Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

**PWYLLGOR CYNLLUNIO POBL A SICRWYDD PERFFORMIAD**
**PEOPLE PLANNING AND PERFORMANCE ASSURANCE COMMITTEE**

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| **DYDDIAD Y CYFARFOD:**<br>**DATE OF MEETING:** | 25 February 2021 |
| **TEITL YR ADRODDIAD:**<br>**TITLE OF REPORT:** | Hywel Dda University Health Board 'Contact First / Urgent Primary Care' Model |
| **CYFARWYDDWR ARWEINIOL:**<br>**LEAD DIRECTOR:** | Jill Paterson, Director of Primary Care, Community and Long Term Care |
| **SWYDDOG ADRODD:**<br>**REPORTING OFFICER:** | Rhian Dawson<br>Integrated System Director Carmarthenshire |

| **Pwrpas yr Adroddiad** (dewiswch fel yn addas)<br>**Purpose of the Report** (select as appropriate) |
|---|
| Ar Gyfer Penderfyniad/For Decision |

**ADRODDIAD SCAA**
**SBAR REPORT**

## Sefyllfa / Situation

Health Board plans are required to evidence commitment and compliance with the national priorities outlined in the 'NHS Wales Annual Planning Framework 2021–22' (WHC, 2020 022) and provide assurance on actions in place to achieve this. Specifically, the plans for 2021-22 need to reflect an ambition and specific actions to build infrastructure and capacity across primary and community care at cluster and pan-cluster level, in order for the aim of 'care close to home' in Wales to be realised.

The 'development and implementation of a comprehensive and sustainable 24/7 Community and Primary care unscheduled care service model' is also a strategic planning objective for 2020 (Planning Priority 5J in the Hywel Dda University Health Board (HDdUHB) 2020 Strategic Objectives and Planning Objective Requirements).

This report outlines the national context associated with prioritising urgent primary care provision by Health Boards in Wales and the roll out of the national 'Contact First' programme. The paper summarises a review of local data which informed the development of our 'Contact First / Urgent Primary Care' model which provides us with the infrastructure on which to build capacity at Cluster / Pan Cluster level to meet the urgent care needs of our population. Finally, the report summarises our implementation of the model to date and presents our high level proposals to further operationalisation of the model during 2021/22.

The People, Planning and Performance Assurance Committee (PPPAC) is requested to acknowledge and support the Health Board's 'Contact First / Urgent Primary Care' model as the framework for investment and delivery of our primary care and community unscheduled care response (Strategic Planning Priority 5J).

## Cefndir / Background

The Strategic Programme for Primary Care remains the All Wales Primary Care response to 'A Healthier Wales'. It has however been refreshed to reflect the pandemic, balancing the emergency response required with planning for subsequent quarters and beyond.

There are six national work streams as illustrated in 'Figure One' below which also encompass a number of key priority areas which include the delivery of essential services; management of COVID-19 patients; care home support; rehabilitation; step up/step down community services; and urgent primary care.

**NB** In this context, Primary Care encompasses contractor services and community care provision.


*Figure 1. Six work streams for the Primary Care Model for Wales*

Furthermore, there has been an increased recognition across the system of the role which primary care can undertake within an innovative and responsive health and care system. As such, the 'NHS Wales Annual Planning Framework 2021–22 (WHC, 2020 022) outlines Ministerial priorities for Health Boards which specifically include Primary Care (and community services) and Timely Access to Care. The latter recognises the significant opportunity which exists to provide alternatives to emergency admission to a hospital bed for people who would benefit from remaining at home.

Utilising the six goals for urgent and emergency care as a framework and prioritising elements of the emerging Welsh Access Model for urgent and emergency care, Health Boards are expected to deliver this vision through integration and collaboration with stakeholders across the health and care system.

**Six Goals for Urgent and Emergency Care (UEC)**


The six goals for UEC were first published in the NHS Wales COVID-19 Operating Framework for Quarters 3 and 4 of 2020/2021. Four of these goals sit within the primary care and community sphere of responsibility clearly demonstrating that primary care and community investment has the greatest opportunity to manage demand on the acute hospital setting.

**Welsh Access Model for Urgent and Emergency Care (Contact First)**

The Emergency Department Quality and Delivery Framework (EDQDF) commenced a programme of work in November 2019 across Wales to develop pathways to reduce demand in Emergency Departments (ED) and which would provide the public with access to alternative and more appropriate clinical support for their needs and contribute to managing the flow into ED.

The outbreak of the novel coronavirus led to a reassessment of the progress made by the EDQDF programme and consideration of how it could be further adapted / expedited. Further integration of the relationship between '111' / NHS direct services and Emergency Departments (EDs) was therefore decided upon as a way to manage social distancing in EDs while also providing patient centred care. This led to the first iteration of the Welsh Access Model to urgent and emergency care and which has most recently been commonly referred to as our 'Phone First' or 'Contact First' model.

The three key features of the 'Contact First' model are:

- **24/7 'Contact First'** - allows patients to book appointments for care which is urgent but not life threatening; it would be clinically staffed and patients would be streamed to specialities / services after a telephone triage. This will be via '111' for residents of HDdUHB
- **Local 'Flow Hub'** - through which patients will be directed to appropriate hospital, Primary or Community services based on a local telephone triage, thereby bypassing the need for the patient to present at the ED. The local 'Flow Hub' may be accessed via '111' enabling patients to access more appropriate and alternative pathways / local treatment options in a scheduled / planned manner. Patients who access ED / Minor Injuries Unit (MIU) directly should also be triaged and redirected via this 'Flow Hub' pathway.
- **'Wait and Care'** – a facility or pathway to provide care and support to those patients who do not require immediate medical or surgical intervention, however may benefit

from diagnostics / Consultant review / care and support from Primary care and Community services to avoid admission.

In July 2020, the Minister for Health and Social Care in Wales announced a redesign of emergency care with a focus on 'Contact First' and the emerging Welsh Access Model.

A phased approach to implement the 'Contact First' service across Health Boards was agreed with the National 'Contact First' Steering Group in December 2020 as follows:

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| **Step 1 Current 111 'ED/MIU' Demand only** | Initial introduction of the 'Contact First' Service by Health Board area for current '111' activity **for patients with an 'ED/MIU' outcome only**.<br>***Key Points to note***<br>▪ No anticipated increase in 111 call demand as a result of implementing this service.<br>▪ Low key communications.<br>▪ Aneurin Bevan University Health Board (ABUHB) & Swansea Bay University Health Board (SBUHB) pace setter pilots with HDdUHB anticipated to follow in March 2021.<br>▪ Health Board sequencing to be formally agreed. |
| **Step 2 Full implementation** | Full implementation of the 'Contact First' service by Health Board to increase call volume in line with the full scope and supported by a full communications plan.<br>***Key Points to note***<br>▪ Health Board sequencing to be formally agreed – HDdUHB proposed end May 2021.<br>▪ Will require additional '111' recruitment (including Call Handlers / Clinical Advisors, Clinical Leadership structure and also wider corporate staff). |

Within the Planning Care Framework, there is an expectation that NHS organisations should demonstrate within their plans how their Primary Care, Community and Secondary care plans for 2021-22 reflect a vision and ambition to build infrastructure and capacity across Primary and Community care at Cluster and pan-cluster level, so that the aim of 'care close to home' in Wales can be realised. This approach includes the development of 'Contact First' and urgent primary care emergency pathway development.

## Asesiad / Assessment

Health Board plans are required to evidence commitment and compliance with the national priorities outlined above and provide assurance on actions in place to achieve this. The development and implementation of a comprehensive and sustainable 24/7 Community and Primary care unscheduled care service model is also a strategic planning objective for 2020 (Planning Priority 5J in the HDdUHB 2020 Strategic Objectives and Planning Objective Requirements).

To support Health Boards to plan their Contact First / Urgent Primary Care response, a maturity matrix was produced nationally against which Health Boards could assess their baseline position and produce their plans or phased implementation. This maturity matrix is appended to this report and the assessment of the HDdUHB position against the matrix has contributed to the phased development and implementation of our 'Contact First' / Urgent Primary Care model.

Furthermore, a review of a pertinent data set was undertaken to contribute to the development of our 'Contact First' / Urgent Primary Care model in order to better understand how inappropriate conveyance rates and the avoidance of unnecessary admissions could be improved.

In brief, the data review outlined opportunities in the following areas;

**1. '111' utilisation by the public and '111' Disposition**

Reviewing the 'busiest days' in EDs for 2019/20 identified that when the '111' data was reconciled with ED data that very few patients contacted '111'. 19% of those who had contacted '111' were given a disposition of ED / MIU. Of these, 50% did not attend. The data clearly demonstrated that 'self-presenters' to ED should be a focus of any urgent primary care model developed.

**2. ED Self Presentation – Opportunities to strengthen identified service need**

The same data was reviewed to better understand why people presented to ED and MIU. This demonstrated that ED attendees could have been redirected or signposted to other services including **Primary Care Contractor Services** (General Medical Services, Dental Services, Optometry Services, Pharmacy services) if '111' or a 'Local Flow Hub' existed.

Moreover, should disposition of MIU or ED be indicated by '111', a scheduled attendance was also considered preferable to improve patient experience and operational performance. Scheduling such attendance was deemed opportune to reduce demand and peak times of pressure and also to ensure that patients waiting are not unduly exposed to COVID-19 transmission due to high numbers preventing adequate social distancing in waiting areas.

The data also demonstrated that urgent diagnostic interventions and advice (e.g., **same day emergency care** (**SDEC) and consultant led 'hot clinics'**) could contribute to reducing unscheduled care demand at the acute hospital 'front door'.

SDEC is not a new concept. Prior to the COVID-19 pandemic, all acute hospitals had an operational SDEC/Ambulatory Emergency Care (AEC) unit with an average of 256 people being seen through the units and 62% of those having a length of stay (LoS) within the SDEC/AEC unit of less than 12 hours.

Reintroducing SDEC/AEC is therefore considered a priority in the Urgent Primary Care model for the improved management of patients with an ED/MIU outcome who have either been referred through the '111 system' or have self-presented to the ED/MIUs. It is also anticipated that the model will enable a seamless urgent emergency care between ED and our out of hours service.

**3. Welsh Ambulance Services NHS Trust (WAST) Conveyance**

Conveyance rates to hospital have consistently reported at approximately 66% in recent years. Many Health Boards have recently provided the Welsh Ambulance Services NHS Trust (WAST) with clinical medical support for the multidisciplinary (MDT) assessment of patients in the community who are waiting for an ambulance alongside WAST registered nurses and Advanced Paramedic Practitioners (APP). This MDT assessment is commonly known as the 'clinical review of the WAST stack' and the manner and degree to which this has been implemented varies across Health Boards. The Health Board had begun to explore

development of such a service prior to the pandemic. Work is now progressing as a matter of priority to initiate this care pathway.

**4. Frailty**

Evidence suggests 20-30% of unplanned admissions in those over 75 years of age could be avoided if an alternative to hospital was available in a timely manner.

The solution to managing demand and 'flow compromise' is well documented by the King's Fund[1] and the British Geriatric Society[2], among others who acknowledge that frailty contributes significantly to acute hospital pressure. This evidence clearly outlines the need for effective and efficient proactive management of frail older people with early targeted intervention for chronological functional decline and clinically led intermediate care provision to manage sudden exacerbation of function from frailty syndrome.

Acknowledging that optimal management of frailty can improve outcomes for this population group and sustain whole system operational performance, Welsh Government have increasingly contributed to funding Health Boards to support the development of community care pathways through Integrated Care Fund (ICF) and Transformation Fund (TF).

The additional funding made available to support the Health Board's implementation of the Urgent Primary Care / 'Contact First model must therefore demonstrate additional benefit and outcomes over and above that of the existing ICF and TF investment and support a 'whole system' approach to the model and pathway development for Primary and Community unscheduled care.

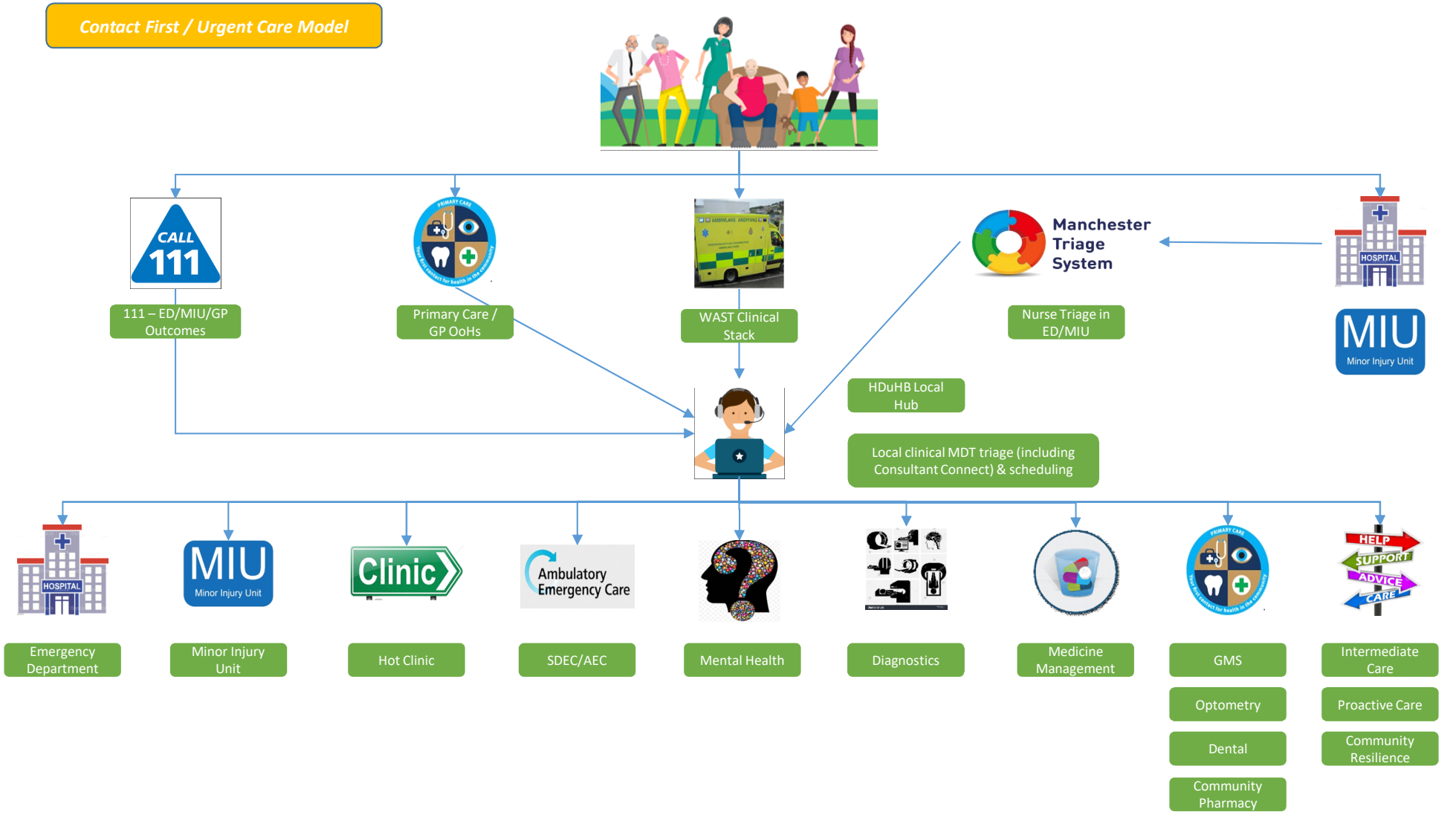
**Hywel Dda University Health Board 'Contact First' / Urgent Primary Care Model**

The Unscheduled Care (USC) Programme and its associated governance structure (see appendix 2) was recently reviewed to consider national expectations against our current USC system position. The USC Programme has consequently developed the Health Board 'Urgent Emergency Care' model (see figure 2 below) for primary care (including community). This model was based on national policy expectations, local strategic intent and the data review outlined above.

[1] Kings Fund ( 2014) https://www.kingsfund.org.uk/sites/default/files/field/field_publication_file/making-health-care-systems-fit-ageing-population-oliver-foot-humphries-mar14.pdf

[2] British Geriatric Society (2016) https://www.bgs.org.uk/resources/resource-series/fit-for-frailty

***Figure 2. Hywel Dda 'Contact First' / Urgent Primary Care Model***



| Achievements to date in implementing our 'Contact First' / Urgent Primary Care Model | | |
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| **Quarter 3 / 4 2020 - 21 'Contact First' / UPC High Level Implementation Plan** | | |
| **HDdUHB UPC Model Component** | **Dependencies** | **Current Position** |
| **HDdUHB Local 'Flow Hub'** | '111' and WAST readiness<br><br>Call handling resource 24/7 to support appointment scheduling of Emergency Department (ED) and Minor Injury (MIU) '111' dispositions<br><br>Quality Assured Directory of Services for alternative pathways | Funding secured through Welsh Government (WG) UPC Pathfinder (2020 / 21) for call handling resource<br><br>'111' / WAST have confirmed sequencing of roll out across Wales; HDDUHB currently March 2021<br><br>Directory of Services (DoS) updated and DoS workstream to progress further development / enhance information available as other alternative pathways progress |
| **Clinical Navigators in the Emergency Department**<br>**(Glangwili General Hospital (**GGH), Withybush General Hospital (WGH), Bronglais General Hospital (BGH)) to triage, treat and signpost patients who attend ED / MIU and who could have been managed by primary care (GMS, dental, optometry and pharmacy)<br><br>This component limited to Quarter 4 period to gather data intelligence regarding public behaviour related to ED attendance (why not primary care) and understanding of '111'<br><br>Utilise this data to support business case 2021/22 for developing appropriate pathways that meet need in primary care (reduce inappropriate ED attendance) | Recruitment of sessional GPs to undertake Clinical Navigator roles in ED | Funding secured through WG UPC pathfinder fund 2020 /21<br><br>Interview pending for Intermediate Care GP early March 2021.<br><br>Nationally led Expression of Interest initiative (EOI) for Remote GP working in UPC attracted x 10 EOIs for Hywel Dda and these are being on boarded to our intermediate care GP 'bank'<br><br>Progressing model for remote clinical navigation based on '111' pathway protocols<br><br>In the absence of Clinical Navigation – prospective / real time data capture by ED Triage Nurses / Admin support |
| **Physician Triage Assessment Service (WAST stack review)** | Recruitment of GPs to undertake the role | Funding secured through WG UPC pathfinder fund 2020/21 |

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| This service places experienced GPs remotely as part of the WAST MDT to support conveyance avoidance and sign posting to alternative pathways<br><br>Utilise this data to support business case for developing appropriate pathways that meet need in primary care (reduce inappropriate ED attendance / conveyance) | Standard Operating Procedure (SOP) development<br><br>Memorandum of Understanding (MOU) agreed by both WAST and HDdUHB | Recruitment pending interviews scheduled for early March 2021.<br>Reviewed job plan of existing Intermediate Care GP (Carmarthenshire) to undertake this role while recruitment completed.<br><br>Attracted interest of local GP partners who have submitted Bevan Exemplar to undertake this role and support development of GP Integrated Fellow role in Intermediate Care.<br><br>SOP and MOU to be completed by end of February 2021. HDdUHB is the first Health Board to formally undertake this service.<br><br>Desktop exercise currently underway testing the remote worker access and being supported by Community Navigators from three Counties to test alternative pathways. |
| **Same Day Emergency Care / Hot Clinics** | WGH data review to provide baseline for the pilot<br><br>BGH Recruitment to medical positions which will support a future SDEC model | First phases of SDEC development have been implemented in Prince Phillip Hospital (PPH) and GGH.<br><br>Plans progressing in BGH and WGH with the latter being supported by existing ambulatory emergency care pathway.<br><br>The Clinical Navigators / Physician Triage and Streaming (PTAS) physicians in their down time can support SDEC in acute sites.<br><br>Further testing of Attend Anywhere / Consultant Connect software to test 'virtual' SDEC and 'Hot Clinic' pathways. |
| **Enhance provision of alternative pathways to support UPC**<br>Optometry Triage | Funding for optometric sessions | Funding secured from WG UPC pathfinder fund 2020/21. |

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| Proactive and Intermediate care Pathways for frail older People. | Implementation of a Local 'Flow Hub' | Has not progressed as '111' disposition 'go live' forecasted for March 2021.<br><br>These pathways exist in each of our three Counties funded by ICF and Transformation. Each County also has a Single Point of Contact to access a range of pathways. Hours of operation and the range of pathways do vary across the Counties. |

## Next Steps

| 2021 – 2022 UPC High Level Implementation Plan and Business Proposal | |
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| **UPC Model Component** | **Dependencies** |
| **Evaluate Data gathered in Quarter 4 2020/21 through Clinical Navigator and PTAS roles and develop business case with Clusters / Pan Cluster** | Primary Care contractor engagement and ownership in data led business case submission for WG UPC funding 2021/22.<br><br>Business case submission to focus on enhancement of Primary Care pathways to reduce ED conveyance / hospital admission e.g.<br>▪ SDEC<br>▪ Hot Clinics<br>▪ Local 'flow hub' development at ?Cluster / Practice / County / Health Board level<br>▪ PTAS (WAST stack review)<br>▪ Intermediate care provision (Falls, Frailty etc.)<br>▪ Mental Health pathways. |
| **Develop HDDUHB Local 'Flow Hub' to meet '111' / WAST requirements for Phase One and Two national 'Contact First' roll out**<br><br>Define Local 'Flow Hub' function i.e. Health Board wide, County System, Cluster – or a blend of all 3 | '111' and WAST readiness.<br><br>Call handling resource 24/7 to support appointment scheduling of all '111' dispositions.<br><br>Secure further funding for 'Flow Hub' call handling from UPC business case submission to WG.<br><br>Quality Assured Directory of Services for alternative pathways. |
| **Physician Triage Assessment Service (WAST stack review)**<br>This service places experienced GPs remotely as part of the WAST MDT to | Funding secured through WG UPC pathfinder fund.<br><br>Ongoing recruitment of GPs to undertake the role. |

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| support conveyance avoidance and sign posting to alternative pathways | Extend existing contracts of intermediate care GPs.<br><br>Memorandum of Understanding and Operating Procedure agreed by both WAST and HDDUHB. |
| **Same Day Emergency Care (SDEC) / Hot Clinics** | Enhancing the clinical and multidisciplinary resource required for alternative pathways to admission.<br><br>Enhance remote ability through Consultant Connect. |
| **Enhance provision of alternative pathways to support UPC** | Data intelligence and submission of successful business case to WG Primary Care Board to enhance alternative pathways in primary care / community – data led development of clinical pathways that represent need at Cluster / County level, i.e. bespoke to need as outlined in the Health Board's strategic and planning objectives (5H and 5J) to:<br><br>▪ Increase 'Time Spent at Home' (reduced bed days in hospital, reduced length of stay in residential/ nursing care, proportionate commissioning of domiciliary care).<br>▪ Reduction in hospital admission (includes intermediate care and proactive care pathways).<br>▪ Support for those at end of life. |

**Armgymhelliad / Recommendation**

PPPAC is requested to;

- Acknowledge and support the Health Board's 'Contact First / Urgent Primary Care' model as the framework for planning and delivering our primary care and community unscheduled care response (Strategic Planning Priority 5J).
- Acknowledge the reporting arrangements for the new model to the Unscheduled Care Steering Group to which monthly highlight reports outlining progress, issues and risks will be presented monthly.
- Acknowledge that implementing the model is dependent on the successful integration of the components of the system across Primary Care, Community and Acute Services. Similarly, budgets and funding investments need to align to the model to ensure maximum impact and hence return on investment.

| **Amcanion: (rhaid cwblhau)<br>Objectives: (must be completed)** | |
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| Committee ToR Reference:<br>Cyfeirnod Cylch Gorchwyl y Pwyllgor: | 5.10 Ensure that best practice and national guidelines are adopted in service development plans and pathways |
| Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol:<br>Datix Risk Register Reference and Score: | Risk number 1027 – Unscheduled Care and Delivery of Q3 / Q4 2020 2021<br>**Inherent Risk Score (L x I):** 5×4=20<br>**Current Risk Score (L x I):** 4×4=16<br>**Target Risk Score (L x I):** 3×4=12 |
| Safon(au) Gofal ac Iechyd:<br>Health and Care Standard(s): | 3.1 Safe and Clinically Effective Care<br>2.1 Managing Risk and Promoting Health and Safety<br>6.1 Planning Care to Promote Independence<br>5.1 Timely Access |
| Amcanion Strategol y BIP:<br>UHB Strategic Objectives: | All Strategic Objectives are applicable |
| Amcanion Llesiant BIP:<br>UHB Well-being Objectives:<br>Hyperlink to HDdUHB Well-being Objectives Annual Report | 4. Improve Population Health through prevention and early intervention, supporting people to live happy and healthy lives<br>8. Transform our communities through collaboration with people, communities and partners |

| **Gwybodaeth Ychwanegol:<br>Further Information:** | |
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| Ar sail tystiolaeth:<br>Evidence Base: | 'NHS Wales Annual Planning Framework 2021 – 22 (WHC, 2020 022)<br>Kings Fund ( 2014)<br>https://www.kingsfund.org.uk/sites/default/files/field/field_publication_file/making-health-care-systems-fit-ageing-population-oliver-foot-humphries-mar14.pdf<br>British Geriatric Society (2016)<br>https://www.bgs.org.uk/resources/resource-series/fit-for-frailty |

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| Rhestr Termau:<br>Glossary of Terms: | Included within the body of the report |
| Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Pwyllgor Cynllunio Busnes a Sicrhau Perfformiad:<br>Parties / Committees consulted prior to People Planning and Performance Assurance Committee: | N/A |

| **Effaith: (rhaid cwblhau)<br>Impact: (must be completed)** | |
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| **Ariannol / Gwerth am Arian:<br>Financial / Service:** | Integrated Impact Assessment template completed |
| **Ansawdd / Gofal Claf:<br>Quality / Patient Care:** | Integrated Impact Assessment template completed |
| **Gweithlu:<br>Workforce:** | Integrated Impact Assessment template completed |
| **Risg:<br>Risk:** | Integrated Impact Assessment template completed |
| **Cyfreithiol:<br>Legal:** | Integrated Impact Assessment template completed |
| **Enw Da:<br>Reputational:** | Integrated Impact Assessment template completed |
| **Gyfrinachedd:<br>Privacy:** | Integrated Impact Assessment template completed |

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| **Cydraddoldeb:**<br>**Equality:** | Integrated Impact Assessment template completed |

# APPENDIX ONE – MATURITY MATRIX CONTACT FIRST (Green – Complete / Amber Progressing)

| | Minimum position for any phone first system pre-Winter | | |
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| **TASK** | **Established** | **Mature** | **Exemplary** |
| **HDdUHB Demand & Capacity Assessment** | Reviewed data and activity patterns to estimate:<br>✓ Minor injury and minor illness volumes attending EDs<br>✓ Map current (under or) over utilisation of capacity within ED /MIU and other direct access pathways.<br>✓ Assess volumes that can be assessed out or booked directly into ED, MAU, MIU, hot clinics, community alternatives.<br>✓ **Undertake table top exercise to review an ED 'busiest' day to test assumptions**<br>✓ Map the critical pathways and capacity into other services for urgent care including respiratory, frailty services, urgent primary and community care<br>✓ Estimated impact on 111 call volumes and staffing requirements (call handling, nurses and clinical hub team). | **In addition to established criteria:**<br>Ability to monitor data and activity in real time across 111, urgent primary care, ED and WAST(e.g. SHREWD and wider NWIS /WG capacity planning work)<br>Policies for management of interface and call flow all in place and agreed (if linked to 111)<br>Increased provision of community based service provision 24 /7.<br>Established more robust mechanism to flex resource to meet demand requirements<br>Identification of new pathways that may require development following on from table top exercises<br>Assess impact of implementation on other parts of the health and social care system e.g. GMS and Care Homes<br>Clinical data on disposition /outcomes and SIUs to be monitored and reviewed<br>Mapped social care pathways and capacity of third sector to support vulnerable patients | In addition to **mature** elements:<br>Mutual aid between organisations when capacity is reached and /or waiting times for ED excess of x hours (18-24 hrs?)<br>As close to real time assessment of waiting times in components parts of NHS system between 111, urgent primary care, WAST and ED /MAU /MIUs etc.<br><br>Patient and clinical evaluation in place and clinical outcomes routinely available.<br><br>Assessment of patients who continue to attend ED despite alternative models in place.<br><br>Assessment of patients who attendance ED despite a Primary Care disposition from 111<br><br>Streamlined and simplified access to a range of clinical services which are aligned to nationally agreed pathways with common entry points |

| | Minimum position for any phone first system pre-Winter | | |
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| **TASK** | **Established** | **Mature** | **Exemplary** |
| **111 Demand & Capacity assessment** | ✓ Call abandonment rate in 111 to be mapped at 5% or less<br>✓ 111 to review impact on call volume, call duration, outcomes measurement and clinical standards (P1,2,3).<br>✓ Staffing at weekends to be reviewed | Demand /capacity analysis to reflect hour by hour variation and response particularly and differences in approach at weekends<br>Disposition outcomes against self-care, community alternatives, ED, 999 to be assessed at local level<br>Ability to implement escalation processes both manually and digitally and with the confidence of all partners 24/7 | Disposition outcomes and activity to be available at a locality /cluster level |
| **Escalation and Business Continuity** | ✓ Escalations systems in place should capacity be reached and sign off by all partners.<br>✓ All services to assess continuity of services if there was an IT or telephony system failure.<br>✓ BCI plan in place at least two weeks ahead of launch. | BCI plan to incorporate wider system /process failures across workforce, service and other unforeseen events (locally) | BCI plans to incorporate wider system /service failures at a national level |
| **Workforce Assessment 111**<br><br>**Workforce continued:**<br><br>**Urgent Primary Care**<br><br>**Flow Centre staffing**<br><br>**Wider urgent primary care, community and acute workforce capacity (24/7)** | **Based on Demand & Capacity planning:**<br>✓ Non-clinical call handlers - sufficient staff to maintain average handling time of 650s<br>✓ Nurse assessment to match revised demand profiles and AHTs of 1100s<br>✓ 111 Clinical Hub support with wider MDT input<br><br>✓ Urgent Primary Care (OOHs) – shift fill for clinicians is maintained above 90%<br><br>✓ Non-clinical call handlers - sufficient staff to maintain average handling time of 650s<br>✓ Nurse assessment to match revised demand profiles and AHTs of 1100s<br>✓ 111 Clinical Hub support with wider MDT input<br>✓ Initial focus on patients with an ED or low acuity 999 disposition (minor illness /injury) that could be dealt with in alternative setting<br>Care navigation role in place to access range of services or alternative pathways. | Systems will consider the implications of workforce across all parts of the system (not component parts) and assess demand increase /decreases and skill mix<br>Shift of staffing resourcing between clinical teams to support initial assessment and first line F2F assessment capacity e.g. hot clinics.<br>Building on lessons from COVID, wider scoping of opportunities for remote working to flex capacity<br>Primary and Community infrastructure to support alternative pathways consistently 24 /7 e.g. district nursing and mental health<br>All staff trained to an agreed standard for clinical triage and assessment (ability to do via telephone, remotely /VC and F2F).<br><br>Risk stratify a wider patient group that can be safety managed within alternative settings other than ED and can be clearly identified and managed at triage<br>Identification of key service priorities that could be resourced /transformed over medium term to offer primary /community alternatives (shift left) | Shared workforce across organisational boundaries and where appropriate, moving to regional and /or national support networks. Examples would include dental assessment, crisis mental health and paediatric response Greater integration across systems, utilising technology to manage patient cohorts differently, sharing workforce across provider boundaries |

| | Minimum position for any phone first system pre-Winter | | |
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| **TASK** | **Established** | **Mature** | **Exemplary** |
| | ✓ Urgent Primary Care (OOHs) – shift fill for clinicians is maintained above 90% | | |
| **Information transfer and use of digital /telephony systems** | ✓ Systems in place to support the transfer of patient details, safety and securely between 111, urgent primary care and ED, MIU and MAU<br>✓ Standardised use of remote working for a range of clinical staff within urgent or USC setting.<br>✓ Ability for 111 to warm transfer patient details (without duplication or secondary agreement) into an LHB queue for further clinical assessment<br>✓ LHB Flow Centre to be able to receive information directly and without the need for telephone discussion or 'fax'<br>✓ The transfer of patient details must be compliant with IG standards<br>✓ (Adastra) system should be robust and stable if being utilised for digital transfer | Established clinical informatics infrastructure for all diagnostic and special patient note look up.<br>E prescribing in place<br>Utilise Virtual Consultation e.g. Attend Anywhere and Consultant Connect to provide specialist advice and support to GP and /or other health professionals across primary and secondary care<br>Dedicated 111 /Phone First slots available within ED, MIU, MAU and /or a range of alternative acute and community clinics (7 days a week)<br>Dedicated 111 /Phone First slots within urgent primary /community care – (OOHs and directly managed practices)<br>Ability for 111 to book a slot or O/P appointment in the receiving Trust and transfer patient notes safely and securely for clinically suitable patients<br>Testing must be completed (in live) one week prior to launch | Full end to end system integration between 111, primary, community and Urgent /USC systems including full access to notes, pan wales<br>Full interoperability across all systems<br>VC system in place to support wider health and social care functions across Wales<br><br>Dedicated 111 slots within GMS practices<br>Systems will transfer patient specific notes without any manual process and will be available in the receiving organisation for clinical view without manual interference (i.e. downloading or printing)<br>Governance arrangements in place and designed to fully support (nationally) an integrated system with clarity about lines or responsibility and accountability.<br>Ability for 111 and/or the CSH to be able to book a 2-4 hour response from community services |
| | ✓ 111 telephony system checked to ensure resilience and capacity for surge demand covering Winter, COVID-19, phone first and other priorities | WAST and Vodafone support 24/7 | 111 telephone system on the same 99.9% resilience as 999 |

| | Minimum position for any phone first system pre-Winter | | |
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| **TASK** | **Established** | **Mature** | **Exemplary** |
| **Directory of Services (DOS)** | ✓ DOS needs to be robustly updated and tested against a checklist pre-launch to maximise opportunities to divert to alternative pathways<br>✓ Top 10 critical pathways (dip-stick) are agreed, clinically appropriate with clear access criteria updated on local and national DOS systems.<br>✓ Ensure services provided by external contractors e.g. Pharmacy and Optometry are updated to reflect any changes since COVID<br>✓ Local DOS leads identified to co-ordinate process<br>Access criteria not restricted to limited number of clinical staff | Clinical pathways and access into services are consistent regardless of team, internal boundaries are and available 7 days a week<br>DOS information routinely updated every 3 months<br>DOS information available to local population (electronically) and regularly promoted<br>New services added to the DOS within one week of going live<br>Cross reference between LHBs to ensure no services are inadvertently missed.<br>Where available, the ability to 'book' video and telephone consultations directly with a service should be fully updated on the DoS | Clinical pathways standardised 24 /7 and across organisational boundaries.<br>DOS information available in one source across health, social care and 3rd sector.<br>All possible services are available and accessible at times of demand.<br>Patients are booked into ED only where clinically appropriate and not because services in the community are not available.<br>There is consistency across LHBs in terms of which services are profiled on the DoS and naming convention applied to enable consistency (this does not mean local service name change in the public domain)<br>Services offer direct booking from 111 /urgent primary care directly with safe transfer of patient information. |
| Ensure **query ED patients /999 disposition patients (low acuity)** are safely triaged and streamed to an alternative services where appropriate | ✓ Suitably qualified clinicians available to triage /streams patients to alternative services where clinically appropriate, using telephone to transfer information to the receiving organisation where possible – **For PTAS initially** | Clinicians to digitally transfer patients to alternative services via appropriate clinical system via PTAS initially<br>The patient may be booked in to the receiving organisation for a remote consultation using telephone or video therefore reducing the need for further face to face contact | The patient will receive additional support to facilitate their onward journey through the use of a named patient co-ordinator<br>Regular review and audit of processes and patient journey to highlight any unintended consequences. |
| **COMMUNICATIONS**<br>Internal to NHS and partners | ✓ A basic communications message is available to all staff via intranet, staff bulletins and department /divisional level.<br>✓ Full alignment with WG Comms Team for this Winter | Regular and ongoing communication strategy established 4 weeks in advance of launch to emphasise benefits /opportunities from the above process (lined to shift left message).<br>Messaging linked to wider preparations for winter planning and next phase of COVID | Online communication portal has been established, populated and communicated to the staff both internally and with local partners in Social Care and 3rd sector etc. |
| **COMMUNICATIONS** – external engagement with public on key messaging and signposting | ✓ 111 to be the access point for all urgent care needs<br>✓ A clear and simple message for the public with reduced need for multiple telephone numbers. | More sophisticated messaged across various multi-media platforms.<br>Active and ongoing engagement sessions with a range of public forums<br>FAQ established and readily available and communicated with local press, AMs, CHC. Further specifics to be added by Communications Teams | Online communication portal has been established, populated and supported across various forms.<br>Primary Care text messaging service is targeting specific patient groups |

| | Minimum position for any phone first system pre-Winter | | |
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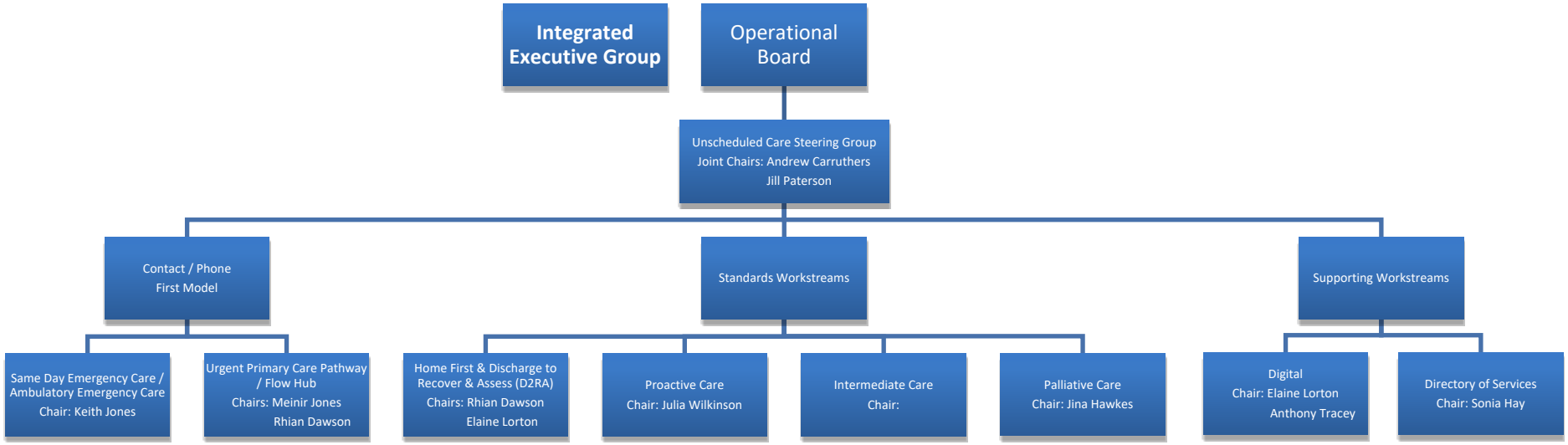
| **TASK** | **Established** | **Mature** | **Exemplary** |
| | ✓ Regularly shared with the public and updated regularly in line with All Wales approach. | | Seldom heard groups/hard to reach communities engaged and in a format that works for them e.g. deaf community. |

## APPENDIX TWO – Unscheduled Care Programme Governance Structure



| Integrated Impact Assessment Tool | Y/N | Evidence & Further Information | Completed By | Evidence (Insert) |
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| **Financial/Service Impacts** | | | | |
| 1. Has the new proposal/service model been costed? If so, by whom? | **N** | **The model brings together existing service provision and nationally expected new services. Each County System will need to determine the cost of roll out of the new model (and services) based on its baseline structure and current performance.** | | |
| 2. Does the budget holder have the resources to pay for the new proposal/service model? Otherwise how will this be supported - where will the resources/money come from i.e. specify budget code or indicate if external funding, etc? | | **While the proposed model is new each County system has been building components of the model over recent years. These have been resourced through core budget as well as external funding from Integrated Care Fund and Transformation Fund.**<br><br>**To implement Contact First / Urgent Primary Care national expectations we were also successful at drawing down WG Urgent Primary Care (UPC) Funding for 2020/21. WG have indicated there is further UPC investment for 21/22 and each Health Board has been requested to submit business cases against our County Plans.** | | |
| 3. Is the new proposal/service model affordable from within existing budgets? | | **As outlined above, much of the model's component parts are supported by external short term funding streams. There is a known risk surrounding sustaining this funding beyond** | | |

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| | | **March 2022 and a need to demonstrate impact of the model on the wider unscheduled care system.** | | |
| 4. Is there an impact on pay or non pay e.g. drugs, equipment, etc? | | **There may be a very minimal impact on community equipment requirements to manage an increased number of patients in their own home.** | | |
| 5. Is this a spend to save initiative? If so, what is the anticipated payback schedule? | | **No** | | |
| 6. What is the financial or efficiency payback (prudency), if any? | | **In terms of prudency, this model:**<br>- **Supports patients to be cared for at home and as such reduces demand on acute hospital while protecting the patient's independence (through reducing risk of deconditioning as an inpatient)**<br>- **Reduced hospital admissions will reduce demand on social care and hence increased access /availability for finite social care resource** | | |
| 7. Are there risks if the new proposal/service model is not put into effect? | | **Non compliance with national expectations**<br><br>**Increasing demand on acute hospital and Welsh Ambulance NHS Services Trust creating escalating pressures for both organisations and increased harm to inpatients and delays in ambulance arrivals for patients waiting in the community** | | |

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| 8. Are there any recognised or unintended consequences of changes on other parts of the system (i.e. impact on current service, impact of changes in secondary care provision on primary care services and capacity or vice versa, or other statutory services e.g. Local Authorities?) | | **There is a recognised potential to destabilise GP workforce – measures have been taken to ensure that this does not happen e.g. GP locum remote working. GPs contribute to business case and development / implementation of the model** | | |
| 9. Is there a need for negotiation/lead in times i.e. short term, medium term, long term? If so, with whom e.g. staff, current providers, external funders, etc? | | **Each service area within the model requires individual assessment at County system level in terms of performance / population need and planning across a timeline to implement. Many of the services require integrated and collaborative working with WAST, Local Authorities and other stakeholders.** | | |
| 10. Are capital requirements identified or funded? | | **No** | | |
| 11. Will capital projects need to be completed in time to support any service change proposed? | | **N/A** | | |
| 12. Has a Project Board been identified to manage the implementation? | | **Yes** | | |
| 13. Is there an implementation plan with timescales to performance manage the process and risks? | | **Yes** | | |
| 14. Is there a post project evaluation planed for the new proposal/service model? | | **Yes** | | |
| 15. Are there any other constraints which would prevent progress to implementation? | | **No** | | |
| **Quality/Patient Care Impacts** | | | | |
| 16. Could there be an impact on patient outcome/care? | | **All new services will be risk assessed to ensure that any patient outcomes are not compromised. New services (such as the Physician Triage and Streaming – PTaS) will be** | | |

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| | | **subject to due scrutiny by appropriate forums and committees.** | | |
| 17. Is there any potential for inequity of provision for individual patient groups or communities? E.g. rurality, transport. | | **No** | | |
| 18. Is there any potential for inconsistency in approach across the Health Board? | | **It is acknowledged that each County System has adapted implementation of some of the services within the model to benefit the differing needs of populations across Clusters. Further the infrastructure of each County system is different. While services offer may be inconsistent we aim to ensure equity of outcomes for our population and have agreed that this will be measured as 'Increasing Time Spent at Home and Independent'; reduced bed days in hospital, enhanced access to social home care and reduced length of stay in residential / nursing care. Each service area should deliver against regionally agreed principles and standards and all contribute to this same population outcome.** | | |
| 19. Is there are potential for postcode lottery/commissioning? | | **As above** | | |
| 20. Is there a need to consider exceptional circumstances? | | **No** | | |

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| 21. Are there clinical and other consequences of providing or delaying/denying treatment (i.e. improved patient outcomes, chronic pain, physical and mental deterioration, more intensive procedures eventually required? | | **No** | | |
| 22. Are there any Royal College standards, NICE guidance or other evidence bases, etc, applicable? | | **There is much evidence outlined in professional standards and National Institute for Clinical Excellence (NICE) guidance that endorses primary care and community pathways to enhance outcomes for people and appropriate reduction of presentation / admission to hospital** | | |
| 23. Can clinical engagement be evidenced in the design of the new proposal/service model? | | **Yes – Medical Directorate are present on the project group as are Cluster Leads and** | | |
| 24. Are there any population health impacts? | | **Micro level - Prevention of deconditioning of frail older inpatients through admission avoidance**<br>**Macro level – Enhances access to urgent hospital care for those who require it when they require it** | | |
| **Workforce Impact** | | | | |
| 25. Has the impact on the existing staff/WTE been determined? | | **Each County System will review current establishment against what is required to deliver the model. There is a recognised need for skill mix consideration and the development of new roles such as Advanced Nurse Practitioners in the community and Intermediate Care Community Physicians** | | |
| 26. Is it deliverable without the need for premium workforce? | | **Yes** | | |

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| 27. Is there the potential for staff disengagement if there is no clinical/'reasonable' rationale for the action? | | **No** | | |
| 28. Is there potential for professional body/college/union involvement? | | **Professional bodies included as necessary and appropriate** | | |
| 29. Could there be any perceived interference with clinical freedom? | | **No** | | |
| 30. Is there potential for front line staff conflict with the public? | | **It has been recognised nationally that clear and consistent communication with the public will be necessary to reduce potential conflict from change while implementing the All Wales 'Contact First' programme. The Health Board will need to ensure that we align our communications to the national messaging.** | | |
| 31. Could there be challenge from the 'industries' involved? | | **None known** | | |
| 32. Is there a communication plan to inform staff of the new arrangements? | | **Operational process for the Service to develop once the model is agreed.** | | |
| 33. Has the Organisational Change Policy been followed, including engagement/consultation in accordance with guidance? | | **N/A** | | |
| 34. Have training requirements been identified and will this be complete in time to support the new proposal/service model? | | **Training requirements have been identified for new service areas e.g. PTaS. This has been developed and undertaken (led by WAST). Each service area within the model will be assessed for training requirements and these needs considered as part of the implementation plan.** | | |
| **Risk Impact** | | | | |

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| 32. Has a risk assessment been completed? | | **Each service area will assess the risk associated with implementation.** | | |
| 33. Is there a plan to mitigate the risks identified? | | **Where risk is identified, a risk mitigating plan will be undertaken and due process followed to mitigate the risk.** | | |
| **Legal Impact** | | | | |
| 34. Has legal compliance been considered e.g. Welsh Language: is there any specific legislation or regulations that should be considered before a decision is made? | | **In developing the 'Local Flow Hub' as part of the model consideration of welsh language requirements will be undertaken.**<br>**In developing services in partnership with other organisations, legal and risk will be consulted via our corporate legal colleagues e.g. when developing associated Service Level Agreements, Partnership Agreements, Memorandum of Understanding.** | | |
| 35. Is there a likelihood of legal challenge? | | **No** | | |
| 36. Is there any existing legal guidance that could be perceived to be compromised i.e. Independent Provider Contracts, statutory guidance re: Continuing Healthcare, Welsh Government Policy etc? | | **No** | | |
| 37. Is there any existing contract and/or notice periods? | | **Each County System may have existing Agreements / Contracts in place to deliver elements of the model which are reviewed routinely to ensure providers are delivering contractual expectations and the service is delivering outcome anticipated for the population.** | | |
| **Reputational Impact** | | | | |
| 38. Is there a likelihood of public/patient opposition? | | **As above re 'Contact First' roll out across Wales** | | |

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| 39. Is there a likelihood of political activity? | | **Unscheduled Care continues to be an area of particular political interest.** | | |
| 40. Is there a likelihood of media interest? | | **Unscheduled Care continues to be an area of particular media interest.** | | |
| 41. Is there the potential for an adverse effect on recruitment? | | **No** | | |
| 42. Is there the likelihood of an adverse effect on staff morale? | | **No** | | |
| 43. Potential for judicial review? | | **No** | | |
| **Privacy Impact** | | | | |
| 44. Has an initial Privacy Impact Assessment (PIA) been undertaken – follow link below? http://howis.wales.nhs.uk/sitesplus/862/page/57738 | | **No - however for new services this will be undertaken as according to due process.** | | |
| 45. Has a full PIA been undertaken – follow link below? http://howis.wales.nhs.uk/sitesplus/862/page/57738 | | **No** | | |
| **Equality Impact (unless otherwise completed as part of the accompanying SBAR)** | | | | |
| 46. Has Equality Impact Assessment (EqIA) screening been undertaken – follow link below? http://www.wales.nhs.uk/sitesplus/862/page/61516 | | **Yes** | | |
| 47. Has a full EqIA been undertaken – follow link below? http://www.wales.nhs.uk/sitesplus/862/page/61516 | | **No** | | |
| 48. Have any negative/positive impacts been identified in the EqIA documentation? | | **No** | | |