Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

PWYLLGOR DATBLYGU STRATEGOL A CHYFLENWI GWEITHREDOL
STRATEGIC DEVELOPMENT AND OPERATIONAL DELIVERY COMMITTEE

DYDDIAD Y CYFARFOD: DATE OF MEETING:	26 August 2021
TEITL YR ADRODDIAD: TITLE OF REPORT:	Regional Integrated Winter Plan 2021/22
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Andrew Carruthers, Director of Operations
SWYDDOG ADRODD: REPORTING OFFICER:	Alison Bishop, Urgent & Emergency Care Lead

Pwrpas yr Adroddiad (dewiswch fel yn addas)
Purpose of the Report (select as appropriate)

Er Sicrwydd/For Assurance

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

This paper provides the Committee with a progress update on Hywel Dda University Health Board's (HDdUHB) winter planning processes in place for 2021/22. The report and the underlying planning is driven from the perspective of maintaining safety, quality and continuity of care for HDdUHB's patients through the most consistently challenging period in the history of the NHS.

Cefndir / Background

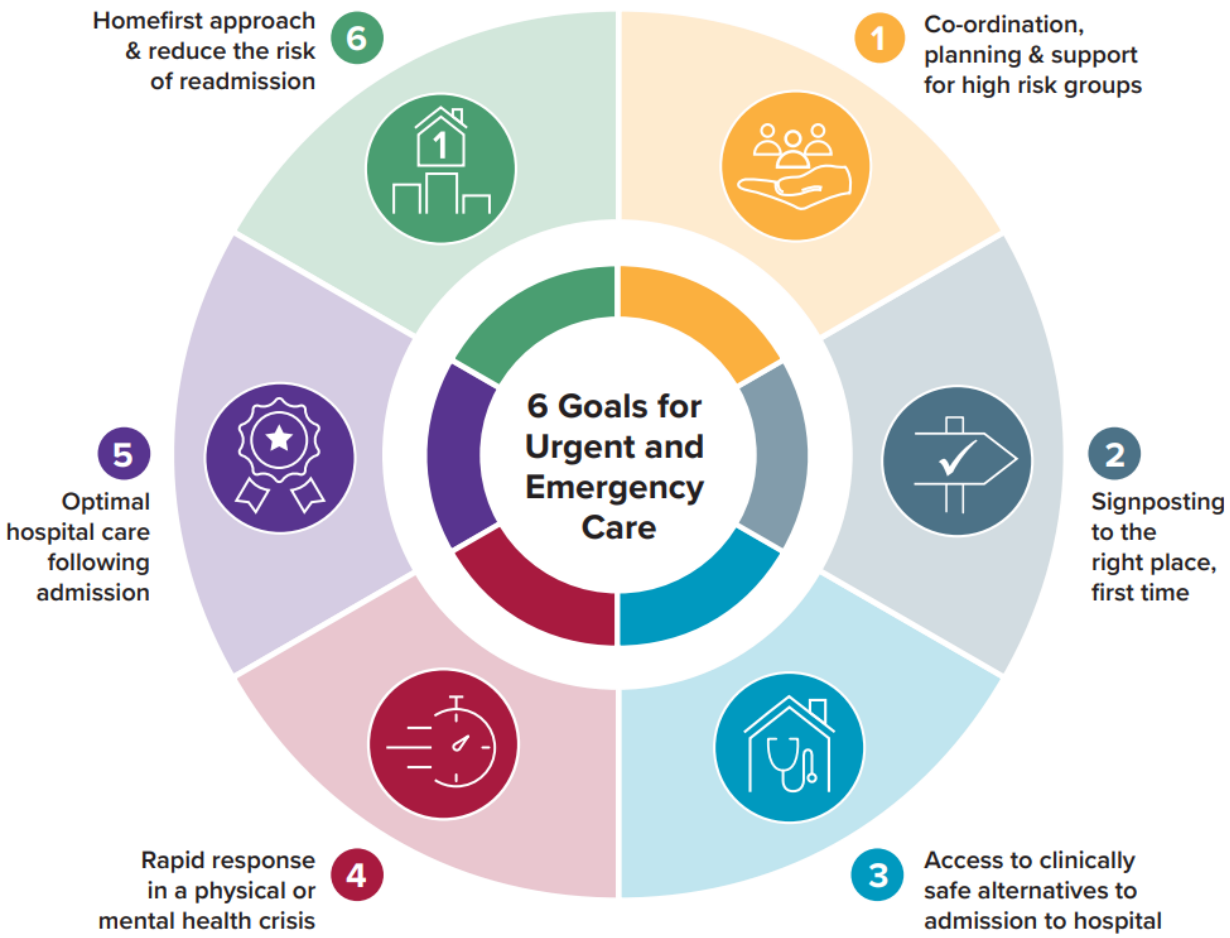
Over the past two winter seasons a risk-centered approach has been used to develop an integrated plan with Local Authority, Welsh Ambulance Service Trust (WAST) and Third Sector providers. The advent of the COVID-19 pandemic added a further layer of complexity to the winter planning process last year, however the same integrated regional approach was utilised.

In contrast to previous years where a generic Winter funding stream has been provided to both health and social care partners, Welsh Government (WG) funding streams for winter 2020/21 were provided against specific work streams; these being:

- Discharge to Recover and Assess (D2RA) funding to support discharge (allocated via the Regional Partnership Board - RPB).
- Urgent Primary Care funding to support alternative access to emergency departments (ED).
- Same Day Emergency Care/ Ambulatory Emergency Care (SDEC/ AEC) to support admission avoidance and front door turnaround.
- 4 Harms additional funding provided to support D2RA funding.
- Quarter 3/4 2020/21 funding to support acute services delivery.

A recurrent theme in feedback to WG colleagues is the challenges in delivering impact and benefit against short-term funding due to, amongst other factors, inability to recruit on a temporary or short-term basis and delays in the provision of funding.

In March 2021, the Minister for Health and Social Services announced a £25m recurrent revenue fund - the Urgent Emergency Care (UEC) Transformation Fund - to enable accelerated delivery of a small number of key deliverables that, when considered together, should form part of an integrated urgent and emergency care model. WG expectations for urgent and emergency care are shaped around six UEC policy goals:



For 2021/22, the funding is targeted towards policy goals two and three, '*Signposting people to the right place, first time'* and *'Assess to clinically safe alternatives to admission to hospital'.*

The Minister also announced the extension of the Transformation Fund in light of the impact of COVID-19 and specifically announced £6m to assist with the scaling of hospital to home models (D2RA) at a regional level to embed a national model of working. The West Wales Care Partnership was awarded £774k as part of this fund for the financial year ending 31st March 2022. This funding supports the delivery of policy goal six, *'Home First approach and reduce the risk of readmission.'*

At the time of preparing this report, WG has not provided any additional specific guidance on winter planning and additional funding for Winter 2021/22.

Asesiad / Assessment

Impact of COVID-19

As reported by the Chief Executive to the Board at its meeting on 29th July 2021, the situation regarding the COVID-19 pandemic has changed markedly since last Winter, in that the early

stages of the third wave of the pandemic are coinciding with the final stages of the largest Mass Vaccination Programme in NHS history.

With improved summer weather, school holidays and an increasingly large proportion of the Health Board's (HB) population having the benefit of 2 vaccination doses, there is room for cautious optimism that this third wave will not be as severe as that experienced over the previous Winter period, when the vaccination campaign had only just commenced. Risks remain and the HB will continue to follow all guidance and advice from WG and the Joint Committee on Vaccinations and Immunisations (JCVI).

HDdUHB's hospitals and community services remain exceptionally busy, with occupancy across the 4 main hospital sites close to 100% at times, with pressure on beds, social care capacity and staffing shortfalls being the main challenges. Whilst sickness levels are currently only slightly above pre-COVID levels, fatigue and the desire on the part of staff to take some annual leave are all playing a part in the current system-wide pressures. As a partial mitigation, the Field Hospital based in the Selwyn Samuel Centre, Llanelli has now been placed in hibernation, enabling staff to be brought back onto the main sites.

The level of pressure seems unlikely to reduce in the foreseeable future, which places further emphasis on the actions set out in the HB's Recovery Plan for 2021/22, particularly in terms of support for staff, health and wellbeing and the work now underway to implement a comprehensive 24/7 out-of-hospital urgent care response.

Work continues to expand planned care services, with theatre capacity across the 4 sites now at approximately 70% and use of the independent sector providing additional short-term capacity. However, with site pressures remaining high there are likely to be times in the coming weeks and months when planned inpatient activity may need to be postponed to deal with unscheduled care pressures and demand for intensive care beds.

The National Modelling Cell is still working through scenarios of the combined impact of COVID-19 and other winter conditions such as Influenza and Norovirus and the impact that this will have on the HB's bed capacity. The greatest risk associated with this impact is the risk to staffing, in terms of sickness levels and also the additional resources that may be required to open additional surge beds and/ or bring the field hospital capacity out of hibernation.

<u>Impact of Respiratory Syncytial Virus (RSV)</u>

RSV is a respiratory virus which is regularly seen in paediatric presentations during the winter months. Due to COVID-19 lock-down measures and the subsequent relaxing of said measures, it had been anticipated that the RSV season is likely to begin earlier than normal in the year, as children begin to mix as restrictions relax. Public Health Wales has announced that the threshold has been met in terms of presentations, meaning the season has now commenced. The season is expected to last until March 2022, with a provisional peak in November 2021.

The vast majority of attenders are likely to require ward-level care (Level 0) - essentially receipt of oxygen to support them as they stabilise. In some cases, where high-flow oxygen is needed, patients may be in receipt of Level 1 care. A minority of presentations may require enhanced care in terms of High Dependency (Level 2). Finally, nominal numbers may result in requiring Level 3 Critical Care - currently this is only offered in Cardiff.

Work is ongoing nationally to forecast the impact on services if the respiratory demand seen in the past 4 years between September and March, i.e. the normal RSV season, increases by 50%, and in the past week a request has been made to model an increase in this demand to 100% surge. This modelling is ongoing across Wales.

For the HB the impact of an increase of 50% in RSV presentations would result in:

- PACU attendances increase from 16 to 24 cases per 24 hours
- Ward Level care increase from 11 to 16.5 cases per 24 hours
- HDU Level care increase from 1.2 to 1.8 patients per 24 hours.

Lengths of stay are shown to range from 4 hours (PACU) to 1.8 days (Ward) to 3.5 days (HDU). It is the length of stay which will directly impact on the HB's ability to manage any surge, especially at ward level where the capacity may be consumed after 2 days.

Analysis has forecasted that, with a projected increase in demand of 50%, there is a gap of 14.45 WTE Registered Nurses**.** Workforce modelling has identified potential redeployments which would enable this gap to be reduced to 3.45 WTE. If this were to be increased to a 100% surge, there would be little further opportunity for redeployment, and therefore a significant risk as recruitment of additional staffing resources would be required.

Surge planning has identified a number of areas in which cost pressures will be incurred, with total costs of RSV surge at this stage being £954k. Confirmation is being sought as to whether financial support from WG is available.

It should be noted that, in the event that a 50% rise in RSV attendances is realised, coupled with ongoing non-infective urgent and routine work, there will undoubtedly be a negative impact on the HB's ability to maintain elective capacity in response to demand and an increase in clinical safety risks, which will ultimately place the service at risk of maintaining delivery.

<u>Impact of Fragile Domiciliary Care Market</u>

The stability of domiciliary care providers is critical to the stability of the whole health and care system. Historically, staff recruitment and retention has been challenging within the care sector, and has run on an average vacancy factor of around 8% to 9%[1]. COVID-19 has exacerbated this and, quite simply, there is no other resource available to fill this void.

The demand for domiciliary care is increasing and continues to outweigh the capacity to supply, with some of the more rural areas considered to be particularly challenging. The current position indicates that although work is ongoing to improve availability of services, the number of people waiting for a package of care continues to rise.

The workforce for the whole health and social care system has become more fragile since the COVID-19 pandemic. This is particularly acute in the domiciliary care sector which historically has experienced recruitment and retention problems, which are now being compounded by staff absences due to self-isolation and self-shielding.

There are other contributing factors which have resulted in the capacity to supply becoming more fragile, which include:

- An evident increased level of frailty in the community which is generating a significantly higher demand on finite social care resource in terms of volume and frequency

- The capacity of Social Workers to review packages more frequently

1. SKILLS FOR CARE: THE STATE OF THE ADULT SOCIAL CARE SECTOR AND WORKFORCE IN ENGLAND (OCT 2019) REPORTED THAT "IN ENGLAND, THE AVERAGE VACANCY RATE WAS 7.8%". SOCIAL CARE WALES WORKFORCE DEVELOPMENT PROGRAMME (SCWWDP) – WORKFORCE DATA COLLECTION 2017: COMMISSIONED CARE PROVIDER SERVICES CARE REPORTED THAT "PROVIDERS COMMISSIONED BY CARMARTHENSHIRE AND SWANSEA HAD THE HIGHEST PERCENTAGE OF REPORTED VACANCIES (9%) IN WALES".

- A reduced independent sector care market due to compromised business viability
- Increased recruitment and retention challenges

Consequently, the fragility in domiciliary care is compounding the HB's UEC system, both in terms of admission avoidance and ensuring efficient discharge from hospital.

There are a number of mitigating actions which contribute to the HB's risk escalation management while longer term sustainability plans are implemented. These include:

- Where appropriate the use of **Step Down assessment beds** to support transfer from the acute hospital setting when domiciliary care is not available;
- **Proportionate commissioning and 'Rightsizing'** – a review is undertaken during the initial weeks of a care package being provided to ensure it optimises the individual's level of independence. This also ensures that additional care capacity is released to support other individuals who may require it;
- **Patch based approach to provision** - collaboration between providers within a geographical area will be promoted and developed. Teams of staff dedicated to working within small "patches" could minimise the spread of infections between communities as well as maximising the time available to provide care by minimising travel time;
- **Routine COVID testing of staff and adherence to self-isolation protocols**
- **Communication with the public** – ensure that consistent messages are communicated to hospital patients and their families about the importance of their cooperation and support in achieving a timely discharge as soon as their treatment is completed – this may mean the acceptance of care and support which meets assessed needs however may not be at the specific times requested by the individual/ family;
- **Workforce Flexibility** – Service Level Agreements have been drafted to deploy health and social care staff to those parts of the system in greatest need. This approach is likely to include deploying staff covering vacancies/ staff absences in domiciliary care services.
- **Peripatetic Workforce** – *in extremis*, each Local Authority may have local arrangements for a pool of health and social care workers to provide surge capacity and to address workforce shortages with in-house services or independent sector providers, wherever needed.

<u>Urgent & Emergency Care Whole System Model</u>

Evaluation of data for both last Winter and the previous 2 years, utilising the Lightfoot data viewer, has identified the following key issues as the root cause of UEC pressures:

- **Conveyance**
  The national target for conveyance by ambulance to hospital is 60% and, while conveyance rates across all 3 counties within the HB are decreasing, they still remain higher than the target. WAST data demonstrates that a higher proportion of older people are conveyed to hospital in Hywel Dda compared to the rest of Wales. Similarly, there is a higher proportion of Health Care Professional requests for conveyance for Older People.
- **Conversion and Admission Rates**
  Conversion rates for frail older people are higher than the national average. Data shows that admission rates for older people aged between 74 – 85 years have been increasing over the past three years, however those for patients over 85 years have

'flat-lined'. It is apparent that complexity associated with frailty syndrome is contributing to long lengths of stay and a considerable impact on hospital 'flow'.

- **Complexity/** frailty management
  The data also demonstrated that the HB's inability to discharge patients (both frail and non-frail) within a 72-hour period resulted in an average length of stay of 21 days.

As part of the Urgent Emergency Care (UEC) Transformation Fund, the HB proposed an ambitious whole system UEC model to address these 3 key issues, locally referred to as the 3C programme. A copy of the UEC model can be found in Appendix 1. This programme will aim to enhance the UEC provision in HDdUHB over the next two years, commencing prior to winter 2021, and aligned to UEC policy goals two and three:

- **Think 111 First**

Development of a Local Streaming Hub which aligns to the national principles of 'Think 111 First'. GP Navigators in the 'Streaming Hub' will assess ED/ MIU dispositions from '111' initially according to the national WAST/ '111' proposed roll out programme across Health Boards.

In time, the 'Streaming Hub' will develop to be able to receive referrals from WAST, ED/ MIU and Primary Care Contractors. The latter specifically will be able to schedule timely appointments to Same Day Emergency Care (SDEC) and/ or 'hot' clinics to support clinical decision making and admission avoidance.

Minimal national standards to implement 'Think 111 First' include 24/7 clinical navigation (assessment) by appropriately qualified physicians and the capacity to schedule onward appointments for ED/ MIU, SDEC/ Hot Clinic and Urgent Primary Care assessment. All calls are mandated nationally to be responded to within a one-hour timeframe.

- **Physician Triage Assessment and Streaming (PTAS) of WAST 'stack'**

GP Navigators in the 'Streaming Hub' will also undertake PTAS of the WAST Clinical Stack. They will identify patients pending ambulance conveyance to hospital and, with the WAST multidisciplinary team, determine whether conveyance can be avoided. Conveyance avoidance will be aided by rapid access to diagnostics in SDEC where appropriate and intermediate care provision in the community.

- **Same Day Emergency Care (SDEC)**

The development of locality/ community SDECs and Hot Clinics will provide vital access points other than the 'front door' for the 'Streaming Hub' to reduce conveyance and consequent hospital admission.

GP access to SDEC for diagnostics and specialist advice to inform decision-making and consequently provide 'hospital care – at home' could contribute to reducing unscheduled care demand at the acute hospital 'front door'.

- **Virtual Urgent Primary Care Centre (UPCC)**

The development of a 'Virtual UPCC' model delivered by Practices and Pan Cluster to accommodate any 'Unmet Primary Care Need' that needs to be redirected to Primary Care by the 'Streaming Hub' when it is established.

This model will provide enhanced access to Urgent Primary Care assessment and treatment by a skilled multi-professional team 24/7 (including integration with GP Out of Hours services). The GPs within the HB clusters clearly articulated their desire to manage their own patients should they present inappropriately to 111, ED and / or WAST, as

opposed to the development of a separate Urgent Care Centre in line with other models across Wales.

Evidence suggests that the enhancement of pathways across primary and community care will contribute to reducing attendance and conveyance by WAST to ED. Specifically, the data indicates that this is particularly the case for frail older people. An enhanced and integrated Primary Care and community provision will support the early identification of patients with complex needs who are at high risk of disease exacerbation and functional decline (including falls), and will provide targeted monitoring and rapid response to health compromise. This 'hospital at home' model will be delivered by multi-skilled professionals in Primary Care, supported by community nursing, social care and therapy.

Three distinct phases of development are proposed below for the Urgent Care model which align to minimal national expectations:

Phase 1: PTAS of WAST Clinical Stack	August 2021
Phase 2: 111 First' ED/MIU Disposition and Scheduling	October 2021
Phase 3: Virtual UPCC Centre	October 2021
Phase 4: Fully Operational Streaming Hub	Autumn 2021

It is acknowledged that the infrastructure to implement the phases outlined above vary across acute hospital sites and Primary Care/ community services in terms of capacity to manage demand, both in terms of numbers and range of alternative pathways. As such, it is anticipated that the implementation of each phase will be assessed, planned and developed according to the baseline position of the site/ service and delivery of the vision across a two-year period.

Evaluation of the impact of these phased changes, locally known as the 'so what' metrics, will be monitored through a performance dashboard which will utilise a minimum data set:

- Reduced conveyance
- Reduced ED attenders
- Reduced occupied bed days
- Reduced numbers of patients with a Length of Stay < 21 days

<u>Regional Transformation Scaling Fund</u>

The aim of this additional funding is to support scaling up of hospital to home models. The D2RA pathways are key to this model and are designed to support people to recover at home before being assessed for any ongoing need. Projects should be focused within the community or people's homes, to deliver what matters to people and reduce the need for primary and secondary interventions.

The intention of the funding is to build on existing D2RA activity in order to scale up work already being undertaken in the regions and, as such, the West Wales Regional Partnership Board has taken the approach to utilise the funding in 2 ways which all align to UEC Policy goal six;

1. To scale up existing initiatives demonstrated to have impacted during Winter 2020/21:
    - Wellbeing officers to provide low-level proportionate assessment and support safe discharges from Prince Philip Hospital and Glangwili General Hospital. Continuation of Winter Protection project, which has supported around 400 discharges with a preventative outcome.
    - Facilitating D2RA pathway 2 through delivering assessments in patients' homes and developing a trusted assessor model to streamline processes and reduce duplication

of effort across the multi-disciplinary professionals. Building on the learning from the current successful winter funding pilot scheme to implement/ support D2RA pathway 2 and front door turnaround.

2. To pilot new initiatives to demonstrate benefit and impact in anticipation of Winter 2021/22

   - Enabling the function of care traffic control at Porth Gofal to facilitate discharge from Bronglais General Hospital and ensure effective community working.
   - Local volunteer support, the recruitment of volunteers to provide short term low level support as part of the well-established PIVOT service in Pembrokeshire. Providing regular contact for people locally who are socially isolated, including face-to-face and remote befriending.
   - Community activities to avoid long-term mental health issues. Establishment of a supported activity programme enabling people to re-engage socially with their communities and avoid long-term mental health issues. A Third Sector-led project.
   - Domiciliary Care Medication Administration and Support, improving the care of clients in domiciliary care settings, through a collaborative regional approach to medicines optimisation. Improvements in discharge planning will support the transition from hospital to home. Improved health outcomes would be expected as a result of improved processes and efficiency for queries with respect to the management of medicines in domiciliary care settings.

The combined impact of all these initiatives, across UEC and also D2RA Pathways, is to ensure that people can access the right care, in the right place, first time at home and not in hospital.

Argymhelliad / Recommendation

The Committee is asked to

- Take assurance from the progress made in regard to preparations for Winter 2021/22.

Amcanion: (rhaid cwblhau) Objectives: (must be completed)	
Committee ToR Reference: Cyfeirnod Cylch Gorchwyl y Pwyllgor:	2.2 Provide assurance to the Board that the planning cycle is being taken forward and implemented in accordance with University Health Board and Welsh Government requirements, guidance and timescales.
Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	Risk no 889 (score 12 - high) Delivery of QTR 2 operating plan - Delayed discharges.
Safon(au) Gofal ac Iechyd: Health and Care Standard(s):	5. Timely Care 3.1 Safe and Clinically Effective Care

Amcanion Strategol y BIP: UHB Strategic Objectives:	2. Living and working well. 3. Growing older well. 4. Improve the productivity and quality of our services using the principles of prudent health care and the opportunities to innovate and work with partners.
Amcanion Llesiant BIP: UHB Well-being Objectives: Hyperlink to HDdUHB Well-being Objectives Annual Report	2. Develop a skilled and flexible workforce to meet the changing needs of the modern NHS 4. Improve Population Health through prevention and early intervention, supporting people to live happy and healthy lives

Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	Welsh Government Winter Planning directives
Rhestr Termau: Glossary of Terms:	Explanation of terms is included within the report
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Pwyllgor Datblygu Strategol a Chyflenwi Gweithredol: Parties / Committees consulted prior to Strategic Development and Operational Delivery Committee:	Winter Planning Steering Group Tactical Group Integrated Executive Team/ Regional Partnership Board Unscheduled Care Steering Group

Effaith: (rhaid cwblhau) Impact: (must be completed)	
Ariannol / Gwerth am Arian: Financial / Service:	All accounted through funding streams outlined above
Ansawdd / Gofal Claf: Quality / Patient Care:	Robust winter plans ensure patient care continues to be provided throughout the winter period.
Gweithlu: Workforce:	Not Applicable
Risg: Risk:	Not Applicable
Cyfreithiol: Legal:	Not Applicable
Enw Da: Reputational:	There could be significant reputational risks for HDdUHB and partners in the event of major incident.
Gyfrinachedd: Privacy:	Not Applicable
Cydraddoldeb: Equality:	The Integrated Winter Plan reflect the needs of the population.

111 First / Urgent Care Model

111 – ED/MIU/GP Outcomes

Primary Care / GP OoHs

WAST Clinical Stack

Manchester Triage System

Nurse Triage in ED/MIU

MIU Minor Injury Unit

Remote Urgent Care Centre

Local clinical MDT triage (including Consultant Connect) & scheduling

Intermediate Care

Proactive Care

Community Resilience

GMS

Optometry

Dental

Community Pharmacy

Medicine Management

Diagnostics

Mental Health

Ambulatory Emergency Care

SDEC/AEC

MIU Minor Injury Unit

Minor Injury Unit

Clinic

Hot Clinic

Emergency Department