Y gofal iawn, yn y lle iawn, y tro cyntaf
Chwe Nod ar gyfer Gofal Brys a Gofal mewn Argyfwng
Right care, right place, first time
Six Goals for Urgent and Emergency Care

GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

Winter Plan Evaluation 2022/23

What we said about our intended Winter Plan approach 2022/23:

- The underlying planning for winter is driven from the perspective of keeping the population safe, whilst at the same time ensuring care is provided in a high quality manner and this is made available in a continuously through the period of greatest system pressure in the NHS calendar.
- This Plan cannot be delivered in isolation, and our partners both within NHS Wales such as WAST, and external partners such our 3 Local Authorities are critical to its delivery.
- In developing this Plan we have sought to ensure that we avoid hospital admissions whenever possible both through trying to limit the spread of COVID-19 and more traditional winter illnesses such as flu, through extensive vaccinations programme, as well as caring for people in their homes and their communities – a fundamental premise to our approach is the 6 Goals of Urgent and Emergency Care through the 3C's – Conveyance; Convergence; Complexity.
- Continued roll-out of our Six Goals for Urgent and Emergency Care Programme including 24/7 Urgent Care Model & Same Day Emergency Care (SDEC).
    - Reducing conveyance to hospital for our frail and elderly population.
    - Reducing conversion rates proportionately where appropriate to do so for our frail and elderly population.
    - Enhancing our inpatient management of complexity (frailty).
    - For 2022/23 we will be focusing to a greater extent on our over 75s. If we can increase our current discharge rate by 10% and reduce our Average Length of Stay by 1 day this would provide with 80 bed equivalent efficiency by October 2022 and 100 by March 2023.
- We are building our community care capacity, and our home-based care initiative is central to this, including growing the total homebased care workforce in the community on a sustainable basis.
- We are also looking at the development of a Step Closer to Home Unit(s) - there are currently a number of 'Ready to Leave' patients waiting for care availability which provides an opportunity to establish and evaluate an alternative model of care by co-locating this patient cohort in a designated ward area within our acute and / or community hospital areas.
- We are continuing to develop other areas of our service model, for example with respect to Mental Health we are the first Health Board in Wales to launch the 111 Mental Health Single Point of Contact (MH SPOC) service publicly. Since 20 June 2022 the service is available 7 days a week from 09.00am to 11.30pm. There will be a phased approach to 24/7 operating hours as additional staff are recruited and on boarded in Autumn whereby the service will operate 24/7.
- Further, we will continue to ensure wherever possible that we maintain our planned care activity given delays in scheduled care treatments can quickly convert into unscheduled care presentations.
- We are currently piloting Delayed Transfers of Care (DToC) reporting for WG. The SharePoint Complex Discharge database provides a 'live' update on patient status that can be used to support DToC reporting.
- With respect to our Winter Respiratory Vaccination Plan 2022/23, this describes how we will work together in this unprecedented season to minimise the co-circulation of Flu and COVID-19, protect those most at risk, and reduce the impact of respiratory illness on health and social care services this winter. These aims will be achieved through the deployment of a wide range of actions to increase uptake of both COVID-19 and Influenza vaccines. Realising a single Flu and COVID-19 programme in 2022/23 will be a significant milestone for the HDdUHB and represents a significant step towards full integration of our vaccination programmes.

Our key deliverables for winter 2022/23

Flu and COVID vaccination

A combined flu and COVID-19 vaccination programme through winter respiratory vaccination delivery plan for 2022/23 that embraces the principles of our Health and Wellbeing Framework, the principles of which recognise the need to shift the culture around vaccination, building on the lessons learnt from the Mass Vaccination Centres and promoting community health and wellbeing. The aim is to maximise uptake through a single programme that enables integrated strategy, planning, governance and public engagement; examines opportunities for integrated delivery (co-administration), transitioning from a single delivery model where possible; and realises benefits for delivery and population health by:

- maximising uptake of both vaccines
- targeted and impactful communications
- service efficiencies

Protected beds for planned care

As a Health Board we are a committed / have the intention to maintain protected beds (as far as possible) through the winter period in recognition of our planned care recovery priorities.

Six Goals for Urgent and Emergency Care

Continued roll-out of our Six Goals for Urgent and Emergency Care Programme including 24/7 Urgent Care Model & Same Day Emergency Care (SDEC).

- Reducing conveyance to hospital for our frail and elderly population.
- Reducing conversion rates proportionately where appropriate to do so for our frail and elderly population.
- Enhancing our inpatient management of complexity (frailty).

Mental Health Single Point of Contact

Building on the success of being an early adopter of the Mental Health Single Point of Contact through the 111 telephone service and moving to an enhanced service that will operate 24/7.

Step Closer to Home Unit(s)

Development of a Step Closer to Home Unit(s) - there are currently a number of 'Ready to Leave' patients waiting for care availability which provides an opportunity to establish and evaluate an alternative model of care by co-locating this patient cohort in a designated ward area within our acute and / or community hospital areas.

Access to NHS dental services

Improving access to NHS dental services through implementing weekend working at Community Dental Services (CDS) sites (primarily Elizabeth Williams Clinic and Cardigan Integrated Care Centre).

Delayed Transfers of Care (DToC)

We are currently piloting DToC reporting for Welsh Government. The SharePoint Complex Discharge database provides a 'live' update on patient status that can be used to support DToC reporting.

Primary Care

The primary care escalation framework across the contractor professions will be brought into discussion on the daily escalation calls to take account of whole system pressures..

Community care expansion

As part of the new Welsh Government mandate around Community Care Capacity Building, creating 1,000 bed capacity, we have agreed through a Planning Objective that by October 2022, through a rapid expansion of community care, supporting more Hywel Dda residents to remain / return home with the objective of 120* fewer non-elective patients in hospital beds on a daily basis.

Respiratory escalation plan

Our respiratory escalation plan supports the management of paediatric patients and contingencies for a surge in demand where respiratory care is indicated. This is an evolution of the plan that was formed following a directive from Welsh Government in 2021.

Planning Developments

We are looking to develop a winter planning viewer that will allow:

- To identify the pre-COVID-19 winter trends compared to current trajectories for certain population cohorts that influence emergency demand
- Allows assumptions about a return rate of demand this winter to be applied and the resulting impact on admissions and beds projected (respiratory being a key feature)
- Allows the impact of potential improvements to be modelled and projected
- The model calculates a total bed occupancy across the system for emergency care, which can be compared to total known bed capacity and indicate if and when restrictions on elective capacity are likely to be made
- By pre-empting this, it is possible to work with elective services to plan alternative arrangements to continue successful delivery against ministerial targets
- The model bridges urgent and elective planning for winter

Introduction to our Six Goals for Urgent and Emergency Care Programme including 24/7 Urgent Care Model & Same Day Emergency Care (SDEC)

The 'development and implementation of a comprehensive and sustainable 24/7 Community and Primary care' urgent care model is a strategic planning objective for the University Health Board and its seven Cluster areas. Our Programme was formally launched in June 2022.

Our premise in developing the model is that the patient receives the 'right care, right place, first time'. The Hywel Dda patient demographic profile has a higher proportion of >65 year olds compared to other areas of Wales and that for our vulnerably frail we should acknowledge that, where safe and appropriate, the 'right care, right place' is home – not hospital. Our data demonstrates that it is our frail that contribute to the greatest demand on our Urgent and Emergency Care (UEC) services. Data also tells us that if vulnerable population group is not discharged within initial 72 hours their Length of Stay (LOS) increases to > 21 days (1 in 5 people over 75 will be admitted to our hospitals as an emergency case this year and spend an average of 28 days as an in-patient)

Data demonstrates that the greatest opportunity for provision of safe, sustainable, equitable and kind UEC is therefore linked with :

1. Reducing Conveyance to hospital for our frail
2. Reducing Conversion rates proportionately where appropriate to do so for our frail population
3. Enhancing our inpatient management of Complexity (frailty)

This is our 3Cs approach to our UEC Transformation, the planning approach for which will align to the 6 Goals UEC national framework

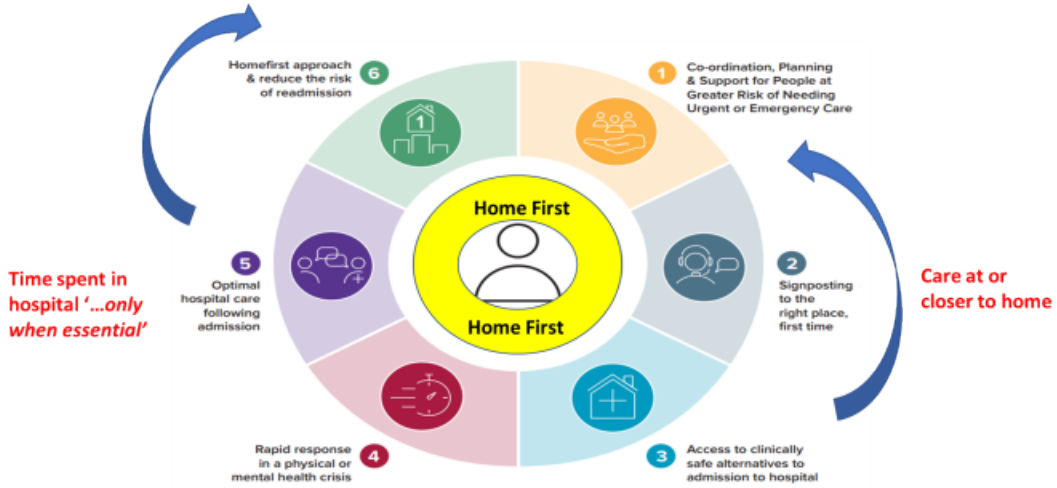
However, for 2022/23 we will be focusing on our over 75s. If we can increase our current discharge rate by 10% and reduce our Average Length of Stay by 1 day this would provide us with 80 bed efficiency by October 2022 and 100 by March 2022. There are on average 58 patients unplaced at our front doors across our health board so this year's improvement should be based on reducing this and getting our front doors working correctly.

Reducing Conveyance to Hospital (Aligning to Policy Goals 1, 2 & 3)

- Stratification of patients whose needs present with increased risk of admission due to the frail nature of their health needs. These patients will be proactively monitored to support early identification of exacerbation / decompensation of their conditions in order that preventative care and treatment is provided in a timely manner and at home where it is deemed safe and appropriate to do so (Policy Goal 1, Policy Goal 2 and Policy Goal 3). These solutions require robust development of digital infrastructure.(outlined in two of our Planning Objectives - 5M and 5R)
- The provision of safe alternatives to hospital care e.g. intermediate care and End of Life / Palliative Care (Policy Goal 3) NB this is described in detail in one of our Planning Objective - 5S)

Reducing Conversion Rates (Aligning to Policy Goals 2, 3, 4 & 6)

- Implementation of Local Flow Hub to manage dispositions from 111 First, WAST and Emergency Departments to stream patients to more appropriate pathways for their needs (UEC Policy Goal 2). It is our expectation to have implemented an integrated UPC pathway across the University Health Board by December 2022
- Enhancing Same Day Emergency Care (SDEC) or Same Day Urgent Care provision to support diagnosis and consequently the delivery of care and treatment in the community – not in hospital (Policy Goal 3) . We will be working towards the Welsh Government expectation that we have a 7/7 12hour SDEC service on all our sites by the end of 2024.



Right Care, Right Place, First Time…….at Home, Not Hospital

Enhancing Inpatient Management of the Complex / Frail (Aligning to Policy Goals 3, 4, 5 & 6)

- Implement the principles and minimum standards of care associated with achieving optimal outcomes for frail inpatients as outlined in the British Geriatric Society Improving Healthcare for Older People' Fit for Frailty' report :
  - 'Turnaround at the Front Door' within 12 hours (50% of all frail attenders) use of Same Day Emergency Care and Intermediate Care / Wrap Around Care
  - Comprehensive Geriatric Assessment and Planning to support discharge for further 25% within 72 hours. Use of Clinical Decision Units, Acute Medical Assessment Units, Frailty Assessment Units
  - For the remaining 25%, Length of Stay should be no more than 10 days. Identify and overcome internal efficiencies to deliver improvement for example SAFER patient bundle, Red2Green, Board Rounds etc. Implementation of Discharge to Assess pathways supported by Enhanced Bridging Service

Further support for our patients Enhanced Bridging Service

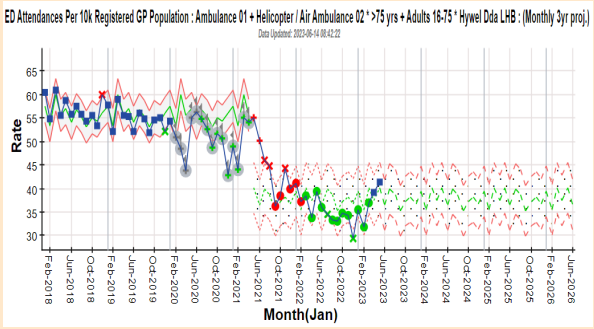
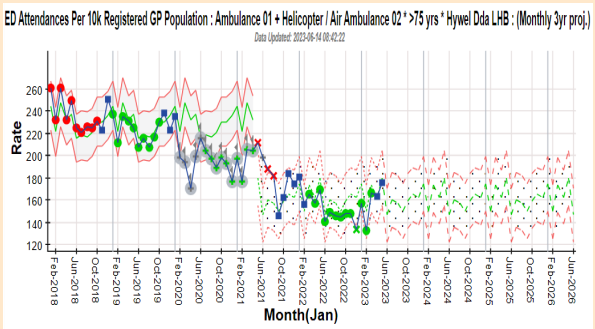
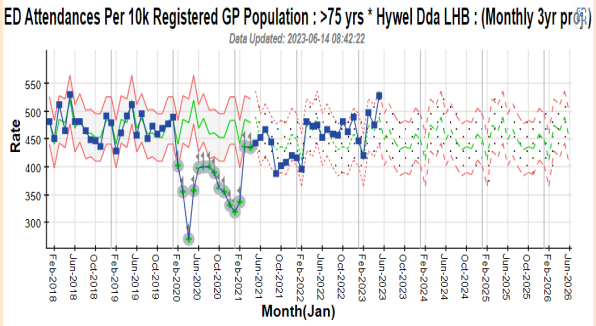
Nationally there is insufficient home based care available to meet the demand. This is impacting on patients who no longer require acute hospital care being able to safely transfer to their next phase of care in the community. Our Home First (integrated intermediate care) service has been reviewing these patients and where able have been expediting their discharge by providing 'bridging' care package until their long term care and support is available. This also reduces further deconditioning and more care requirement due to prolonged hospital stay.

There is a requirement for us to increase 'bed capacity' in the community by 120. Recruitment has commenced to enhance our Home First service with sufficient home care workers to reduce the number of 'Ready to Go' patients waiting for home care in our inpatient units. Further this resource will contribute to the provision of 'safe alternatives to hospital admission'. Development will continue to ensure that the workforce capacity is developed further in order to bridge a safe and sustainable transfer home for those:

- individuals at home to prevent or reduce the risk of an urgent admission to hospital / residential care
- individuals in an acute or community hospital bed who require care to enable their discharge home
- individuals in an Interim care bed to support transfer home

Y gofal iawn, yn y lle iawn, y tro cyntaf
Chwe Nod ar gyfer Gofal Brys a Gofal mewn Argyfwng
Right care, right place, first time
Six Goals for Urgent and Emergency Care

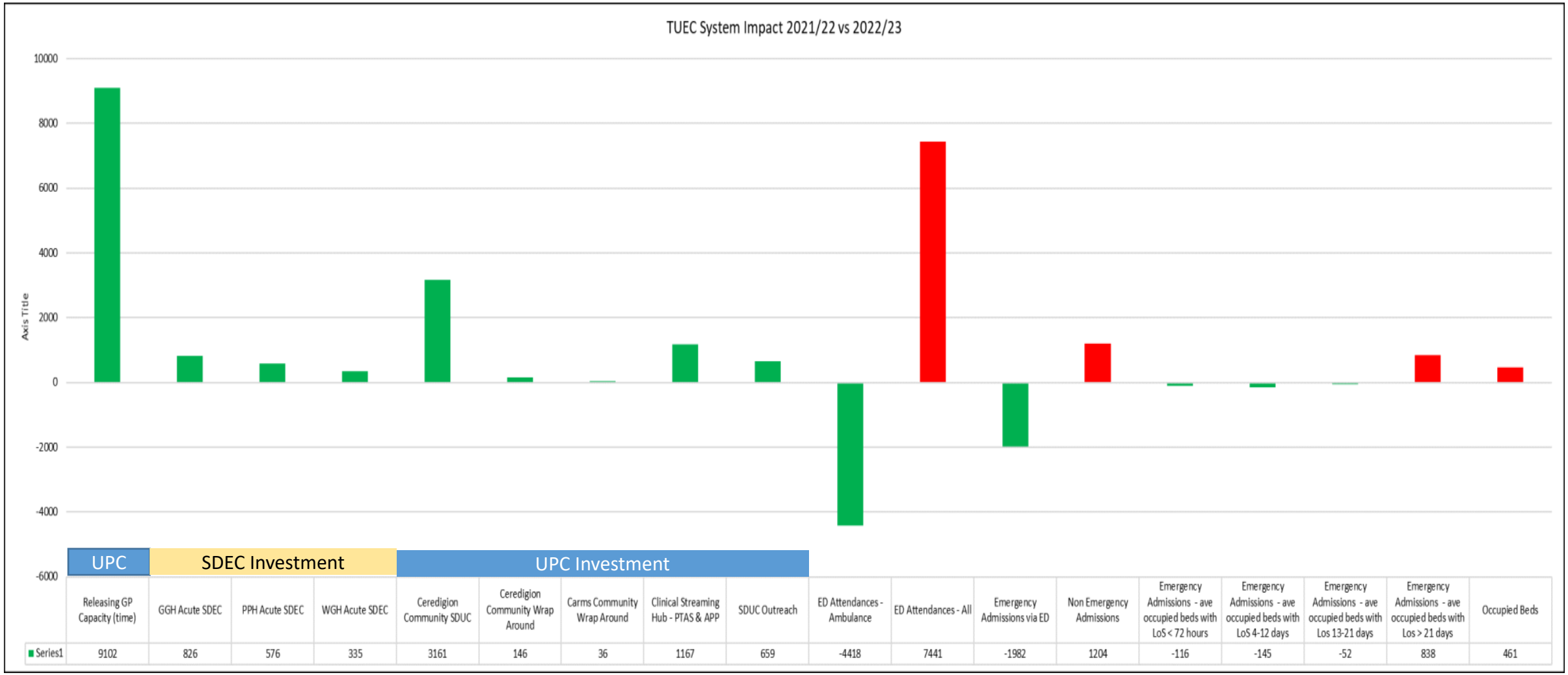
GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

Targeted Programme Outcome	Planning Objective	Actions initiated	Impact achieved
Reduction in Conveyance & Self- Presentation Reduction Aligning to Policy Goals 1,2 & 3	• Stratification of patients whose needs present with increased risk of admission due to the frail nature of their health needs. These patients will be proactively monitored to support early identification of exacerbation / decompensation of their conditions in order that preventative care and treatment is provided in a timely manner and at home where it is deemed safe and appropriate to do so (Policy Goal 1, Policy Goal 2 and Policy Goal 3). These solutions require robust development of digital infrastructure. (outlined in two of our Planning Objectives - 5M and 5R) • The provision of safe alternatives to hospital care e.g. intermediate care and End of Life / Palliative Care (Policy Goal 3) NB this is described in detail in one of our Planning Objective - 5S)	APP navigator model piloted in Carmarthenshire. Currently being evaluated to consider spread and scale across other counties within the region. Intermediate Care / Home First hubs established providing direct access for health care colleagues to alternative pathways & delivery of the PTAS model Virtual UPCC model developed and implemented – 77% GP practices signed up to deliver model, working alongside Community wrap around resources to enable care to be delivered closer to home and provide alternatives to admission Fit2Sit protocol re-established Proactive monitoring and tech solutions for long term conditions – evaluation of projects to enable scale up where appropriate Protocols established to facilitate direct referrals from WAST to SDECs	All Adults  >75s  

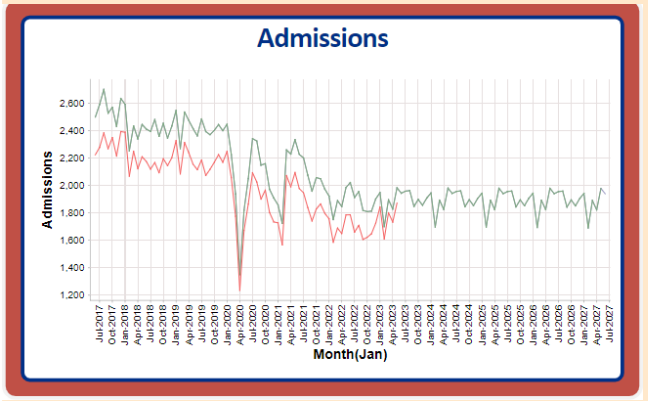
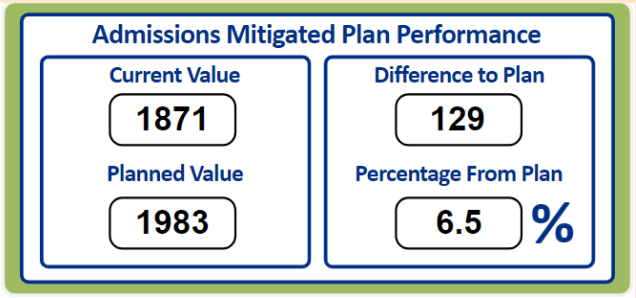
Y gofal iawn, yn y lle iawn, y tro cyntaf
Chwe Nod ar gyfer Gofal Brys a Gofal mewn Argyfwng
Right care, right place, first time
Six Goals for Urgent and Emergency Care

GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

TUEC System Investment Impact 2021/22 vs 2022/23
Urgent Primary Care and Same Day Emergency Care

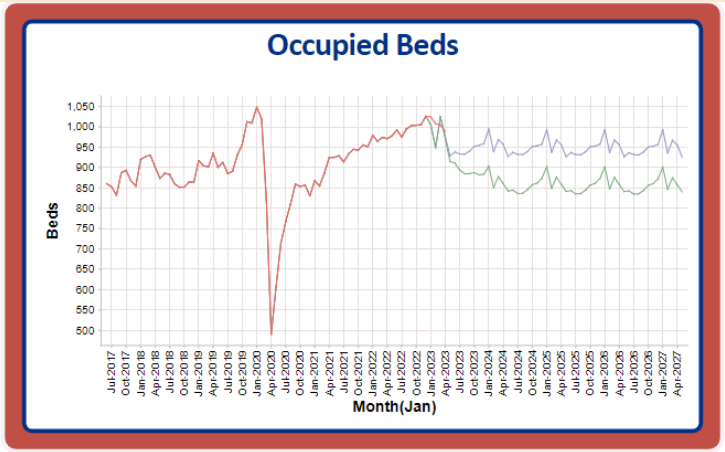
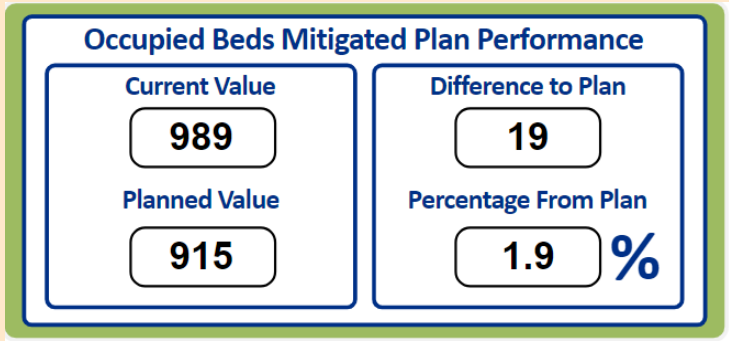


	UPC	SDEC Investment			UPC Investment												
	Releasing GP Capacity (time)	GGH Acute SDEC	PPH Acute SDEC	WGH Acute SDEC	Ceredigion Community SDUC	Ceredigion Community Wrap Around	Carms Community Wrap Around	Clinical Streaming Hub - PTAS & APP	SDUC Outreach	ED Attendances - Ambulance	ED Attendances - All	Emergency Admissions via ED	Non Emergency Admissions	Emergency Admissions - ave occupied beds with LoS < 72 hours	Emergency Admissions - ave occupied beds with LoS 4-12 days	Emergency Admissions - ave occupied beds with Los 13-21 days	Emergency Admissions - ave occupied beds with Los > 21 days	Occupied Beds
Series1	9102	826	576	335	3161	146	36	1167	659	-4418	7441	-1982	1204	-116	-145	-52	838	461

Targeted Programme Outcome	Planning Objective	Actions initiated	Impact achieved
Reduction in Conversion Rates Aligning to Policy Goals 2,3,4 & 6	• Implementation of Local Flow Hub to manage dispositions from 111 First, WAST and Emergency Departments to stream patients to more appropriate pathways for their needs (UEC Policy Goal 2). It is our expectation to have implemented an integrated UPC pathway across the University Health Board by December 2022 • Enhancing Same Day Emergency Care (SDEC) or Same Day Urgent Care provision to support diagnosis and consequently the delivery of care and treatment in the community & not in hospital.	SDEC re-established on all acute sites SDUC and outreach service in South Ceredigion established Peer review of SDEC / SDUC services undertaken early 2023 – early indications demonstrate positive clinical engagement and **the opportunity for cross pollination of models** Demand and capacity modelling of SDEC requirements to understand the need, if any, of 7 days services Mental Health single point of contact & alternative pathways established Mental Health twilight service being introduced Alignment with Safe Care Collaborative program	**All Adults**   

Y gofal iawn, yn y lle iawn, y tro cyntaf
Chwe Nod ar gyfer Gofal Brys a Gofal mewn Argyfwng
Right care, right place, first time
Six Goals for Urgent and Emergency Care

GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

Targeted Programme Outcome	Planning Objective	Actions initiated	Impact achieved
Enhancing Inpatient Management of the Complex / Frail Aligning to Policy Goals 3, 4, 5 & 6	• Implement the principles and minimum standards of care associated with achieving optimal outcomes for frail inpatients as outlined in the British Geriatric Society Improving Healthcare for Older People ' Fit for Frailty' report; ○ 'Turnaround at the Front Door' with in 12 hours (50% of all frail attenders) use of Same Day Emergency Care and Intermediate Care / Wrap Around Care ○ Comprehensive Geriatric Assessment and Planning to support discharge for further 25% within 72 hours. Use of Clinical Decision Units, Acute Medical Assessment Units, Frailty Assessment Units ○ For the remaining 25%, Length of Stay should be no more than 10 days. Identify and overcome internal efficiencies to deliver improvements for example SAFER patient bundle, Red2Green, Board Rounds etc. ○ Implementation of Discharge to Assess pathways supported by Enhanced Bridging Service	Digital solution commissioned from Third Party; Frontier platform designed and built for automatic prediction of EDD - discovery phase completed and roll out commenced February 2023 Early identification of frail elderly methodology including CGA agreed and roll out commenced Pilot of reporting of pathways of care delays undertaken to re-establish processes across the three LA areas HDuUHB were key members of the national group developing the Optimal Hospital Flow Toolkit building on best practice of board round initiatives undertaken by Quality & Improvement Colleagues and roll out of Real Time Demand & Capacity (RTDC) programme – targeted roll out for key areas commencing March 2023	**All Adults**  

Y gofal iawn, yn y lle iawn, y tro cyntaf
Chwe Nod ar gyfer Gofal Brys a Gofal mewn Argyfwng
Right care, right place, first time
Six Goals for Urgent and Emergency Care

GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

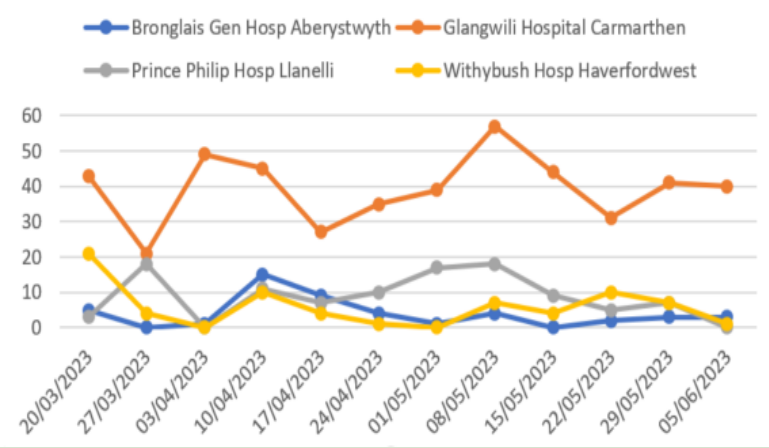
Targeted Operational Outcome	Actions Initiated
Ambulance Handover Delays Number of delays Lost hours Emergency Department 12 hour performance Red Performance	Consequential impact of APP Navigator/PTAS model on front door demand Impact of SDEC developments in reducing ED capacity pressures supporting improved handover performance and reduced ED LoS Deep dive reviews into extended handover delays and identification of site specific lessons Executive Team to visit Cardiff & Vale UHB to explore actions taken to improve handover delays Phased development of front door streaming models WGH & GGH Extension of RTDC models from GGH to other sites Refreshed focus on SAFER methodology and Boards Rounds

Y gofal iawn, yn y lle iawn, y tro cyntaf
Chwe Nod ar gyfer Gofal Brys a Gofal mewn Argyfwng
Right care, right place, first time
Six Goals for Urgent and Emergency Care

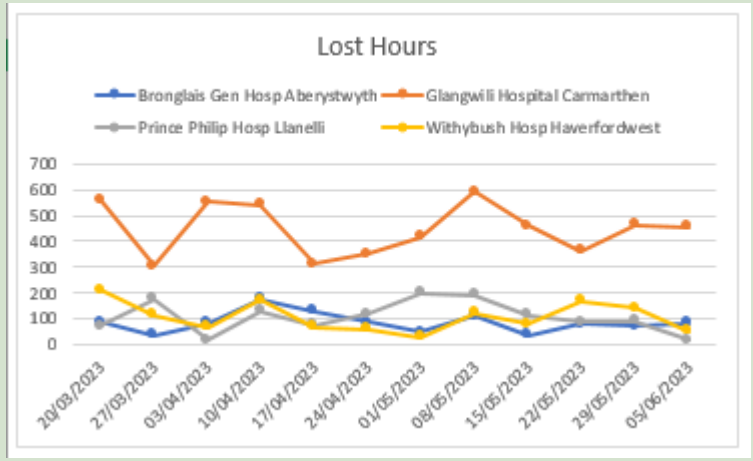
GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

Impact to date

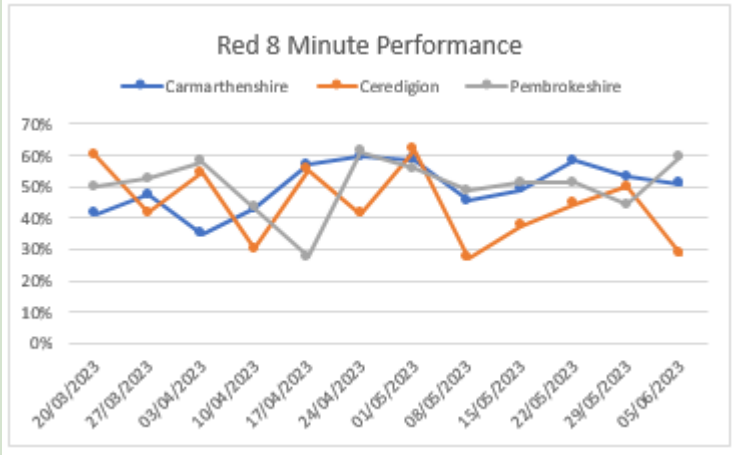
Ambulance delays > 4 hours



Ambulance Lost Hours

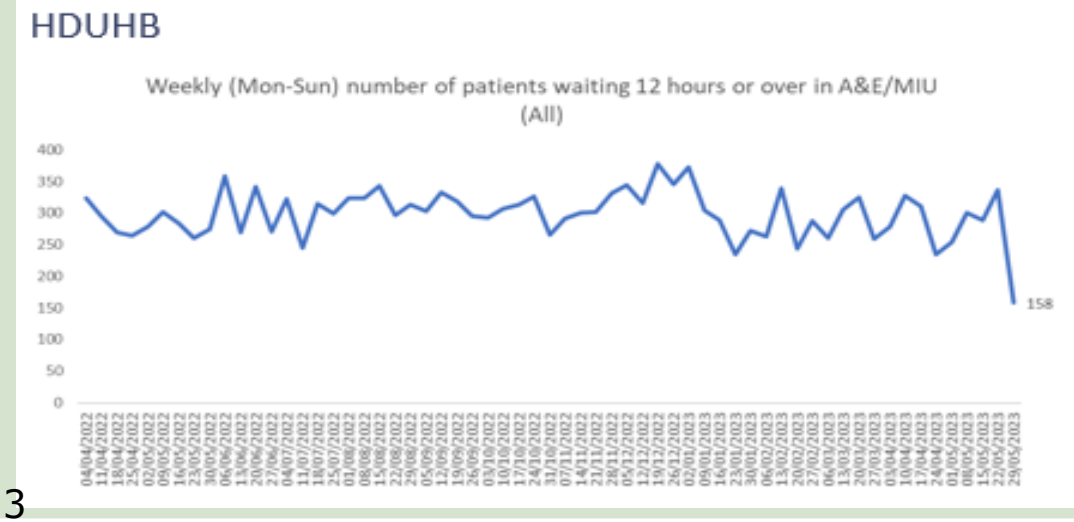


Ambulance Red Performance

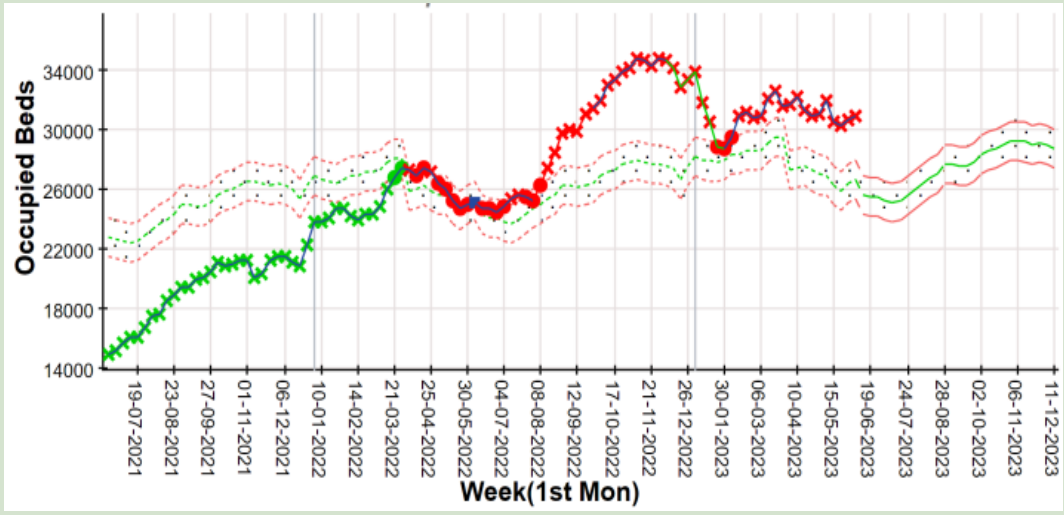


Data source: EASC and WAST handover notifications

Emergency Department 12 Hour performance



Occupied Bed Days Patients LoS > 21 days



Y gofal iawn, yn y lle iawn, y tro cyntaf
Chwe Nod ar gyfer Gofal Brys a Gofal mewn Argyfwng
Right care, right place, first time
Six Goals for Urgent and Emergency Care

GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

TUEC Priorities going into 2023 – 24

Y gofal iawn, yn y lle iawn, y tro cyntaf
Chwe Nod ar gyfer Gofal Brys a Gofal mewn Argyfwng
Right care, right place, first time
Six Goals for Urgent and Emergency Care

TUEC 6 Goals Programme Priorities 2023/24

GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

Initiative	Actions	Timescale
Regional Clinical Streaming Hub (Policy Goal 2 & 4)	APP Navigator scale up and roll out	External evaluation due end Feb 2023
	Agreement of optimal 24/7 model (integration with GPOOHs resources) and outcome measures	From March 2023
	Roll out of Community Wellbeing Responders aligned to GP OOH and WAST	From end March 2023
Care Home Support (Policy Goal 2)	Immedicare Pilot (Carmarthenshire)	May/June 2023
	Consultant Connect model with secondary care support (Pembs)	End March 2023
Health & Care system for Older People in West Wales (Policy Goals 1 and 6)	Development of Home First approach for West Wales – What good should look like?	End March 2023
	Scale up of Home First to 7 days	From May 2023
	Regional Integrated Demand & Capacity Modelling & Commissioning of services to meet needs	Autumn 2023
Same Day Emergency Care (Policy Goal 3)	Development of HDdUHB model following on from lessons learnt from peer review, including modelling of scale of opportunity Submission of Reviewed SDEC plan 24 March 2023 Implementation of new model	End March 2023 From April 2023
Front Door Streaming / Assessment Units (Policy Goal 3 and 5)	Modelling of front door assessment unit provision for each acute site	From March 2023
	Development and implementation of acute site operational plans	From end Feb 2023
SAFER Implementation (Policy Goal 5)	Phased implementation of SAFER and Frontier Discharge platform	From March 2023

Recommendation

- For the Committee to receive assurance from the Winter Plan Evaluation 2022/23 Presentation.