WINTER THEMES 2019/20 – OUTLINE FRAMEWORK

Llywodraeth Cymru
Welsh Government

Introduction:

- This framework is intended to aid local planning and delivery for the remainder of 2019/20, with the challenges of the winter period in mind.
- It describes seven themes and related actions that have been co-produced with senior NHS clinicians and directors following an in-depth whole system review of winter 18/19.
- The Welsh Government expects each Health Board to describe how it will work with partners to deliver the required action set out in the framework document by using the provided winter operational tool / template.
- All completed winter operational tool / templates should be signed off by Health Board executive boards, Regional Partnership Boards and relevant clinical leads from the community and acute sector.
- They should be submitted to the Welsh Government (Jamie.wardrop@gov.wales) by **23 October 2019.**

Theme		Context	Principles and assumptions	Required action
1.	**Optimising cross organisational and sector working to support resilience**	Activity is increasing and identifying workforce capacity to supplement and support delivery of existing service models across the urgent and emergency care system which continues to be challenging. There were a number of initiatives delivered over winter 2018/19 that focused on increasing capacity by using third sector organisations, social care and hospital based services. These included: • a range of work undertaken with care home providers nationally, ranging from multi-agency and multi-disciplinary teams, community support teams, additional GP support, advance care planning support from Macmillan nurses to acute geriatric reviews in larger care homes; • Use of pharmacists across the system to support patients with medicines management and improve quality of care and experience; and	• Joined up planning and delivery across service divides: primary and specialist care, physical and mental health, acute hospital, social care and ambulance services (emergency and non-emergency). • Understanding and forecasting local flows, pressure points (demand, aligning and building capacity) to reduce variation. • Identifying areas of the urgent and emergency care pathway where third sector organisations could be mobilised quickly to add capacity (e.g. to provide short term home care). • Utilisation of available capacity through dynamic and pro-active management of flow between hospital sites within health boards and regionally.	Health Boards should work with partners to deliver the following: • Local focus on a model for delivery of advance care planning (ACP) to support the management of people in care homes; • continue to develop and deploy *Stay Well at Home Plans* or the *My Winter Health Plan* which are communicated and supported by primary care practitioners, social care, public service and third sector partners; • maximise the direct enhanced services (DES) for care home residents; • develop plans for a 'pharmacists in ED service', and other parts of the system where they will add value (e.g. clinical hubs/WAST Clinical Support Desk); • make optimal use of the '*ED well-being and home safe'* service (delivered by British Red Cross) by clearly identifying patients who would benefit from transport and resettlement home (evaluation available); and • focus on embedding the *'hospital to a healthier home'* pilots (delivered by care and repair) by enabling case workers to

		• '*Emergency Department well-being and home safe*' (delivered by the British Red Cross) and '*Hospital to a healthier home*' services (delivered by Care and Repair Cymru) were also established through the National Programme for Unscheduled Care (NPUC). These services aimed to improve patient experience and avoid social admissions via Emergency Departments and enable rapid discharge of patients who require home adaptations respectively.		access ward rounds and review medically fit lists (evaluation available).
2.	**Urgent primary care/ out of hours (OOH) resilience**	There are ongoing challenges related to primary care OOH shift fill and increasing demand on primary care services has been a risk identified by most Health Boards. The additional monies provided for winter 2018/19 by the NHS Wales 111 programme and Welsh Government enabled identification of a number of approaches to meeting these challenges thereby helping to mitigate the demand risk. This included the deployment of Advanced Paramedic Practitioners (APPs) and mental health practitioners to support OOH primary care services,	• Align capacity to meet forecasted demand surges. • Introduce new innovative models to support 24/7 working. • Introduce new innovative models to stream patients e.g. Home Visits and Mental Health patients, APP Rotational Model. • Delivery of 111/OOHs national standards. • Develop new innovative models of urgent care working at	Health Boards should: • Use the 111/OOH Demand and Capacity Tool to undertake an assessment of demand to support action planning; • review current OOHs home visits and look at delivering alternative models e.g. MDT; • focus on pathways for patients requiring: i) urgent dental access; ii) adult mental health crisis support, (determining both the need and availability of trained staff to deliver a telephone advice service); and

		both of which could be judged to have been successful in either avoiding unnecessary attendance or admission, to support people to stay at home safely. Urgent Primary Care Pilots (UPCP) clusters tested new approaches during normal patterns of winter out of hours demand (2018/19) with strategies aligned to the needs of the local population. The key findings of the pilots suggest the methods applied could significantly improve the quality of care. The lack of infrastructure or prior experience in this area meant the Pilot Champions were pioneering new ways of working. The evaluation concluded that there are further opportunities to be explored to cover a larger span of services to improve urgent care to be considered for 2019/20. Health Boards should build on the foundations of Pilot 2 as part of their winter planning. *****More information on accessing the national winter funding budget for UPCPs will be shared with HBs in early September*****	cluster/practice level in OOHs. • All practices in the cluster footprint should support and co-operate with the proposals even if they may not wish to actively participate. • New models must not adversely impact on another service (either across primary care or other services such as ED). • Appropriate data sharing agreements and appropriate governance are in place. • Ensure monthly payment mechanisms are in place to reimburse cluster/ practices.	iii) palliative care (specifically requiring pain relief within 2 hours). • each Health Board to implement rollout of primary care escalation tool (option appraisal to be circulated in October 2019); • collaborate with WAST on the APP Rotational Model; • review each cluster OOHs urgent care demand profile; • work with each cluster/practices to define and agree appropriate models and infrastructure – target peak demand at weekends and bank holidays; • Implement communication plan which will require careful consideration to ensure patient awareness and expectation is matched to the offer; • agree robust key performance indicators.

3.	**Preventing unnecessary conveyance and admission to hospital**	Activity across the system is increasing and there is anecdotal evidence of an increase in self presenters to ED with more acute or complex complaints. However, it is clear that a proportion of patients either dial 999 and are conveyed to hospital or self-present at EDs that could safely stay in the community and avoid the need to be assessed and treated in EDs, including through redirection to more appropriate services. A number of initiatives designed to enable people with urgent care needs to stay in their homes and avoid conveyance by ambulance to ED were tested last winter. These included: • Non-injured falls response services procured by WAST and delivered by St John. A full assessment of the project (undertaken by WAST and NCCU) will help support a national rollout with clarity over the type and capacity of the service. • WAST enhanced Clinical Support Desk. • HB staff working alongside colleagues in WAST to screen	• WAST review of the non-injured falls response service should be considered by HBs and scaled up if appropriate to reduce unnecessary conveyance. • In line with primary care model urgent care delivery milestone, HBs need to establish a clear and consistent system for staff to review the WAST stack to avoid unnecessary conveyance of people to hospital settings. • Opportunities for further assessment and support in the community should be maximised, in line with the 'assess to admit' (rather than admit to assess model). • For example *D2RA Pathway 1*: refers to MDT supported turnaround at the hospital 'front door', for further assessment and support in the individual's own environment.	Health Boards should: • Consider the WAST/NCCU review of the non-injured falls response service for scale up if appropriate to reduce unnecessary conveyance; • locally HBs should work with WAST to review demand for non injurious falls to implement a complimentary service; • work with WAST on missed opportunities to bypass EDs, for example, rapid assessment clinics, direct acute admissions; • establish a clear and consistent system for staff to review the WAST stack to avoid unnecessary conveyance of people to hospital settings; • work alongside WAST to understand the availability of paramedic capacity to respond to primary care OOH home visits for example through the APP Rotational Model; • redirection of patients from Emergency Department to alternative pathways, self-care or relevant community services (NPUC guidance available); • work with GPs to ensure their telephone messages provide the appropriate options

		calls and signpost to more appropriate services - there is an opportunity to manage demand more appropriately if a clear and consistent approach is taken by HBs to redirect and manage calls to WAST in a more systematic way. • The Single Integrated Clinical Assessment Triage (SICAT), which involves a GP being placed in WAST's Clinical Contact Centres, has been evaluated and is available to Health Boards (regional commissioning is preferable for WAST, rather than by HB). Other initiatives have focused on preventing admission for those people who present or are conveyed for initial urgent assessment.	• A focus on "shift left" initiatives in the five step emergency ambulance care pathway, where it is clinically safe and appropriate to do so.	for optimum outcome for the patient and system; • work with WAST on developing pathways that reflect high demand categories and ensure the access criteria and opening times are clear and understood by WAST; • improve/increase MDT supported turnaround at the hospital 'front door', for further assessment and support in the individual's own environment (D2RA Pathway 1).
4.	**Discharge to assess/ recover (D2AR)**	The NPUC '*Every Day Counts*' programme delivered by the NHS Wales Delivery Unit has highlighted evidence that successful implementation of the 4 Discharge to Recover then Assess (D2RA) pathways can have significant impact on the wider health and social care system, as well as on outcomes for individuals.	• Each HB should articulate the practicalities for delivery of each of the D2RA pathways in its region. • Community service capacity, including reablement-focussed domiciliary care, will need to be	HBs should work with partners to: • Align commissioning to the '*Every Day Counts*' project and seek to implement D2AR pathways in readiness for Winter 2019/20; • each HB will be required to baseline its current activity in relation to each of the 4 D2RA Pathways and develop a plan as to how it will address gaps/capacity

		The D2RA ethos is predicated on people remaining in hospital when this is the only environment that can meet their clinical needs. Recovery and assessment is most effectively delivered in the individual's home environment. The effective delivery of the D2RA pathways is predicated on responsive community services including Community Resource Teams, Acute Response Teams, and reablement focussed domiciliary care. Local commissioning for implementation of the 4 D2RA Pathways should reflect the output of the national 'Right-Sizing Community Services for Discharge' project. This project is being supported for every RPB in Wales by the NHS Delivery Unit and the Institute of Public Care. A number of HBs have also attempted to increase the provision of domiciliary care in their regions as this has been identified as a key barrier to enabling people to leave hospital when ready. WAST operated an enhanced NEPTS discharge and transfer services through the second half of the 2018/19 winter, which was well received by health boards.	realigned/increased to meet that demand. • *D2RA Pathway 2:* Supports people to recover in their own homes, prior to assessment for any longer-term support. This should be the default pathway for all individual's deemed likely to require short or longer-term support. Services involved in delivering this can include Community Resource Teams (CRTs), Local Authority Reablement, District Nursing/Acute response Teams, Third Sector and Housing. • D2RA Pathway 4: Supports people to recover in their **existing** care home placement, with appropriate NHS and social care in-reach. (Links also to the Improvement Wales Care Homes Collaborative).	shortfalls, in order to maximise D2RA potential locally • ensure local commissioning for implementation of the 4 D2RA Pathways reflects the output of the national 'Right-Sizing Community Services for Discharge' project **(NHS Delivery Unit and the Institute of Public Care);** • engage local care home providers in the implementation of D2RA Pathway 4, using the '*What Good Looks Like*' Guidance. • Work with collaboratively with WAST and other providers, to develop a range of transport options to facilitate timely transfer and discharge.

5.	**Community step down capacity**	All HBs and local authority partners, commission varying amounts of additional capacity within either care homes or through domiciliary care agencies in order to provide a flexibility of approach to patients who may be waiting for the commencement of long term social services or care home arrangements. The majority of HBs have commissioned step up/down beds to support patients who may require respite, long term placements or support at home. This capacity now appears to be built into the overall system. However, it would appear that it is insufficient or not flexible enough to meet the overall demand.	• D2RA Pathway 3: Supports people to recover in an intermediate care/step-down bedded facility. • This should be considered if D2RA Pathway 2 is ruled out due to complexity of need, including for example the need for overnight support. • When implementing D2RA Pathway 3, spot purchasing of care home beds should be avoided in favour of, for example, commissioned units within care homes. This will ensure the appropriate therapies/NHS support is provided to maximise the individual's potential for independence. • D2RA Pathway 3 can in theory be delivered in Community Hospitals, but only if the facilities and therapies input are appropriate to support independence.	• Each RPB should undertake a demand and capacity analysis to support the commissioning requirement for the coming winter; • national guidance on '*What Good Looks Like*' for D2RA Pathway 3 should be implemented once published in September to support HB implementation **(NPUC Delivery Unit project);** • Avoid spot purchasing individual beds in care homes and block commission specifically for step-down care. • each area/footprint should then work with Local Authority partners look to jointly commission the required capacity to support this patient cohort **(NPUC Delivery Unit project).** • Each HB must deliver a plan as to how it intends to adapt and resource therapy and activity input into community hospitals.

6.	**An enhanced focus on the respiratory pathway**	There is clear evidence that activity increases across the system for patients with respiratory complaints over the winter period. Ambulance calls for 'breathing difficulties' were the highest category of incident over winter 2018/19; out of hours primary care consultations for respiratory complaints quadrupled over a 3 week period between the end of December and mid January 2018/19 when compared to the median consultation rate for the year; and admissions increased nearly four fold over winter 2018/19 when compared to the summer period. The influenza vaccination rate for asthmatics was just 33% across Wales in 2018/19, and 60% for people with COPD. However, an NPUC review of winter funded initiatives for 2018/19 indicated HBs planned only *eight* respiratory based actions, and six of these were related to Laboratory Based Rapid testing in ED. There are clear opportunities to focus on prevention strategies, management of people in the community and acute hospital sites.	• Each primary care cluster should undertake an assessment of local 'at risk' population groups e.g. asthmatics and COPD. • HBs / primary care clusters, WAST and NHS Wales 111 should baseline existing capacity to provide an urgent care response or advice to patients with respiratory complaints in the community. • Using this information, HBs, WAST and NHS Wales 111 should develop short action plans focused on: 1) Prevention 2) Enabling people with urgent respiratory care needs to stay at home 3) Management in hospital settings	HBs should work with partners to: • Nominate an Immunisation Champion for Respiratory Medicine and ensure this is reflected as a priority in their job plan; • assess primary care cluster risk stratification of respiratory groups and identify best practice; • ensure primary care clusters audit the influenza vaccine call and recall system for those with chronic respiratory disease in general practice and report on percentage uptake with robust systems in place as evidenced by letter/telephone call or text; • assess current information on influenza vaccination provided to respiratory patients across healthcare system (primary and secondary care and information type – leaflet/screen or personal recommendation); • review 2018/19 staff vaccination rates in Respiratory Team (who should be exemplars for the service); • review the number of community pharmacies engaged in the 2018/19 flu campaign and their contribution to raising awareness of need for flu vaccination in those on repeat prescriptions for inhaled steroids.

7.	**An enhanced focus on the frailty pathway**	Care of frail individuals is difficult, due to complex comorbidities, vulnerability to deterioration and increased social needs, compounded by the need for consistent ongoing management despite frequently fragmented health service delivery. Frail patients are particularly vulnerable and are at higher risk of complications from prolonged inpatient stays such as loss of muscle mass and functional status, loss of confidence, hospital-acquired infections, and delirium. The support required for frail, elderly and complex patients is growing with a need to improve quality of services, provide coordinated care closer to home and in turn support system flow by reducing emergency hospital admissions.	• The main focus for frailty is on improving care and support. • Frailty should be identified with a view to improving outcomes and avoiding unnecessary harm. • Recognise that many older people with frailty in crisis will manage better in the home environment but only with appropriate support systems. • Identifying frail older adults or those at risk of frailty should be one of the foundations of care, since it is a complex and important issue associated with aging, with implications for both the patients and the use of the health services. • Primary care review of older people (either medical intervention or medicines review or any other interaction such as one of the long term conditions clinics). • Identifying frail patients within a few hours of	HBs should: • Work with clusters to undertake risk stratification of population (electronic frailty index); • focus on medicines optimisation - this may be via the new Quality Assurance and Improvement Framework within the 2019-20 GMS Contract; • Develop local integrated, whole system solutions to build resilience for older people with varying degrees of frailty based around personal and community resources; • Review the role of ED/Assessment Units and in reach teams to support the admission avoidance agenda. Ensure WAST is engaged in pathways, in particular, access criteria and opening times; • Ensure all EDs set up an acute frailty service/in-reach model to identify and stream people with frailty to receive the most appropriate care quickly (within 1 hour); and • free up hospital beds and reduce unnecessary hospital attendances and admissions (local solutions to develop Acute Frailty Units including advice/daycase).

			their arrival to hospital enables prompt, targeted management based on a comprehensive geriatric assessment approach. It also allows screening and treatment to start with the appropriate skilled multidisciplinary team as soon as the patient arrives in hospital. • Faster specialised same day treatment and safe discharge home with links to community services, enhances recovery and associated care planning (which can include end of life care planning) are all benefits of dedicated frailty services.	

N.B. Several themes include within this framework require delivery of action which are also the subject of the 'national delivery milestones for the Primary Care Model for Wale's set by the Minister for Health and Social Services for March 2019 and for 2019-20.

For example, by March 2019, health boards were required to maximise the directed enhanced service for care home residents in the top 20% admitting care homes. By October 2019, health boards are required to deliver the directed enhanced service to all residents of care homes.