



CYFARFOD BWRDD PRIFYSGOL IECHYD UNIVERSITY HEALTH BOARD MEETING

DYDDIAD Y CYFARFOD: DATE OF MEETING:	29 September 2022
TEITL YR ADRODDIAD: TITLE OF REPORT:	Winter Plan 2022/23
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Andrew Carruthers, Director of Operations
SWYDDOG ADRODD: REPORTING OFFICER:	Daniel Warm, Head of Planning

Pwrpas yr Adroddiad (dewiswch fel yn addas)

Purpose of the Report (select as appropriate)

Ar Gyfer Penderfyniad/For Decision

ADRODDIAD SCAA SBAR REPORT

Sefyllfa / Situation

Welsh Government have asked all Health Boards to develop Winter Plans for 2022/23, and that they be shared with them for inclusion in a National Winter Plan.

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 that this is made available continuously through the period of greatest system pressure in the NHS calendar. 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 an extensive vaccination 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. Further, we will continue to ensure, wherever possible, that we maintain our planned care activity, given that delays in scheduled care treatments can quickly convert into unscheduled care presentations.

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 programme in 2022/23 will be a significant milestone for the HDdUHB and represents a significant step towards full integration of our vaccination programmes. Maximising uptake of Flu and COVID vaccinations through a single programme enables integrated strategy, planning, governance and public engagement; examines opportunities of integrated delivery (co-administration), transitioning from a single delivery model where possible; and realises benefits for delivery and population health:

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

As we enter the winter of 2022/23, we should also be mindful of the wider societal context which the Hywel Dda's demographic faces, the potential impact that this might have on their health and – as a consequence – their demands for our services.

This Plan describes the actions that Hywel Dda University Health Board (HDdUHB) will take to deliver services through the winter of 2022/23 for our population.

Cefndir / Background

The Winter Plan for 2022/23 builds on the actions already set out in the 2021/22 Plan, and ensures that its key aims are identified in collaboration with our strategic partners across the region, such that:

- Health and social care partners across the West Wales region work together to ensure our population is kept as safe as possible this winter and support the most appropriate use of, and trust in, health and social care services.
- This means ensuring that people can keep themselves well as much as possible and when the need for care and support cannot be averted, this is received in the best way possible.
- We are working together a single whole-system basis so we consider all parts of the patient journey people may take. This is from self-care, support in people's homes or from the charities, social enterprises and voluntary groups through to primary care services in villages and high streets to planned and emergency hospital care.
- The Health Board is unable to do this on its own. It needs the support of every single member of the public to play their part - and there are a number of ways people can help.

This Plan cannot be delivered in isolation, and our partners both within NHS Wales such as WAST, and external partners such our three Local Authorities, are critical to its delivery.

As mentioned above, a fundamental premise to our approach is the 6 Goals of Urgent and Emergency Care through the 3C's – Conveyance; Convergence; Complexity, which will involve:

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

To achieve these ends, the expectations from Welsh Government are:

- The request for Winter Plans this year recognises that we are still transitioning out of the pandemic and that our health and care systems remains stretched.
- It is not intended that this is a new piece of planning work, rather that it is an opportunity to share the most up to date iteration of plans which have been developing, particularly for vaccination and urgent and emergency care, over the last few months.
- The format of each organisation's Plan will be for each Board to determine; however, Plans will need to provide the detail to feed into the National Winter Plan, particularly with respect to:
 - Population Health (Vaccinations)
 - 6 Goals of Urgent and Emergency Care
- It intended that this is the final year where a separate winter plan is developed and that in the future the detail of planning for winter will be contained within IMTPs (Integrated Medium Term Plans)

Welsh Government has indicated that the National Winter Plan will be based around the following structure:

1. Introduction – To be completed by WG policy leads
 - Purpose of winter planning.
 - Alignment to national programme
 - Outcomes from winter planning
2. Population Health
 - Preparation for coming months – WG Chief Scientific Officer paper on what to expect
 - Vaccination – Programme Team WG & NHS Wales
3. 6 Goals for Urgent & Emergency Care
 - Expectations of enhanced actions – National Goal SRO's
 - Response from NHS Wales organisations & RPB's – Directors of Planning
4. Governance – Director of Operations NHS Wales
 - Expected approval process in organisations
 - Role of regional partnership boards
 - Publication of plan
5. Appendix
 - Information to support decision making

Consequently, Welsh Government are expecting local Winter Plans to focus on sections 2 (Population Health) and 3 (6 Goals for Urgent and Emergency Care).

Population Health - Winter Respiratory Vaccination Delivery Plan 2022/23

The Health Board's Winter Respiratory Vaccination Plan 2022/23 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. The evidence is pointing to a severe flu season this autumn / winter and co-circulation of Flu and COVID. We must, therefore, ensure we do all we can to increase uptake of both vaccines – to protect individuals, communities and the health and care system.

The principles of HDdUHB's Health and Wellbeing Framework continued to be encompassed in the delivery plans in terms of recognising the need to shift the culture around vaccination, building on the lessons learnt from the Mass Vaccination Centres and promoting community health and wellbeing.

Capitalising on lessons learnt from the COVID-19 Vaccination programme and building on the population's enthusiasm for the programme and the use of social media platforms, the following principles will be followed on a national basis:

- Maintain consistency across the vaccine programmes. The HDdUHB plans to bring all of the vaccine programmes under the Vaccination Saves Lives (VSL) branding in the future, and to continue to differentiate our audiences by age using the established principle of applying the brand mark within different colour palettes where audiences remain distinct. The aim will be to show a whole life programme i.e. 'Vaccination Saves Lives' through the life cycle.
- Capitalise on the interest and demand for COVID-19 vaccines - anecdotally it is recognised that people's interest in receiving their Flu vaccine waned as soon as a COVID-19 vaccine became available; therefore, aligning Flu with the VSL branding helps to reinforce that a Flu vaccine is equally as important as a COVID-19 vaccine.
- Ensuring the branding will be consistent and straightforward for the public to understand and appreciate why they need to be up to date with both vaccines in order to protect themselves and their families.

- The VSL branding has been used widely throughout the COVID-19 vaccine rollout. People recognise and trust it, and this trust will be utilised to promote the uptake of other vaccine programmes.

With this in mind, the core themes for the 2022/23 programme are:

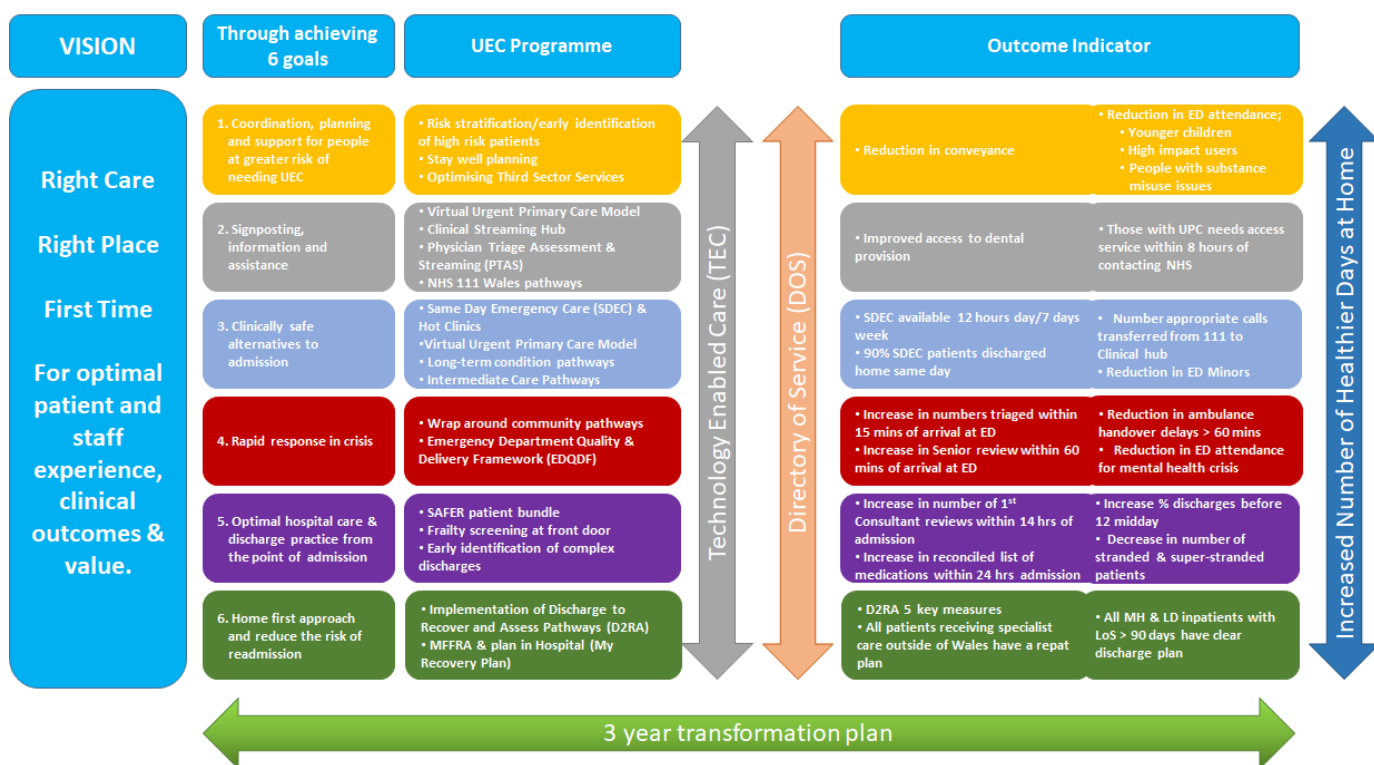
- Focusing on health as an asset, with messaging using the national programme 'Vaccination Saves Lives'. By using positive messages around protecting ourselves and others, rather than focusing on messages around needing the winter respiratory vaccines because of a chronic illness or age, focus has been shifted from mitigating illness to maintaining wellness.
- Ensuring a joined-up approach throughout the season, engaging early with stakeholders, aligning the HDdUHB staff campaign with the core public health winter respiratory vaccine campaign, and working as a unified multidisciplinary team, both to plan before the season and to troubleshoot during it.
- Building further on the previous national Flu Immunisation campaigns, the COVID-19 vaccine delivery milestones, and reviewing how this brand could be extended to the wider vaccination and immunisation agenda.
- Ensuring that sufficient attention is directed at the risk groups for flu that Welsh Government has prioritised for 2022/23 in line with the JVCI COVID-19 priority groups.

For section 3, Welsh Government have set out the priority areas against each of the 6 Goals for Urgent and Emergency Care:

Goal	Winter priorities
1 Coordination, planning and support for people at greater risk of needing urgent care	Health Boards to increase profile and distribution to vulnerable groups of 'My Winter Health Plan' document
	Health Boards to utilise the Pan Cluster Planning Group arrangements to coordinate and plan with partners
	Health Boards to optimise use of:
	1) Emergency Department Wellbeing and Home Safe service (delivered by British Red Cross); and 2) Hospital to a Healthier Home service (delivered by Care and Repair)
2 Signposting people with urgent care needs to the right place, first time	Health Boards to accelerate plans to deliver NHS 111 Wales MH 'press 2' pathway
	Accelerate plans for NHS 111 Wales urgent dental pathways with support from Chief Dental Officer /LHB Clinical Leads
	Resilient NHS 111 Wales / UPC OOH services
	Incorporate Primary & Community escalation as part of the wider whole system escalation mechanisms
3 Clinically safe alternatives to admission	Robust triangulation of clinical care and handover between GMS / 111 / UPC OOH services
	Use of the Urgent Primary Care Centres and evaluation to inform Health Board planning
	Health Board implementation of the Community Nursing Specification
	The Delivery Unit report published in April 2022 on step up Intermediate Care sets out clearly the projected number of intermediate care visits / teams that would be needed based upon figures that had been supplied and modelled. Health Boards and Local Authorities should have a clear plan in response to this work
	Seven day same day emergency care services throughout winter period
4 Rapid response in crisis	Health Boards to optimise use of Mental Health crisis response transport pilot (delivered by St. John)
	Continued expansion of remote clinical support services through the consolidation and expansion of the use of 'ECNS' and 'PTAS' Models, to ensure that patients awaiting an emergency ambulance response are clinically assessed within 20 minutes of their call.

	Enhanced delivery of EASC improvement plan actions (WAST)
	Enhanced delivery of ambulance patient handover improvement plan actions (Health Boards)
5 Optimal hospital care and discharge practice from the point of admission	To embed v1 of the optimal patients flow framework at ward and hospital level and commence national reporting against agreed measures (the measures will be determined as part of the expert group work over the next 3 months)
	Consistent delivery of new repatriation policy following publication in January 2023
6 Home first approach and reduce risk of readmission	Consistent reporting of Delayed Transfers of Care
	Increased compliance with D2RA Pathways
	Current Interim Placements reviewed and Step Down to Recover Rehabilitation Implemented to support better outcomes for the person
	Step Down to Recover Community Bedded Facilities developed and operationalised.
	Workforce key roles recruitment campaign and options delivered

In building the 6 Goals of Urgent and Emergency Care around the 3C's of Conveyance; Convergence; Complexity, we aim to take a whole-system approach to the way in which we assess impact. The diagram on below summarises the approach we are taking; the links to the Urgent and Emergency Care Programme; key enablers and outcome indicators which we will measure in order to ascertain the impact / effectiveness of the system:



Asesiad / Assessment

The HDdUHB response is written around the following structure:

1. Introduction and Background
 - Foreword
 - Key deliverables
 - Bed capacity
2. How are we ensuring our approach to population health
 - Winter respiratory vaccination plan
3. 6 Goals for Urgent and Emergency Care

- Goal 1: Coordination, planning and support for people at greater risk of needing urgent care
- Goal 2: Signposting people with urgent care needs to the right place, first time
- Goal 3: Clinically safe alternatives to admission
- Goal 4: Rapid response in crisis
- Goal 5: Optimal hospital care and discharge practice from the point of admission
- Goal 6: Home first approach and reduce risk of readmission

4. Supporting Information

- Homebased care
- Paediatric Services Surge Plan including RSV (Respiratory Syncytial Virus)
- Financial considerations and workforce considerations
- Planning considerations
- Concluding remarks

Plans must be submitted to the Director of Planning Delivery Unit by the end of September 2022. Following submission, scrutiny sessions of plans will form part of October 2022 Integrated Quality, Performance and Delivery Meetings for organisations (there will be no separate winter sessions unless there are significant concerns).

Key deliverables for Winter 2022/23 include:

- A combined flu and COVID vaccination programme through winter respiratory vaccination delivery plan for 2022/23 that embraces the principles of HDdUHB's 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.
- To maximise uptake through a single programme which 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
- As a Health Board we are committed / have the intention to maintain protected beds (as far as possible) through the winter period in recognition of our planned care recovery priorities.
- 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)
- 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.
- 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.
- 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).
- As part of the new Welsh Government mandate around Community Care Capacity Building, creating 1,000 bed capacity, we have agreed a Planning Objective which will by October 2022, through a rapid expansion of community care, support more Hywel Dda residents to remain /

return home with the objective of 120* fewer non-elective patients in hospital beds on a daily basis

- 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.
- HDdUHB is currently piloting Delayed Transfers of Care (DToC) reporting for WG. The SharePoint Complex Discharge database provides a 'live' update on patient status which can be used to support DToC reporting
- 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.

Further, in order to assess impacts on beds and to support the planning of services through the winter, we are looking develop a Winter Planning viewer. This will:

- Identify the pre-COVID winter trends compared to current trajectories for certain population cohorts which influence emergency demand
- Allow 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)
- In turn allow the impact of potential improvements to be modelled and projected
- Allow the model to calculate 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
- Allow the model to bridge urgent and elective planning for winter

Argymhelliad / Recommendation

The Board is asked to **TAKE ASSURANCE** from and **APPROVE** the Winter Plan for 2022/23 and its onward submission to Welsh Government.

Amcanion: (rhaid cwblhau)

Objectives: (must be completed)

Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	Not applicable
Safon(au) Gofal ac Iechyd: Health and Care Standard(s):	All Health & Care Standards Apply
Amcanion Strategol y BIP: UHB Strategic Objectives:	All Strategic Objectives are applicable
Amcanion Cynllunio Planning Objectives	All Planning Objectives Apply

Amcanion Llesiant BIP: UHB Well-being Objectives: Hyperlink to HDdUHB Well-being Objectives Annual Report 2018-2019	9. All HDdUHB Well-being Objectives apply
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Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	Not applicable
Rhestr Termiau: Glossary of Terms:	WAST – Welsh Ambulance Service NHS Trust SRO – Senior Responsible Owner RPB – Regional Partnership Board JVCI – Joint Committee on Vaccination and Immunisation
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Cyfarfod Bwrdd Iechyd Prifysgol: Parties / Committees consulted prior to University Health Board:	Strategic Development and Operational Delivery Committee Operational Planning and Delivery Programme

Effaith: (rhaid cwblhau) Impact: (must be completed)	
Ariannol / Gwerth am Arian: Financial / Service:	This is a key component in the delivery of the Winter Plan for the period 2022/23
Ansawdd / Gofal Claf: Quality / Patient Care:	This is a key component in the delivery of the Winter Plan for the period 2022/23
Gweithlu: Workforce:	This is a key component in the delivery of the Winter Plan for the period 2022/23
Risg: Risk:	Risks will be assessed as part of the ongoing process of both the development of the 2022/23 Plan and its subsequent monitoring
Cyfreithiol: Legal:	As above
Enw Da: Reputational:	Hywel Dda University Health Board needs to meet the targets set in order to maintain a good reputation with Welsh Government, together with our stakeholders, including our staff
Gyfrinachedd: Privacy:	Not applicable
Cydraddoldeb: Equality:	Consideration of Equality legislation and impact is a fundamental part of the planning of service delivery changes and improvements.

Hywel Dda University Health Board Winter Plan 2022/23



Section 1:

Introduction and Background

Foreword

This document provides Hywel Dda University Health Board's (HDDUHB) Winter Plan for 2022/23, and responds to Welsh Government's (WG) request to feed into the overarching NHS Wales Winter Plan for 2022. Welsh Government have noted the following:

- It intended that this will be the final year where a separate winter plan is developed and that in the future the detail of planning for winter will be contained within IMTPs (Integrated Medium Term Plans)
- The request for Winter Plans this year recognises that we are still transitioning out of the pandemic and that our health and care systems remain stretched.
- It is not intended that this is a new piece of planning work, rather that it is an opportunity to share the most up to date iteration of plans which have been developing, particularly for vaccination and urgent and emergency care, over the last few months.
- The format of each organisation's Plan will be for each Board to determine; however, Plans will need to provide the detail to feed into the National Winter Plan, particularly with respect to:
 - Population Health (Vaccinations)
 - 6 Goals of Urgent and Emergency Care

The Winter Plan for 2022/23 builds upon the actions already set out in the 2021/22 Plan, and ensures that its key aims are identified in collaboration with our strategic partners across the region, such that:

- Health and social care partners across the West Wales region work together to ensure our population is kept as safe as possible this winter and support the most appropriate use of, and trust in, health and social care services.
- This means ensuring that people can keep themselves well as much as possible and when they need care and support, receive it in the best way possible.
- We are working together a single whole-system basis so we consider all the parts of the journey people may take. This is from self-care, support in people's homes or from the charities, social enterprises and voluntary groups through to primary care services in villages and high streets to planned and emergency hospital care.
- We can't do this on our own. We need every single member of the public to play their part - and there are a number of ways people can help.

The underlying planning is driven from the perspective of maintaining safety, quality and continuity of care for our patients through the most consistently challenging period in the NHS calendar. In developing this Plan we have sought to ensure that we avoid hospital admissions as much as possible both through trying to limit the spread of COVID 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:

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

However, 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. 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 services at our front doors working correctly.

In parallel to ensuring that we are doing all we can with respect to Urgent and Emergency Care, we also aim to ensure a resilience around the planned care system such that it continues to deliver care to those who need it - as a Health Board we are a committed / have the intention to maintain a level of protected beds (as far as possible) through the winter period in recognition of our planned care recovery priorities.

The University Health Board has undertaken detailed analysis of the demand for beds and compared this to ward-level bed capacity. As part of this planning the University Health Board has designated 101 beds as either surge beds (62) or beds which should no longer be in use to support bed spacing (39). Our analysis forecasts that, with current demand levels, these beds will be need to be used in the winter months with around half of these required over summer months. Indeed, through the pressures of this winter period, the majority of these beds have been in use.

If required we shall implement our business continuity plans

Flu and COVID vaccination

A combined flu and COVID 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 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).



Our key deliverables for winter 2022/23

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 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



Modelling our Bed Capacity and Demand



Current Position

Working with our data analytics partner we have extensively evaluated patterns of bed demand as we emerge from a highly atypical period. Early COVID waves substantially reduced the number of patients admitted to hospital for non-COVID conditions and, initially, led to fewer delays in discharge. Multiple waves of COVID over a two-year period has meant that, until recently, bed demand had not fully returned to pre-COVID levels. Even now the system has not returned fully to a pre-COVID state, with differential impacts across sites and categories of patients. This makes the planning for bed capacity more uncertain than it ever was pre-COVID.

Initiatives such as Same Day Emergency Care, Community Same Day Urgent Care with outreach and wrap around services and Urgent Primary Care have demonstrated an impact on hospital demand providing an alternative to admission. Unsurprisingly, this has been particularly evident in the shorter stay patient cohorts. At the other end of the inpatient process we have seen length of stay increase, driven by increased discharge delays. This has offset the efficiency gains, resulting in bed pressures and restricting our ability to resume elective activity.

Following the emergence from winter into summer there are indications of improvement which has allowed us to reinstate elective bed capacity and, in recent weeks, contributed to fewer delays at our Emergency Departments. Protected elective beds are now in place across our sites, with plans for a further 10 beds at Glangwili to support reinstatement of ENT and Urology inpatient operating. This will provide up to 98 inpatient beds for electives across the University Health Board (subject to the availability of appropriate staffing levels), in addition to daycase capacity which will, by the beginning of May 2022, include the new two-theatre day surgery unit in Prince Philip Hospital.

The work being done on Urgent and Emergency care, in conjunction with our plans for home-based care, is expected to deliver a reduction in demand of 100 beds by the end of March 2023. Whilst there is confidence in the opportunity and the delivery of the programme it is recognised that this is a substantial acceleration of the original benefits realisation and is unprecedented in its scale impact. This is however commensurate with the challenge facing the health and care system post-pandemic.

Recognising the current challenges our expectation is that delivery of these plans will allow the following improvements through 2022-23: decongestion and reduced delays at the front-door including an improvement in ambulance response times (phase 1); protected bed capacity for ENT and Urology inpatients in Glangwili (phase 2); dedicated winter surge capacity to allow continued protection of elective beds (phase 3); bed reductions, initially to support safe staffing levels (phase 4a) and subsequently to support delivery of our financial route map (phase 4b).

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Protected Elective Beds

As a Health Board it is the intention to maintain these protected beds (as far as possible) through the winter period in recognition of our planned care recovery priorities. Our ring-fenced beds by acute hospital site are:

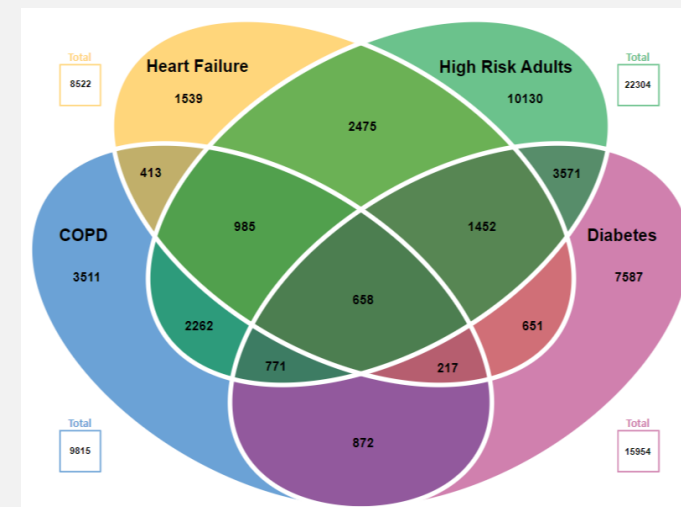
- Prince Philip:
 - Ward 6 – elective orthopaedics; Ward 7 – cancer / elective surgery
- Bronglais:
 - Rhiannon Ward – elective orthopaedics and mixed surgery
- Glangwili:
 - Merlin Ward – ENT and Urology; Cothi Ward – Gynaecology
- Withybush:
 - Ward 9 – temporary designation as Day Surgical Ward (during period of remedial Fire Safety Works until Christmas) with planned return to protected elective beds from January 2023.

Medium-Term Plan

Over the past two years the University Health Board has made extensive use of data analytics to understand the factors driving demand for hospital beds, to identify opportunities to improve pathways for patients and reduce harm. This work identified, through benchmarking, that Hywel Dda has comparatively longer hospital stays and opportunities existed to reduce short-stay admissions. As mentioned earlier significant progress has been made with this latter category following the introduction of Same Day Emergency Care units across the University Health Board.

Condition-level analysis has also identified four population cohorts, often overlapping due to multiple co-morbidities, that are particularly important to hospital admission rates and bed occupancy. Improvement work has commenced on Frailty and Heart Disease pathways, across primary and secondary care and using a Value Based Health Care approach, to re-model care.

In addition, several other planning objectives detailed in this plan are expected to contribute to reducing the likelihood of hospitalisation for patients and promote early discharge when admission is necessary. These include 5H, 5J, 5S, and 5Q, which are expanded upon later. Across all these areas we have identified opportunities totalling 150-200 patients who are currently occupying a hospital bed who could have their needs more appropriately met in their communities if the right service was available for them. The first area we are targeting is the Heart Failure pathway where the Value Based Health Care team and Service Improvement team have worked with primary and secondary care to fundamentally redesign the pathway. This new model was finalised and endorsed by the Health Board during quarter one and is now in implementation phase.



Section 2:

How are we ensuring our approach to population health

How are we ensuring our approach to population health

Winter Respiratory Vaccination Delivery Plan 2022/23

The Health Board's Winter Respiratory Vaccination Plan 2022/23 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. The evidence is pointing to a severe flu season this autumn / winter and co-circulation of Flu and COVID. We must, therefore, ensure we do all we can to increase uptake of both vaccines – to protect individuals, communities and the health and care system.

As we approach the winter months and begin the roll-out of the programme, we will adapt and evolve if changes for example are made to eligible groupings as notified by the JCVI (Joint Committee on Vaccination and Immunisation) for either flu or COVID vaccinations.

The principles of HDdUHB's Health and Wellbeing Framework continued to be encompassed in the delivery plans in terms of recognising the need to shift the culture around vaccination, building on the lessons learnt from the Mass Vaccination Centres and promoting community health and wellbeing.

Capitalising on the lessons learnt from the COVID-19 Vaccination programme and building on the population's enthusiasm for the programme and the use of social media platforms, the following principles will be followed on a national basis:

- Maintain consistency across the vaccine programmes. The HDdUHB plans to bring all of the vaccine programmes under the Vaccination Saves Lives (VSL) branding in the future, and to continue to differentiate our audiences by age using the established principle of applying the brand mark within different colour palettes where audiences remain distinct. The aim will be to show a whole life programme i.e. 'Vaccination Saves Lives' through the life cycle.
- Capitalise on the interest and demand for COVID-19 vaccines - anecdotally it is recognised that people lost interest in receiving their Flu vaccine as soon as a COVID-19 vaccine became available, therefore bringing Flu in line with the VSL branding helps to reinforce that a Flu vaccine is equally as important as a COVID-19 vaccine.
- Ensuring the branding will be consistent and simple for the public to understand and know why they need to be up to date with both vaccines in order to protect themselves and their families.
- The VSL branding has been used widely throughout the COVID-19 vaccine rollout. People recognise and trust it, and this trust will be utilised to promote the uptake of other vaccine programmes.

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Realising a single Flu and COVID programme in 2022/23 will be a significant milestone for the HDdUHB and represents a significant step towards full integration of our vaccination programmes. Maximising uptake of Flu and COVID through a single programme enables integrated strategy, planning, governance and public engagement; examines opportunities of integrated delivery (co-administration), transitioning from a single delivery model where possible; and realises benefits for delivery and population health:

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

This Plan has been developed to maximise alignment with the HDdUHB COVID-19 Mass Vaccination Delivery Plan and the HDdUHB Seasonal Influenza Delivery Plan and is a live document subject to amendment as the season unfolds, as further Welsh Health Circulars are published, and as the HDdUHB derives learning from delivery of both vaccines. This season will require maximum flexibility from services charged with delivery of actions within this Plan, to rapidly respond to changes in policy, guidance and priorities as they emerge from the JCVI and Welsh Government.

With this in mind, the core themes for the 2022/23 programme are:

- Focusing on health as an asset, with messaging using the national programme 'Vaccination Saves Lives'. By using positive messages around protecting ourselves and others, rather than focusing on messages around needing the winter respiratory vaccines because of a chronic illness or age, focus has been shifted from mitigating illness to maintaining wellness.
- Ensuring a joined-up approach throughout the season, engaging early with stakeholders, aligning the HDdUHB staff campaign with the core public health winter respiratory vaccine campaign, and working as a unified multidisciplinary team, both to plan before the season and to troubleshoot during it.
- Building further on the previous national Flu Immunisation campaigns, the COVID-19 vaccine delivery milestones, and reviewing how this brand could be extended to the wider vaccination and immunisation agenda.
- Ensuring that sufficient attention is directed at the risk groups for flu that Welsh Government has prioritised for 2022/23 in line with the JCVI COVID-19 priority groups.

How are we ensuring our approach to population health

Vaccine Supply

Flu vaccines orders were completed across the HDdUHB and Primary care contractors as per agreed process and are anticipated to begin arriving in late September 2022 for both adult and children vaccine preparations. No delays are currently identified in the order system. Order amounts were calculated on previous uptake levels and reviewed against possible increases in uptake likely from the population uptake in COVID-19 vaccines. Over previous years a central buffer stock supply has been secured nationally, however to date this has not been confirmed for the 2022/23 programme. If no central contingency stock is made available and uptake with co-administration increases uptake there is a risk that demand will exceed supply.

The autumn programme for COVID-19 will see the introduction of a new bivalent vaccine, which is an adapted vaccine which targets two different coronavirus variants – the original virus from 2020 and the Omicron variant. The first new vaccine available will be the Moderna vaccine and it is anticipated that Pfizer will also have a bivalent vaccine soon after the start of the autumn programme. Due to the transition to a bivalent vaccine for 2022/23 campaign for all eligible groups the initial supply of vaccine will be at a capped amount per week until additional supply is confirmed. Therefore, the pace of delivery will be planned around the amount of vaccine available.

For the small number of our population who are unable to receive an mRNA vaccine for their booster there will be a small stock of Novavax available which will be managed centrally through our Immunisation & Vaccination team and Pharmacy leads.

Delivery schedule for COVID-19 mRNA vaccine has been confirmed and this will involve central ordering by HDdUHB leads resulting in direct delivery to each primary care contractor and Mass Vaccination Centre with a supply supported within the hospital pharmacy site. The HDdUHB has the infrastructure required to enable the movement of vaccine from its hospital pharmacy site onto primary care contractors should demand require.

The supply of original Pfizer vaccine will be supporting the delivery of Leave no-one behind and primary doses for those who previous have not come forward or need to complete their primary course.

Proposed Vaccine Delivery Plan

It is vital that a coordinated seamless delivery programme is delivered by GPs, Mass Vaccination Centre, Community Pharmacies and the HDdUHB's School Nursing, Occupational Health and Immunisation & Vaccination Teams. The vaccinations for the eligible groups will be delivered by a variety of health care professionals in order to maximise vaccine uptake and maintain baseline services.

GP and Community Pharmacies

Our primary care contractors are key to delivering both flu and COVID-19 vaccines this autumn, maximising the opportunity to co-administer wherever possible and vaccine supply allows. They will deliver the vaccinations in accordance with the JCVI eligibility groupings, and we will adapt to these if changes are made through the winter months:

It is important to recognise there are a small number of GP practices across the HDdUHB footprint who will not be able to support the COVID-19 vaccine delivery plan this autumn. The population of these practices will be invited to their nearest Mass Vaccination Centre for their COVID-19 vaccines whilst they will continue to be invited by their GP for their flu vaccines as per previous years.

Similarly, it is important to acknowledge there is a small number of community pharmacies supporting the COVID-19 delivery plan this autumn as opposed to the flu delivery plan across all our community pharmacies. Details of the community pharmacies offering COVID-19 vaccines will be made available via the HDdUHB website, all communications issued by HDdUHB and will be readily available in their own community communication used by their pharmacy.

Community pharmacies play a pivotal role in supporting vaccination across care home staff for flu delivery with increased engagement each year recognised. With this in mind, we will endeavour to ensure staff from Mass Vaccination Centres are deployed to support those community pharmacies not delivering COVID-19 vaccines in their care home staff clinics across the counties.

How are we ensuring our approach to population health

Mass Vaccination Centres

All six Mass Vaccination Centres will be available across the autumn programme to support delivery of both COVID-19 and flu vaccines to identified eligible groups. Accessibility of our Mass Vaccination Centres has changed from the 1st September 2022 as we will not be offering drop in vaccines for the autumn booster to the wider population. The Mass Vaccination Centres will be supporting the following:

- Healthcare workers (including healthcare students) – COVID-19 and flu vaccines
- Social Care workers – COVID-19 vaccine
- Population in eligible groups 50 years and older, care home residents, people aged 5-49 in at risk groups or family members of immunosuppressed not supporting COVID-19 delivery by GP – COVID-19 vaccine
- Acute and Community site Inpatients – flu & COVID-19 vaccines

It is important to note that when invited to attend an Mass Vaccination Centre all staff groups and the population not able to receive their COVID-19 vaccine with their GP will be supported to attend a community pharmacy nearer their home if more suitable for them. In order to ensure we have offered everyone their invite for a COVID-19 vaccine, as per Welsh Government Strategy ambition, we will be providing an initial invite to these dedicated groups to their nearest Mass Vaccination Centre.

In order to ensure we have reached any lower uptake groups there will be monthly vaccine equity group meetings and we will enable staff to reach out to our communities across the three counties to deliver both flu and COVID-19 vaccines. Links will also be explored across Maternity ante-natal services to ensure staff are available to administer both flu and COVID-19 vaccines during clinic opportunities.

Inpatient vaccination for both flu and COVID-19 will be critical to the prevention of transmission of winter respiratory viruses this autumn / winter. Staff will be reaching into all sites across acute, community and mental health to ensure those patients most at risk are receiving their vaccines in a timely manner.

Health Board School Nurses

2021/22 saw the expansion of the school children flu campaign to include all secondary aged children up to year 11 in addition to the primary school children campaign. The School Nursing teams have prepared an autumn term programme for delivery of nasal flu vaccine to all age years eligible across our schools. In order to ensure core school nursing roles and responsibilities are maintained during this crucial term for our children and young people the school nursing teams will be supported by staff from the Mass Vaccination Centre as well as staff from the Immunisation & Vaccination Team.

Consent forms will be sent to all children via their schools on their return in early September 2022 with the proposed start date of the vaccination programme beginning at the end of September. Delivery plan will be shared with our Local Authority Education leads and Head teachers.

Immunisation & Vaccination Team

The experience and knowledge within this small team will be crucial in ensuring we are able to maintain delivery of all immunisations and vaccinations during this period. They will actively support any staffing needs within the school flu programme as well as supporting our inpatient and housebound vaccination for those not being delivered by their GP.

During this autumn / winter period the team will be available to continue to support GPs in ensuring we are offering all childhood immunisation to those requiring and will ensure no child is not receiving their vaccine due to system or staffing pressures.

Occupational Health Team

The Occupational Health team will be supporting the roll out of the flu vaccines following the initial invite to an Mass Vaccination Centre. This will be through the use of regular drop in clinics on the acute hospital sites as well as supporting training of peer vaccinators at ward / department level. Where opportunities align staff from Mass Vaccination Centre will ensure COVID-19 vaccines are available at the drop in sessions on site and will also be available to support ongoing flu delivery, recognising the additional pressures within the Occupational Health service and their need to maintain essential services.

Proposed 'Surge' Vaccination Plan

Whilst there is no current directive of the need to provide COVID-19 vaccines outside of the eligible groups this autumn / winter with the prediction of a COVID-19 wave during the autumn period it has been suggested that there may be a further review of the provision of an additional booster for the rest of the population.

With this in mind a surge plan will be developed to take into account two possible delivery time periods, namely pre-Christmas and post Christmas. This delivery will be focused in the Mass Vaccination Centre approach and will not be aligned to a flu plan for this group.

How are we ensuring our approach to population health

Risks

There are a number of risks identified for both the proposed delivery plan for the autumn programme and also to note for the 'surge' vaccination plan and are detailed below:

- Dependent on the vaccine supply there could be an impact on the fluidity of programme delivery
- Training requirements and necessary supporting information not available at the start of the programme with sufficient time to enable all staff to attend
- Staff availability across Mass Vaccination Centre and supportive in reaching approach to inpatients and any subsequent population groups needing to be brought to an Mass Vaccination Centre
- Potential staffing deficit if COVID-19 or other sickness surges during the surge period or vacancies increase across vaccination team
- Potential risk that patients will choose one or other vaccine and not attend for both, or attempt to attend a Mass Vaccination Centre
- Primary care contractors may encounter difficulties in continuing delivery for both COVID-19 and flu vaccines following start of programme

Mitigations

In order to mitigate for the above the following actions are detailed below:

- Close working with national teams to ensure vaccine supply is able to continue to support delivery plan
- Delivery plan updates on weekly basis from primary care contractors to enable fluid approach to vaccine supply
- Weekly detailed scheduling for Mass Vaccination Centre clinics tailored to vaccine availability
- Training package supported by Senior Nurse Immunisation & Vaccination Team, working closely with PHW, to ensure roll out across primary care and Mass Vaccination Centre for both COVID-19 and flu
- Extension of temporary contracts of existing Mass Vaccination Centre staff to end March 2023 via Use of Resources group to ensure expertise and skills maintained to match delivery timescale and prevent impact on wider HDdUHB services
- Working with primary care contractors to ensure no-one left behind for their autumn booster if they have not come forward at first invite or do not wish to have vaccines co-administered
- Weekly close working between programme leads and Primary care leads to ensure rapid relocation of population for COVID-19 vaccines in place if any issues arise in a practice.

Current Actions and Next Steps

Due to the added complexity of delivering the above, the winter respiratory vaccination programme will be carefully monitored through a variety of means to ensure its effective delivery:

- Fortnightly partnership (IN-FLU) meetings will be held throughout the autumn / winter for delivery partners to check progress against partnership priorities and to address any emerging operational issues from the Project Plan. This meeting will include any updates following the receipt of new Welsh Health Circulars, COVID-19 vaccine developments, and Flu and COVID-19 surveillance.
- Fortnightly partnership meetings of COVID-19 Vaccination Group to ensure alignment and employment of measures that can impact on maximising shared benefits and uptake by eligible at-risk populations and delivery of COVID-19 vaccines is maintained as per plan.
- Specific Issue meetings will be arranged with the Delivery Lead to mitigate any risks to the delivery of the programmes.
- In-season performance reports will be provided to SDODC, and quality and safety issues reported through the Medicines Management Group up to the Quality, Safety & Experience Committee (QSEC), as required.
- Reporting and escalation of issues to through Directorate Governance.
- In the 2021/22 season, Occupational Health provided monthly reports for directorate leads on staff uptake at ward and department level. These were disseminated by directorate leads to ward and department managers to enable positive action in areas of low uptake. Due to the update of the Occupational Health Staff Record system, ward-level data monitoring is currently challenging; the focus this programme will be to record both the Flu and COVID vaccinations with the Welsh Immunisation System (WIS) and to provide a reporting / uptake on a regular basis throughout the programme at HDdUHB level.
- The Public Health Team will produce regular uptake reports and analysis, using data from the Vaccine Preventable Disease Tabular Programme (VPDP) team within Public Health Wales (PHW), together with local and national campaign and surveillance updates. These reports will be provided to Practice Managers, Practice Flu Leads and Cluster Leads on a weekly basis during Phase One of the campaign. These comprehensive documents provide tailored information at a practice, cluster, county and HDdUHB level, alongside comparators with other Health Boards and the Wales average.
- Cluster-level uptake reports will be provided for discussion at Cluster/ Locality meetings throughout the season.
- HDdUHB representatives will participate in fortnightly National Influenza Action Group (NIAG) teleconferences and report back actions and emerging issues to local partners. National Winter Respiratory Vaccination Programme planning meetings will also be attended on a weekly basis to discuss emerging progress across Wales.
- An end-of-season debrief session will be held for all partners to evaluate and begin the planning process for the 2023/24 season.

We will continue to learn and adapt as appropriate through the roll-out of the programme to ensure that are able to deliver our winter Respiratory Vaccination Delivery Plan accordingly

Section 3:

Six Goals for Urgent and Emergency Care

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

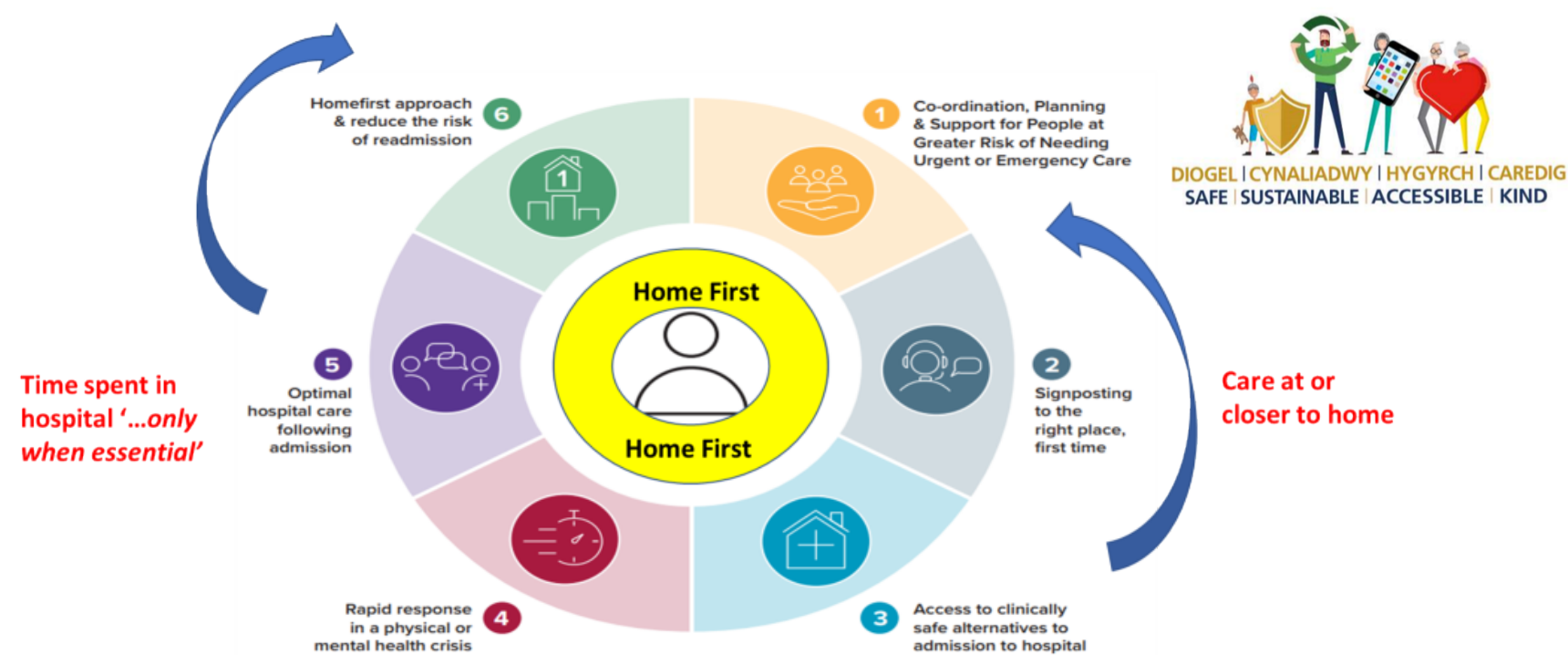
However, for 2022/23 we will be focusing on our over 75s. If we can increase our current discharge rate by 10% and reduce our Average Length of Stay by 1 day this would provide us with 80 bed efficiency by October 2022 and 100 by March 2022. There are on average 58 patients unplaced at our front doors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



SIX POLICY GOALS FOR URGENT AND EMERGENCY CARE

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)

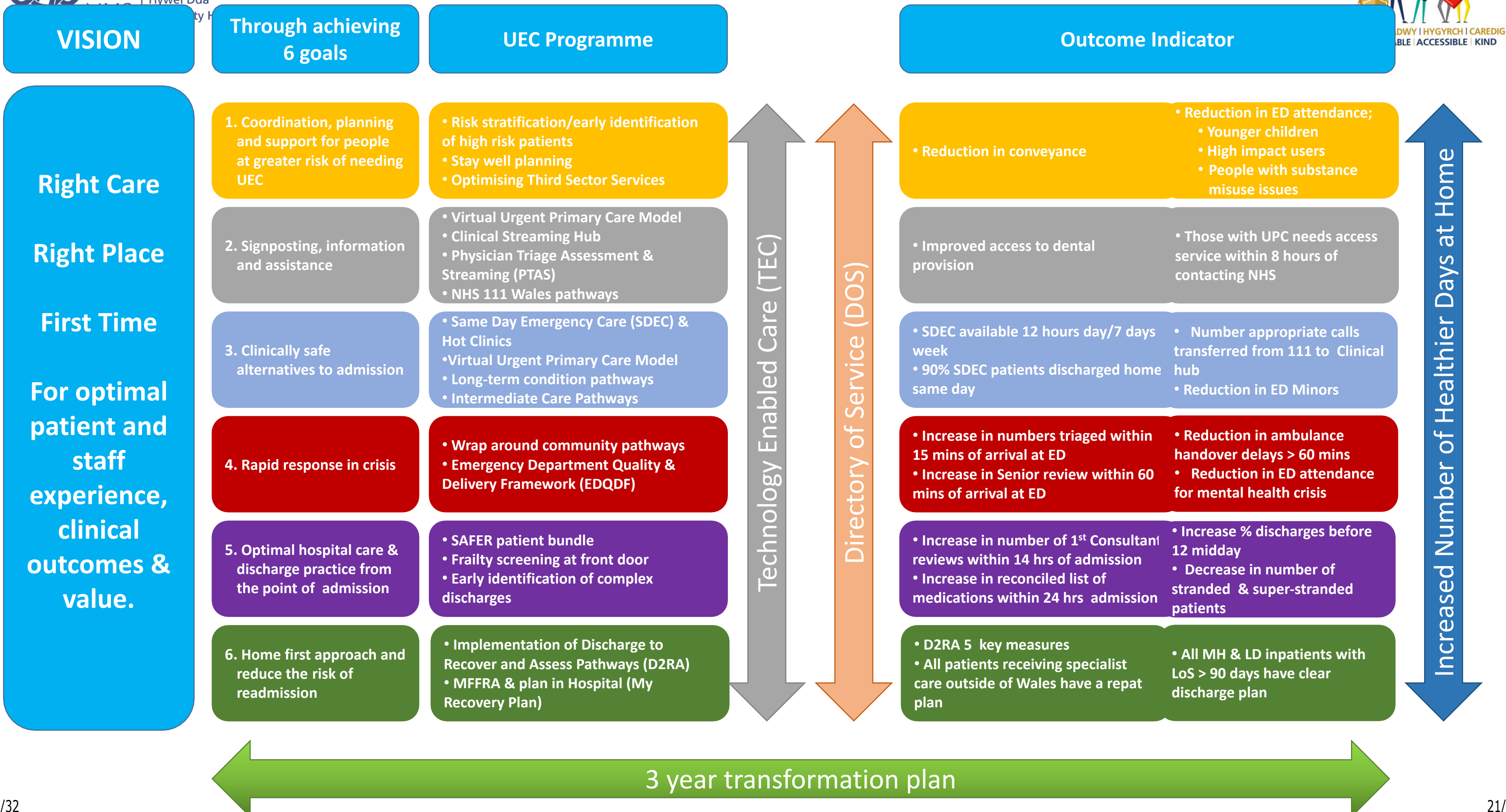
- Implement the principles and minimum standards of care associated with achieving optimal outcomes for frail inpatients as outlined in the British Geriatric Society Improving Healthcare for Older People’ Fit for Frailty’ report :
 - ‘Turnaround at the Front Door’ within 12 hours (50% of all frail attenders) 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



Goal 1: Coordination, planning and support for people at greater risk of needing urgent care

Winter Priorities	What is Hywel Dda doing
Health Boards to increase profile and distribution to vulnerable groups of 'My Winter Health Plan' document	<ul style="list-style-type: none"> • HDdUHB has set up a Equity Advisory Group chaired by our Public Health Team The main task of the group is to highlight, discuss and advise any areas of inequity across our Health Board in relation access to services, health, population needs. This is particularly focused around deprivation, inequalities and protected characteristics. Issues that are currently being dealt with include our flu and COVID vaccinations programme, the cost of living crisis, and free school meals (for example we have set up an initiative such that those people in receipt of a free school meal are entitled to access our canteens if they are accessing our hospitals for an appointment and would otherwise miss their free school meal) • We are also doing a significant amount of work with our Ukrainian visitors and other groups including asylum seekers • Additional actions, for example in Ceredigion whereby Engagement with District and Specialist nurses to use the 'My Winter Health Plan' has commenced with Clinical Nurse Leads.
Health Boards to utilise the Pan Cluster Planning Group arrangements to coordinate and plan with partners	See slide 16
Health Boards to optimise use of: 1) Emergency Department Wellbeing and Home Safe service (delivered by British Red Cross); and 2) Hospital to a Healthier Home service (delivered by Care and Repair)	<ul style="list-style-type: none"> • Carmarthenshire – The Carmarthenshire United Support Programme (CUSP) is well established and consists of 3rd Sector providers including Care & Repair and British Red Cross among others as a constituted group providing low level care to people in their own homes either to prevent admission or support on discharge • Ceredigion - Do not commission either the Emergency Department Wellbeing and Home Safe Service nor the Hospital to a Healthier Home Service. The Local Authority do commission the 'Cwtch' service delivered by British Red Cross and Care and Repair do deliver the Rapid Response Adaptations Programme (RRAP) service • Pembrokeshire – the PIVOT service is well established and includes both the British Red Cross (referral management and caseworker service 7 days, 8.00 to 20.00) and West Wales Care and Repair services alongside Home from Hospital Service and six week low level community support through Volunteering Matters. This service will continue to support patient care, transfer home and opportunities to optimise this will be taken. Additionally, the Hospital to Healthier Homes service will be available 8 to 17 Monday to Friday working closely wit the Joint Discharge Team to provide early intervention around housing issues preventing discharge.

Primary Care

Primary Care

Through working with the four contractor professions the focus over the next 12/24 months will be stabilising sustainable service provision as we move into the recovery phase of the COVID-19 pandemic. Our key priority for 2022/23 onwards will continue to be to support service modernisation that provides timely and appropriate access to local services, using contract reform and Accelerated Cluster Development (ACD) as drivers for change.

Sustainability of all Primary Care contractor service provision remains a key priority, recognising the period of instability that many contractors have experienced at times throughout the pandemic. The anticipated outcome of the contract reform negotiations will also help to shape the future sustainable service provision alongside a workforce strategy that supports the implementation of the Primary Care Model for Wales by bringing other professional groups such as Audiology, Occupational Therapy, Physiotherapy etc. into direct access services through General Medical Services.

General Medical Services (GMS)

- Use the outcome of the Five Facet Survey to inform the development of a Primary Care Estates Strategy, alongside the nationally produced ARCHUS estates document
- Develop a strategic document that sets out the future aspiration for sustainable Primary Care service provision in Hywel Dda
- Continue to evaluate and promote the use of digital solutions to improve timely access to care;
- Continue to review and revise the proactive sustainability support package
- Consider options to allow the return of Health Board Managed Practices back to independent contractor status
- Undertake a review of both National and Local Enhanced Service specifications and funding
- Develop and embed the principles of Accelerated Cluster Design as part of the development of Integrated Localities;
- Lead and support the implementation of contract reform;
- Continue to support the commissioning of any ongoing vaccination programmes coming out of the COVID-19 pandemic
- Implement solutions that assist with the Urgent Primary Care model

Dental Services:

- Support the ongoing implementation of Contract Reform in line with national guidance
- Review the commissioning arrangements for in hours urgent access and out of hours dental services
- Review the pathway for paediatric, special care and tier 2 minor oral surgery dental services including the development of a specialist services and a review of General Anaesthetic provision
- Review the pathway for paediatric dental services including the development of a specialist service and a review of General Anaesthetic provision
- Review the orthodontic waiting lists which have been generated as a result of the COVID-19 pandemic
- Continue with the review of the Community Dental Service
- Reinstate contract management in line with the reset of services;
- Continue to review and revisit the use of digital solutions to support the ongoing modernisation of service provision

Community Pharmacy

- Continue to review and revise the Pharmaceutical Needs Assessment
- Support the ongoing development and implementation of the Community Pharmacy Cluster Lead role particularly in respect of the development of ACD.
- Continue to scale up and roll out the Community Pharmacy Walk-In Centres aligning to sustainable service provision and unscheduled care pathways
- Support the reintroduction of suspended Enhanced Services e.g., Sore Throat Test and Treat and roll out training for Triage and Treat to increase the number of pharmacies offering, as part of the recovery programme
- Continue to support and develop Independent Prescriber roles and making service links across Pharmacy and General Medical Practice
- Continue to review and revisit the use of digital solutions to support the ongoing modernisation of service provision

Optometric Services:

- Roll out of the pathways developed throughout the red phase of the pandemic with a shift of resource to support service development
- Support the development and implementation of contract reform
- Continue to review and revisit the use of digital solutions to support the ongoing modernisation of service provision.
- Review and revise the Glaucoma pathway through regional working with Swansea Bay University Health Board.
- Develop and implement an improved service specification to support the Complex Contact Lens pathway.
- Work with South West Wales Regional Optometric Committee (SWWROC) and Optometry Wales to establish urgent eye care access via 111. This service will allow patients to access the most appropriate advice and services for eye related advice or care



Implement primary care contractor solutions that contribute to the provision of a 24/7 Urgent and Emergency Care pathway

Clusters and Accelerated Cluster Design



Each of the seven established Clusters have been aligned to an Integrated Locality Planning Group established in each of the three Counties, thereby ensuring the integration of plans, joint prioritising of needs for the population and effective use of resources. The Cluster role allows for place-based understanding of the population needs and local assets. Specific Cluster projects may vary on this basis and projects are reviewed on a regular basis to ensure they meet their aims and continue to be relevant. Over the next 12 months the Accelerated Cluster Development programme will be implemented across the region. Professional Collaboratives will align with the Clusters and the Pan Cluster Planning Groups and the Integrated Locality Plan will be the driver behind resource decision making.

Our People & Communities

Place-based
Starting well
Living well
Aging well
Social model for health & wellbeing

Professional groups

Inter & intra-professional dialogue & co-operation
Improve patient care & experience
Professional experience to inform priority setting & planning

Our 7 Clusters

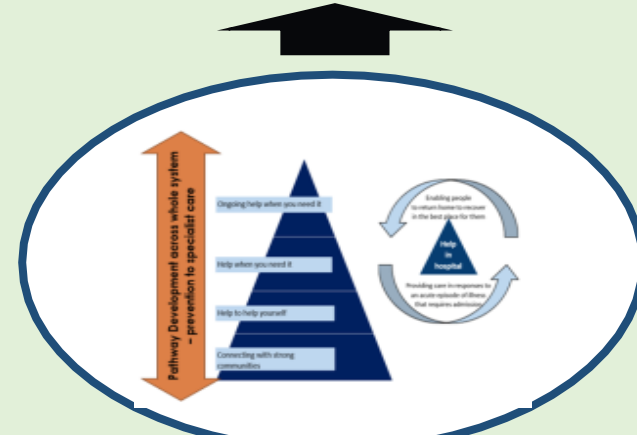
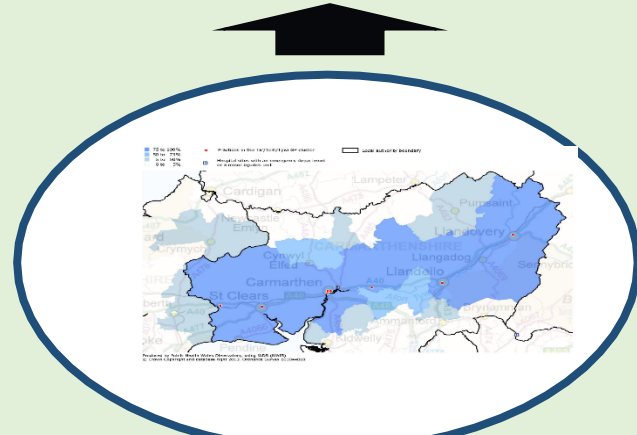
Support & enable collaborative service planning & delivery
Understanding of local needs
Setting of local priorities
Propose effective local solutions & dynamic problem-solving approach

Our 3 Integrated Localities

Variety of stakeholders on a County population footprint
Deliver strategic aims
County population needs assessments & integrated plans

Our Regional Plan

Driven by national guidance & planning principles
Consistency of outcomes, principles & standards
Sustainable use of resources
Single mechanism for pathway redesign & resource use



Alignment to our communities – local knowledge & relationships with regional consistency & equity of outcomes

Transparent, clear, whole system, supported and forward thinking approach to operational planning & delivery

- **Mental Health / Wellbeing** (20 projects) – projects aimed at improving mental health and wellbeing. Working with specialist staff, local authorities, and other partners, providing timely access to support for adults, families and young people.
- **Responding to COVID** (16 projects) – supporting the vaccination programme and those with Long Term COVID. Increasing the number of Chronic Disease Clinics in order to reduce annual review backlogs. Specialist clinics to support Secondary Care, and additional support to reduce administrative backlogs.
- **MDT Working / Recruitment of other Roles** (16 projects) – Reducing pressures on Secondary Care and improving community access by enhancing cluster services e.g. recruitment of Occupational Therapist; physiotherapists; Cluster Pharmacists; Care Co-ordinators; Respiratory Specialist Nurses and providing better Psychological support to patients.
- **Integration of Services / Community Based Services** (10 projects) – Enhancing the service provision for patients, including Phlebotomy Services where hospital provision is reduced; Integrating the Community Cardiology model to support the reduction of patients with palpitations and Atrial Fibrillation managed in Secondary Care; Providing access to Community Catheter Clinics; Providing support to patients with long-term conditions who attend multiple organisations to develop co-ordinated Care Plans.
- **Specialist Support / Services** (9 projects) – Increase identification and support those suffering from domestic violence. Providing Dermatology Clinics to support diagnosis and provide minor surgery for patients. Providing support for individuals with chronic or life limiting conditions. Providing opportunities for patients with Dementia to take part in regular exercise. Supporting those with lung conditions through weekly singing sessions. Providing a Dietetic led Irritable Bowel Syndrome Service.
- **IT Equipment / Digital Solutions** (7 projects) – Ensuring patients are able to connect to their GP and Cluster through 'My Surgery App'; Providing online registrations for new patients via 'Campus Dr'; Better monitoring of patients with chronic or life limiting conditions using 'Delta wellbeing' to provide monitoring at home.
- **Workforce Sustainably / Workforce** (6 projects)– Providing increased training opportunities to Optometrists, therefore enabling the cluster to deal with more acute problems and improving workforce sustainability.
- **Screening** (6 projects) – Early diagnosis improves cancer outcomes, and due to the pandemic uptake has reduced. Clusters are targeting various areas, such as Bowel, Cervical, Breast and Abdominal Aortic Aneurysm to improve patient uptake.
- **Other (5 projects)** – Varying projects including Point of Care testing for patients presenting with respiratory illness; Increasing access to defibrillators; Ensuring facilities and premises are suitable and adaptable to changing needs.

Goal 2: Signposting people with urgent care needs to the right place, first time

Winter Priorities	What is Hywel Dda doing
Health Boards to accelerate plans to deliver NHS 111 Wales MH 'press 2' pathway	<ul style="list-style-type: none"> Through the Transforming Mental Health consultation process the need for a local Mental Health Single Point of Contact (MH SPOC) was agreed, however in early 2021 Welsh Government announced their intention to implement a national MH SPOC through the 111 telephone service. Hywel Dda were invited to be a pathfinder for the development of the national service and were able to shape the service model, helping to ensure that local care is provided by locality based across the Health Board footprint, which is in keeping with the recommendations of the consultation. Following the success of the pilot Welsh Government provided recurrent funding to all Health Boards in September 2021 through the Mental Health Service Improvement Fund, to establish the service 24/7. These monies enabled us to recruit a range of Band 5 Well-being Practitioners and Band 6 Mental Health (MH) Practitioners alongside a Band 7 Clinical Lead and Band 5 Service Co-ordinator. Following several months of piloting the service Hywel Dda are now the first Health Board in Wales to launch the service publicly. Since 20th June 2022 the service is available 7 days a week from 09.00am to 11.30pm. It is available to any individual of any age residing within the Health Board footprint of Ceredigion, Carmarthenshire and Pembrokeshire. This includes anyone visiting the area, including those who may be homeless or living in temporary accommodation. It is an open access all age telephone triage service which is accessed via the national 111 call line, by selecting Option 2. To date there has been very positive feedback from service users and partner agencies such as GP and Police colleagues. There will be a phased approach to 24/7 operating hours throughout the summer period as additional staff are recruited and on boarded in Autumn whereby the service will operate 24/7. A dedicated Professional Line was launched in mid August and is available 7 days a week 365 days a year. It can be accessed by a wide range of professional partners such as Police, A&E, WAST, Local Authorities, GP's and Education colleagues etc. It can be accessed via telephoning a local 01267 rather than through 111, which will ensure less traffic on the public line to help minimise call waiting times. A qualified Mental Health Practitioner will provide advice, guidance and assessment support to professional partners in respect of complex mental health presentations. We are currently working with MH Crisis Teams (All age) MIU, A&E and Police colleagues to agree baseline data for MH presentations/referrals in these services. As part of the WG funding we will be undertaking a full evaluation of the service after the first 12 months based on the following agreed outcomes: <ul style="list-style-type: none"> Improve the callers experience and outcomes Streamlined referral process Increased outcomes for professional partners Provide early intervention for mental ill health issues Provide information & options for self-care and support Provide navigation to appropriate services/non statutory support for welfare issues Reduce the demand on ED/GP/Police/WAST/MH crisis services Make seamless referrals to crisis teams (if necessary) Provide professional mental health advice for other agencies such as GP's/WAST/Police Qualitative experience of MH Services and wider professional network Qualitative experience of service user Quantitative measurement through satisfaction questionnaires
Accelerate plans for NHS 111 Wales urgent dental pathways with support from Chief Dental Officer /LHB Clinical Leads	<ul style="list-style-type: none"> 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) Scoping the potential to run further urgent dental clinics at Amman Valley and Llandovery Community Hospitals during the week days. There is the potential need for capital investment to ensure the revised Infection Prevention & Control measures are in place Considering opening the second surgery on the mobile dental unit based on site at St David's Park (first surgery open five days a week from 1 September 2022) Looking to develop clinical triage in place that will enable risk stratification of patients to identify those that need immediate treatment and those that can be seen within 48 hours.

Goal 2: Signposting people with urgent care needs to the right place, first time (continued)

Winter Priorities	What is Hywel Dda doing
Resilient NHS 111 Wales / UPC OOH services	<ul style="list-style-type: none">• Data suggests that the utilisation of 111 by our population is lower than that of other Health Boards across Wales. Similarly data is suggesting our ED attendance is higher relative to population size. Work is progressing to better understand this data set and an action plan will be developed to increase uptake of 111 and reduce any unnecessary ED attendances throughout winter• To implement a 24/7 clinical consultation line for Care Homes (Residential and Nursing)• To integrate existing GP OOH pathways with other existing 24/7 UPC services in the community (palliative care, intermediate care)• To explore next day scheduling to MIU, SDEC, UPC (in hours) from GPOOHs
Incorporate Primary & Community escalation as part of the wider whole system escalation mechanisms	<ul style="list-style-type: none">• The Health Board has developed escalation processes for both Community Nursing and Community Hospitals based on national triggers; local triggers; and actions, based on the main four escalation status levels for Health Boards and WAST.• These levels and the triggers which support them will be used to determine the appropriate response to escalating and de-escalating emergency pressures and the actions necessary to protect core services, in order to supply the best possible level of service with the resources available.• Examples of actions for each level can be found on the next two slides (and is not intended to be a complete list)

Goal 2: Signposting people with urgent care needs to the right place, first time

Community Nursing	
<p>Level 1:</p> <ul style="list-style-type: none"> • Maintain usual practice • Routine reviews of caseloads being undertaken by DNTL • Potential issues are recognised and highlighted to Clinical Lead Nurses in timely manner. • Staffing rotas are completed in line with e-roster policies 	<p>Level 2:</p> <ul style="list-style-type: none"> • As per Level 1 • Team leaders to undertake additional caseload reviews to review potential discharges from caseload • Review staffing levels for week and identify any potential shortfalls requiring bank cover as early as possible • Review staff options within own service, move cover from another day, request own staff to do overtime etc. • Discuss with Locality/ Clinical lead nurses if likely to require Bank Cover (additional bank capacity required unplanned from forecast) • Follow Bank/Agency Escalation Plan if unable to cover staff shortages with Bank (Review Escalation Level if this is required) • Review and cancel all management / non clinical activities for Band 6 and Band 7 staff • B7 escalated to fully clinical role (supernumerary status to be cancelled). Report on DATIX including risk assessment and all mitigating actions taken
<p>Level 3:</p> <ul style="list-style-type: none"> • As per Green Level 1 and Yellow Level 2 • Clinical Lead Nurses to review existing staffing within all localities and utilise existing bank shifts where necessary • Clinical Lead Nurses to liaise across localities to review staffing requirements and caseload reviews • Identify patients suitable for discharge from community nurse caseloads • Increase numbers of HCSW if required to manage RN deficit • Cancel all study leave / training days • Offer additional hours for substantive part time/full time staff, overtime and agency authorisation • Review and cancel all management / non clinical activities for Band 6 / Band 7's • B7 escalated to fully clinical role (supernumerary status to be cancelled) • Clinical Lead Nurse to provide oversight on a daily basis to support clinical team • Consider deployment of specialist nurses, educators, workforce from therapy services (following risk assessment of reducing/standing down these services) • Identify community resources for redeployment into 'core' community nursing teams – e.g. CNS teams, Clinical / Corporate roles to be scoped • Escalate to Locality Managers, Heads of Community Nursing and General Managers • Articulate Community Nursing pressures to primary care services, local GPs and acute services • Report on DATIX including risk assessment and all mitigating actions taken 	<p>Level 4:</p> <ul style="list-style-type: none"> • As per Level 1-3 • Locality Managers/clinical lead nurses and Heads of Community Nursing to work closely with local authority and 3rd sector to review alternative support models • Notify Primary Care and Acute Care Services that Community Nursing Services are unable to accept any non-priority 1 patients. • All non 'core' community services reviewed and services redeployed to provide support to community teams which may impact on capacity to manage acute service referrals • Review staffing deficits and ensure up to date risk assessment has been completed outlining all actions taken in Levels 1-3 plus: • Clinical lead nurse to work clinically to support core patient care • Consider alternatives to RN cover where possible (consider clinical and non-clinical support) • Consider Enhanced Pay Opportunities to reduce staffing deficits • Consider cancelling or reducing other community services to support • Update DATIX and feedback outcome to Senior Nurse

Goal 2: Signposting people with urgent care needs to the right place, first time

Community Hospitals

<p>Level 1</p> <ul style="list-style-type: none"> • Daily review of staffing levels to ensure Community Hospitals are staffed adequately <ul style="list-style-type: none"> ○ Roster policy is being followed ○ Outstanding shifts escalated appropriately ○ Concerns over potential staffing deficits highlighted and escalated accordingly • Ensure all patients ready to be discharged do so with appropriate support. • Utilise all opportunities for rehabilitation and ambulatory care • Regular board rounds in place: <ul style="list-style-type: none"> ○ All patients have an expected Date of Discharge ○ Patients due for discharge and those causing clinical concern are identified at the Board/Ward Round ○ Identify and escalate all obstructions to discharge (use PSAG board) ○ Potential delays or issues to be escalated as soon as possible to maintain patient flow • Weekly MDT held • GP maintaining ward reviews and ward rounds at least once weekly • Ward sister / Therapy Lead / Clinical Lead Nurse (CLN) to ensure community hospital attendance at acute hospital morning bed meetings to update on ward position and any predicted staffing issues <p>Level 3:</p> <ul style="list-style-type: none"> • Ensure all actions from Level 1 and 2 have been exhausted and ensure information is available to provide accurate updates <ul style="list-style-type: none"> ○ Ensure all inpatient plans are reviewed and updated: ○ Increase bi-weekly board rounds to daily ○ Request all patients have medical review to confirm Medically Fit / Non Medically Fit status ○ Increase formal MDT meetings to bi-weekly with medical input as required to identify medically optimised patients ○ Ensure all patients have Estimated Dates of delivery reviewed and updated • Liaise with joint discharge team, acute care, intermediate care, primary care and local authority to review and expedite early supported discharge <ul style="list-style-type: none"> ○ Consider short term placements to maximise bed availability / Review options for interim placements unable to access long term placements ○ Consider Intermediate Care Beds / Continuing Care Beds ○ Review packages of care and care needs to facilitate discharges ○ Escalate patients requiring funding for short term care packages / care homes ○ Escalate need for additional surge beds to be opened or additional beds funded • Staffing deficits to be risk assessed and escalated for authorisation to escalate to off contract agencies to maintain staffing levels. <ul style="list-style-type: none"> ○ Increase numbers of HCSW if required to manage Registered Nurse deficit ○ Review wider community capacity to support / ART / CNS Teams / District Nurse Teams ○ Ward Manager / B7 escalated to fully clinical role (supernumerary status to be cancelled) ○ Clinical Lead Nurse to provide oversight on a daily basis to support clinical team and ward ○ Senior Nurse/ CLN / Head of Nursing to review forthcoming week staffing levels across service area/sit ○ Consider reducing/cessation of scheduled services and deploying staff ○ Consider deployment of specialist nurses, educators, workforce from therapy services and/or deployment of alternative workforce e.g. therapy teams to create a ‘wraparound’ team (following risk assessment of reducing/standing down these services) ○ Consider limiting workload to available staffing through closing beds in wards where staffing levels not achieved /most affected • Joint meeting between community management teams and local authority teams to review and resolve DToC delays • CLN from Community Hospitals and SNM from Acute sites to liaise and consider potential deployment of any available staff from acute sites to maintain beds in Community Hospitals • CLN to escalate community hospital position at 10am and 4pm site calls 	<p>Level 2:</p> <ul style="list-style-type: none"> • Update community hospital status on daily SITREPS highlighting potential delays in admissions • Ensure changing position is escalated through county management teams detailing specific pressures. • Ensure all actions from Level 1 have been actioned and exhausted, ensuring that all information is timely and relevant in order to provide an update as require • Utilise professional judgement in relation to staffing needs and consider: <ul style="list-style-type: none"> ○ Senior Sister/Charge Nurse to review and realign staffing rosters to reflect needs of current patient cohort: This should include a review of the workforce skill mix ○ Offer additional hours for substantive part time/full time staff, overtime and agency authorisation ○ Request booking of temporary staff (bank and contract agency) through Bank Office ○ Consider limiting workload to available staffing through holding empty beds in wards for shifts when staffing levels not achieved ○ Report on DATIX including risk assessment and all mitigating actions taken • Maintain normal staffing levels within community hospitals and community services. <ul style="list-style-type: none"> ○ Utilise bank or agency as appropriate • Inform relevant Operational manager / General Manager to request help in DTOC avoidance. <p>Level 4:</p> <ul style="list-style-type: none"> • Ensure all actions from Level 1, 2 & 3 have been exhausted and ensure information is available to provide accurate updates • All medical / GP teams requested to re-review patients and risk stratify potential discharges • All admissions into empty beds or discharge beds to be suspended • Review staffing deficits and ensure up to date risk assessment has been completed outlining all actions taken in Levels 1-3 plus:: <ul style="list-style-type: none"> ○ Clinical lead nurse to work clinically to support core patient care ○ Consider alternatives to RN cover where possible (consider clinical and non-clinical support) ○ Consider cancelling or reducing other community services to support transfer to community staff to support community hospitals(e.g. closing ART Caseload) ○ Utilise professional judgement in relation to staffing needs and consider: ○ Deployment of ‘wrap-around team’ workforce (following risk assessment of standing down the services currently provided by these staff) ○ Deployment of nurse registrants working in non-clinical roles (following risk assessment of standing down these services) ○ Review current patient waiting list and consider accepting patients from acute sites with low acuity who may be outside of the agreed community hospital patient criteria ○ CLN / CHoN/GM to escalate position and potential need to close beds to Acute CHoN / SNM / GM ○ Potential for urgent staff deployment from acute sites to maintain community hospital beds to be reviewed ○ Daily meetings between SNM and CLN to commence until position stabilised ○ Decision to close / reduce beds to be taken by CMT after discussion with Acute hospital teams ○ Reduce the bed base number until the number of available staff required to meet patients’ acuity/dependency needs in line with planned roster staffing 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Goal 3: Clinically safe alternatives to admission

Winter Priorities	What is Hywel Dda doing
Robust triangulation of clinical care and handover between GMS / 111 / UPC OOH services	<ul style="list-style-type: none"> Our GMS practices have benefited from UEC funding to enhance their workforce sufficiently to accommodate an additional 2 appointments per practice per day directed to them by our Urgent Primary Care Streaming Hub. Our Home First (UPC and Intermediate Care) community capacity has also benefited from UEC funding to enhance the MDT and ‘wrap around’ care capacity to support patients to remain at home for their urgent care and treatment where it is safe for us to do so. Taking referrals from WAST and GPs currently – planning to integrate with GPOOH in time for winter. The Home First service continues to support conveyance avoidance targeting the WAST stack and benefits from an APP navigator for our Carmarthenshire residents which will continue through the winter period – we anticipate that this model will expand to cover Pembrokeshire and Ceredigion in time for the winter period Care Homes continue to present significant demand to WAST and our Emergency Departments. Our UPC Streaming Hub will benefit from a 24/7 Care Home Clinical Consultation pathway commencing beginning December for Carmarthenshire Care Homes. It is anticipated that the business intelligence from this will provide us with the blue print to deliver this locally through Delta Wellbeing. The Delta Connect 24/7 Response in Carmarthenshire will provide ‘eyes on’ assessment and support for patients waiting ambulances in the Carmarthenshire area for Winter. It is anticipated that this model is rolled out across Pembrokeshire and Ceredigion providing resource is available
Use of the Urgent Primary Care Centres and evaluation to inform Health Board planning	<ul style="list-style-type: none"> The virtual UPC service and Streaming Hub has been operating in its first phase since October 2021 we are reviewing the evaluation and data to understand our ‘true demand’ and inform our planning. Further we are consulting with our patients to determine ‘what matters’ to them in terms of Urgent Primary Care and will develop our services according to this. We are also consulting with our UPC OOH staff to understand ‘what matters’ to them in order to develop a sustainable model / workforce.
Health Board implementation of the Community Nursing Specification	<ul style="list-style-type: none"> The Health Board have developed a community nursing service model that is delivered across the footprint of HDdUHB, and while there are some local differences in service delivery across each county, there are overarching service aims, objectives, principles and functions provided Our vision is to improve the health and well-being of our population by empowering and supporting people to live well and remain in their own communities. Our objectives align to the principles and strategic direction of the Healthier Mid and West Wales Strategy, our local integrated county and locality plans as well as national strategies and include: <ul style="list-style-type: none"> Prioritising equitable and accessible person-centred care, treatment or support Ensuring a preventative, proactive and population health centred approach Delivering a system wide approach to providing high quality care closer to home Promoting self-care and well-being – ‘help to help yourself,’ encouraging an approach to care which values re-ablement and independence Delivering safe, effective and value-based health care Promoting ageing and dying well Ensuring there is a skilled, strong, flexible and sustainable workforce with clear career and development opportunities to meet the changing needs of the population Promoting and embedding Technology Enabled Care into all aspects of community nursing services Recognising the value of informal carers as well as developing strong integrated partnership working across all health and social care and 3rd sector organisations to empower and support individuals to live as well as possible, ensuring safe, sustainable, accessible and kind services are available when needed. Community nursing services operate 7 days a week, 24 hours a day. HDdUHB, District nursing teams operate a core service between the hours of 8am – 6pm* with other community services such as acute response teams (ART) or community resource teams (CRT) providing cover during out of hours, usually between 6pm – 8am (*some local county differences may apply) There are 7 localities across HDdUHB and each geographical locality will have several integrated community networks / neighbourhoods consisting of district nursing teams working closely with a variety of other health, social and third sector partners. This enables the provision of a whole system approach of neighbourhood nursing model of care in line with accelerated cluster development. The introduction of Malinko as a scheduling tool will also enable community nursing teams to more easily capture and report on key measurable metrics.

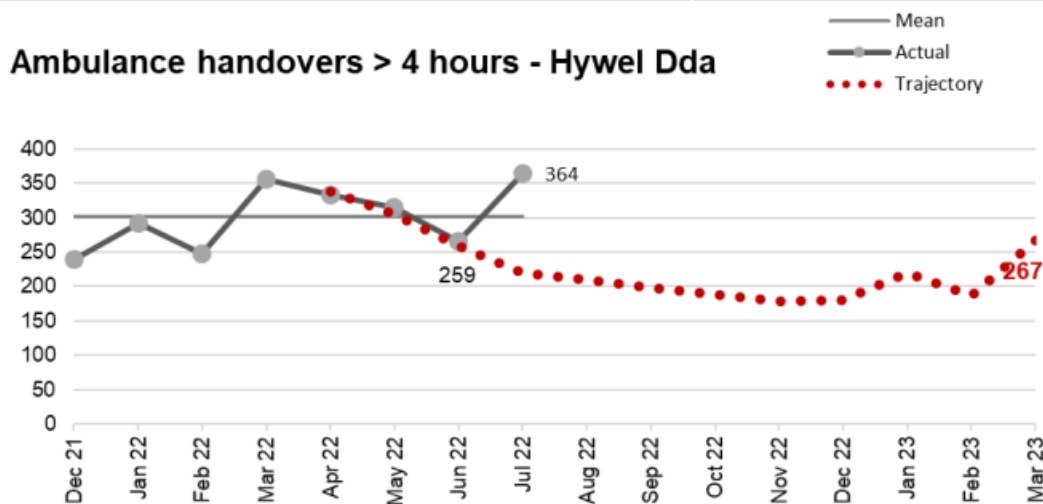
Goal 3: Clinically safe alternatives to admission (continued)

Winter Priorities	What is Hywel Dda doing
<p>The Delivery Unit report published in April 2022 on step up Intermediate Care sets out clearly the projected number of intermediate care visits / teams that would be needed based upon figures that had been supplied and modelled. Health Boards and Local Authorities should have a clear plan in response to this work</p>	<ul style="list-style-type: none"> We have recently commenced recruitment to enhance our Home First service with additional care workers that will create additional intermediate care step up capacity. We acknowledge that community intermediate care bed capacity is not sufficient to meet the anticipated demand – we have however increased capacity in a residential care setting and in our community hospital bases to accommodate additional patients. Our community bed model is being reviewed to ensure we optimise the use of our available intermediate care bed capacity. Currently the Length of Stay is too long affecting flow and the number of ‘bed turns’ we are able to achieve. Critical to the model will be to admit from the community or our hospital ‘front doors’, currently the majority of community intermediate care beds are patients transferred following a prolonged inpatient stay. The length of stay in our community intermediate care beds should be no more than 10 days – we are beyond achieving that currently <p>Pembrokeshire:</p> <ul style="list-style-type: none"> Integrated Single Point of Contact (SPOC) operating 8 to 6, 7 days a week, which accepts referrals for safe alternatives to hospital admission. Providing a coordinating response across planned, intermediate and urgent response teams to ensure the patient has the right care at the right time and keeping them at home and maximising independent. Realign Acute Response Team and Care at Home Team into one team to enable a flexible and sustainable workforce to deliver crisis and home based response Reduce duplication and administrative work of our clinical teams by redirecting all referrals through the coordination centre and recruitment of administrative support Recruitment of a Urgent and Intermediate Care medical workforce team Further recruitment of the home based care service specifically supporting bridging care for reablement, D2RA pathway 2 and packages of care, working closely with local authority Scope and develop a proposal for potential new service model for Sunderland ward for a proportion of the beds to be utilised as an intermediate care step up and step down facility – this model would promote the movement across the intermediate care setting, moving patients from acute setting, rehabbing and returning home with support from intermediate care services in the community, and in return bringing patients in directly for periods of rehab and convalescence directly from community intermediate care settings. Scoping the opportunity/feasibility to develop a UIC medics advice and guidance telephone line on Consultant Connect Intermediate Care Nursing and Therapies working 7 days a week to prevent admissions into hospital. Recruitment and embedding an Urgent and Intermediate GP, Clinical Fellow and ANP workforce model to provide medical input where needed
<p>Seven day same day emergency care services throughout winter period</p>	<ul style="list-style-type: none"> Our SDECs are currently working during core Monday to Friday hours (9-5) with the exception of Withybush which operates across a 12 hour period (0900 – 2100hrs). Sustaining this provision is however challenging due to workforce compromise. We are undertaking an analysis to understand the ‘true demand’ for SDEC which will inform targeted opening across a 7/7 period to ensure we maximise impact based on demand

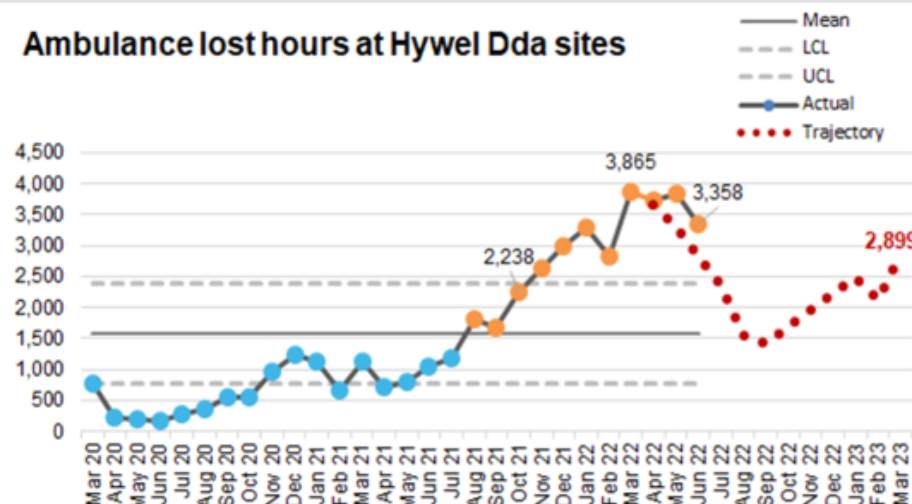
Goal 4: Rapid response in crisis

Winter Priorities	What is Hywel Dda doing
Health Boards to optimise use of Mental Health crisis response transport pilot (delivered by St. John)	<ul style="list-style-type: none"> In May 2021 Welsh Government provided funding to pilot a 6-month Mental Health conveyance scheme to support service user flow to and from inpatient settings which has recently been extended up until March 2022. The service has been operational since 1st May 2021 and is being provided by St. Johns Cymru, with 1 full time vehicle with a 2 person crew from 10.00am – 10.00pm 7 days per week. Outside of these hours (10.00pm – 10.00am) there is an on-call system in place. This service has greatly reduced NHS and partnership organisations staff time in having to provide transport, with over 500 conveyances being undertaken in the first 12 months. We are working with Welsh Government to agree the service needs for the procurement of the Mental Health Conveyance Scheme going forward with confirmation that they will fund the service sustainable following the success of the pilot. This includes ensuring that service user feedback collated by the Health Board is incorporated into the commissioning of the future service model including: unmarked vehicles, cars rather than ambulances (unless a stretcher is required), 24/7 availability (no on-call) and informal uniforms etc. Between 1st May 2021 – 30th April 2022 St. John's conveyed over 400 individuals. This had a direct reduction in staffing time and meant that staff no longer had to transport individuals and/or attend as escorts for these 400+ journeys. WG are currently evaluation the service prior to a public procurement exercise.
Continued expansion of remote clinical support services through the consolidation and expansion of the use of 'ECNS' and 'PTAS' Models, to ensure that patients awaiting an emergency ambulance response are clinically assessed within 20 minutes	<ul style="list-style-type: none"> Our UPC Streaming Hub is operational Monday – Friday which provides GP led to remote PTAS across Pembrokeshire and Carmarthenshire. The Streaming Hub has benefited from an APP navigator focusing on the Carmarthenshire WAST stack during the last 12 weeks. Evaluation from this initiative has indicated a significant reduction in ED disposition. WE are confident that this model will extend to Pembrokeshire and Ceredigion in time for winter. Remote Clinical Consultation for Care Homes across a 24/7 period will be available through our UPC Streaming Hub from early December Delta Connect Rapid Response is available 24/7 in Carmarthenshire to provide low level 'eyes on' assessment and support for those pending ambulance in the community. We anticipate that this model will be rolled out across the other Counties resource dependent
Enhanced delivery of EASC improvement plan actions (WAST)	<ul style="list-style-type: none"> WAST have produced a Performance Improvement Plan which acts as a rolling tactical. WAST have noted that this will replace seasonal plans The WAST Performance Improvement Plan includes forecasts and modelling based on two scenarios: most likely scenario (MLS) and reasonable worst case (RWC). These scenarios use predicted values for patient demand, time at scene, time at hospital and unit hours production, as agreed by the Forecasting & Modelling Group (which includes representatives from the National Collaborative Commissioning Unit and the Delivery Unit) The Forecasting & Modelling Group is currently working on winter modelling. The first iteration will be up to the end of the first week in 2023, followed by a second iteration through to 31 March 2023. This forecasting and modelling will include COVID-19 forecasts and flu forecasts. These winter models will include scenarios in which hospital handover delays decrease in line with current Heath Board trajectories and include our own increases in staffing availability as the 100 additional frontline staff become operational. This will allow us to make an assessment of the best case performance over the winter period, which can be fed back to EASC, Welsh Government and the Minister. The Health Board will work with WAST to ensure that the implications for the Health Board are clearly understood

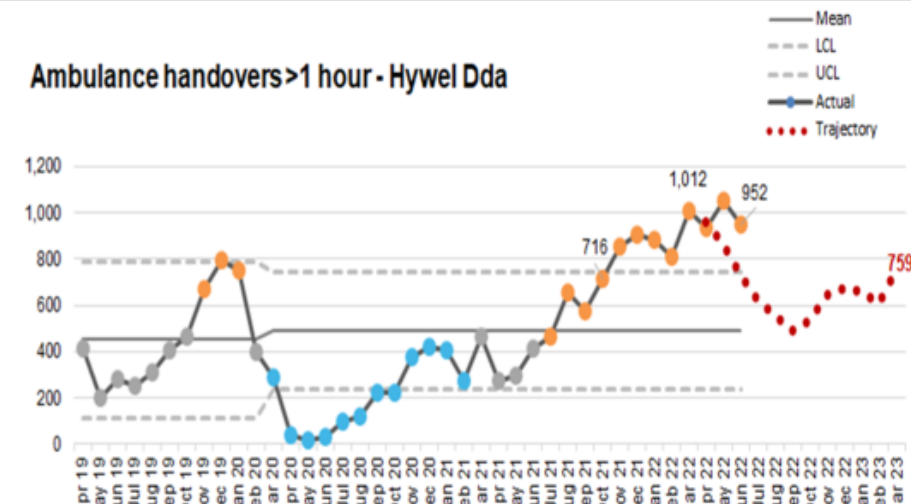
Ambulance handovers > 4 hours - Hywel Dda



Ambulance lost hours at Hywel Dda sites



Ambulance handovers > 1 hour - Hywel Dda



Goal 4: Rapid response in crisis (continued)

Winter Priorities	What is Hywel Dda doing
Enhanced delivery of ambulance patient handover improvement plan actions (Health Boards)	<p>Established a joint Operational Delivery Group (ODG) with WAST & Hywel Dda colleagues, working on 5 key overarching actions:</p> <ul style="list-style-type: none"> Roll out of SDEC – this has now been achieved in Glangwili, Withybush and Prince Philip with a nurse led SDUC established in Cardigan. Currently Bronglais does not have capacity to introduce this but we will review going forward. The main purpose of the SDEC concept is to convey appropriate patients directly there and avoid unnecessary pressure on the Emergency Departments. We are reviewing this activity on an ongoing basis. Use of GP to Consult before Convey – this has resulted in GP surgery private access numbers being added to Consultant Connect allowing speedier access by ambulance crews to the patient’s own GP and thus re-directing patient needs more appropriately rather than conveying unnecessarily to Emergency Departments. While reviewing this action we also agreed to trial an ‘APP Navigator’ model focussing on Carmarthenshire. This has seen a WAST APP being based within Eastgate in a shared facility undertaking an MDT approach to providing alternative treatment / referral pathways for patients. To date this has been hugely successful in diverting patients away from the Emergency Department and freeing up ambulance response. Ability for social care access in Carmarthen to see if that alters on-scene outcomes, even just ability to understand an individual’s care arrangements – we have now provided operational ambulance crews with the social care contact details from the three County areas so that all social care queries can be addressed without unnecessary conveying patients to Emergency Departments with solely social care issues. EMT and whether the skillset could support staffing shortfalls in ED – this concept was considered due to significant nursing shortages within the Emergency Department, particularly Glangwili and Withybush. However, it was realised at an early stage that the job descriptions of WAST band 3 & 4 staff were quite limiting to the needs within the Emergency Department. Therefore, as an action this was dropped and the health board started recruiting more HCSW to address Emergency Department staffing issues. Activity related to discharge from ED and whether dedicated transport was warranted – this action would allow for speedier flow from the Emergency Departments and indeed any outstanding late discharges from wards. This would also prevent an emergency ambulance undertaking such patient movements which would further reduce their availability to respond to outstanding emergency calls. This action is now at the stage where we will approach the Commissioner for funding to progress over the winter months. <ul style="list-style-type: none"> To support this work, a pilot is being considered whereby WAST provide additional 3 private (NEPTS) vehicles at three sites (Prince Phillip, Glangwili & Withybush), for the period Monday-Sunday, for a period of six months, the aim to support improved flow across these three key sites in HDdUHB.

Goal 5: Optimal hospital care and discharge practice from the point of admission

Winter Priorities	What is Hywel Dda doing
To embed v1 of the optimal patients flow framework at ward and hospital level and commence national reporting against agreed measures (the measures will be determined as part of the expert group work over the next 3 months)	<ul style="list-style-type: none">In anticipation of v1 of the Optimal Patient Flow Framework, we have undertaken Stranded Patient reviews utilising SAFER methodology. This has provided us with qualitative and quantitative baseline data on which to base our improvement plans in this area.The Assistant Director of Nursing will be leading this improvement work as Chair of Policy Goal 5 of the 6 Goals UEC ProgrammeWe anticipate that the national measures will include length of stay > 21 days as well as the number of patients who are ‘Ready to Go’. Our performance dashboard includes this metric.
Consistent delivery of new repatriation policy following publication in January 2023	The Health Board will respond to the new repatriation policy following publication in January 2023

Step Closer to Home Unit

Background / Context

It is acknowledged that in-patients have differing needs and many whilst requiring support, do not need medical or nursing intervention daily. There are a group of patients who are unable to go home for a variety of reasons but do not need the level of care provided on a conventional ward and should be encouraged to retain their independence whilst they wait for transfer home. These patients are often referred to as Medically Optimised or ‘Ready to Leave’.

Medically Optimised is defined as the point at which the senior clinician has determined that the patient no longer requires their intervention for that acute admission of care. These patients continue to undergo assessment and intervention by the multi disciplinary team (MDT) which could include rehabilitation and processes necessitated by the Mental Capacity Act and Court of Protection. In summary, these patients have not yet had their definitive needs agreed to support safe transfer to the next stage of their care.

‘Ready to Leave’ the point at which the clinician and the multi disciplinary team have agreed that the patient has achieved all their goals for that acute admission of care. This is generally the point at which the patient is ‘waiting’ for care and support to ensure safe transfer to the next stage of their care. In summary, this is the point at which the patient has definitive care and support needs.

Aim

To implement a model of care for ‘Ready to Leave’ patients on our acute and / or community sites

Objectives -

- 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
- This ward could provide care that ‘mirrors’ the care plan (and package) which the patient would be receiving on transfer home with their care package. This care would need to adopt an ‘asset based’ approach with care workers only providing a level of care which they are unable to do themselves. This approach ensures that no further deconditioning takes place while waiting for care with the aim to increase confidence and a sense of independence. Patients should be encourage to use the facilities as if it was their ‘home’. Families should also be encouraged where IP&C allows to support care provision.
- The community Homefirst service will in reach to the ward daily to review their multidisciplinary plan of care and expedite with any available ‘bridging’ capacity

Goal 6: Home first approach and reduce risk of readmission

Winter Priorities	What is Hywel Dda doing
Consistent reporting of Delayed Transfers of Care (DToC)	<ul style="list-style-type: none"> HDdUHB is currently piloting DToC reporting for WG. The SharePoint Complex Discharge database provides a ‘live’ update on patient status that can be used to support DToC reporting
Increased compliance with D2RA Pathways	<ul style="list-style-type: none"> The key limiting factor in implementing fully the D2RA pathways is access to homebased care to support Pathway 2. This is being address through the region’s partnership approach to the Building Community Home Care Capacity ambition (see below). Further, anticipating efficient and effective commissioning for D2RA pathways is dependent on effective Optimal Discharge Planning and Coordination. ‘Stranded patient’ reviews have been undertaken in Glangwili and Bronglais to date and have both demonstrated non compliance to best practice. Improvement plans across the sites will be overseen by our Assistant Director of Nursing who is the Chair of Policy Goal 5 of the 6 Goals UEC Programme
Current Interim Placements reviewed and Step Down to Recover Rehabilitation Implemented to support better outcomes for the person	<ul style="list-style-type: none"> All patients pending care and support availability are offered alternative interim placements. Few patients consent to this as an option. We have taken legal advice and have been advised that enforcing transfer could be challenged legally. We continue not to offer home of choice i.e patients will be transferred to a home that can meet their needs while waiting for their home of choice <p>Pembrokeshire: Scope and develop a proposal for potential new service model for Sunderland ward for a proportion of the beds to be utilised as an intermediate care step up and step down facility – this model would promote the movement across the intermediate care setting, moving patients from acute setting, rehabbing and returning home with support from intermediate care services in the community, and in return bringing patients in directly for periods of rehab and convalescence directly from community intermediate care settings.</p> <p>Processes in place through the Joint Discharge Team and Local Authority to continuously review Interim Placements in the county and offer ICB when patients are ready to leave on a social care pathway. ICB leaflet to be developed setting out expectations from the beginning of their hospital stay.</p>
Step Down to Recover Community Bedded Facilities developed and operationalised. Workforce key roles recruitment campaign and options delivered	<p>Integrated Enhanced Homebased Care (PO 4Q)</p> <p>As part of the new Welsh Government mandate around Community Care Capacity Building, creating 1000 bed capacity, we have agreed through a Planning Objective that by October 2022, through a rapid expansion of community care, support more Hywel Dda residents to remain / return home with the objective of 120* fewer non elective patients in hospital beds on a daily basis The scope is to</p> <ul style="list-style-type: none"> To grow the total homebased care workforce in the community on a sustainable basis. To develop a consistent and regional set of principles which can be owned and implemented as most appropriate in each County System. The focus of the teams will be to support independence, re-ablement or enablement and the Home First principles. We seek to do this in partnership recognising the impacts on the experience and outcomes for individuals and the wider population. We seek to share the responsibility and risk in the design, implementation and resourcing and will ensure senior consistent representation in a regional steering group and local Operational Delivery Groups. <p>Further details are provided on the slide 28</p> <p>Further in Ceredigion, the Interim Placement Scheme which enables timely assessment has operated successfully for a number of years. Both funding and capacity in the independent nursing home sector limit the number of beds available for patients to use the scheme. Conversations with the Local Authority have commenced to explore options of using the residential care home sector for appropriate patients.</p>

Section 4:

Other Supporting Information

Homebased Care and Regional Support to the national initiative in saving 1000 bed days

Introduction

The West Wales Region plan (which includes our three Local Authority partners as well as Hywel Dda) to co-ordinate a regional model which will then be delivered at place on the basis of local partner configuration. Our 5 agreed objectives are:

- To grow the total homebased care workforce in the community on a sustainable basis.
- To develop a consistent and regional set of principles which can be owned and implemented as most appropriate in each County System.
- The focus of the teams will be to support independence, re-ablement or enablement and the Home First principles.
- We seek to do this in partnership recognising the impacts on the experience and outcomes for individuals and the wider population.
- We seek to share the responsibility and risk in the design, implementation and resourcing and will ensure senior consistent representation in a regional steering group and local Operational Delivery Groups.

The regional model will provide additional capacity to bolster the provision of home care and support in the short term where other forms of care are not available within a timescale that is deemed reasonable relative to the risk in the system. It enhances the community workforce which will integrate and enhance health and social care provision in partnerships between the Health Board and the Local Authorities. Care may be provided :

- for those individuals at home to prevent or reduce the risk of an urgent admission to hospital
- for those individuals in an acute or community hospital bed who require care to enable them to transfer home for their assessments.
- for those individuals in an acute or community hospital bed who require care to enable them to transfer home whilst waiting for their assessed long term care provision

Bed Benefit Analysis

Hospital bed occupancy varies between the 4 acute hospitals and more so if the community hospital beds are included. Analysis on best outcomes from Lightfoot has highlighted:

- 80 occupied bed efficiency by October by increasing front door turnaround and recuing overall LOS by 1 day for people over 75 years – 100 beds by March 2023
- 100 occupied bed efficiency by October by increasing front door turnaround and recuing overall LOS by 1 day for people over 65 years.

The aim is to create capacity in the system through efficiency in order that we can accommodate pressure that being exerted in that system and we believe that this is a realistic assessment of achievable delivery .

It is expected that through reducing the decondition that people experience following long lengths of hospital stay, and the timely intensive intermediate care provision, that there will be a reduction in care packages. This will be monitored as part of the programme.

Homebased Care and Regional Support to the national initiative in saving 1000 bed days

Community Bed Benefit

Based on the operational impact of similar teams in Pembrokeshire and Carmarthenshire the following benefit has been provisionally submitted to Welsh Government :

- 52 community beds in Carmarthenshire – assuming full 35 WTE staff employed
- 38 beds in Pembrokeshire – assuming full 35 WTE staff employed

In addition the following community capacity has also been submitted :

- 14 beds Ty Pili Pala in Carmarthenshire
- 9 bed Hillside & Havenhurst in Pembrokeshire

This generates total of 113 beds against a Welsh Government ask of 117. Impact on acute difficult to assess due to multiple compounding factors but Lightfoot analysis of the whole UEC system remains extant and noting that that the community bed benefit is additional and not in the run rate

Delivery Plan

Improving processes at the front door - using SDEC and optimising use of assessment units - with the objective of discharging more people within 72 hours is assumed to result in a reduction of 1 day LoS by October 2022. Focussing on reducing conveyancing and processes in the Emergency Department to avoid admission is assumed to reduce the admission rate by 10% by October 2022 (using urgent & intermediate care community resource) – 4 people per day.

Enhancing community care capacity will provide reassurance and reduce the delivery risk of achieving these efficiencies despite the reported levels of acuity and complexity of patients presenting as emergencies. This action dependent on successful recruitment which may be phased over longer period of time 6 – 18 months.

- Carmarthenshire developing a short term intermediate care function with additional c.32 WTE joint reablement/rehabilitation/assess at home staff.
- Ceredigion are starting from a preferable position in terms of Length of Stay and Bed Occupancy – reviewing opportunities to increase the joint enablement scheme following evaluation of the Transformation Funded scheme. Long Term Care has a capacity gap of c.58 WTE staff – this will deliver 6 intermediate care bedsIncrease Health & Social Care Worker roles, Development of Provider Hub to support independent sector with training, recruitment and retention in order to increase commissioned community care capacity
- Pembrokeshire developing intermediate care function and jointly growing long term care capacity through recruitment of 85 WTE joint health & social care support workers and 15 joint apprentices.
- Direct payment and micro-enterprises to be further developed in each Local Authority area.

Risks to delivery

- Recruitment – significant challenges due to current employment market. There is a need to consider wholesale Wales-wide approach to remuneration of the care sector.
- Training & Induction – challenges in sufficient on-boarding and induction capacity to support rapid recruitment and on-boarding at scale.
- Regulation & registration – need to support the registration costs for those delivering social care – £35 every three years but may be a disincentive when choosing employer. The regulation of health employed staff delivering social care in a community setting also needs review.
- Driving – to deliver community care staff need to be able to drive and either need their own vehicle or use of a pool car36/40

Paediatric Services Surge Plan including RSV

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 direction from Welsh Government in 2021. In keeping with that specific request, this plan supports a 20% - 50% increase in presentations of the Respiratory Syncytial Virus (RSV), and a 32-52% increase in HDU admissions, recognising the pressures and restrictions within the wider critical care pathway.

Levels of Care

- Level 0 (Patients whose needs can be met through normal WARD care in an acute hospital)
- Level 1 (Patients at risk of their condition deteriorating, or those recently relocated from higher levels of care, whose needs can be met on an acute ward with additional advice and support from the critical care team.)
- Level 2 (Patients requiring more detailed observation or intervention including support for a single failing organ system or post-operative care and those 'stepping down' from higher levels of care.)
- Level 3 (Patients requiring advanced respiratory support alone or monitoring and support for two or more organ systems. This level includes all complex patients requiring support for multi-organ failure.)

Current position and methods of respiratory clinical care escalation.

- Within HDdUHB, all acute inpatient paediatric cases are managed at the Glangwili site at Carmarthen and the Bronglais site in Aberystwyth. In terms of critical care, Glangwili houses a Level 1 Paediatric High Dependency Unit (PHDU) and currently, where patients escalate to requiring Level 2 care or above, they are retrieved by the WATCH team or by EMERTs to a critical care centre elsewhere in Wales or England, depending on available capacity.
- The direction given to the HDdUHB (reflective of the wider critical care pathway constraints) is that in addition to managing a surge in all RSV admissions, including ward and Level 1 care, the HDdUHB must now manage L2 care internally, with cases escalating to L3 (intubated patients) being retrieved to a tertiary site.
- In the event that a patient's condition requires escalation to L2 or L3 care, the following processes are currently observed:
- Within Glangwili Hospital (Carmarthenshire) the PHDU is staffed by trained level 1 HDU nurses with an agreement that where a patient deteriorates, the anaesthetic team attend to support the care delivery within the HDU setting. If intubation is indicated, then the child is transferred to theatres where they will be supported until the retrieval service arrives.
- In Ceredigion, where a level 1 presentation is identified, there is a designated stabilisation space at Bronglais Hospital (the paediatric team is supported by the intensive care team- and transfer to the ICU is supported to allow for intervention and stabilisation). The patient will then be subject to transfer to a designated/ approved hospital.
- In Withybush Hospital (Pembrokeshire), there are no on-site acute paediatric services. WAST EMS pathways and GP admissions are routinely directed to the Glangwili site. However, in the event of a walk-in presentation requiring stabilisation etc., this is managed by the existing Emergency Department team- with remote support and advice available from the on call paediatric team in Glangwili.
- In short- and in differing ways- each hospital deals with level 1 level care and where deterioration occurs, requiring a step-up to level2/3 care, support mechanisms are in place until patients are retrieved by WATCH or EMERTS services.

Surge Planning- update and position.

- Glangwili Hospital is to be considered as the receiving hub for all inpatient/ respiratory presentations where L2 HDU care (or potential for deterioration) is identified- for all HDdUHB paediatric cases under 5 years of age.
- Bronglais is to be considered as a spoke unit with limited ability to intervene in high-dependency cases- any L1 cases will require direction to Glangwili where additional input is provisionally identified or clinically required.
- Withybush (Pembrokeshire) does not have any guaranteed on-site paediatric back-up and so in order to minimise risk to paediatric attendances at the emergency department, all acute presentations (especially under 5 years of age with respiratory illness) MUST be sent to Glangwili wherever possible, subject to satisfactory assessment of condition and where immediately life threatening presentations are not evident.
- Primary care flow will be assessed to ensure referrals from across the HDdUHB footprint are directed appropriately, reducing unnecessary presentations at Withybush and Bronglais- therefore reducing risk.
- WAST emergency respiratory conveyances (under 5 years of age) will be directed to Glangwili for acute clinical management where identified by crews as clinically safe to do so. The risks to presenting to a ED without Paediatric on-site support has been considered as a part of this plan.
- Given the geographical locality in which the HDdUHB is based, transfers of unstable paediatric patients from peripheral units is extremely challenging and at this time, anaesthetic and paediatrician support to provide escort and clinical input during transfer is unlikely to be readily available.
- For reference- modelling has shown that PACU demand in the Glangwili hub increases from approximately 14:00 hours daily, peaking at 18:00- 20:00 each evening.

Financial Considerations and Workforce Considerations

Financial

- Our work on Transforming Urgent and Emergency Care (TUEC) and Home Care Service have or are anticipated to start within this financial year.
- The current information obtained from our work with Lightfoot suggests that the current SDEC and UEC interventions have ensured that a reduction in the number of beds against the counterfactual scenario (i.e. what would have happened if they were not in place). However, this benefit has been offset with demand and the significant increase in Ready to Leave and Medically optimised patients
- The assumption is these initiatives will not bring a direct financial benefit this year as they will instead reduce current pressures, providing an improvement in quality plus additional capacity for winter/planned care. However further benefits will assist the delivery of reduced operational expenditure
- As part of the longer term approach Target Operating Model (ToM) the in-year approach to TUEC the foundations of the ToM have been established through the Welsh Government 6 Goals of Urgent and Emergency Care
- Health Boards must prioritise the implementation of Same Day Emergency Care services so that they support 100% of type 1 Emergency Departments, allowing for the rapid assessment, diagnosis, and treatment of people presenting with certain conditions, and discharge home same day where clinically appropriate, twelve hours a day and seven days a week – by April 2025.
- In order to implement the pertinent TUEC Operating Modelling, there was a total funding allocation of £5.76m. The £5.76m was based on the TUEC plan across the 3 Counties
- The £5.76m was predicated on the Welsh Government allocation of £2.8m (recurring 2022/23 until the end of 2025/26) with the Health Board match funding said allocation with an additional £2.8m. The residual £160k is comprised of Triumvirate funding, which is a ring fenced allocation to fund key enabling roles such as the Programme Director and Clinical Lead roles
- Operational Pressures are intrinsically linked to the current level of Ready to Leave (RtL) and Medically Optimised (MO). In response to this significant challenge, both the Health Board and Local Authorities have identified the fundamental need to support timely and prompt discharge
- The Home Care Service is intended to support system flow by ensuring patients are promptly discharged through the joint recruitment of Health and Social Care provision. The service will address both Intermediate and Interim Care costs across Carmarthenshire and Pembrokeshire
- It is envisaged that the Home Care Service will support the 120 bed reduction (linked to the 1000 beds across Wales). Moreover, it will also ensure that patients receive the appropriate care and reduce the risk of deconditioning and future re-admissions
- The anticipated recruitment benefits for the patients based on acuity and the level of support required. However, it is hoped that for each WTE recruited the benefit will be 1.6 to 1.9 patients being effectively supported.
- The financial expenditure will be predicated on the recruitment and model of care. However, the current model across Pembrokeshire and Carmarthenshire indicates a recurrent cost to the Health Board of circa £1.2m per annum (subject to full recruitment of the roles)
- Finally, the Home Care Service, like the TUEC will form part of the longer term Target Operating Model. Both of these programmes are quintessential enablers to managing and supporting demand across the Counties. They collectively intertwine Demand Management principles and system flow, whilst delivering quality of care for the patients

Workforce

- With respect to workforce, we will need to manage our sickness levels.
- Additionally we will need to ensure we continue to recruit to appropriate positions. For example with respect to our homecare bridging service there are significant challenges due to current employment market. There is a need to consider wholesale Wales-wide approach to remuneration of the care sector.
- We will need to ensure that are staff are deployed appropriately e.g. for our Winter Respiratory Vaccination Delivery Plan; or with respect to our escalation processes for both Community Nursing and Community Hospitals
- We will continue to develop appropriate delivery models, for example, we are also consulting with our UPC OOH staff to understand ‘what matters’ to them in order to develop a sustainable model / workforce; and in Pembrokeshire we are realigning our Acute Response Team and Care at Home Team into one team to enable a flexible and sustainable workforce to deliver crisis and home based response.

Planning Developments

As a Health Board we are currently developing two ‘data’ viewers

1. An operational viewer to understand the current position. Examples of the charts that are currently being developed are:



2. A planning viewer to support future planning and scenario modelling which will:
 - Identify the pre-COVID winter trends compared to current trajectories for certain population cohorts that influence emergency demand
 - Allow 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)
 - In turn allow the impact of potential improvements to be modelled and projected
 - The model to calculate 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

Concluding Remarks

- 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 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 20th 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 programme in 2022/23 will be a significant milestone for the HDdUHB and represents a significant step towards full integration of our vaccination programmes.
- We will continue to adapt to the situation as Winter approaches, and in doing so we also aim to develop our Winter Planning processes through improved use of data, modelling and scenario setting.
- Additionally, 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.
- As a Health Board we have Business Continuity plans in place if required.