objective</th>
<th>Task</th>
<th>Timescale</th>
<th>Lead(s)</th>
<th>Comments</th>
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<tbody>
<tr>
<td>3.1 By 2019, NHS 111 will be able to book people into urgent face to face appointments where this is needed.</td>
<td></td>
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<tr>
<td>3.1.1 Work is taking place within Rotherham to enable 111 to book directly into practices for telephone triage.</td>
<td>Ongoing – 2019</td>
<td>Jacqui Tuffnell, Head of Co-commissioning, RCCG</td>
<td></td>
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<tr>
<td>3.1.2 OOhs bookings - action plans being developed in partnership with OOhs provider and NHS 111.</td>
<td>Ongoing – 2019</td>
<td>Julia Massey, Contracts Manager, RCCG</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.1.3 OOhs bookings - initial bookings will be for a limited number of specific DX codes with an outcome of GP appointment within 1-2 hours.</td>
<td>December 2017?</td>
<td>Julia Massey, Contracts Manager, RCCG</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.1.4 OOhs bookings - meeting to be scheduled August/September to progress.</td>
<td>September 2017</td>
<td>Julia Massey, Contracts Manager, RCCG</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Priority 4 – Ambulance Service</td>
<td>Objective</td>
<td>Task</td>
<td>Timescale</td>
<td>Lead(s)</td>
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<tr>
<td>4.1 Continue to work ARP recommendations – October 2017</td>
<td>YAS participated in the pilot programme for ARP and are currently operating version 2.2. Target to be delivered on a Yorkshire and Humberside footprint.</td>
<td>October 2017</td>
<td>Julia Massey, Contracts Manager, RCGG</td>
<td>Greater Huddersfield CCG is the lead commissioner for ambulance services in Y&amp;H.</td>
</tr>
<tr>
<td>4.2 Hear and Treat as % of total ambulance activity – March 2018</td>
<td>Plans in place to deliver increase the number of clinician with YAS ROC and deliver this on a Yorkshire and Humberside footprint.</td>
<td>March 2018</td>
<td>Julia Massey, Contracts Manager, RCGG</td>
<td>Greater Huddersfield CCG is the lead commissioner for ambulance services in Y&amp;H.</td>
</tr>
<tr>
<td>4.3 See and Treat as % of total ambulance activity – March 2018</td>
<td>Plans in place to deliver on a Yorkshire and Humberside footprint.</td>
<td>March 2018</td>
<td>Julia Massey, Contracts Manager, RCGG</td>
<td>Greater Huddersfield CCG is the lead commissioner for ambulance services in Y&amp;H.</td>
</tr>
</tbody>
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<thead>
<tr>
<th>Priority 5 - Primary Care</th>
<th>Objective</th>
<th>Task</th>
<th>Timescale</th>
<th>Lead(s)</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>5.1 GP Access – 100% population coverage evening and weekend appointments by March 2019</td>
<td></td>
<td>December 2017</td>
<td>Jacqui Tuffnell, Head of Co-Commissioning, RCGG</td>
<td>Plans in place to deliver by December 2017.</td>
<td></td>
</tr>
<tr>
<td>5.2 GP Practices to meet seven national core requirements – March 2018</td>
<td>5.2.1 Advertising and ease of access - relaunch Autumn, part of quality contract requirement.</td>
<td>November 2017</td>
<td>Jacqui Tuffnell, Head of Co-Commissioning, RCGG</td>
<td></td>
<td></td>
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<tr>
<td>5.2.2 Digital – using telehealth, upgraded telephone systems, commencing work on e-consultation</td>
<td>March 2018</td>
<td>Jacqui Tuffnell, Head of Co-Commissioning, RCGG</td>
<td></td>
<td></td>
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<tr>
<td>5.2.3 Effective access to the wider whole system - Hub arrangements set up like 'normal' routine and not requiring the sending practice to action diagnostics</td>
<td>September 2017</td>
<td>Jacqui Tuffnell, Head of Co-Commissioning, RCGG</td>
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</table>
### Appendix 1 A&E Delivery Plan – Rotherham High Impact Change Action Plan June 2017

<table>
<thead>
<tr>
<th>Key Milestone</th>
<th>Actions</th>
<th>Start Date</th>
<th>End Date</th>
<th>Lead Organisation</th>
<th>Progress/ Comments</th>
<th>Rag Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Full integration of discharge planning</td>
<td>Map out current teams/function of Transfer of Care Team, Hospital Social Work and MDTs</td>
<td>July 2017</td>
<td>August 2017</td>
<td>RFT/RMBC</td>
<td>Exercise undertaken through 2x workshops with staff to understand current position including FTEs across each service and main function.</td>
<td></td>
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<tr>
<td></td>
<td>Discussion with Doncaster re; their model including possible secondment of Doncaster colleague (6 month).</td>
<td></td>
<td>August 2017</td>
<td>RFT/CCG/RMBC</td>
<td>Doncaster visit by all partners in late July to understand model and bring back learning. Secondment not available – however Rotherham staff experience of model is being utilised</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Agree shared model for integration of discharge function</td>
<td>September 2017</td>
<td>All</td>
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<tr>
<td></td>
<td>Integration of Hospital Social Work into new model for discharge. Formalise links with Mental Health and Community Teams</td>
<td>December 2017</td>
<td>RFT/CCG/RMBC</td>
<td>Standard operating procedures in development. Identification of appropriate office space underway.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Agree Joint Reporting and Data Set</td>
<td>Agree revised joint reporting structure and governance for reporting (acute, social care and non acute).</td>
<td>July 2017</td>
<td>September 2017</td>
<td>CGG/TRFT/RMBC</td>
<td>Change 2 Leads for performance (CCG/RMBC/TRFT) met and agreed process for sharing data set.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Agree process for signing off delays (acute, social care and non acute)</td>
<td>July 2017</td>
<td>September 2017</td>
<td>CGG/TRFT/RMBC</td>
<td>Standard Operating Procedures are being developed to support appropriate and consistent</td>
<td></td>
</tr>
<tr>
<td>Key Milestone</td>
<td>Actions</td>
<td>Start Date</td>
<td>End Date</td>
<td>Lead Organisation</td>
<td>Progress/Comments</td>
<td></td>
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</tr>
<tr>
<td>Awareness training to include full understanding of Care act 2014</td>
<td>Awareness training required to ensure principles of Care Act implemented – Prevent, Reduce, Delay (Home First) All appropriate Health colleagues complete the E-Learning training commissioned by RMBC</td>
<td>August 2017</td>
<td>March 2018</td>
<td>TRFT Support from Nigel Mitchell RMBC</td>
<td>Change 3 E-Learning packages available through RMBC – TRFT lead to be identified to ensure work is progressed</td>
<td></td>
</tr>
<tr>
<td>Ensure a Universal Home First Approach is offered</td>
<td>Expanded Integrated Rapid Response – incorporate enabling/reablement into the provision to provide a universal offer of discharge home as pilot provision NB requires investment possible IBCF</td>
<td>July 2017</td>
<td>October 2017</td>
<td>CCG/RMBC Jacqui Clark</td>
<td>Change 4 Business Case for additional resource has been agreed and will be funded through IBCF. RMBC are currently in negotiation with provider for a proposed start date in October 2017</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Map current DST activity in acute setting. Revise and implement new pathway to D2A provision at Waterside Grange Longer term solutions – • Review of Discharge to Assess beds [potential to shift financial resource to home model] • Review of enabling service provided by RMBC</td>
<td>July 2017</td>
<td>October 2017</td>
<td>CCG RMBC Support from partners</td>
<td>Pathway process has been developed for 3 of the 6 beds at Waterside Grange. New process to be phased in throughout September</td>
<td></td>
</tr>
<tr>
<td>Agree escalation process and response</td>
<td>All partners on EMS</td>
<td>July 2017</td>
<td>August 2017</td>
<td>All partner leads</td>
<td>All changes All partners have triggers and actions agreed</td>
<td></td>
</tr>
<tr>
<td>TRFT revise triggers for acute and community</td>
<td></td>
<td>September 2017</td>
<td>TRFT</td>
<td></td>
<td>Report taken to TRFT transformation board to revise triggers – work is ongoing</td>
<td></td>
</tr>
<tr>
<td>Key Milestone</td>
<td>Actions</td>
<td>Start Date</td>
<td>End Date</td>
<td>Lead Organisation</td>
<td>Progress/Comments</td>
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</tr>
<tr>
<td>Social Care offer in new Emergency Centre</td>
<td>Consider how social care will support the new EC model of front end streaming (admission avoidance)</td>
<td>July 2017</td>
<td>March 2018</td>
<td>RMBC</td>
<td>Change 4: RDASH integration progressing well. Social Care involved in the frailty team. Further work to embed model and understand role of social care as team becomes integrated.</td>
<td></td>
</tr>
<tr>
<td>Review 7 Day Offer</td>
<td>Review 7 Day services offer across acute/community – opportunities to expand or reconfigure provision to better meet need. Provision of robust 7 day week offer from social care providers (Dom Care/Residential Care)</td>
<td>July 2017</td>
<td>September 2017</td>
<td>RMBC</td>
<td>Change 5: Helen Brown change lead working on therapy pathway and options for flexibility in provision (expansion of OT offer to meet need of service). Potential to take longer to implement service redesign.</td>
<td></td>
</tr>
<tr>
<td>Develop trusted assessor model with social care providers</td>
<td>Pilot and look to roll out trusted assessor model in social care – Residential Care</td>
<td>September 2017</td>
<td>March 2018</td>
<td>Jacqui Clark RMBC / CCG</td>
<td>Change 6: Work underway to integrate discharge team. Workshop took place July 2017 with partners and patients reviewing for IRR/CCC.</td>
<td></td>
</tr>
<tr>
<td>Patient and Family Choice (19% of DTOCs in 2015-16)</td>
<td>Improve early identification of patient likely to need care home admission. Re-design of discharge leaflet.</td>
<td>September 2017</td>
<td>March 2018</td>
<td>TRFT</td>
<td>Change 7: Reviewing this for IRR/CCC.</td>
<td></td>
</tr>
<tr>
<td>Review MoU Agreement</td>
<td>Review of MoU Agreement already in place, to reflect changes in the discharge teams (as above). All partners to implement MoU which includes Trusted Assessor</td>
<td>December 2017</td>
<td>January 2018</td>
<td>CCG/RMBC support from Partners</td>
<td>Change 1 &amp; 3</td>
<td></td>
</tr>
<tr>
<td>Key Milestone</td>
<td>Actions</td>
<td>Start Date</td>
<td>End Date</td>
<td>Lead Organisation</td>
<td>Progress/Comments</td>
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<tr>
<td>Review and streamline discharge pathways</td>
<td>Map current position across the discharge pathways (currently 3 in place – discharge home, discharge to intermediate care beds, and discharge to nursing/assessment beds).</td>
<td>July 2017</td>
<td>October 2017</td>
<td>CCG/RMBC</td>
<td>Change 1 &amp; 3</td>
<td></td>
</tr>
<tr>
<td>NB links to wider place plan priority re; reablement review</td>
<td>Streamline processes and ensure all relevant partners are aware of the pathways.</td>
<td>March 2018</td>
<td></td>
<td>Support from partners</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Rag Rating:
- **Blue**: completed
- **Amber**: Risk to Delivery to timeframe
- **Green**: On Track
- **Red**: Off Track
Appendix 2 A&E Delivery Plan – Discharge to Assess Pilot

DRAFT

Rotherham CCG
Discharge to Assess Pilot
Waterside Grange
1. Introduction

Rotherham Clinical Commissioning Group (RCCG) commission 14 Discharge to Assess beds (D2A) across 2 placements:

- Waterside Grange Nursing Home
- Oakwood Community Unit

It is believed that patient flow within these beds may not be optimised and therefore this process will be a pilot of an alternative way of working to improve patient flow.

The new pathway will see Waterside Grange Nursing Home D2A team with support from the Rotherham Foundation Trust (RFT) Transfer of Care (TOC) Team identify 3 beds within the existing provision of 6 D2A beds. These beds will be called CHC D2A Bed 1, 2 and 3 and will be utilised to reduce length of stay in hospital by transferring patients who are medically fit for discharge but require an NHS Continuing Health Care (CHC) Assessment. The difference between the CHC 3 beds and the remaining 3 beds is that the RCCG CHC team will be involved in the agreement of placements that are highly likely to require nursing input (at some level).

2. Eligibility Criteria

Patients will fulfil all the following criteria before they can be admitted to CHC D2A bed. They will;

- Be medically stable and safe to transfer with no further need for acute care
- Confirmation from NHS RCCG CHC Service that the patient has a screened in NHS Continuing Health Care Checklist
- Have a Rotherham GP
- Will have where necessary undergone a Mental Capacity Assessment and, a Best Interests Meeting will be documented in the patient’s records.
- Have full understanding of the short term nature of the placement
- Be a clear record of agreement on the understanding of the short term nature of the placement with the patient and/or representative

3. Process for Placement

RFT TOC team will identify patients who are medically fit for discharge but who cannot be discharged home due to the need for an NHS CHC Assessment. Ward Staff will complete a NHS CHC Checklist and consent form, and indicate clearly on the front page of the checklist that it is a CHC D2A Checklist, and send to the CHC service either by fax to 01302 568279 or email to RCCG.continuingcareroth@nhs.net. The CHC team will complete a CHC Checklist Outcome form and return to the TOC Team within a maximum of 48 working hours but with a commitment to try to respond on the same working day.
Where the outcome form confirms that the patient is eligible for an NHS CHC Decision Support Tool (DST) to be completed and the patient is approved for a CHC D2A bed at Waterside Grange, the TOC team will contact the RFT Care Coordination Centre (CCC) and confirm pathway outcome and the CCC will complete the Transfer of Care Documentation in liaison with the ward staff. The CCC will be aware of bed capacity and will work with Waterside Grange Nursing Home to ensure that a bed is available and that the provider can meet the needs of the patient.

The transfer of the patient to Waterside Grange Nursing Home will take place within 24 hours; the CCC will arrange transport and co-ordinate the discharge. Ward staff will collate and provide appropriate information to contribute to completion of the DST which should be made available on the day of the assessment and will also ensure that all appropriate equipment, including a minimum of 28 days medication, 1 week of dressings if appropriate, and continence aids are available ready for discharge. The discharging ward will provide a verbal hand over to Waterside Grange Nursing Home prior to the patient’s discharge. The patient will be discharged with the relevant discharge documentation as per Trust Policy.

The TOC team will inform the CCC that the patient has triggered the need for a DST and the CCC will contact the CHC team, Rotherham Metropolitan Borough Council (RMBC), patient and where appropriate their representative to book an appointment for the assessment, the assessment date should be within 10 working days of the patients transfer to the CHC D2A bed. The ward staff will advise the patient and family that there is no longer a need to remain in an acute bed and that the patient will need to transfer to an alternative level of care. Families will be advised by ward staff not to terminate tenancies or take any steps to dispose of property assets at this time. Families will also be advised that placements to the CHC D2A beds are for assessment purposes only. Ward staff will explain that placements last for a maximum of 4 weeks with an expectation that the patient is discharged shortly after completion of the NHS CHC assessment.

The date of assessment will be confirmed in writing to the family and D2A provider using a standard letter provided (Appendix 2).

See diagram on page 5 for flow chart of CHC D2A process

4. Assessment Process

The CHC Nurse Assessor, Social Care Assessor and a Waterside Grange carer/nurse who knows the patient will meet with patient and/or representative at Waterside Grange to complete the Decision Support Tool (DST). The assessment will be completed within 10 working days of the patients discharge from hospital.

The relevant professionals will have gathered available evidence to inform the assessment. The CHC Nurse Assessor will submit the completed DST and supporting evidence to the CHC service. The CHC Service will provide an outcome to the TOC service within 2 working days of the decision being made.

Where the DST MDT agree the recommendation of a DST completed on this pathway the recommendation will be ratified without prejudice to any other ratification process. However where the DST MDT are in dispute on the eligibility recommendation, the DST and the
recommendation will be considered in line with the Quality Assurance Control process of the CHC team (see section 6).

The CHC nurse will verbally inform the patient and/or representative of the eligibility outcome. The CHC Service will send a letter to the patient and where appropriate the representative to confirm the outcome within 48 hours.

5. Discharge Process

Where the outcome of the eligibility is:

**NHS Continuing Healthcare:** The CHC Nurse assessor will lead on the discharge arrangements in accordance with RCCG’s CHC Commissioning Policy and within 2 working days.

**NHS Funded Nursing Care:** The TOC Team or Social Care will lead on the discharge within 2 working days. The CCC will confirm the placement and the date of discharge with the CHC Team.

**Joint Health and Social Care:** The nurse assessor and social care assessor will jointly lead on the discharge within 2 working days in accordance with RCCG’s CHC Commissioning Policy, this will be an interim funding agreement that is without prejudice to prevent a delay in the discharge and once the appropriate split of funding is agreed between CHC and RMBC, in accordance with RCCG’s CHC Standard Operating Policy, this will be back dated to the date of discharge.

**Social Care only:** The Social Care Team Manager will record the funding commitment in line with RMBC policies and procedures. Social Care assessor will assess the patient for the need for a package of care to be provided in the patient’s own home or in twenty four hour residential care.

6. Case Management

Case management responsibility for all patients in the D2A Units will lie with Rotherham FT. Both of the D2A Units are nurse-led, incorporating long-arm consultant support. In the Community Unit medical cover will be provided 24/7, 365 days/year by an RFT consultant. Medico-legal responsibility will lie with the consultant. In the Nursing Home there will be consultant cover 9am – 6pm, Monday – Friday. All patients will be temporarily registered with the Intermediate Care GP Service and medico-legal responsibility for these patients will lie with the GP practice. Out of hours medical cover will be provided by Rotherham’s GP OOH service.

*Readmission to Hospital*

The principle is to return the patient to the D2A Unit if possible. If the patient is not able to return to the D2A Unit, the CCC will give notice to the provider verbally and in writing and...
CHC team will be informed. Beds in the D2A Unit can be kept open for up to 48 hours for readmissions. If the patient is able to return to the D2A Unit consideration will be given to extending the assessment period.

**Complaints and serious Incidents**

Complaints should be submitted to the relevant D2A provider and dealt with according to their internal complaints process. A log of all complaints and serious incidents, including details of complaint/incident and level of seriousness, will be submitted to commissioners on a monthly basis.

**Safeguarding Issues**

Safeguarding issues will be dealt with under standard procedures and referred to Rotherham MBC where appropriate. The safety of the patient will be of paramount concern. Rotherham FT, Rotherham CCG and Rotherham MBC will work in partnership to ensure patient safety.

**Disputes following assessments for CHC**

Where disputes arise between Rotherham CCG and Rotherham MBC in respect of the patient’s eligibility for NHS continuing healthcare, Rotherham CCG’s CHC Dispute Resolution policy will be followed. During the period of the dispute RMBC and RCCG will agree an interim funding arrangement that will be without prejudice to prevent a delay in the discharge and once the eligibility outcome is agreed between CHC and RMBC, this will be backdated to the date of discharge.

7. **Monitoring Arrangements**

- The CCC will maintain a current and complete patient tracking record for each patient.
- An audit trail and copies of written funding agreements will be included in patient files
- The CCC will maintain a database of patients, where they are placed and when reviews are scheduled
- The CCC Team will send a monthly report as previously agreed under the D2A MOA.
- Performance of all partners to this agreement will be measured using the KPI agreed under the D2A MOA
- Performance management of the Discharge to Assess Care Pathway will be overseen by the ALOC Performance and Service Improvement Group.
Appendix 1

CHC D2A Process Flow chart

RFT identify appropriate patient for CHC D2A bed, complete NHS CHC Checklist/Consent form and send to CHC service, clearly identifying the request is for access to a CHC D2A bed.

The CHC team will screen the NHS CHC checklist and provide RFT TOC team of the Outcome

NHS CHC Checklist does not have the required information and is returned to the RFT TOC team

NHS CHC Checklist meets the criteria for full assessment.

NHS CHC Checklist does not meet the criteria for full assessment. Decision and rationale sent to patient and referer

RFT arrange transfer of patient to CHC D2A bed within 24 hours.

RFT arrange date of assessment and invite RMBC social worker, CHC nurse assessor and patient, and where appropriate their representative.

CHC nurse completes DGT, ensuring that everyone’s information is represented and identifies a level of need in each domain.

MDT in dispute on the recommendation and submits to CHC for approval, case follows the dispute procedure and an appropriate offer of interim funding is agreed between CHC and RMBC Social Care.

MDT agrees recommendation and submits to CHC for approval, recommendation approved:

CHC - CHC service lead on case
JPOC – CHC and RMBC Social Care lead on case
SCO – TOC or RMBC Social Care lead on case.
## 4 Hour Access Recovery Plan: Immediate Actions – August 2017; Version 2

<table>
<thead>
<tr>
<th>BRAG</th>
<th>Key Issue</th>
<th>Owner</th>
<th>Recommendation (including ECIP)</th>
<th>Timescale</th>
<th>Specific Actions</th>
</tr>
</thead>
</table>
| Blue      | 1.0 Streaming Processes           | Kerry Barnard Motion, UECC | Recommendations from the external review was to review Manchester Streaming and to ensure that value added steps in the process (eg Blood tests) are taken following initial Streaming by an Emergency Department Assistant; this recommendation was implemented | 30/09/17    | Review streaming guidance to ensure it is line with best practice.
Agree a mentor to support the nursing staff.
Implement training plan.
Manchester triage to be used for majors patients. |
| Red       |                                    |                        |                                                                                                 |             | Review proposed tool by medical team.
Develop training to improve streaming process. |
| Amber     |                                    |                        |                                                                                                 |             | Streaming to PC currently at 32% of total attendance.
Streaming to minors TBC.
Streaming to majors TBC. |
| Green     |                                    |                        |                                                                                                 |             | Business case predicated on 40% of total attendances streamed to primary care.
Streaming tools reviewed by clinical teams.
Mentor identified and supernumerary. |

- **Blue**: completed
- **Red**: Not started
- **Amber**: Started with difficulties
- **Green**: Started and on track

**1.0 Streaming Processes**

1.1 Inappropriate streaming of patients
<table>
<thead>
<tr>
<th>Key Issue</th>
<th>Owner</th>
<th>Recommendation (including ECIP)</th>
<th>Timescale</th>
<th>Specific Actions</th>
<th>Baseline metrics</th>
<th>Progress metrics</th>
<th>Comments</th>
<th>ERAG</th>
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</thead>
</table>
| 1.2 Waiting time for assessment excessive                                | Kerry Barnard Maton, UECC                 | Implement basic streaming for primary care and minor injury streams  
Revisit SEPIA to reflect UECC escalation protocols                                                                                                                                                                                                                                                                                                           | 30/09/17   | Time to triage average  
TBC following implementation                                                                                                                                                                                                                                                                                              |                 |                  | As above  
Met with Chris Birks - trigger tools in dashboard to reflect the escalation process                    |      |
<p>|                                                                          | Kerry Barnard Maton, UECC                 | Ensure that an Emergency Department Assistant (EDA) is allocated to support the value added steps in Streaming                                                                                                                                                                                                                                                                                                         | 6/07/17    | EDA is allocated to support the Streaming process, this is evidenced within the E-Rostering System                                                                                                                                                                                                 | N/A             | N/A              | Completed                                                                                       |      |
|                                                                          |                                            | Identify additional examination rooms to support the Streaming process                                                                                                                                                                                                                                                                                                                                          | 6/07/17    | Due to the nature of the environmental constraints whilst the ED is in a temporary location, additional clinical space in the dental suite has been identified to support the minors work-stream. This frees up clinical space for Streaming for the EDA - this will not be a concern when the department moves into the UECC as there is identified clinical space for both Streaming and EDA Support | 3 rooms     | 9 rooms          | Completed                                                                                       |      |
|                                                                          |                                            | Ensure that the review of the Manchester Streaming template within the Meditech system is reviewed based on the ECIP recommendations                                                                                                                                                                                                              | 06/07/17   | Meditech template has been reviewed by the IT working Group                                                                                                                                                                                                                                                                             | N/A             | N/A              | Completed                                                                                       |      |</p>
<table>
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<tr>
<th>Key Issue</th>
<th>Owner</th>
<th>Recommendation (including ECIP)</th>
<th>Timescale</th>
<th>Specific Actions</th>
<th>Baseline metrics</th>
<th>Progress metrics</th>
<th>Comments</th>
<th>BRAG</th>
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<tbody>
<tr>
<td></td>
<td></td>
<td>Adopt a train the trainer approach to Manchester Streaming by having key trainers in Manchester Streaming</td>
<td>06/07/17</td>
<td>Key Trainers have completed the train the trainer programme in relation to Manchester Streaming and are rolling our training / refresher training to all UECC staff allocated to Streaming</td>
<td>0 trainers</td>
<td>4 trainers</td>
<td>Completed</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>Ensure all relevant staff complete Manchester Streaming Training</td>
<td>September 2017</td>
<td>The Key Trainers have attended training and are working with colleagues who are identified to work within Streaming to offer training and refresher training</td>
<td>10 trained</td>
<td>35 trained (on-going)</td>
<td>On-going</td>
<td></td>
</tr>
<tr>
<td>1.3</td>
<td>Ensure that the correct workforce is allocated to streaming</td>
<td>UECC Rotas have been reviewed and E-Rostering reflects the workforce required in each area of the UECC, which includes Streaming. There is an escalation process in place to ensure that the required workforce is allocated to Streaming to support the required Streaming Assessment performance, quality and safety requirements</td>
<td>31/10/17</td>
<td>Complete the capacity and demand profile work in relation to all work-streams; triage, resuscitation area, RAT, paediatrics, majors, minors, primary care Review existing UECC workforce against the capacity and demand model Review workforce requirements against financial assumptions Recruit to workforce model agreed by Divisional and Executive</td>
<td>17 nurses</td>
<td>22 nurse</td>
<td>Capacity and demand review completed 7 additional staff required - 5 approved for budget 5 additional staff recruited (3 external from Sheffield 2 internal)</td>
<td></td>
</tr>
<tr>
<td>1.4</td>
<td>SEPIA to better display UECC activity and escalation</td>
<td>Chris Birks, Interfacing and Systems Developer</td>
<td>Ensure that average Streaming times are displayed on the ED Sepia screen to act as a status at a glance for use by the Nurse in Charge and Consultant in Charge</td>
<td>11/08/17</td>
<td>Revise SEPIA to reflect UECC escalation protocols</td>
<td>N/A</td>
<td>N/A</td>
<td>Met with Chris Birks Trigger tools in dashboard to reflect the escalation process</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Chris Birks, Interfacing and Systems Developer</td>
<td>Review status at a glance options for use by the Nurse in Charge and Consultant in Charge</td>
<td></td>
<td>Matron Barnard and Mark Hill (Head of Nursing) have met with Chris Birks on the 29th June 2017 to devise a prototype of the requirements of a status at a glance</td>
<td>N/A</td>
<td>N/A</td>
<td></td>
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<tr>
<td>Key Issue</td>
<td>Owner</td>
<td>Recommendation (including ECTP)</td>
<td>Timescale</td>
<td>Specific Actions</td>
<td>Baseline metrics</td>
<td>Progress metrics</td>
<td>Comments</td>
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<tr>
<td>superevision and mentorship required for their role</td>
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<td>3.0 Workforce</td>
<td>3.1 Workforce – Medical, Review UECC medical workforce requirements (based on actual activity)</td>
<td>Losing PC and OOH workforce due to IR35 need to retain full workforce</td>
<td></td>
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<tr>
<td>Dr Jez Reynard, Clinical Lead Michelle Teague, Head of UECC</td>
<td>Recruitment of Medical staff</td>
<td>Consultant interviews to take place w/c 3 July 2017</td>
<td>31 July 2017</td>
<td>Consultant interviews to take place w/c 3 July 2017</td>
<td>N/A</td>
<td>N/A</td>
<td>2 substantive consultants recruited (starting Nov)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Consultant recruitment</td>
<td>Review capacity and demand of the medical team</td>
<td>2 August 2017</td>
<td>Review capacity and demand of the medical team</td>
<td></td>
<td></td>
<td>1 long-term locum consultant recruited (start date to be confirmed)</td>
<td></td>
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<tr>
<td></td>
<td>- Middle grades – development of CESR programme and business case to BIC</td>
<td>Remove ED clinics to free up consultants to populate weekend rota</td>
<td>(BIC)</td>
<td>Remove ED clinics to free up consultants to populate weekend rota</td>
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<td></td>
<td></td>
<td>Reduce Agency costs by recruitment of MGs</td>
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<td>Reduce Agency costs by recruitment of MGs</td>
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<tr>
<td></td>
<td></td>
<td>Recruitment event</td>
<td></td>
<td>Recruitment event</td>
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<tr>
<td>Dr Jez Reynard, Clinical Lead Michelle Teague, Head of UECC</td>
<td>Review of rotas and rota support</td>
<td>Relocate ROTA team</td>
<td>31/10/17</td>
<td>Relocate ROTA team</td>
<td>2 weeks forward view</td>
<td></td>
<td>Team aware of move plans and office identified</td>
<td></td>
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<td></td>
<td></td>
<td>Work with the ROTA team to ensure rotas are completed 3 months in advance</td>
<td></td>
<td>Work with the ROTA team to ensure rotas are completed 3 months in advance</td>
<td>TBC % Vacancy rate</td>
<td></td>
<td>Met with rota team</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>MG agency to sign up for 3 month placements</td>
<td></td>
<td>MG agency to sign up for 3 month placements</td>
<td></td>
<td></td>
<td>CVs reviewed for 3 monthly placements</td>
<td></td>
</tr>
<tr>
<td>Derek Thomson, Head of Medical Workforce supported by Cheryl Clements, Executive HR Director Michelle</td>
<td>Delivery of PC and OOH workforce</td>
<td>Collate info from workforce via questionnaire</td>
<td>15/09/17</td>
<td>Collate info from workforce via questionnaire</td>
<td>36 current but from October unknown approx. 10</td>
<td></td>
<td>Completed questionnaire</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Meeting to be set up with individual clinicians</td>
<td></td>
<td>Meeting to be set up with individual clinicians</td>
<td></td>
<td></td>
<td>Meetings taken place with DT/CC/MT</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Meet with Rotherham Federation</td>
<td></td>
<td>Meet with Rotherham Federation</td>
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<tr>
<td></td>
<td></td>
<td>Recruitment event to be held</td>
<td></td>
<td>Recruitment event to be held</td>
<td></td>
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<tr>
<td>Key Issue</td>
<td>Owner</td>
<td>Recommendation (including ECIP)</td>
<td>Timescale</td>
<td>Specific Actions</td>
<td>Baseline metrics</td>
<td>Progress metrics</td>
<td>Comments</td>
<td>BRAG</td>
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</tr>
<tr>
<td>Teague Head of UECC</td>
<td>Mark Hill Head of Nursing</td>
<td>Recruit to the substantive role of Matron for UECC</td>
<td>17th July 2017</td>
<td>Current Acting Matron for the Emergency Department in place. The substantive recruitment is ongoing and will be completed by the 16th July 2017</td>
<td>1 WTE on secondment</td>
<td>1 WTE substantive</td>
<td>Completed</td>
<td></td>
</tr>
<tr>
<td>Mark Hill Head of Nursing</td>
<td></td>
<td>Externally advertise for the role of Senior Sister / Senior Charge Nurse for the UECC</td>
<td>30/09/17</td>
<td>External recruitment via NHS Jobs completed</td>
<td>1</td>
<td>5.47WTE</td>
<td>Bend 7 senior nurse budget is 5.47WTE. Currently 6.94WTE in post (0.8 WTE maternity cover)</td>
<td></td>
</tr>
<tr>
<td>Mark Hill Head of Nursing</td>
<td></td>
<td>Recruit to the roles of Senior Sister / Senior Charge Nurse for the UECC</td>
<td>Completed 17th July 2017</td>
<td>Action Completed</td>
<td>Recruit to vacant hours not fulfilled by the recruitment process to date</td>
<td>1</td>
<td>5.47WTE</td>
<td>As above</td>
</tr>
<tr>
<td>Kerry Barnard Matron</td>
<td></td>
<td>Continue to actively recruit to Registered Nurses and Support staff roles within the UECC</td>
<td>Ongoing</td>
<td>U ECC recruitment event held. Rolling advert (Monthly) for Band 5 Registered Nurses maintained via NHS Jobs and interviews commenced for shortlisted candidates</td>
<td>N/A</td>
<td>N/A</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Kerry Barnard Matron Suzanne Owens Lead Educator and Practitioner</td>
<td></td>
<td>Review the induction and ongoing education, training and competency for Registered Nurses</td>
<td>30th August 2017</td>
<td>Draft Induction and Competency Documents completed and consultation process underway</td>
<td>N/A</td>
<td>N/A</td>
<td>Completed</td>
<td></td>
</tr>
<tr>
<td>Sally Kilgariff General Manager, Integrated Medicine</td>
<td></td>
<td>Leadership team support</td>
<td>To commence 29 June 2017</td>
<td>Twice daily senior huddles with senior manager/exec support</td>
<td>N/A</td>
<td>N/A</td>
<td>Twice daily huddles commenced as planned on 29 June 2017</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>6 July 2017</td>
<td>Head of UECC in place supporting operational management</td>
<td></td>
<td></td>
<td>Care UK staff to TUPE from October, GM of Care UK now undertaking Head of UECC role.</td>
<td></td>
</tr>
<tr>
<td>ECIP Recommendations</td>
<td>Maxine Dennis Director of</td>
<td>Ongoing support to be requested from ECIP following</td>
<td>Throughout August/Sept ember 2017</td>
<td>Identify and request support from ECIP for the clinical team</td>
<td>N/A</td>
<td>N/A</td>
<td>ECIP ED consultant visiting to work clinically with the team on 23</td>
<td></td>
</tr>
<tr>
<td>Key Issue</td>
<td>Owner</td>
<td>Recommendation (including ECIP)</td>
<td>Timescale</td>
<td>Specific Actions</td>
<td>Baseline metrics</td>
<td>Progress metrics</td>
<td>Comments</td>
<td>BRAG</td>
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<td>------</td>
</tr>
<tr>
<td>Operations</td>
<td>recent visit from clinical leads</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>August 2017</td>
<td></td>
</tr>
<tr>
<td><strong>Rules of Urgent Care</strong></td>
<td><strong>Improvement outcome will be evidenced by a reduction in specialty specific breaches</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dr Reynard Clinical Lead for ED</td>
<td>Revise the ED Rules of Urgent Care specific to ED</td>
<td>6 July 2017</td>
<td>Current guidelines need to be reviewed and be more specific, Development of role specific professional standards</td>
<td></td>
<td></td>
<td>Update in progress, not yet completed</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Directors of Clinical Services and General Managers</td>
<td>All Divisions to have their own Rules of Urgent Care to respond to ED pressures, including specific responsibilities for key roles</td>
<td>30 June 2017</td>
<td>Key roles to be identified by each Division, Rules of Urgent Care Drafted, Final versions to be agreed with ED clinicians</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Conrad Wareham Medical Director</td>
<td>No specialty to divert to ED without discussion with the ED consultant in charge</td>
<td>With immediate effect</td>
<td>All specialties have agreed</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chris Holt Director of Transformatio n &amp; Strategy</td>
<td>Trust-wide Summit</td>
<td>End September 2017</td>
<td>Summit to support development of clinical pathways, including clinical leads and management teams from each Division</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**4.0 Escalation**

<table>
<thead>
<tr>
<th>Escalation</th>
<th>Owner</th>
<th>Recommendation (including ECIP)</th>
<th>Timescale</th>
<th>Specific Actions</th>
<th>Baseline metrics</th>
<th>Progress metrics</th>
<th>Comments</th>
<th>BRAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dr Kay Stenton, Clinical Lead, UECC</td>
<td>Revision of ED workload escalation triggers in line with EMS levels for the UECC</td>
<td>6/07/17</td>
<td>These need to be monitored throughout July 2017 as the UECC becomes fully functional</td>
<td></td>
<td></td>
<td>Completed, operational reviews will take place to monitor</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dr Jez Reynard, Clinical Lead for ED</td>
<td>Implement clinical navigation to move patients across streams in line with departments internal escalation protocols</td>
<td>N/A</td>
<td>01/10/17</td>
<td></td>
<td></td>
<td>Not yet commenced</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Key Issue</td>
<td>Owner</td>
<td>Recommendation (including ECIP)</td>
<td>Timescale</td>
<td>Specific Actions</td>
<td>Baseline metrics</td>
<td>Progress metrics</td>
<td>Comments</td>
<td>BRAG</td>
</tr>
<tr>
<td>--------------------------------------------------------------------------</td>
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<td>-------------------------------------------------------------------------------</td>
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</tr>
<tr>
<td>Early Flow/Transfers to Ward from AMU by 10.00am</td>
<td>Mark Hill Head of Nursing</td>
<td>Develop a Standard Operating Procedure (SOP) to support ward staff in the facilitation of early flow from the base medical wards to ensure early flow from the Acute Medical Unit by 10am</td>
<td>14th July 2017</td>
<td>SOP to be developed and implemented</td>
<td></td>
<td></td>
<td>Draft SOP currently out for consultation with colleagues</td>
<td></td>
</tr>
<tr>
<td>Improvement outcome will be measured by monitoring the number of pre-noon discharges on a daily, weekly and monthly basis</td>
<td>Mark Hill Head of Nursing Gail Smith Matron, Quality Governance</td>
<td>Risk assessment to be completed in relation to the risks and mitigations identified by the completion of the SOP</td>
<td>Completed</td>
<td>Risk assessment to be undertaken</td>
<td></td>
<td></td>
<td>Individual ward risk assessments completed and amalgamated to one divisional risk – Datix 5123</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Mark Hill Head of Nursing</td>
<td>Implement and monitor the SOP to support ward staff in the facilitation of early flow from the base medical wards to ensure early flow from the Acute Medical Unit by 10am</td>
<td>14th July 2017</td>
<td>Implementation of SOP Monitor SOP in line with mitigations included in the risk assessment</td>
<td></td>
<td></td>
<td>Implementation of current draft SOP in line with the mitigating actions identified in risk 5123 which is been monitored daily by Gail Smith, Matron for Quality Governance</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Sally Kilgariff General Manager</td>
<td>Work to be undertaken to address data quality issues with monitoring pre-noon discharges</td>
<td>31 July 2017</td>
<td>Track daily recording of pre-noon discharges</td>
<td></td>
<td></td>
<td>New daily SITREP implemented w/ c 7/8/17 which includes pre-noon discharges. This will enable tracking at patient level to support</td>
<td></td>
</tr>
<tr>
<td>Key Issue</td>
<td>Owner</td>
<td>Recommendation (including ECIP)</td>
<td>Timescale</td>
<td>Specific Actions</td>
<td>Baseline metrics</td>
<td>Progress metrics</td>
<td>Comments</td>
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</tr>
<tr>
<td>Matrons, Division of Integrated Medicine</td>
<td>Monitor the daily performance, quality and safety of early flow from AMU to the medical Wards</td>
<td>Daily</td>
<td>Track daily recording of pre-noon discharges</td>
<td>Less than 20%</td>
<td>35%</td>
<td>New daily Sitrep implemented from w/c 7 August 2017, which includes pre-noon discharges.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Weekend ways of working</td>
<td>Dr Shaun Nakash, Acute Physician Lead</td>
<td>Implementation of revised ways of working</td>
<td>30 September 2017</td>
<td>Define and implement structure of acute take, including realignment of job plans</td>
<td></td>
<td></td>
<td>Draft paper outlining proposed new model for acute take. To be reviewed with workforce and plans to reconfigure beds prior to winter.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Louise Deskin AGM, Integrated Medicine</td>
<td>Business Case to be developed to support weekend working arrangements for medical on-call</td>
<td>30 September 2017</td>
<td>Revise proposal for weekend working, to ensure support for wards (both consultant and junior workforce)</td>
<td></td>
<td></td>
<td>Initial business case submitted to BIC in April, needs revising in line with current availability of consultant workforce.</td>
<td></td>
</tr>
<tr>
<td>Information Dashboard for 4-Hour Access Performance</td>
<td>Tom Ridgeway Head of Performance</td>
<td>Development of new divisional performance dashboards specific to 4-Hour Access performance</td>
<td>31 July 2017</td>
<td>Develop a 4-hour access performance dashboard that also covers; all ED clinical quality indicators, wider Divisional metrics that support 4-hour performance and trends performance</td>
<td>N/A</td>
<td>N/A</td>
<td>Completed – dashboard developed using the Power BI tool. Teams developing skills to use and interpret the data</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Chris Birks Interfacing and Systems Developer</td>
<td>Further development of Sepia to support visual management in UECC (including divisional/specialty views of current demand in ED)</td>
<td>7 July 2017</td>
<td>Revise the Sepia urgent care screen to support the visual management in ED by displaying activity by work-stream. This will support live management of capacity and demand – and staff deployment</td>
<td>N/A</td>
<td>N/A</td>
<td>First version of new screen completed. Further information streams to be added.</td>
<td></td>
</tr>
</tbody>
</table>

### 5.0 Pathways

#### 5.1 Primary Care Streaming

<table>
<thead>
<tr>
<th>Owner</th>
<th>Recommendation (including ECIP)</th>
<th>Timescale</th>
<th>Baseline metrics</th>
<th>Progress metrics</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Michelle Teague Head of UECC</td>
<td>Implementation of primary care stream once UECC functional</td>
<td>31 July 2017</td>
<td>0</td>
<td>1</td>
<td>Completed – see 1.0 streaming</td>
</tr>
<tr>
<td>Key Issue</td>
<td>Owner</td>
<td>Recommendation (including EGIP)</td>
<td>Timescale</td>
<td>Specific Actions</td>
<td>Baseline metrics</td>
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</tr>
<tr>
<td>5.2 Ambient Assessment/CDU Pathways</td>
<td>Dr Kay Stenton, Clinical Lead, UECC</td>
<td>Alternative pathways for patients who would previously be admitted to CDU</td>
<td>Proposed pathways agreed – implementation from 29 June 2017</td>
<td>Outline pathways in place – to be reviewed by 10 August 2017</td>
<td>2 trolleys allocated for ‘CDU’</td>
</tr>
<tr>
<td></td>
<td>Dr Shaun Nakash, Acute Medicine Clinical Lead &amp; Janies Barnard, ANP</td>
<td>Ambulatory pathways</td>
<td>30 September 2017</td>
<td>Define the ambulatory care pathways</td>
<td>Implement the new pathways</td>
</tr>
<tr>
<td>5.3 NHS 111 direct booking into PCC (OOH)</td>
<td>Michelle Teague, Head of UECC Andrew Mellor, GP OOH Clinical Lead</td>
<td>National requirement NHS England</td>
<td>31/10/17</td>
<td>Review PCC appointments</td>
<td>Review DX codes relevant to direct booking</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Visit Sheffield OOH</td>
<td>Review of systm1 when implemented to allow access to bookable appointment</td>
</tr>
<tr>
<td>5. Review all pathways from ED to specialty</td>
<td>Dr Kay Stenton, Clinical Lead UECC Joanne Martin, Project Manager UECC Michelle Teague, Head of UECC</td>
<td>N/A</td>
<td>1/11/17</td>
<td>Set up task and finish group</td>
<td>List pathways for review in priority order</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Develop a plan to revised pathways</td>
<td>Implement/mainstream revised pathways</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Develop a monitoring system to look at baseline referrals V revised referrals</td>
<td></td>
</tr>
<tr>
<td>6.0 Meditech</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Key Issue</td>
<td>Owner</td>
<td>Recommendation (including GID)</td>
<td>Timescale</td>
<td>Specific Actions</td>
<td>Baseline metrics</td>
</tr>
<tr>
<td>-----------</td>
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<td>------------------</td>
</tr>
<tr>
<td>6.1 Full review of Meditech post implementation</td>
<td>Chris Holt, Director of Transformation &amp; Strategy Jez Reynard, Clinical Lead ED</td>
<td>Workforce feedback suggests review required</td>
<td>30/09/17</td>
<td>Clinical and Management Lead(s) support team to be developed Arranged for Sunderland to visit Workshop UECC team to understand challenges and any support that can be offered</td>
<td></td>
</tr>
</tbody>
</table>
## Appendix 3: Examples of the Escalation Management System Triggers

### 1. The Rotherham NHS Foundation Trust

<table>
<thead>
<tr>
<th>Trigger</th>
<th>EMS Level</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>4hr ED Performance</strong></td>
<td></td>
</tr>
<tr>
<td>No current risk of patients waiting more than 4 hours in ED</td>
<td>✓</td>
</tr>
<tr>
<td>Risk of one or more patients waiting more than 4 hours in ED within the next hour</td>
<td></td>
</tr>
<tr>
<td>One or more patients waiting more than 4 hours and a decision is unlikely to be made for the next hour</td>
<td></td>
</tr>
<tr>
<td>One or more patients waiting more than 4 hours and a decision is unlikely to be made for the next 4 hours</td>
<td></td>
</tr>
<tr>
<td><strong>Transfer of Ambulance patient care</strong></td>
<td></td>
</tr>
<tr>
<td>Transfer of Ambulance patient care is shorter than 15mins</td>
<td>✓</td>
</tr>
<tr>
<td>Transfer of Ambulance patient care is between 15 &amp; 30mins</td>
<td></td>
</tr>
<tr>
<td>Transfer of Ambulance patient care is between 31 &amp; 60mins</td>
<td></td>
</tr>
<tr>
<td>Transfer of Ambulance patient care is longer than 60mins</td>
<td></td>
</tr>
<tr>
<td><strong>Expected capacity vs expected demand</strong></td>
<td></td>
</tr>
<tr>
<td>Expected admission capacity greater than or equal to expected admission demand for the next 24 hours</td>
<td>✓</td>
</tr>
<tr>
<td>There is an expected admission capacity deficit of less than 10% of expected demand for the next 24 hours</td>
<td></td>
</tr>
<tr>
<td>There is an expected capacity deficit of between 10% and 20% of expected demand for the next 24 hours</td>
<td></td>
</tr>
<tr>
<td>There is an expected capacity deficit of more than 20% of expected demand for the next 24 hours</td>
<td></td>
</tr>
<tr>
<td><strong>Elective Work</strong></td>
<td></td>
</tr>
<tr>
<td>Elective work proceeding as planned.</td>
<td>✓</td>
</tr>
<tr>
<td>Up to 10% of elective and urgent inpatient work cancelled on the day.</td>
<td></td>
</tr>
<tr>
<td>10% to 90% elective and urgent inpatient work cancelled for the next 24 hours.</td>
<td></td>
</tr>
<tr>
<td>More than 90% elective work including oncology patients cancelled for the next 24 hours.</td>
<td></td>
</tr>
<tr>
<td><strong>8 hour Trolley Waits</strong></td>
<td></td>
</tr>
<tr>
<td>Patients subject to a decision to admit not at risk of 8 hour trolley waits.</td>
<td>✓</td>
</tr>
<tr>
<td>Risk of one or more patients subject to a decision to admit at risk of waiting 8 hours on a trolley in the next 2 hours.</td>
<td></td>
</tr>
<tr>
<td>One or more patients subject to a decision to admit now waiting longer than 8 hours on a trolley.</td>
<td></td>
</tr>
<tr>
<td>One or more patients subject to a decision to admit now waiting longer than 8 hours on a trolley and at risk of waiting longer than 12 hours.</td>
<td></td>
</tr>
<tr>
<td><strong>Medical Outliers</strong></td>
<td></td>
</tr>
<tr>
<td>Medical outliers form less than 0.5% of total inpatient population.</td>
<td>✓</td>
</tr>
<tr>
<td>Medical outliers form between 0.5% and 1% of total inpatient population.</td>
<td></td>
</tr>
<tr>
<td>Medical outliers form between 1% and 3% of total inpatient population.</td>
<td></td>
</tr>
<tr>
<td>Medical outliers form more than 3% of total inpatient population.</td>
<td></td>
</tr>
<tr>
<td><strong>Cubicles in ED</strong></td>
<td></td>
</tr>
<tr>
<td>Cubicles in ED are less than 80% occupied.</td>
<td>✓</td>
</tr>
<tr>
<td>Cubicles in ED are 80% -100% occupied.</td>
<td></td>
</tr>
<tr>
<td>All Cubicles in ED are full and patients are waiting in planned overflow areas.</td>
<td></td>
</tr>
<tr>
<td>All Cubicles in ED are full and patients are expected to wait in unplanned</td>
<td></td>
</tr>
<tr>
<td>EMS Level</td>
<td>1</td>
</tr>
<tr>
<td>-----------</td>
<td>---</td>
</tr>
<tr>
<td>Trigger</td>
<td></td>
</tr>
<tr>
<td>overflow areas.</td>
<td></td>
</tr>
</tbody>
</table>

### Resuscitation Bays
- More than 1 resuscitation bay available for immediate use. ✓
- Only 1 resuscitation bay available for immediate use. ✓
- No formal resuscitation bay available in ED for the next 30 minutes. ✓
- No formal resuscitation bay available in ED for next hour. ✓

### Beds in Assessment Areas
- Beds in Assessment areas are less than 90% occupied. ✓
- Beds in Assessment areas are 90%-99% occupied. ✓
- No Assessment area beds for up to 3 hours minimum. ✓
- No Assessment area beds for more than 3 hours. ✓

### Planned Additional Bed Capacity
- Planned additional bed capacity on standby. ✓
- Planned additional bed capacity open and less than 80% occupied. ✓
- Planned additional bed capacity open and more than 80% occupied. ✓
- All planned additional bed capacity open and full; unplanned capacity in use. ✓

### Infection Control Measures
- No loss of admission bed capacity due to infection control measures. ✓
- Partial or whole ward closed to admission or discharge due to infection control measures. ✓
- More than one ward closed to admissions or discharge due to infection control measures with local restrictions on visiting. ✓
- More than one ward closed to admissions or discharge and whole Hospital closed to visitors due to infection control measures. ✓

### Critical Care Capacity
- Critical care capacity less than 80% occupied. ✓
- Critical care capacity is 80%-100% occupied. ✓
- All formal critical care capacity occupied and planned overflow areas in use. ✓
- All formal critical care capacity occupied and planned overflow areas in use. Potential transfers identified but unresolved. ✓

### Gender Specific Bed Availability
- Gender specific beds available as planned. ✓
- Patient moves required, expected within 1hr. ✓
- Patient moves required, expected within 4hrs. ✓
- Patients waiting for appropriate gender beds; non-planned or available. ✓

### Medically Fit For Discharge
- MFFD cases form less than 9% of the inpatient total. ✓
- MFFD cases form between 9% and less than 11% of the inpatient total. ✓
- MFFD cases form between 11% and 13% of the inpatient total. ✓
- MFFD cases form more than 13% of the inpatient total. ✓

Action cards for key staff/services in response to the above escalation levels have also been agreed at TRFT and are detailed in TRFT’s Operational Escalation Plan July 2016.
## 2. Yorkshire Ambulance Service

### EMS Triggers - Community Services

<table>
<thead>
<tr>
<th></th>
<th>Level 1: Planned Operational Working</th>
<th>Level 2: Moderate Pressure</th>
<th>Level 3: Severe Pressure</th>
<th>Level 4: Extreme Pressure</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Staffing</strong></td>
<td>Normal staffing levels available</td>
<td>≤70% of normal staffing levels available</td>
<td>≤60% of normal staffing levels available</td>
<td>≤50% of normal staffing levels available</td>
</tr>
<tr>
<td>Assessment &amp; Discharge Notices Allocated</td>
<td>Discharge Notices - All packages in place for patients within required timescales</td>
<td>Discharge Notices Submitted - All packages in place but discharge notice referrals &gt;10 for previous day</td>
<td>Discharge Notices Submitted - 0-10 patients with no package set up and outside timeline</td>
<td>Discharge Notices &gt;10</td>
</tr>
<tr>
<td>Patients in Hospital awaiting choice of care home</td>
<td>≤4 patients in hospital waiting for discharge to care home</td>
<td>5-10 patients waiting for discharge to care home</td>
<td>11-15 patients waiting for discharge to care home</td>
<td>&gt;15 patients waiting for discharge to care home</td>
</tr>
<tr>
<td>Enabling &amp; Domiciliary Care Capacity</td>
<td>Full enabling capacity</td>
<td>Delays in accessing enabling capacity. No issues accessing domiciliary care</td>
<td>Delays in accessing enabling capacity and localised delays (less than one day/specific areas only) in accessing domiciliary care</td>
<td>Emergency visits only. Business Continuity Plan Enacted</td>
</tr>
</tbody>
</table>

## 3. Social Care
Appendix 4: A&E Delivery Board Baseline Assessment - Acute Care

**Blue** = Scheme already in place/alternative in place

**Green** = actions in place and on track for initiative to be implemented within rapid implementation guidance timeframes

**Amber** = in plans, but risks associated with delivery

**Red** = no evidence of existing implementation or in system plans

### 1. ED Streaming

<table>
<thead>
<tr>
<th>Initiative</th>
<th>Statement of good practice</th>
<th>Rotherham</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>All major specialties have a consultant immediately available on the telephone to provide advice &amp; streaming for ED &amp; primary care</td>
<td></td>
<td>Blue</td>
<td>Protocols agreed with all specialties along with an admission protocol on where patients go on arrival (Who Admits Who guidance)</td>
</tr>
<tr>
<td>There is a primary care stream available (if activity levels justify it) with the capacity to meet the true patient demand</td>
<td></td>
<td>Blue</td>
<td>Primary care are present within the ED department</td>
</tr>
<tr>
<td>Patients presenting with mental health illness are assessed, managed, discharged or admitted within the ED standard</td>
<td></td>
<td>Blue</td>
<td>Protocol in place however challenges are faced during out of hours in regard to the provision to see patients within the 4 hour standard</td>
</tr>
<tr>
<td>There is an ambulatory emergency care service available for 12 hours per day, 7 days per week which manages at least 25% of the emergency take</td>
<td></td>
<td>Green</td>
<td>Service provision in terms of recruitment to nurse practitioner posts to support the ambulatory care pathway, Lead Practitioner appointment to develop service and 7/7 working</td>
</tr>
<tr>
<td>There is an acute frailty service available 12 hours per day, 7 days per week which treats all eligible patients</td>
<td></td>
<td>Blue</td>
<td>Specialist Frailty Unit Due to be opened in March 2017. Pathways currently in place in Acute Medical Unit and Acute Medical Wards*</td>
</tr>
<tr>
<td>Community and intermediate care services respond to requests for patient support within 2 hours</td>
<td></td>
<td>Green</td>
<td>TRFT have on site community services and there are jointly commissioned intermediate care services, protocols are in place to ensure that referrals are picked up within a specified time frame with 24/7 access*</td>
</tr>
</tbody>
</table>

### 4. Improved flow

<table>
<thead>
<tr>
<th>Initiative</th>
<th>Statement of good practice</th>
<th>Rotherham</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>SAFER patient flow bundle implemented on assessment and medical wards as a bare minimum, to improve patient flow</td>
<td></td>
<td>Green</td>
<td>SAFER bundle audits in place</td>
</tr>
<tr>
<td>What percentage of the base wards on each acute site has SAFER in place?</td>
<td></td>
<td>80-90%</td>
<td>Across all medical and surgical wards</td>
</tr>
<tr>
<td>The use of the red and green day approach has been considered</td>
<td></td>
<td>Blue</td>
<td>The approach in Rotherham currently is &gt; 14 day Length of Stay reviews in place</td>
</tr>
<tr>
<td>A baseline assessment of the effective use of EDDs and Clinical Criteria for Discharge has been carried out</td>
<td></td>
<td>Green</td>
<td>SAFER bundle audits in place and daily ward round pro-formas</td>
</tr>
<tr>
<td>Ward round checklists are in use in all wards in the acute hospital/s</td>
<td></td>
<td>Green</td>
<td>Daily ward round pro-formas in use</td>
</tr>
<tr>
<td>Systems are in place to review the reasons for any inpatient stay that exceeds six days</td>
<td></td>
<td>Blue</td>
<td>The trigger used by TRFT is 14 days, although flags are available for all patients at 7 days Length of Stay or more</td>
</tr>
<tr>
<td>A ‘home first: discharge to assess’ pathway is in operation across all appropriate hospital wards</td>
<td></td>
<td>Blue</td>
<td>There is a discharge to assess model in place with a designated bed base. Further development and work is needed to embed a ‘Home First’ approach</td>
</tr>
<tr>
<td>Trusted assessor arrangements are in place with social care and independent care sector providers</td>
<td></td>
<td>Green</td>
<td>TRFT are currently rolling this initiative out as a pilot from 12 September 2016</td>
</tr>
<tr>
<td>A standard operating procedure for supporting patients’ choice at discharge is in use, which reflects the new national guidance</td>
<td></td>
<td>Amber</td>
<td>TRFT do a small number of assessments in the acute trust due to availability of specific care beds. This is monitored locally and where ever possible ALOC are used.</td>
</tr>
<tr>
<td>There is a responsible director in the trust who will monitor the DTOC situation daily and report regularly to the board on this specific issue</td>
<td></td>
<td>Green</td>
<td>There is policy in place regarding supporting patient choice but no Standard Operating Procedure. The policy does detail the process for communication with families and patients and how to support appropriate choice with early conversations.</td>
</tr>
</tbody>
</table>

### 5. Improved discharge processes

<table>
<thead>
<tr>
<th>Initiative</th>
<th>Statement of good practice</th>
<th>Rotherham</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>At least 90% of continuing healthcare screenings and assessments are conducted outside of acute settings</td>
<td></td>
<td>Green</td>
<td>TRFT do a small number of assessments in the acute trust due to availability of specific care beds. This is monitored locally and where ever possible ALOC are used.</td>
</tr>
<tr>
<td>A standard operating procedure for supporting patients’ choice at discharge is in use, which reflects the new national guidance</td>
<td></td>
<td>Green</td>
<td>There is policy in place regarding supporting patient choice but no Standard Operating Procedure. The policy does detail the process for communication with families and patients and how to support appropriate choice with early conversations.</td>
</tr>
<tr>
<td>Related to the above, there is a named senior individual in every CCG and SSD who will be the single point of contact for the nominated trust exec.</td>
<td></td>
<td>Blue</td>
<td>This exists, however work remains around the application and interpretation of DTOC guidance</td>
</tr>
</tbody>
</table>
### Appendix 5: A&E Delivery Board Baseline Assessment – NHS 111 and Ambulance

**Blue** = Scheme already in place/alternative in place

**Green** = actions in place and on track for initiative to be implemented within rapid implementation guidance timeframes

**Amber** = in plans, but risks associated with delivery

**Red** = no evidence of existing implementation or in system plans

<table>
<thead>
<tr>
<th>Initiative</th>
<th>Rotherham</th>
<th>Rotherham Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Principles for a Clinical Advisory Service and implementation in progress with a “Go Live” for December 2016, 2) Funding for 2017/18 to be agreed.</td>
<td>Green</td>
<td></td>
</tr>
<tr>
<td>2) existing clinical advisors planned according to demand, 2) Phased implementation planned over 4 year period within the CAS, 3) recruiting to the planned establishment remains a challenge, 4) Current funding is non-recurrent.</td>
<td>Green</td>
<td></td>
</tr>
<tr>
<td>The A&amp;E Delivery Board has plans in place to meet this requirement</td>
<td>Green</td>
<td></td>
</tr>
<tr>
<td>Clinical expertise availability is planned according to demand</td>
<td>Green</td>
<td></td>
</tr>
<tr>
<td>1) existing clinical advisors planned according to demand, 2) Phased implementation planned over 4 year period within the CAS, 3) recruiting to the planned establishment remains a challenge, 4) Current funding is non-recurrent.</td>
<td>Green</td>
<td></td>
</tr>
<tr>
<td>The A&amp;E Delivery Board has a lead starting to integrate the NHS 111 service and local Out of Hospital Provision, particularly OOH</td>
<td>Amber</td>
<td></td>
</tr>
<tr>
<td>The Rotherham A&amp;E Delivery Board has no plans to integrate the GP OOH Service with NHS 111. The focus is on the integration of GP OOH with the Emergency Centre</td>
<td>Amber</td>
<td></td>
</tr>
<tr>
<td>The A&amp;E DoS service type is ranked as low as possible, apart from other A&amp;E-type services and services not commissioned within the CCG</td>
<td>Blue</td>
<td></td>
</tr>
<tr>
<td>1) YAS is capable of facilitating this via DOS (NHS 111) 2) local offer is not consistent therefore standardisation is challenging.</td>
<td>Amber</td>
<td></td>
</tr>
<tr>
<td>There are alternative services which can accept NHS Pathways outcomes for conditions that can be managed outside A&amp;E E.g. limb injuries, bites, stings, plaster cast problems, suspected DVT, falls</td>
<td>Amber</td>
<td></td>
</tr>
<tr>
<td>The A&amp;E Delivery Board knows demographics of the area, including if there is a greater demand for OOH services are generated from the elderly</td>
<td>Green</td>
<td></td>
</tr>
<tr>
<td>1) CCGs get an MDS monthly, including full patient episode.</td>
<td>Green</td>
<td></td>
</tr>
<tr>
<td>The A&amp;E Delivery Board has agreed workforce and service plans in place to deliver an increase in ‘Hear and Treat’ and ‘See and Treat’</td>
<td>Amber</td>
<td></td>
</tr>
<tr>
<td>1) Principles for a Clinical Advisory Service and implementation in progress. 2) Funding for 2017/18 to be agreed.</td>
<td>Amber</td>
<td></td>
</tr>
<tr>
<td>There is an ambulance trust executive lead on the A&amp;E Delivery Board able to deliver the required service changes</td>
<td>Blue</td>
<td></td>
</tr>
<tr>
<td>Executive lead has been identified.</td>
<td>Blue</td>
<td></td>
</tr>
<tr>
<td>There are working definitions of ‘Hear and Treat’ and ‘See and Treat’ agreed across the local health economy and a baseline workforce profile to deliver an increase in these dispositions</td>
<td>Amber</td>
<td></td>
</tr>
<tr>
<td>1) Working definition for “Hear and Treat” and See and “Treat” 2) Workforce plan in development</td>
<td>Amber</td>
<td></td>
</tr>
<tr>
<td>There are alternative services which can accept ambulance dispositions or referrals and these mapped across localities</td>
<td>Amber</td>
<td></td>
</tr>
<tr>
<td>1) local offer is not consistent therefore standardisation is challenging.</td>
<td>Amber</td>
<td></td>
</tr>
<tr>
<td>The A&amp;E Delivery Board has established local mechanisms for increasing clinical input into green ambulance dispositions particularly at times of peak demand</td>
<td>Green</td>
<td></td>
</tr>
<tr>
<td>1) The Clinical Advisory Service will service both NHS 111 and 999. 2) CAS due to “Go Live” in December 2016.</td>
<td>Green</td>
<td></td>
</tr>
<tr>
<td>The A&amp;E Delivery Board has agreed workforce and service plans in place to deliver an increase in ‘Hear and Treat’ and ‘See and Treat’</td>
<td>Amber</td>
<td></td>
</tr>
<tr>
<td>1) Principles for a Clinical Advisory Service and implementation in progress. 2) Funding for 2017/18 to be agreed.</td>
<td>Amber</td>
<td></td>
</tr>
</tbody>
</table>
Appendix 6: TRFT Vision for Community Based Healthcare by December 2017

Developing The Rotherham NHS Foundation Trust’s Vision for Community Based Healthcare by December 2017

In a typical day at Rotherham NHS Foundation Trust we:

- Make 120 home visits, helping keep people at home
- Look after 20 nursing home patients
- Take 10 calls through our Care Coordination Centre
- Have 50 patients on our DN caseload
- Admit 50 emergency patients into hospital - of which 30 are >65 yrs
- Have 300 locality patients in hospital
- Have 90 patients in hospital on a community team caseload
- Help discharge 50 patients back to their locality

Why are we Transforming?

Locally
Our hospital is getting full
Our local population is living longer, with increasingly complex health issues.
We want to continuously improve the quality of the care we provide.

Nationally

NHS England’s Five Year Forward View report outlined the need for the integration of care services (Primary, Secondary and Social) in order to sustain an affordable and effective healthcare system.

Our Trustwide objectives help to shape our vision:

- Patient: Excellence in Healthcare
- Colleague: Engaged, Accountable Colleagues
- Governance: Trusted, open governance
- Finance: Strong financial foundations
- Partners: Securing the future together

The Future of Community Based Healthcare in Rotherham (watch the full video on YouTube)

Our 15/16 Programme of work centred around 5 key areas.

1. Restructure Emergency Access and Admissions Departments to reduce waiting times
2. Introduce rigour and structure so we can better manage our bed base.
3. Streamline our Admission and Discharge Pathways to ensure the right care is provided in the right place
4. Integrate Acute and Community Care Pathways so patients can enjoy seamless care
5. Develop closer working partnerships with Social Care, Mental Health, Palliative Care and the Voluntary Sector

These have laid the foundations for the next phase of the transformation that will see us providing pre-emptive, proactive, localised care.

Some of the highlights from 15/16 include:

- Successfully embedding our District Nurses into 7 Locality Teams
- Recruitment of more Community Nursing staff and increased number of nurses available
- Increased GP satisfaction rates for the Community Nursing Services
- Reduction in the number of patients who stay in hospital for 14 days or longer
- Establishment of a Single Point of Safarri, via our Care Coordination Centre for GPs, Hospital Wards and Community Nurses
- Introduction of Multi-disciplinary hospital and intermediate care ward rounds
- Development of an animated video to share the vision of healthcare in the future for the Rotherham Health Economy

A Clinical Portal developed by Rotherham NHS FT for Rotherham

One of the most exciting developments of 2015/16 was the SERPA Clinical Portal. This allows our locality teams to see where their patients are being cared for, be it at home, in hospital or in intermediate care/ nursing homes. They can then easily see their patients care plans.
The Rotherham NHS Foundation Trust 2016/17 Transformation of Acute and Community Integrated Healthcare Programme

Making it Work

In line with NHS England’s Five-Year Forward View, Rotherham intends adopting a model of ‘place-based systems’ of care whereby the local population have their health and social care needs met by a local entity, known in our case as an Integrated Locality Team.

From a healthcare perspective our Community Nursing services already operate in 7 localities which in essence are our foundations.

A key deliverable during 16/17 is to pilot one of the localities as a truly integrated model of care provider.

The pilot will see a single team made up of Health Care professionals (including nurses, therapists and physicians), Social Care professionals, Mental Health nurses and psychiatrists, End of Life & Palliative care professionals, as well as members from the Voluntary Services Sector coming together under one-roof. The team will be responsible for their cohort of the Rotherham population (circa 35,000 out of 260,000) in terms of getting them well and keeping them well.

The overarching theme of providing care closer to home will see services in-reaching into hospitals and places of intermediate care, getting them back into their own communities and ultimately back home. It is also about keeping people well by doing more pre-emptive and proactive work in terms of self-care and education.

The 2016/17 programme will focus on 5 priority areas in order to address the Trust’s short term needs of achieving and maintaining its key performance targets but also contribute to its medium and ultimate longer term vision of delivering the Rotherham Integrated Care Model. The following provides a snapshot of the key areas and their associated outcomes:

Emergency Access and Admission Avoidance:
Recruitment to and development of the ED workforce, embed good practice ways of working, alignment of assessment units, invest in ambulatory emergency care and development of a frailty unit.

Structured Management of the Inpatient Bed Base
Embedding of the SAFER care bundle, structure of weekend and OOH’s working (7/7), establishment of medical workforce model for inpatient wards, launch of a Hospital at Night model.

Admission to Discharge Pathways
Multi-disciplinary oversight of medically fit for discharge patients, review of Intermediate Care pathways and settings, launch of a Complex Discharge and Transfer of Care team, closer alignment with care homes and care home providers, and further development of alternative levels of care.

Community and Locality Working
Launch of the locality pilot, appointment and development of the community physician role, integration and development of Integrated Rapid Response team and Care Coordination Centre and strengthening our palliative care offering.

Daily Operational Management
Establishment of an escalation management system and surge plans, development of the Trust and site coordination team, structured site meetings, daily sit-reports on pressures in the acute and community settings, review of flex / surge beds and a ward re-configuration programme.

Underpinning these above priority areas is the development of the new integrated Urgent and Emergency Care Centre.