GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol
Cwm Taf
University Health Board

Your ref/eich cyf:
Our ref/ein cyf: JP/ME
Date/Dyddiad: 1 March 2019

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Dept/adran: Chief Operating Officer

Dr Dai Lloyd AM
Chair, Health, Social Care and Sport Committee
National Assembly for Wales
Cardiff Bay
CARDIFF
CF99 1NA

Dear Dr Lloyd,

WINTER PREPAREDNESS ENQUIRY

Thank you for your letter of 30 January 2019 asking for information following on from the winter preparedness meeting that was held in July 2018.

You asked two questions, the first one regarding the clinical pathways in place within the Health Board area, and how well they are use. In response, I can confirm that there are a number of clinical pathways within Cwm Taf Health Board, including a number within the Community and Medicine. Some examples have been detailed below for your information:

Working in Partnership with WAST

In partnership with the Welsh Ambulance Service (WAST) there are currently a number pathways in place which include Mental Health, Resolved epilepsy, Resolved hypoglycaemia, Falls, Minor Injury Unit, Advanced Practitioners, Community Integrated Assessment Referral, Ambulatory Emergency Care unit Referral, COPD Pathway, Social Services Stay Well @ Home Referral, Royal Glamorgan Referral to Bed Manager, District Nursing Services Referral and GP Out of Hours service. As part of the Winter Planning process pathways are reviewed as part of the overarching strategic plan to reduce conveyances to hospital. These pathways also have an impact on ambulance handover as well as patient flow within the hospital.

Your second query concerned the effectiveness of the pathways and their influence in reducing pressure on the A&E Department and ambulance handovers. I am pleased to be able to confirm that the pathways are proving efficient and have supported the flow of patients through the winter months in particular. Some of these pathways work better than others and we have identified areas where improvements could be made and are working actively at the present time with WAST to further improve them.

I should also draw your attention to the fact that the UHB has a policy of not holding ambulances outside our hospitals, thus reducing the amount of time that ambulances need to be off the road within the Cwm Taf area (our current performance against the 15 much harder target is just under 95%, which is consistently the best UHB performance on this metric in Wales).

In responding to your question relating to clinical pathways, how effective they are and the reduction of pressure on A&E, I would like to note that within Cwm Taf we have an whole systems approach to managing demand. Detailed below are some initiatives which is

having a considerable impact in firstly best meeting patients' needs and secondly enabling us to manage demand within the system.

Stay Well@Home Service

The aim of the service is to improve communication and performance of health and social care services at the critical interface that occurs during presentation at A&E and hospital admission through to discharge.

The SW@H service has been developed to undertake:

- Initial assessments and commission/provide health, social care and third sector community support to facilitate safe and timely return home from A&E and the Clinical Decision Unit (CDU), preventing unnecessary admission; and
- Integrated complex discharge assessments for those patients who are admitted, applying the default position that individuals are supported to return to a community setting.

The SW@H Service provides for the residents of Rhondda Cynon Taf and Merthyr Tydfil and consists of a multidisciplinary hospital based team (Social Workers, Occupational Therapists, Physiotherapists and Therapy Technicians), sited within the acute hospitals of Prince Charles (PCH) and Royal Glamorgan (RGH), and a range of community based responses across health and social care. The service is operational 7 days a week, 365 days a year, between the hours of 8am and 8pm. Below outlines the different services within SW@H:

- SW@H hospital based team (RGH & PCH);
- Nursing @Home;
- Rhondda Cynon Taff Support @Home; and
- Merthyr Tydfil Initial Response Service.

In addition to the above the **Age Connects Better at Home Service** at Royal Glamorgan and Prince Charles Hospital also supports the Stay Well@Home service. They provide a hospital discharge service from Royal Glamorgan Hospital and Prince Charles Hospital. Cwm Taf residents aged 50+ are taken home between 10am and 8pm, 5 days a week. An on call service is available at weekend and bank holidays. Age Connects Morgannwg also offer support for a further 6-8 weeks if needed through a variety of other services and can provide signposting and information to patients who could benefit from help from other third sector partners. The majority of patients supported live alone and are over the age of 70, with a significant number over the age of 80.

In summary the first year evaluation of the SW@H service, which has been undertaken using a wide range of performance indicators has shown that:

- There has been **measurable improvement** for patients aged > 61 who have a zero Length of stay (LOS). The data suggests that a change has occurred in the performance of the system, which we believe is related to the introduction of the SW&H service.
- There has been slight improvement for patients aged over 75 who have a zero LOS.
- There has been **measurable improvement** for patients aged over 75 who have a 1-2 day LOS.
- There has been **measurable improvement** for patients aged > 61 who have a 5+ day LOS.
- There has been **measurable improvement** for patients aged over 75 who have a 5+ day LOS.
- There has been a **measurable improvement** in average LOS for patient agent >61 who stay more than 5 days has improved.

- In addition noting the positive support provided to the SW@H Service by Age Connects Better at Home Service i.e 1,357 referrals, 1216 discharges and 919 patients being signposted to other third sector services.

Mostly importantly it is evident from the feedback provided by both service users and providers, that the Stay Well@Home Service is well received and is providing a positive outcome for patients.

Virtual Ward Model in Cynon

A virtual ward initiative is in place within the Cynon Valley North Cluster. Four GP Practice involved support patients with frailty and complex health and social care needs and enable them to remain supported within their homes/ community. This multi-agency and multi-disciplinary team involves primary care (e.g GP, Practice Nurse, Occupational Therapist, Pharmacist, @Home Team, District Nursing), Third sector (care and repair, community coordinators), Social Care and the Welsh Ambulance Services Trust in an anticipatory approach to provide support to the top service users in the Cluster.
The aims are:

- Improving patient care and access;
- Proactive healthcare delivery by using information on hand to target vulnerable groups;
- Improve communication between a range of stakeholders from health and social care, as well as the third sector;
- Improving patient Records to be able to use them proactively; and
- Utilise a multidisciplinary team to construct holistic care plans built around patient need.

During the two years this initiative has been in place it has had a positive impact on the number of patient contacts within the GP practice, reduced hospital admissions and conveyance to hospital as well as positive outcomes for the patients. The lessons learnt from the use of Multi-professional and multi-disciplinary teams has been used to inform the wider 'transformation' plans across Cwm Taf.

Managing Demand at the Front Door

Plans are in place to manage the demand in the emergency departments and ensure that patient flow is maintained across the whole system. Initiatives include clinically led interventions such as additional consultant ward presence at peak times; additional staff to cover surge areas; corridor nurses / twilight shifts / waiting room presence in the emergency departments; and additional junior medical staff to cover surge / outlier capacity.

We also have plans in place for surge capacity on the acute and community sites. On the PCH site this will involve the care of additional patients in the Clinical Decisions Unit (CDU) and the use of treatment rooms on certain wards and this approach will introduce 9 additional beds to the PCH 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 and this approach will introduce 8 additional beds to the RGH site. On the community hospital sites this will include the use of day rooms and / or treatment rooms. The associated staffing issues will be managed by the Head of Nursing / senior nurses on each of the site.

Maintaining Patient Flow

A number of initiatives are already in place to maintain the patient flow during periods of predicted high demand. These include a senior nurse presence on the acute sites on Sundays; safety huddles and board rounds; additional transport services and reverse triage on the medical wards to facilitate early discharges. Discussions continue with our local authority colleagues in respect of DTOC, complex care packages and investment in transitionary care placements to expedite patient flow.

Our Plans for the Future - Redesigning Service Delivery

During the last winter period it became clear that a number of service redesign issues needed to be progressed as a priority to ensure that we can meet the expected demand on services across all settings.

The Health Board has on 21st September 2018 submitted a bid to the National Transformation Fund to develop a number of additional services that build on our SW@H and virtual ward services.

Integrated Community Care, Closer To Home:

- The further development, at a cluster level, of a proactive outward facing assistive technology model through utilisation of appropriate assessment, proactive calling, equipment and rapid response service, enabling people to maintain their independence at home.
- With support of the Local Medical Council (LMC) and the Community Health Council (CHC), scale up and further develop anticipatory support and care models, e.g., virtual ward and neighbourhood nursing. This will create technology enabled, cluster level, multi-agency, multi-professional Enhanced Community Resource Teams. It is recognised that this model will evolve as we better understand the impact of supporting people for longer in their own homes. This will include the wider impact on all partners, including health, social care, housing and third sector. The actions arising from our assessment, will form part of the second tranche of transformation.
- The design, development and delivery of 'Stay Well in Your Community' to provide improved community support to maximise the use of community assets including an integrated, collaborative and coproductive approach to information, advice and guidance; community hubs, social prescribing/community coordination, befriending, and supporting volunteers and peer support groups.

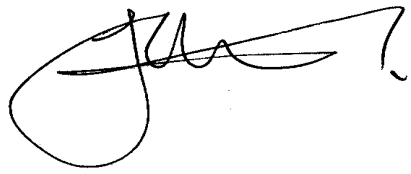
Rapid Response Services:

- To provide the platform for a Single Point of Access in readiness for the new 111 service and to transform GP Out of Hours, into an Urgent Primary Care Out of Hours Service including the adoption of a prudent workforce model and the development of an Machine Learning / Artificial Intelligence driven symptom checker application to reduce in and out of hours demand on General Practice.
- Roll out the next phase of the Integrated Stay Well@Home rapid response service across Cwm Taf, to enable referral, via a single point of access, from community based health, wellbeing, pre-hospital and social care professionals. The ambition, following a detailed evaluation of the first phase of Stay Well@Home, due in September 2018, is to further strengthen plans based on the wider impact on all partners of maintaining people for longer in their own homes.

We are hopeful that the above developments will be in place so that benefits can be realised for Winter 2019 – 2020.

I trust that this information answers your questions appropriately – I would be happy to provide additional explanation if it is required.

Yours sincerely,



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Chief Operating Officer