WINTER PLANNING AND PREPAREDNESS PLAN 2016-2017

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APPROVED BY:	Cwm Taf Executive Board
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1. INTRODUCTION

This plan sets out the University Health Board seasonal planning and delivery arrangements for unscheduled care (including mental health) and seeks to provide assurance to the Board that the organisation has robust plans in place to respond to anticipated increased pressures and seasonal risk factors during the 2016-17 winter period. It seeks to also provide assurance that we will preserve elective capacity as far as possible to allow scheduled care services to continue during the winter months as set out in the All Wales Delivery Framework and meet the legal requirements of the Mental Health Act.

The plan does not rely upon the introduction of surge capacity although there are plans in place for the short, medium and longer term and it is important that the plan is considered in conjunction with other plans and policies as listed in Appendix 2.

The plan has been developed in collaboration with key partners including primary care, the Welsh Ambulance Services NHS Trust, Merthyr Tydfil Local Authority and Rhondda Cynon Taf Local Authority. It aims to demonstrate how joint plans will ensure the delivery of safe and high quality services to the population during potential periods of pressure.

The Winter Planning and Preparedness Plan: -

- reflects a whole system approach to the delivery of services over the forthcoming winter period;
- builds upon lessons learnt within Cwm Taf over recent years and the best practice, knowledge and experiences of our peers;
- identifies the potential risks and sets out options and solutions to mitigate against them.

It is vital that the standard of care, quality of services and legal requirements are maintained even during the most challenging of situations. The potential impact on the patient experience is considerable and during the winter period we will aim to ensure: -

- no avoidable deaths, injury or illness
- no avoidable suffering or pain
- no unnecessary waiting or delays
- no inequality of access to our services
- no referral to high cost mental health placements

2. KEY AREAS OF RISK

The key areas of risk associated with planning for the winter period relate to the following areas: -

- cold weather and the associated respiratory infections;

- older people and chronic medical conditions;
- influenza and the potential for pandemic outbreaks;
- infectious disease outbreaks including diarrhoea and vomiting and noro viruses;
- major incidents and escalation;
- capacity and the need for surge planning to meet increased pressures;
- extreme weather events linked to climate change e.g. heavy snow falls, flooding etc;
- staff availability and sustainability during long periods of pressure;
- maintaining patient dignity at all times regardless of the level of pressure;
- the ability to meet the legal requirements of the Mental Health Act and prevent out of area high cost placements.

Appendix 1 provides analyses of the risks and the risk adjusted score following implementation of the enclosed plan.

There are a number of policies and procedures in place to mitigate against these known risks which have been appended within this document. A list of key documents is attached at **Appendix 2.**

3. SEVERE WEATHER CONTINGENCY PLAN – SNOW & ICE

The Severe Weather Contingency Plan for snow and ice has been developed to assist managers and staff deal with a snow and / or ice severe weather event that impacts on the normal operating (business continuity) of the University Health Board **(Appendix 3)**.

The aim of the plan is to maintain either the normal business of the Health Board or an acceptable level of business wherever reasonably practicable. This will be achieved through meeting the following objectives: -

- Maintain effective management arrangements to minimise the risks to patient safety;
- Maintain effective management arrangements to minimise the risks to staff health, safety and welfare;
- Work with partner agencies to communicate and minimise the risks to the public.

The plan was last activated from 18 to 23 January 2013 and includes a comprehensive system for workforce continuity, including 4x4 transport, which has been evaluated as highly effective. Whilst it is felt to be robust, it is reviewed and revised annually to ensure that lessons learnt have been considered and incorporated.

Following the last activation a full University Health Board debrief was undertaken to receive feedback and to learn lessons for the next iteration

of the contingency plan. These lessons were incorporated into both the Severe Weather Contingency Plan and this Winter Plan.

4. INFECTION CONTROL OUTBREAK MANAGEMENT PROCEDURE

The Infection Control Outbreak Management Procedure sets out the action required to ensure prompt action in the event of an outbreak or an infection control incident. It gives information on the recognition, management, monitoring and control of an outbreak of an infectious disease within the Health Board **(Appendix 4)**. It identifies also the personnel involved and their responsibilities. Outcomes from previous requirements to activate the policy have provided assurance re the effectiveness of the procedures.

Each incident will require individual planning, although basic processes will often be common throughout. The Health Board will manage outbreaks of infection within its hospitals and community services whilst outbreaks occurring in the community will be managed by the Consultant in Communicable Disease Control (CCDC), Public Health Wales.

5. SHORT TERM SURGE CAPACITY PLANNING

During times of extreme pressure when there are delays and the capacity in the Emergency Departments is severely compromised, the Assistant Directors of Operations (Unscheduled Care / Scheduled Care / Mental Health), or in their absence the Head of Nursing on the DGH site, will support the wards in taking an additional patient into the clinical areas where appropriate.

On the PCH site this will involve the care of additional patients in the Clinical Decisions Unit and the use of treatment rooms on certain wards. This approach will introduce 9 additional beds to the PCH site and the associated staffing issues will be managed by the Head of Nursing on the site.

On the RGH site this will involve the care of patients in the Acute Emergency Care Unit and the waiting rooms on wards 2 & 8. This approach will introduce 8 additional beds to the RGH site and the associated staffing issues will be managed by the Head of Nursing on the site.

All decisions will be based on accurate and timely information and the potential / real risk to the organisation as a whole. This decision making process will be supported by bed management meetings on each site.

The nurse in charge of the receiving ward will be responsible for making the decision on the most suitable placement of an additional patient and this may involve sitting a patient awaiting discharge out of their bed.

6. EMERGENCY PRESSURES ESCALATION PROCEDURE

Over recent months the Health Board has undertaken a comprehensive review of its Emergency Pressures Escalation Procedure alongside those developed by the WAST. Revised documents have been developed, approved and made available to all relevant staff. Action cards have been printed for key staff members and desk top escalation charts have been provided for all acute and community ward areas, bed managers and the emergency departments. The escalation level across all Health Board sites is now displayed on the intranet site and this is updated at least once per day, as and when required, by the Assistant Director of Operations (Unscheduled Care) and the site based Heads of Nursing.

The triggers for the emergency departments, acute hospitals and community hospitals are included as **Appendix 5**. The associated actions are clearly set out within the Escalation Procedure and will be utilised during the winter period. They are not repeated within this plan.

7. OPERATIONAL WINTER READINESS

The operational lead within the Health Board is the Chief Operating Officer. On a day to day basis the Assistant Director of Operations (Unscheduled Care) will take the lead role and will chair the Local Winter Pressures Group. The membership of the Local Winter Pressures Group is set out below: -

Membership of the Local Winter Pressures Group

- Assistant Director of Operations (Unscheduled Care)
- Clinical Director Acute Medicine and A&E
- Head of Nursing Royal Glamorgan Hospital
- Head of Nursing Prince Charles Hospital
- Head of Nursing Localities
- Head of Primary Care
- Locality Manager Rhondda, Taf Ely, Merthyr Tydfil and Cynon Valley
- Representative Rhondda Cynon Taf Local Authority
- Representative Merthyr Tydfil Local Authority
- Representative Welsh Ambulance Services NHS Trust
- Assistant Director of Operations (Scheduled Care)
- Assistant Director of Operations (Mental Health)
- Infection Control Lead
- Directorate Manager Acute Medicine / A&E
- Directorate Manager Surgery, T&O and Urology
- Assistant Director of Therapies & Health Sciences
- Assistant Director (Facilities)
- Head of Business Support (Operations)
- Third sector representatives
- Head of Communications and Media Management
- Contingency Manager
- Operations Manager GP Out of Hours Service

Meetings of the Local Winter Pressures Group will be scheduled on a fortnightly basis and officers will send a deputy if they are unable to attend.

The group will be established for the sole purpose of providing tactical and operational level oversight and timely input throughout the winter period. It will review the bed occupancy levels on each site during the winter period and will match resources to meet peaks in demand. The group will agree joint actions that can be implemented immediately to manage periods of high demand.

Any areas of concern and key risks will be highlighted to the Chief Operating Officer on a daily basis and action will be taken to alert the Chief Executive and other Directors on an exception reporting basis.

During times of severe pressure over a continued period the Chief Operating Officer will establish a strategic planning group (Gold/Silver Command) with the following core membership: -

- Chief Operating Officer
- Assistant Director of Operations (Unscheduled Care)
- Assistant Director of Operations (Scheduled Care)
- Assistant Director of Operations (Mental Health)
- Assistant Director of Nursing
- Head of Business Support (Operations)
- Rhondda Cynon Taf Local Authority
- Merthyr Tydfil Local Authority
- Welsh Ambulance Services NHS Trust

The Strategic Group may seek additional representation from any of the above officers and it will meet as and when required.

8. PROTECTING THE ELECTIVE CAPACITY

The anticipated increase in unscheduled activity during the winter period provides a significant challenge to managing elective activity, avoiding cancelations and therefore meeting the RTT performance targets and trajectories as set out in the Scheduled Care Delivery Plan. We recognise that the patient experience is equally important to this group and we will endeavour to maintain elective work as far as possible during periods of surge.

The Assistant Director of Operations (Scheduled Care) will ensure that elective activity is planned and scheduled against the predicted peaks in emergency activity and will provide assurance by 18 October 2016 to ensure that: -

- routine elective work will be reduced over the Christmas and New Year period to provide additional capacity to meet the expected demand.

- named individuals to liaise with regarding elective activity will be on each acute site during this period;
- elective and planned activity is reduced, with a focus on provision of day cases, for the first two weeks of the New Year to create capacity should the expected surge in non-elective demand be realised;
- staff resources are redeployed and work flexible across departments to support activity during peak times;
- the smooth return to elective capacity is planned for January 2017 taking account of the potential continued demand for general and critical care beds;
- during periods of high emergency demand patients will be prioritised as follows; known cancers, urgent suspected cancers, clinically urgent; 52 week breaches; 36 weeks. No routine elective work that require beds will be scheduled during such periods
- plans are in place to ring fence surgical capacity as appropriate;
- the preference for cohort / buddy ward management of medical outliers is agreed with the appropriate Clinical Directors by 18 October 2016;
- plans are in place to restart elective work earlier if emergency demand does not reach the expected levels.

9. MEDIUM AND LONGER TERM SURGE CAPACITY

During periods of high activity the number of patients allocated to inappropriate inpatient settings increases and this can result in increased risk from a patient care perspective whilst making the task of senior clinical review difficult. The University Health Board has therefore identified surge capacity areas on the DGH sites as follows: -

- Ward 34 at Prince Charles Hospital – 12 beds
- Ward 9 at the Royal Glamorgan Hospital – 8 beds

These beds will provide additional short stay capacity to maintain day case activity during peaks in emergency demand. This surge capacity has recently been tested and has been proven to increase day case activity and improve RTT performance.

The introduction of additional capacity will provide the opportunity to cohort patients appropriately, reduce the numbers of medical outliers and improve medical efficiency and productivity. The Heads of Nursing will ensure that the area is robustly managed to ensure that appropriate flow is maintained within the system. The Head of Nursing will also develop plans to ensure that the surge capacity can be opened quickly to respond to pressures on the system and this may include the recall of staff on annual leave. It is however acknowledged that the ability to ensure the appropriate level of staffing in the surge capacity areas is a significant risk to the organisation.

The Head of Nursing for the community hospitals, and in their absence the locality manager, will identify an area that can be utilised to increase the

inpatient capacity on the Ysbyty Cwm Rhondda and Ysbyty Cwm Cynon sites, this may be a treatment room or day room dependant on the facilities available. The Head of Nursing in conjunction with the Senior Nurse will also be responsible for identifying the most suitable patients for this environment to minimise the risk and maintain patient safety. The use of non commissioned areas will be risk managed on a daily basis by the Senior Nurse / Head of Nursing and areas will be decommissioned at the earliest opportunity in response to a decrease in escalation levels across the acute and community sites.

The decision to open the identified additional surge capacity will rest with the Assistant Director of Operations (Unscheduled Care) and this decision making process will be supported by bed management meetings on the site.

In addition during October / November, we will work with the local authorities to project manage the discharge of a cohort of long stay patients and subsequently release capacity in the community hospitals to improve patient flow.

10. CRITICAL CARE SERVICES

Existing critical care networks will be utilised to deliver surge capacity when required and this will be managed in line with existing protocols to manage patients appropriately across the South Wales area.

Mental health critical care in both adult and CAMHS will have ring-fenced provision for emergency care patients detained under the Mental Health Act and avoid out of area high cost placement. These areas include the Psychiatric Intensive Care Unit at the Royal Glamorgan Hospital, Ty Llydiard inpatient CAMHS unit and the older persons mental health assessment wards on both the Royal Glamorgan and Prince Charles Hospital sites.

11. SUPPORTING THE EMERGENCY DEPARTMENT

A range of actions are already underway to improve system performance in the acute part of the unscheduled care pathway and these include: -

- Further increase in the hours covered by acute physicians to integrate with the emergency departments to support more effective front-door decision making;
- Utilise alternative areas to protect minor injuries stream e.g. use of AECU, outpatient areas and planned dedicated area;
- Development of ambulatory care facilities aligned with the emergency departments on both acute sites with read across to CIAS and @Home services;
- Development of the new medical model to facilitate direct specialty referral preventing delays and ensuring early senior assessment.

- Development of integrated Therapy Assessment Teams on both acute sites;
- Review on a case by case basis those patients who remain in the emergency department over 12 hours to understand the reasons and highlight issues within the patient pathway.

During times of increased pressure on the front door of the hospital services the Acute Medicine, and A&E Directorate and mental health Crisis Resolution & Home Treatment (CRHT) will need to ensure that staffing levels meet the expected peaks in demand. This will include the provision of consultant cover throughout the day and early evening, additional middle grade cover between 1600 and 2200 hours, additional nursing and support staff provided as and when required to support the additional activity and additional senior manager support for the emergency departments.

A successful pilot Discharge Support Service was run in PCH with Age Connects Morgannwg from January to June 2016. This was extremely well received by patients and staff alike and highlighted the benefits of additional dedicated capacity to take patients home promptly and safely. This has not only improved patient experience but also importantly facilitated effective patient flow and length of stay. Discussion is ongoing to move out of the pilot stage and to embed the service at both district general hospitals.

All acute departments and specialties will be expected to adhere to the Emergency Department Policy for Making and Accepting Referrals at all times to ensure effective patient flow through the departments. All clinical teams will respond within 60 minutes of a request by the emergency department to give a specialist opinion and when a patient requires admission to the specialty identified, it will be the responsibility of that clinical team to identify a bed on an appropriate ward as quickly as possible.

Mental health emergencies are expected to adhere to government standards for Crisis Resolution Home Treatment and the legal requirements of the Mental Health Act (1983) and Mental Health Measures (2012). Additionally the CAMHS emergency network for the Cardiff & Vale and Abertawe and Bro Morgannwg areas will liaise closely with relevant managers in these areas via the CAMHS Clinical Director and the Assistant Director of Operations for Mental Health.

The development of an acute oncology service to provide urgent assessment, rapid initial management and appropriate specialist input for any patient presenting acutely with problems relating to cancer or its treatment is contributing to improved flows both at the front door and for patients within hospital settings.

The essence of acute oncology service is to accelerate, coordinate and signpost patients on to the correct assessment and treatment pathway and ensure consistent access to oncology expertise, wherever the patient presents. Management of the unscheduled presentation of cancer outpatients is fundamental in avoiding inappropriate admission and reducing lengths of stay.

The recruitment of additional acute care physicians to integrate with the emergency departments to support more effective front-door decision making has improved flows at the front door by extending the hours of cover and releasing speciality physicians to undertake daily board / ward rounds therefore improving care planning and discharge processes. Work is ongoing to ensure that all patients have an anticipated date of discharge soon after admission and detailed care plans to ensure discharge at the earliest opportunity.

12. WARD BASED CARE

Many of the bottle necks and delays within the system occur during the early part of the day and weekend discharge rates are minimal. Plans are already being implemented as part of the Unscheduled Care Services Updated Delivery Plan to: -

- Continue the daily multidisciplinary board rounds on DGH sites
- Monitor the implementation of the anticipated day of discharge model on all hospital sites in line with the frailty model
- Monitor implementation of criteria led discharge across all hospital sites
- Utilise the discharge lounges facilities on each DGH site
- Audit and monitor the live bed management / patient transfer system
- Continue with daily deep dives at each of the community hospitals.

These plans are supported through the "Focus on Flow" work that is being lead by the Assistant Directors of Unscheduled Care, Nursing and Patient Care & Safety and a daily support system is now in place across all sites.

13. LOCALITY BASED CARE

One element of current community health service provision which represents a key development in the shift to 'out of hospital' care to date, is our @Home range of services which include:

- Community Integrated Assessment Service (CIAS)
- Community Ward
- Community IV antibiotics
- Reablement service
- Care Home Support Team

These services help bridge the gap between core primary / community and secondary care services and support our district nursing and GP colleagues in complex assessment and care in the community.

The reablement service is aligned with the Local Authority (LA) model of working and is accessed through the LA single point of access. This comprises of the services therefore already integrated with the LA and has been since its inception.

Moving forward this year the UHB has worked with partners to bring the service elements of @Home together offering further potential to support admission avoidance and to support earlier discharge through:

- Integration and co-located at a UHB @Home level within Dewi Sant Hospital
- One clinical management structure covering all of the localities UHB @Home services, to manage the operations and to drive service change
- Single point of access for all referrals within the UHB @Home Service
- One triage service daily for all referrals received and allocate according to need
- Provide rapid response, i.e. within 4 hours, 9am-5pm 7 days a week
- operate a 72 hour wider team including medical response 5 days a week 9am-5pm
- Be more closely aligned with existing reablement services within the LA building on the current informal pathways

During times of increased pressure on the acute sector, these services will be fully utilised to capacity and the Localities Manager will ensure that the service can respond and provide additional support to individuals in the community who are at risk of admission to hospital or who are starting to fail at home. The @Home Service will also facilitate discharge from secondary care by delivering rehabilitation at home during times of increased service pressures.

Within Cwm Taf there are two community hospitals serving the local populations and supporting the two district general hospitals. The multi disciplinary team working across community hospitals will facilitate early complex discharge. This will often include the utilisation of rapid response teams from Third Sector organisations such as Care and Repair and the Red Cross and Age Connect Morgannwg.

The medical and nursing teams supporting community hospitals will also provide out-reach support for the community ward and IV service.

The locality teams have developed a supplementary business continuity plan for implementation during periods of escalation and the detail of this is not repeated in this plan.

14. DIAGNOSTIC AND SUPPORT SERVICES

Diagnostic and support services are crucial to the delivery of safe and effective patient care services during periods of increased winter service pressures. Each department will develop its own business continuity plan by no later than 14 October 2016 to ensure that it can cope during winter pressures and to ensure that it can respond quickly to increased service pressures. This will include the following areas as a minimum: -

- Radiology
- Pathology including mortuary
- Pharmacy
- Catering, Housekeeping and Linen services
- Procurement / stores
- HSDU
- Porters and security
- Patient Transport Services
- Phlebotomy

15. MENTAL HEALTH (Adult & CAMHS)

The Assistant Director of Operations (Mental Health) will ensure that services are flexible and can respond quickly to changes in the level of demand so that: -

- The escalation levels for both adult mental health services and CAMHS are regularly assessed and communicated;
- Standards of care and patient quality in both adult mental health and CAMHS are maintained and the Board is regularly appraised of risks due to pressures;
- The legal requirements of the Mental Health Act (1983) and Mental Health Measures (2012) are maintained without the need for referral to high cost placements in England or legal challenge by patients / advocates;
- Clinical staff continue to undertake timely reviews of inpatients under their care to ensure these patients received the optimum level of care in relation to their mental health needs;
- The working hours for the mental health liaison teams that support patients who present at emergency departments will be considered and if possible increased to meet the demand;
- Arrangements have been agreed by no later than 16 October 2016 to ensure access to services over the Christmas and New Year period to identify and maintain vulnerable people in the community.

16. PRIMARY CARE

Primary care services will continue to act as the first point of access for emergency services and GPs will continue to prevent hospital admissions where appropriate and to keep patients at home as long as possible with alternative care plans in place. The following services will be utilised as fully as possible during the winter period to reduce reliance on the acute sector and secondary mental health services:-

- Maximise GP access during core hours;
- Ensure primary care support to patients with chronic conditions;
- Fully utilise the resources within the Primary Care Support Unit, community resource team and primary care mental health teams:
- Fully utilise the @home services for appropriate conditions.

To build capacity within the primary care teams to see the most complex patients in need of urgent consultation by:-

- The introduction of appropriate sign posting of patients to alternative primary care professionals, dentists, optometrists and pharmacists based on assessment of identified need
- Encouraging the utilisation of the common ailments scheme within community pharmacies where appropriate
- Encouraging the use of alternative methods for GP consultations such telephone triage and advice software such as WebGP

Proactive work being undertaken to manage demand includes: -

- One practice has commenced a pilot for the virtual ward and further work will continue. This is aimed at keeping patients at home. This is now being scaled up to a cluster wide pilot for refining and further testing.
- Detailed demand and capacity work is ongoing within OOH. This will include an analysis of the peak times for demand and reorganising resources within primary care centres.
- A joint bid has been submitted to Welsh Government by the health board and WAST to pilot a scheme where a GP accompanies a paramedic on OOH house calls. Again this is aimed to reduce conveyance rates to hospital.
- Joint pathways have been agreed with WAST for chronic conditions such as diabetes, falls and respiratory. Where patients can be kept at home the paramedics will pass information into the GP and District Nurse and a visit will be made to the patient within 48 hours.
- Four cluster schemes have commenced around chronic conditions management. These include COPD where a team will follow up a patient recently discharged from hospital following an acute exacerbation of COPD to ensure they are not relapsing and at risk of a further admission. Other schemes which are led by GPsWSI are

cardiology, MSK and diabetes. Cluster practices can refer into these services for specialist chronic conditions advice.

The Head of Primary Care will work with the Locality Clinical Directors to encourage GP practices to schedule increased emergency appointments during January 2017 to reduce the pressure on the Out of Hours Services, Emergency Departments and the Ambulance Service.

An alert system is already in place to advice primary care practices when there is a high level of emergency pressure that impacts on patient flow and this will be utilised appropriately during the winter period.

17. GP OUT OF HOURS SERVICES

The Head of Primary Care will ensure that robust GP Out of Hours Services are in place during the winter period to alleviate pressure on the emergency departments and the Ambulance Service. Additional GP support for the OOH services over Christmas / New Year and other peak times during the winter will be included in service plans. Should the level of GP Out of Hours Services fall below the planned level, the option for GP services to be delivered from the emergency departments during times of peak activity will be considered.

18. DEVELOPMENT OF A WORKFORCE PLAN

The delivery of many of the actions for the University Health Board set out above relies on the availability at short notice of additional staff. The Directorate Managers for each area are developing workforce plans by 16 October 2016. The workforce plans will: -

- Set out how pressures on services and the impact on staff will be managed;
- Identify areas where short term contracts could be beneficial in health and social care settings;
- Identify how workloads will be prioritised to ensure that the patient flow is maintained;
- Identify how surge capacity will be staffed to maintain patient safety and dignity at all times;
- Review the allocation of annual leave during key periods.

19. NHS / SOCIAL CARE JOINT ARRANGEMENTS

Delivering sustainable unscheduled care services for the population of Cwm Taf involves the about the delivery of joined up services across acute, primary care and across health and social care. To do this partnership working is key ensuring there is a clear focus on shared priorities and delivering the best possible unscheduled care and associated services within the resources available to all of the partners.

During the winter of 2015/16 the health board saw an extended period of Gold Command, during which both health and social care services were required to enhance their working relationship and refocus their immediate priorities to deal with the escalation and demand. Some of the lessons learned from last year were:

- There is currently no joint service provision to address admission avoidance at A & E. Good practice elsewhere has identified that joint working between health & social care is more effective if it happens when people attend A & E or have been hospitalised and require community health and/or social care support on discharge.
- For some time there has been evidence to confirm significant deficits in the communication flow between agencies for hospital discharge
- Our current processes are cumbersome and inhibiting thereby creating delays by default. Commitment to WCCIS from all agencies would address this.
- There are currently limited service arrangements to support 7 day discharge from hospital.

It was recognised during the period of reflection that although many of the community services work well there are opportunities to utilise them earlier in the patient pathway to avoid admission and reduce hospital length of stay through a more integrated and co-ordinated team. Cwm Taf is therefore in the process of developing an Integrated Assessment & Response Service. The aim of the service is to improve individual service user outcomes through enhanced communication and integration of health and social care services at the critical interface that occurs during presentation at A&E and hospital admission through to discharge. This service will complement the existing discharge services already in place (e.g. the Health and Social Care Discharge Coordinators, the Psychiatric Liaison Service and Discharge Liaison Service). It is envisaged that this service will be partially functioning at the start of 2017 hwoever elements of the service may be in place prior to this time.

20. AMBULANCE SERVICES

The Assistant Director of Operations (Unscheduled Care) will continue to work closely with the Head of Operations at the Welsh Ambulance Services NHS Trust (WAST) to maximise use of alternative pathways of care to prevent conveyance to ED, to facilitate flows through the unscheduled care system, to safely avoid hospital admission and to maintain the good performance against the ambulance response time targets.

Across Wales, WAST will be implementing additional measures to support efficiency and improve flow across the unscheduled care system. These measures will include:

a) The implementation of new escalation plans
b) Revised arrangements for Duty Operational Managers to support services out of hours
c) 12 new Hear and Treat clinicians in our Clinical Contact Centre, targeting both 999 calls and calls from the Police service
d) A review of ambulance capacity and demand undertaken by ORH Ltd
e) A 2 week plan covering the Christmas and New Year period
f) The introduction of additional capacity vehicles which will be utilised to release ambulances at sites where hospital handovers are extensive
g) Targeted use of PAS

In Cwm Taf, specific areas of work spanning the winter period of 2016-17 will include: -

1) Reducing Conveyance Rates to ED
2) Commencement of the next Phase of the Explorer Project
3) Reducing demand
4) Collaborative working

Reducing Conveyance rates to ED

We will aim to reduce the conveyance rate of patients transported to the Emergency Department by at least 5%. We will do this through the refresh and reinvigoration of alternative care pathways, led by our Advanced Paramedic Practitioners. Alternative care pathways include Mental Health, At home services, District Nursing, Medical Assessment Unit, Neck of Femur, Social Services, Minor Injury, COPD and Ambulatory Care.

In addition, we will develop a pathway specifically for D&V which will be operational in advance of the winter period.

We will continue to collect patient experience data in relation to these referrals to alternatives to ED, and will work with colleagues on our Clinical Modernisation Board to automate the collection of data to evidence referrals to alternative care pathways, and the subsequent reduction in conveyances to ED.

Commencement of the next Phase of the Explorer Project

Through the next phase of the Explorer project, we will implement the pilot scheme of a community paramedic role. This role will be fully integrated within a GP cluster multi disciplinary team and the Out of Hours services, working across traditionally boundaries within the unscheduled care system. The community paramedics, whilst still responding to life threatening and immediately life threatening 999 calls (Red and Amber1 calls) within a footprint area, will focus on safely reducing admissions to hospital, supporting patients to remain at home and reducing admissions

from nursing homes. We will plan to implement the community paramedic pilot ahead of the winter period.

Reducing demand

We will continue to jointly target our frequent callers in conjunction with the Health Board multi disciplinary team, and will specifically target high volume care homes.

We have recently implemented our first Joint Integrated Management plan for a persistent frequent caller. This is a joint plan signed off by the ED Consultant and WAST Medical Director. When the caller rings 999, the call will be routed to the Clinical Desk in Cwmbran and will be triaged through the Manchester Triage Tool. An ambulance will only be sent if deemed clinically appropriate.

We will implement more of the JIMPs where appropriate in order to reduce demand and conveyance rates. This will be done through the well established Frequent Flyer group, jointly attended by WAST and LHB.

We will also target high volume care home (top 10) callers and seek to instigate a care home working group. This will explore interventions for non conveyance, and will assume responsibility for the ISTUMBLE pilot across CT nursing/care homes.

We will also participate in a new approach to pilot appropriately trained and equipped Community First Responders (CFRs) to attend non injury fallers in the Pontypridd area

Collaborative working

We will continue to work with our blue light partners such as South Wales Fire and Rescue. We will monitor the co-responder scheme run out of Treharris Fire Station which is a hard to reach area within 8 minutes.

Additionally, WAST and the Health Board will:

- Continue to adopt a zero tolerance approach to ambulance delays;
- Maintain ambulance response time performance for immediately life threatening calls under the new Clinical response model
- Maintain the flow of Card 35 hospital care practitioner (HCP) admissions and continue to target the use of our Urgent Care staff at our low acuity Green3 HCP admission activity
- Maintain use of private ambulances where supply allows to increase production of ambulances at key times
- Maximise Emergency Medical Service, Unit Hours Production (EMS UHP) on key identified high demand dates and plan for UHP in excess of 90% across a 24 hour period
- Liaison on OOH cover, particularly at weekends;

- Close integration with bed management staff to support flow between sites;
- Winter fleet preparedness (4x4 capacity, winter tyres);
- Estates preparedness to maintain access and egress to places of work;
- Robust management of sickness absence abstractions;
- Management support both in and out of hours;
- Joint decision making and maintaining channels of communication;
- Continued input to Winter Planning Group;
- Maximise use of additional community first responders, particularly at weekends;
- Maximise use of own transport / taxi transport where clinically appropriate

21. CHRISTMAS AND NEW YEAR SERVICE PROVISION

The Christmas and New Year period is a crucial time for the health and social care system and the Head of communications and Media Management will ensure that detailed plans are developed by 14 October 2016 to ensure that arrangements for services that will remain operational and those that will close are well publicised and understood by staff and the local population.

The opening times for key services including GP practices, GP Out of Hours Services, mental health primary care services, pharmacies and minor injuries units will be well publicised in early December in an attempt to manage the pressure on the system.

The detailed plans will set out also how staffing levels in key areas such as emergency departments will be mapped against historic peaks in activity and how additional management support will be made available to expedite discharges during the holiday period. This will include reference to the support available from key partners including the Welsh Ambulance Services NHS Trust and the local authorities.

The wards will ensure that patients are safely discharged prior to the holiday period and during December plans will be developed to ensure that those patients that will remain in a hospital setting have a 4 day plan of care in place for the Christmas and New Year period.

The table included as **Appendix 6** (to be updated early December) illustrates the arrangements for the health and social care services that will remain operational and those that will close over the holiday period.

22. PREVENTION AND PROTECTION

Key features of the plan are the need to prepare for adverse weather conditions that may increase demand on services or compromise business continuity and to raise awareness of the public health impact and effects of winter particularly on populations most at risk in terms of social,

economic, behavioural and other contributing health factors. The following sections set out the plans in respect of preparedness, prevention and protection activities.

Weather Watch

The last few years have shown us how vulnerable we are to the weather and climate change as we have experienced extreme weather events including a harsh winter during 2012-13. Such events have a direct impact on our communities and on our ability to deliver essential services.

In recent years the ability to forecast severe weather events has become more accurate. This advance has allowed organisations to plan for these events and ensure that adequate arrangements are in place to minimise the risk to normal business.

The Health Board, as a Category 1 Responder under the Civil Contingencies Act 2004, has an agreement with the Metrological Office (Met. Office) to automatically receive advanced warnings and alerts of severe weather within its catchment area. This arrangement is called the National Severe Weather Warning Service (NSWWS) alert and consists of a database of Health Board contacts held by the Met. Office.

The database has been arranged to ensure that the correct personnel are informed, via email, of the forecast events e.g. road ice alerts are sent to Facilities staff.

When snowfall is forecast the Met Office issues an NSWW as soon as the risk is identified. These warnings are updated on a regular basis to reflect the increased/decreased risk.

These alerts are based on the level of disruption as opposed to the level of risk that snow or icy conditions will occur; these are described as follows:

Yellow alert: minimum amount of disruption/any disruption will be transient

Amber alert: disruption can be expected to last for some time

Red alert: significant disruption can be expected to last for some time.
The details of duration and any specific considerations such as loss of infrastructure (e.g. power) will be included in the narrative of the alert.

Once the alerts are received by personnel within the Health Board it is the responsibility of managers to;

- Cascade the information to staff
- Ensure that suitable arrangements are in place

- Minimise the risk to the business and the health, safety and welfare of both patients and staff

Seasonal Flu Campaign

We are working towards a comprehensive action plan for increasing the uptake of flu immunisation in the 'over 65's' and 'at risk population groups', and for our staff. It is by increasing uptake that we best protect our population, our staff from infection and the service from excessive demand. Children in primary school in reception class, year 1, 2 or 3 will also be offered the nasal spray flu vaccine in school. If you have a child in this age group you will receive a letter and consent form from school a few weeks before the vaccination date. The Head of Nursing Localities leads this work, supported by other Executive Directors and the Immunisation Coordinator, with a committee structure in place to ensure wide engagement.

The plan focuses on: -

- increasing uptake in the over 65s and others at risk by increasing uptake in GP practices;
- ensuring midwives and primary care support uptake in pregnant women;
- involving community pharmacy as an alternative venue for patients who are not being vaccinated by their GP;
- Working with Community Facilitators raising awareness to residents across Cwm Taf;
- 13 out of 21 care homes will be trained in Anaphylaxis and Flu awareness. Trained care homes will vaccinate in house.
- a campaign to increase uptake in staff, to protect them and their patients and family, supported by a comprehensive communication campaign. Nursing staff are asked to champion this approach and support delivery to colleagues;
- a programme to immunise children, as this is expected to reduce the spread of flu. This year it will target 2 and 3 year olds (not in school) via primary care; and Nursery, reception and school children in years 1, 2 and 3 via school nurses.

The Seasonal Flu Management Plan is attached as **Appendix 7** (currently being updated).

Pneumococcal vaccine

We continue to encourage the use of pneumococcal vaccine in those for whom it is recommended. We have ensured that GPs are sent messages reminding them of the value of this vaccine, and this is reinforced by our immunisation coordinator and prescribing advisers.

23. COMMUNICATIONS

The University Health Board will continue to promote the national Choose Well campaign and adapt it to fit local needs and circumstances. The aim of Choose Well is to help alleviate some of the pressures in the accident and emergency departments and to redirect the public to the most appropriate care setting which may be self care, GP, pharmacist, dentist or a minor injuries unit etc. A Health Board wide communication campaign has been developed to ensure staff, patients and the public are well informed and can cascade key messages more widely – **(Appendix 8)**

The communications team will build on last year's campaign to promote the use of the Minor Injuries Units at Ysbyty Cwm Rhondda and Ysbyty Cwm Cynon by working with staff, the local media and our stakeholders to raise awareness of the services available.

This will continue to be an important priority as we aim to ensure the public can make informed choices about appropriate points of access to services.

Greater use will be made of the Health Board's new website to provide winter health advice, building on the Welsh Government's 'Keep Well This Winter' campaign. It will provide updates about severe weather and act as a central point of information for the public regarding health board decisions about patient care and services affected by the weather. The website will be supported by the use of social media in English and Welsh.

Other tools to be used to communicate winter health messages / arrangements include: -

- Targeted media campaigns (for example minor injuries; seasonal flu);
- Use of local press;
- Local radio station support;
- Public health campaigns on immunisation / Keep Well This Winter;
- Internally – chief executive weekly blog;
- SharePoint intranet for staff information;
- Your Healthcare e-newsletter to external stakeholders and public
- Public Fora
- Events with third sector providers and community groups such as the Older People's Forums.

The "Phone First" for Minor Injuries approach at Ysbyty Cwm Rhondda ensures that patients phone ahead on a dedicated number and they are then assessed by staff experienced in telephone triage and directed to the most appropriate service for their injury. This will continue to relieve some of the pressure on the emergency departments during the winter period.

The Health Board will continue to routinely ask patients about their experience of the unscheduled care system and any audits of the patient

experience will be fed back to staff. In addition we plan to maintain close contact with the CHC members to brief them on pressures during the winter period.

24. CONCLUSION AND ORGANISATIONAL RISKS

Although all reasonable action has been planned to respond to the anticipated winter surge there remain, nonetheless, a number of risks including: -

- the availability of the workforce and the ability to recruit quickly to staff turnover;
- the fact that additional costs may be incurred during the winter period particularly in relation to additional surge capacity in order to maintain safety and patient flows within the system;
- the management of elective activity throughout the winter and the impact on achievement of the performance targets by the end of March 2016;
- failure to deliver the cancer access targets;
- failure to meet the legal requirements of the Mental Health Act (1983) and Mental Health Measures (2012) without the need for high cost out of area placements in England
- the potential impact on staff during extended times of increased activity.

These risks will be managed over the winter period and any areas of concern will be highlighted to the Chief Operating Officer on a daily basis, action will be taken to alert the Chief Executive and other Directors on an exception reporting basis.

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Appendix 1

Risk Analysis

The plan takes a risk management approach to ensure adequate arrangements are in place for the potential winter scenarios. The following sections: identify and score the key hazards (based on the experience of previous years); use historical data to forecast the expected demands on critical service areas; and then provide a risk adjusted rating based on the actions identified within this plan.

The plan does not intend to remove all possible risk but does aim to highlight these risks and ensure these are mitigated as much as is possible.

Consequence		Insignificant	Minor	Moderate	Major	Catastrophic
Likelihood		1	2	3	4	5
Rare	1	1	2	3	4	5
Unlikely	2	2	4	6	8	10
Possible	3	3	6	9	12	15
Likely	4	4	8	12	16	20
Almost Certain	5	5	10	15	20	25

	1 – 3	Low risk
	4 – 6	Moderate risk
	8 – 12	High risk
	15 – 25	Extreme risk

Hazard	Likelihood	Impact	**Total Score**	**Residual risk score following controls within this plan**
A. Insufficient acute adult bed capacity (excluding critical care)	5	4	**20**	**9**
B. Infection control outbreak	5	3	15	**6**
C. Adverse weather	4	4	16	**8**
D. Inability to maintain core elective capacity	5	4	20	**9**
E. Inability to meet cancer standards	3	3	9	**4**
F. Inability to maintain 4 hour target	5	4	20	**12**
G. Inability to maintain 8 hour target	5	4	20	**12**
H. Inability to maintain 12 hour target	4	4	16	**6**
I. Inability to meet stroke targets	3	3	9	**6**
J. Inability to maintain appropriate staffing levels	5	4	20	**12**

Appendix 2

REFERENCES

- All Wales Delivery Framework
- Elastic Wards Policy
- Emergency Pressures Escalation Procedure
- Emergency Department Policy for Making and Accepting Referrals
- Infection Control Outbreak Management Procedure
- Seasonal Flu Plan
- Severe Weather Contingency Plan
- Unscheduled Care Delivery Plan
- Scheduled Care Delivery Plan
- Welsh Ambulance Service NHS Trust Strategic Winter Framework 2016/17
- Mental Health Act (1983)
- Mental Health Measures (2012)
- Welsh Government CRHT standards

Appendix 3

Severe Weather Contingency Plan – Snow & Ice

Severe weather snow 14-15 revised C

ADVERSE WEATHER What you need to kn

Appendix 4

Outbreak Management Procedure

Appendix 4 Outbreak Procedure - Infection

Appendix 5

	LEVEL 1 - NO CAPACITY ISSUES	LEVEL 2 - MODERATE PRESSURE	LEVEL 3 – SEVERE PRESSURE	LEVEL 4 - EXTREME PRESSURE
Triggers		Overview – Requires focussed actions to allow de-escalation to level 1 (any 4 triggers applicable)	Overview – Requires high level actions to allow de-escalation to levels 2/1 (any 4 triggers applicable)	4 CORE TRIGGERS APPLICABLE This level of escalation will require a series of interventions well over and above normal service provision. Risk management of actions taken will need to be documented throughout
Emergency Department	• Emergency admission are within predicted levels • No predicted breaches against targets • Available resuscitation and trolley capacity in the emergency departments • Ambulance patients – transfer of care within 15 minutes • Beds available in assessment units • No assistance being provided to other sites / health boards	• Emergency admission are likely to exceed predicted levels • Anticipated breach of targets (excluding clinical exceptions) • Ambulance patients – transfer of care more than 15 minutes but less than 30 minutes • Patients in emergency department corridor without an identified space available within 30 minutes • Up to 2 minors cubicles blocked by majors patients • Patients waiting more than 1 hour for first contact with assessing clinician (majors & minors) • Ability to provide resuscitation capacity	• Emergency admission are exceeding predicted levels • Breaches in targets have occurred • Unable to provide resuscitation facility • Patients in the emergency department corridor without an identified space available within 60 minutes • More than 3 minors cubicles blocked by majors patients • Ambulance patients – transfers of care more than 30 minutes but less than 60 minutes • Patients waiting more than 2 hours for first contact with assessing clinician (majors & minors)	• Emergency admission have significantly exceeded predicted levels • Significant breaches in targets have occurred • Emergency department capacity unable to meet further demand • Ambulance patients – transfer of care more than 60 minutes • Patients waiting more than 4 hours for first contact with assessing clinician (majors & minors)

Community Hospital	• Patient flow maintained and monitored by Senior Nurse via board rounds and local arrangements • Predicted discharges for following week 15 patients or more • Actual discharges for the previous week 15 patients or more • No delays in transferring patients into community Hospital	• Senior Nurse to undertake daily deep dives on wards and discuss individual patients with medical, therapy and social care teams • Escalation to Heads of Nursing and Locality Managers – undertake deep dives as required on site, minimum twice per week. • Weekly patient flow management meeting. • Escalation to Local Authority teams to expedite patient's discharges and provide expert advice to community Hospital staff. • Predicted Discharges for following week 10-15 patients • Actual discharges for the previous week 10 – 15 patients • Patients waiting more than 3 days to transfer and more than 6 patients on the transfer list	• Senior Nurse to undertake daily deep dives on wards and discuss individual patients with Consultant and therapy team leaders. • Escalation to Heads of Nursing and Locality Managers – undertake daily deep dives on site. • Head of Nursing to provide weekly briefing report to Assistant Director of Operations (Unscheduled Care) • Predicted discharges for following week less than 10 patients • Actual discharges for the previous week less than 10 patients • Patients waiting more than 8 days to transfer and more than 10 patients on the transfer list	• Be prepared to accept patients in to non commissioned areas in order to share risk and maintain safest possible service to patients • Consider the options to offer non clinical staff the opportunity to work as health care support workers if additional staff is required. • Predicted Discharges for following week less than 5 patients • Actual discharges for the previous week less than 5 patients • Patients waiting more than 10 days to transfer and more than 20 patients on the transfer list • Assistant Director to undertake deep dives across all areas
Mental Health & CAMHS	• Available PICU capacity • Beds available for admissions within all specialities	• Limited PICU capacity • Occupancy more than 85% • Transfers to treatment wards and specialist dementia beds expedited to create admission capacity • All leave beds utilised • Home treatment teams supporting early discharge	• No PICU or admission capacity • Home treatment teams at capacity • Patients being admitted out of area to meet the legal requirements of the Mental Health Act	• No PICU or admission/ assessment beds available • Patients unable to be admitted to out of area mental health placements due to no emergency provision and breaches in the legal requirements of the Mental Health Act (1983) • Failure to meet the legal requirement of the Mental Health Measures (2012) due to workforce demand

Children's Wards	• Occupancy rates less than 85% • No delayed transfers of care • Predicted and known capacity to accommodate emergency and elective admissions • Available HDU bed • Available cubicles • Adequate Medical Staff cover • Adequate nursing staff to cover ward and HDU if required	• Occupancy rate more than 85% • Children being admitted or transferred out to outlying speciality • Routine electives under review • Only one cubicle available • No acute beds available within the next 30 minutes • One HDU patient • Insufficient medical staff on SHO and Registrar Rotas. • Insufficient nursing staff to provide HDU care	• Occupancy more than 90% • 2 HDU patients • One cubicle available within the next hour • Discharges and transfer less than predicted and will impact significantly on capacity. • Children waiting more than 1 hour if assessed as green on clinical priority assessment and 30 minutes if assessed as amber, for first contact with assessing clinician. • Medical staff shortage at SHO or Registrar rotas	• Admissions have significantly exceeded predicted levels • Occupancy more than 95% • No cubicles available • 2 or more HDU patients • All children waiting more than one hour for first contact with assessing clinician. • All planned admissions cancelled. • Medical staff shortage at both SHO and Registrar rotas.
Acute Hospital	• Predicted and known capacity to accommodate emergency and elective admissions (including community beds) • Available CCU, HDU & ITU capacity • No known external factors to impact upon capacity • Normal operating • Occupancy rate are at less than 85% • No delayed transfers of care • No critical care delays • Less than 5 medical outliers • All performance targets have been met • No additional beds opened • Elective lists proceeding as scheduled	• CCU, HDU & ITU delayed transfers of care identified • Patients being admitted or transferred to an outlying speciality • Unplanned bed closures i.e. infection outbreak • Routine electives under review • Occupancy rates more than 85% consistently for 1 week • Medical outliers more than 10 for more than 5 days • Critical Care DTOC more than 2 days for any one patient • No acute beds available within the next 30 minutes • More than 5 DTOCs waiting more than 3 days	• All available staffed bed capacity in use • Divert within health board in place • Occupancy rates more than 90% consistently for 1 week • 12 hour waits in the emergency department without clinical reason. • More than 20 medical outliers for more than 5 days • Critical Care DTOC for more than 5 days for any one patient • More than 10 DTOCs waiting more than 3 days • Limited ability to create CCU, ITU & HDU capacity • Discharges and transfers less than predicted and will impact significantly on capacity	• No CCU, HDU or ITU capacity available • All planned admissions have been canc • Commissioned additional capacity in us • Seek external divert options • No transfers or discharges taking place • 5 or more 12 hour waits in the emergency department without clinical reason.

GP Out of Hours	• No known external factors to impact upon capacity • All shifts covered	• Patient demand is starting to exceed normal levels • Running low on appointments at primary care centres • Routine patients waiting more than 1 hour for telephone triage • Urgent patients waiting more than 20 minute for telephone triage	• Patient demand has exceeded predicted levels • Very few appointments available at primary care centres • Routine patients waiting more than 2 hour for telephone triage • Urgent patients waiting more than 1 hour for telephone triage • Excessive demand for home visits • Not all GP shifts covered • Unable to source more GPs to alleviate pressure	• Patient demand has significantly exceeded predicted levels • No appointments available in primary care centres • Routine patients waiting more than 4 hours for telephone triage • Urgent patients waiting more than 2 hours for telephone triage • Excessive demand for home visits • Significant gaps in GP rota
Neonatal Unit	• Cot occupancy rates less than 80% • Patient acuity level less than 75% • Adequate medical staff cover (Minimum cover out of hours: one SHO for neonates only (applies to RGH) or one SHO shared with paediatrics (applies to PCH), one registrar shared with paediatrics, one consultant shared with paediatrics) • Adequate nursing staff to deliver care in line with All Wales Neonatal Standards • Sufficient Equipment to care for current workload with capacity for additional babies transferred in	• Cot occupancy rate more than 80% • Acuity level more than 75% • Level of activity actual and anticipated is beyond the cot capacity available • Potential in-utero transfers to the other maternity unit within the health board due to unavailability of neonatal cots • There is insufficient equipment immediately available to provide care for any emergency admissions	• Cot occupancy more than 100% • Patient acuity level more than 90% • Cot availability for emergency babies only • Medical staff shortage at SHO or Registrar rotas • Infection on the Unit which cannot be contained in line with infection control procedures • Insufficient key equipment immediately available to provide care for current babies on the Unit and any emergency admissions • Level of acuity exceeds nursing staff available as per All Wales Neonatal Standards	• Patient acuity level more than 100% • The remaining cot availability has been utilised, and there is an expected admission from maternity unit • Ex-utero or in–utero transfers out not possible due to unavailability of neonatal cots • Medical staff shortage at both SHO & Registrar rotas • There is insufficient key equipment immediately available to provide care for current babies on the Unit and an emergency admission is expected

Appendix 6

Christmas and New Year Service Provision

CHRISTMAS AND
NEW YEAR SERVICE I

To be updated early December.

Appendix 7

Seasonal Flu Management Plan.

To be updated.

Appendix 8

Communication Plan for Winter 2016 - 2017

Adobe Acrobat
Document