Agenda - Y Pwyllgor Iechyd, Gofal Cymdeithasol a Chwaraeon

Lleoliad:

Ystafell Bwyllgora 3 – Y Senedd

Dyddiad: Dydd Iau, 19 Gorffennaf 2018

Amser: 09.00

I gael rhagor o wybodaeth cysylltwch a:

Claire Morris

Clerc y Pwyllgor

0300 200 6355

SeneddIechyd@cynulliad.cymru

Yn ei gyfarfod ar 11 Gorffennaf, derbyniodd y Pwyllgor gynnig o dan Reol Sefydlog 17.42(vi) i benderfynu gwahardd y cyhoedd o'r cyfarfod heddiw ar gyfer eitemau 1 a 2.

1 Bil Awtistiaeth (Cymru): trafod y dull gweithredu ar gyfer gwaith craffu Cyfnod 1

(09.00 - 09.15) (Tudalennau 1 - 17)

Papur Cwmpas a Dull

2 Cyllideb Ddrafft 2019-20, gwybodaeth i wneud cais amdani gan Fyrddau Iechyd ac Awdurdodau Lleol

(9.15-9.30) (Tudalennau 18 - 20)

Gwybodaeth i wneud cais amdani gan Fyrddau Iechyd ac Awdurdodau Lleol

3 Cyflwyniad, ymddiheuriadau, dirprwyon a datgan buddiannau

4 Parodrwydd ar gyfer y gaeaf: Sesiwn dystiolaeth gyda Bwrdd Iechyd Prifysgol Betsi Cadwaladr

(9.30 - 10.10) (Tudalennau 21 - 108)

Gill Harris, Cyfarwyddwr Gweithredol Nyrsio a Bydwreigiaeth, Bwrdd Iechyd Prifysgol Betsi Cadwaladr

Cynulliad Cenedlaethol Cymru
National Assembly for Wales

Chris Lynes, Cyfarwyddwr Ardal Gwasanaethau Clinigol (gorllewin), Bwrdd Iechyd Prifysgol Betsi Cadwaladr

Meinir Williams, Cyfarwyddwr Ysbyty, Bwrdd Iechyd Prifysgol Betsi Cadwaladr

Briff Ymchwil

Papur 1 – Llywodraeth Cymru

Papur 2 – Conffederasiwn GIG Cymru

Papur 3 – Bwrdd Iechyd Prifysgol Betsi Cadwaladr

5 Parodrwydd ar gyfer y gaeaf: Sesiwn dystiolaeth gyda Bwrdd Iechyd Prifysgol Hywel Dda a Bwrdd Iechyd Addysgu Powys

(10.10 – 10.50) (Tudalennau 109 – 139)

Joe Teape, Dirprwy Brif Weithredwr / Cyfarwyddwr Gweithrediadau, Bwrdd Iechyd Prifysgol Hywel Dda

Rhiannon Jones, Cyfarwyddwr Gofal Cymunedol ac Iechyd Meddwl, Bwrdd Iechyd Addysgu Powys

Papur 4 – Bwrdd Iechyd Prifysgol Hywel Dda

Papur 5 – Bwrdd Iechyd Addysgu Powys

Egwyl (10.50 – 11.00)

6 Parodrwydd ar gyfer y gaeaf: Sesiwn dystiolaeth gyda Bwrdd Iechyd Prifysgol Abertawe Bro Morgannwg a Bwrdd Iechyd Prifysgol Caerdydd a'r Fro

(11.00 – 11.40) (Tudalennau 140 – 162)

Chris White, Prif Swyddog Gweithredu dros dro, Bwrdd Iechyd Prifysgol Abertawe Bro Morgannwg

Steve Curry, Prif Swyddog Gweithredu, Bwrdd Iechyd Prifysgol Caerdydd a'r Fro

Papur 6 – Bwrdd Iechyd Prifysgol Abertawe Bro Morgannwg

Papur 7 – Bwrdd Iechyd Prifysgol Caerdydd ar Fro

7 Parodrwydd ar gyfer y gaeaf: Sesiwn dystiolaeth gyda Bwrdd Iechyd Prifysgol Cwm Taf a Bwrdd Iechyd Prifysgol Aneurin Bevan

(11.40 – 12.20) (Tudalennau 163 – 186)

John Palmer, Prif Swyddog Gweithredu, Bwrdd Iechyd Prifysgol Cwm Taf

Dr Paul Buss, Cyfarwyddwr Meddygol, Bwrdd Iechyd Prifysgol Aneurin Bevan

Papur 8 – Bwrdd Iechyd Prifysgol Cwm Taf

Papur 9 – Bwrdd Iechyd Prifysgol Aneurin Bevan

Egwyl (12.20 – 13.00)

8 Parodrwydd ar gyfer y gaeaf: Sesiwn dystiolaeth ag Ymddiriedolaeth GIG Gwasanaethau Ambiwlans Cymru

(13.00 – 13.40) (Tudalennau 187 – 196)

Patsy Roseblade, Prif Weithredwr dros dro, Ymddiriedolaeth GIG Gwasanaethau Ambiwlans Cymru

Richard Lee, Cyfarwyddwr Gweithrediadau, Ymddiriedolaeth GIG Gwasanaethau Ambiwlans Cymru

Claire Bevan, Cyfarwyddwr Gweithredol Ansawdd, Diogelwch a Phrofiad Cleifion, Ymddiriedolaeth GIG Gwasanaethau Ambiwlans Cymru

Papur 10

9 Parodrwydd ar gyfer y gaeaf: Sesiwn dystiolaeth gyda Chymdeithas Cyfarwyddwyr Gwasanaethau Cymdeithasol Cymru

(13.40 – 14.20) (Tudalennau 197 – 212)

Jenny Williams, Llywydd, Cymdeithas Cyfarwyddwyr Gwasanaethau Cymdeithasol Cymru

Sue Cooper, Is-lywydd Cymdeithas Cyfarwyddwyr Gwasanaethau Cymdeithasol Cymru

Briff Ymchwil

Papur 11

10 Papurau i'w nodi

(14.20)

10.1 Ymchwiliad i atal hunanladdiad – nodiadau cyfarfod y Pwyllgor â Tir Dewi

(Tudalennau 213 – 218)

Papur 12

10.2 Ymchwiliad i atal hunanladdiad – nodiadau cyfarfod y Pwyllgor â Sefydliad Jacob Abraham

(Tudalennau 219 – 221)

Papur 13

10.3 Llythyr gan Gadeirydd y Pwyllgor Deisebau at Gadeirydd y Pwyllgor Iechyd – Sgrinio ar gyfer Diabetes Math 1 – 13 Gorffennaf 2018

(Tudalennau 222 – 223)

Papur 14

11 Cynnig o dan Reol Sefydlog 17.42 i benderfynu gwahardd y cyhoedd o weddill y cyfarfod hwn

(14.20)

12 Parodrwydd ar gyfer y gaeaf: trafod y dystiolaeth

(14.20 – 14.30)

Mae cyfyngiadau ar y ddogfen hon

Eitem 2

Yn rhinwedd paragraff(au) vi o Reol Sefydlog 17.42

Mae cyfyngiadau ar y ddogfen hon

Mae cyfyngiadau ar y ddogfen hon

Vaughan Gething AC/AM
Ysgrifennydd y Cabinet dros Iechyd a Gwasanaethau Cymdeithasol
Cabinet Secretary for Health and Social Services

Llywodraeth Cymru
Welsh Government

Ein cyf/Our ref MA/P/VG/2319/18

Dr Dai Lloyd AC
Cadeirydd
Y Pwyllgor Iechyd, Gofal Cymdeithasol a Chwaraeon
Bae Caerdydd
Caerdydd
CF99 1NA

10 Gorffennaf 2018

Annwyl Dai,

Diolch am eich llythyr ar 30 Mai 2018 yn gofyn am sicrwydd a gwybodaeth ynghylch parodrwydd ar gyfer gaeaf 2018/19. Mae fy ymateb i bob un o'r pwyntiau a godwch i'w weld isod.

Diweddariad ar argymhellion y Pwyllgor yn ei adroddiad a gyhoeddwyd ym mis Rhagfyr 2016.

Gweler Atodiad A.

Pa gamau pellach y mae Llywodraeth Cymru wedi'u cymryd i liniaru'r pwysau ar y GIG a'r gwasanaethau cymdeithasol yng Nghymru yn ystod cyfnodau prysur y gaeaf.

Dylid cydnabod bod sefydliadau iechyd a gofal cymdeithasol yng Nghymru eisoes wedi dechrau cynllunio ar gyfer gaeaf 2018/19 a bod Llywodraeth Cymru yn dal i'w cefnogi mewn sawl ffordd, gan gynnwys drwy ein cyfarfodydd cynllunio tymhorol cenedlaethol sy'n sail i'w cynlluniau tymhorol, a'r rheini'n cynnwys camau i fod yn barod at y gaeaf nesaf.

Cynhaliwyd y digwyddiad ymgysylltu diweddaraf ar wrthsefyll pwysau dros y gaeaf ar 1 Mai 2018 ac roedd dros 90 o gynrychiolwyr o'r gymuned iechyd a gofal cymdeithasol yn bresennol. Roedd y digwyddiad yn gyfle i bob system gofal iechyd lleol fwrw golwg yn ôl ar aeaf 17/18; beth a weithiodd yn dda; beth na wnaeth weithio; a chanfod y blaenoriaethau ar gyfer gaeaf 18/19.
Cynhaliwyd gweithdai hefyd ar gyfer rheoli atgyfeiriadau ambiwlans gan Weithwyr Gofal Iechyd Proffesiynol yn well, rheoli risg drwy'r holl system, cynllunio ar gyfer rhyddhau cleifion, creu gwell cysylltiad rhwng capasiti a galw, a gwasanaethau gofal sylfaenol y tu allan i oriau.

Bydd Aelodau hefyd yn ymwybodol imi wneud ymrwymiad i werthuso gaeaf 2017/18. Cafodd adolygiad yn dilyn hynny ei drefnu gan Simon Dean, Dirprwy Brif Weithredwr GIG

Bae Caerdydd • Cardiff Bay
Caerdydd • Cardiff
CF99 1NA

Canolfan Cyswllt Cyntaf / First Point of Contact Centre:
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Gohebiaeth.Vaughan.Gething@llyw.cymru
Correspondence.Vaughan.Gething@gov.wales

Rydym yn croesawu derbyn gohebiaeth yn Gymraeg. Byddwn yn ateb gohebiaeth a dderbynnir yn Gymraeg yn Gymraeg ac ni fydd gohebu yn Gymraeg yn arwain at oedi.

We welcome receiving correspondence in Welsh. Any correspondence received in Welsh will be answered in Welsh and corresponding in Welsh will not lead to a delay in responding.

Cymru a chadeirydd y Rhaglen Genedlaethol ar gyfer Gofal Heb ei Drefnu. Fel rhan o'r adolygiad hwn, ceisiwyd barn ystod eang o randdeiliaid gan gynnwys byrddau iechyd lleol, awdurdodau lleol ac Ymddiriedolaeth Gwasanaethau Ambiwlans Cymru, gan roi sylw i farn gyfun partneriaid allweddol yn y digwyddiad uchod a chanfod y prif flaenoriaethau ar gyfer y gaeaf sydd i ddod.

Cyflwynwyd adroddiad yn gwerthuso gaeaf 2017/18 i Fwrdd y Rhaglen Genedlaethol ar Gyfer Gofal Heb ei Drefnu ar 21 Mehefin a bydd hwn yn cael ei gyhoeddi maes o law. Mae'r gymuned iechyd a gofal cymdeithasol eisoes wedi gweld yr adroddiad a'i gasgliadau er mwyn gallu'i ddefnyddio wrth ddechrau cynllunio, a bydd Llywodraeth Cymry yn parhau i weithio gyda gwasanaethau i roi'r hyn a ddysgwyd ar waith a chyflwyno gwelliannau cynaliadwy.

Mae ein cronfa gofal sylfaenol a'r gronfa gofal integredig wedi parhau i fuddsoddi mewn ffyrdd newydd a gwell o ateb anghenion iechyd a llesiant pobl drwy ddull integredig a chydweithredol, gan gynnwys rhoi sylw i anghenion gofal heb ei drefnu ac anghenion brys pan na ellid bod wedi atal y rhain.

Cyhoeddodd Llywodraeth Cymru 'Cymru Iachach: ein Cynllun Iechyd a Gofal Cymdeithasol' ar 11 Mehefin gan ganolbwyntio ar ddarparu gofal a chymorth di-dor ar sail 24/7 er mwyn atal yr angen i roi gofal heb ei gynllunio ar gyfer anghenion iechyd a llesiant. Pan fydd anghenion o'r fath yn bodoli, mae'r model yn darparu ar gyfer ateb y rheini yn y ffordd iawn, ar yr adeg iawn, yn y cartref neu mor agos â phosibl at gartref.

Mae Clystyrau a Byrddau Partneriaeth Rhanbarthol yn parhau i aeddfedu fel dulliau o gynllunio a darparu gwasanaethau ar y cyd, a hynny gan fyrddau iechyd, awdurdodau lleol a darparwyr gwasanaethau annibynnol ac yn y trydydd sector. Mae potensial y model trawsnewid cenedlaethol ar gyfer gofal sylfaenol a chymunedol yn dal i esblygu ac yn Atodiad B rwyf wedi atodi'r disgrifiad diweddaraf o'r gwahanol elfennau sy'n rhan ohono er budd y Pwyllgor. Mae'r model hwn yn sail i'r pum blaenoriaeth a fydd yn llywio cynlluniau cyflenwi integredig ar gyfer gaeaf 2018-19.

Fel rhan o drafodaethau contract y Gwasanaethau Meddygol Cyffredinol yn 2018/19, cytunwyd y byddai'r Fframwaith Ansawdd a Chanlyniadau yn cael ei lacio am flwyddyn gyfan er mwyn ysgafnhau'r pwysau gwaith mewn Ymarfer Cyffredinol. Mae proffesiwn y meddygon teulu wedi croesawu hyn ac mae iddo fanteision penodol yn ystod cyfnod y gaeaf. Er bod llawer o waith y Fframwaith Ansawdd a Chanlyniadau yn dal i fynd rhagddo, nid oes yn rhaid dychwelyd gwybodaeth ar adegau penodol, ac mae hynny'n cael gwared ar bwysau. Mae gwaith yn mynd rhagddo i ystyried pa ddull y dylid ei ddefnyddio yn y dyfodol ar gyfer gwella ansawdd mewn Ymarfer Cyffredinol.

At hynny, dangosodd y cyfnod diwethaf o bwysau yn ystod y gaeaf pa mor bwysig yw cyfathrebu cadarn rhwng gofal sylfaenol a gofal eilaidd. Roedd Cylchlythyr Iechyd Cymru diweddar (WHC 2018 014 - Safonau Cyfathrebu Cymru Gyfan rhwng Gofal Sylfaenol a Gofal Eilaidd) yn cyflwyno nifer o safonau cyfathrebu er mwyn gwella'r ymwneud rhwng gofal sylfaenol a gofal eilaidd ac osgoi dyblygu gwaith. Mae hyn yn bwysig i gydweithwyr yn y system iechyd a gofal cymdeithasol, ond mae hefyd yn gwbl hanfodol bod cleifion yn cael eu gweld yn y lle iawn gan y gweithiwr proffesiynol iawn. Datblygwyd y safonau hyn gyda golwg ar leihau'r problemau sy'n codi pan fydd y gwasanaeth o dan y pwysau mwyaf.

At hynny, mae £50 miliwn o gyllid wedi'i roi o'r Gronfa Gofal Integredig yn 2018/19 er mwyn parhau i gefnogi ystod eang o gynlluniau sy'n bodoli'n barod i atal derbyniadau heb fod angen i'r ysbyty, atal derbyniadau i ofal preswyl heb fod hynny'n briodol, atal oedi wrth

ryddhau pobl o'r ysbyty, ac yn y pen draw, i helpu gyda'r broses o integreiddio iechyd, gofal cymdeithasol a thai.

Mae *Symud Cymru Ymlaen* yn cynnwys ymrwymiad i gadw'r Gronfa Gofal Integredig ac rydym yn parhau i weithio gyda phartneriaid rhanbarthol i ganfod yr amcanion a'r blaenoriaethau i'r gronfa yn y dyfodol.

Bydd byrddau partneriaeth rhanbarthol yn sicrhau bod partneriaid yn defnyddio cyllidebau a ffrydiau cyllido yn effeithiol, gan gynnwys y Gronfa Gofal Integredig a'r Gronfa Gofal Sylfaenol, er mwyn cydlynu'r modd y caiff cyllid ei wario a sicrhau'r buddion gorau posibl i ddinasyddion wrth ymateb i'r asesiad o'r boblogaeth sy'n ofynnol o dan y Ddeddf.

<u>Cynllunio ar gyfer gaeaf 2018/19 – y camau nesaf</u>

- Gorffennaf 2018 – Bydd Llywodraeth Cymru yn cyhoeddi canllawiau cenedlaethol er mwyn adlewyrchu canfyddiadau'r gwerthusiad o'r gaeaf a helpu i gynllunio ar gyfer gaeaf 2018/19.

- Gorffennaf / Awst – Llywodraeth Cymru a Thîm y Rhaglen Genedlaethol ar gyfer Gofal Heb ei Drefnu i sefydlu proses werthuso glir er mwyn helpu i ddarparu gwasanaethau'n lleol a sefydlu proses ar gyfer monitro cynnydd.

- Awst – GIG Cymru ac arweinwyr awdurdodau lleol i fynd i weithdy yn trafod eu cynlluniau ar gyfer y gaeaf yn unol â'r blaenoriaethau y cytunwyd arnynt ar gyfer 2018/19.

- Diwedd Awst – GIG Cymru ac awdurdodau lleol i gyflwyno cynlluniau cyflenwi integredig ar gyfer y gaeaf i Lywodraeth Cymru fel rhan o'r broses sicrwydd.

- Yn yr hydref, Llywodraeth Cymru i gynnal cyfarfodydd integredig ar y gallu i wrthsefyll pwysau dros y gaeaf, a hynny gyda byrddau iechyd, awdurdodau lleol ac Ymddiriedolaeth Gwasanaethau Ambiwlans Cymru, er mwyn helpu i edrych ar sut y mae cynlluniau i wrthsefyll pwysau dros y gaeaf yn cael eu datblygu.

- 14 Medi – Llywodraeth Cymru, Tîm y Rhaglen Genedlaethol ar gyfer Gofal Heb ei Drefnu ac Uned Gyflenwi GIG Cymru i roi adborth i sefydliadau ynghylch eu cynlluniau.

- 28 Medi – y cynlluniau cyflenwi terfynol ar gyfer y gaeaf i'w cyflwyno i Lywodraeth Cymru – er y dylid nodi y bydd y cynlluniau ar gyfer y gaeaf yn rhai 'byw' a fydd yn cael eu hadolygu ar sail unrhyw newidiadau yn y galw lleol.

- Medi/Hydref – GIG Cymru ac Awdurdodau Lleol i fod yn bresennol mewn digwyddiad cenedlaethol ar wrthsefyll pwysau yn ystod y gaeaf, er mwyn paratoi at y gaeaf.

- Canol Rhagfyr – Llywodraeth Cymru i gynnal galwadau integredig gyda Byrddau Iechyd Lleol ac awdurdodau lleol er mwyn asesu'r gwaith o gynllunio a gweithredu ar y cyd.

- Canol Ionawr 2019 – Llywodraeth Cymru i gynnal galwadau 'integredig' dilynol gyda Byrddau Iechyd Lleol ac awdurdodau lleol.

- Ebrill – Bwrdd y Rhaglen Genedlaethol ar gyfer Gofal Heb ei Drefnu i gomisiynu adolygiad o aeaf 2018/19, sef adolygiad a gynhelir gan Lywodraeth Cymru a Thîm y Bwrdd ar y cyd â phartneriaid allweddol, gan gynnwys cyrff proffesiynol.

Er nad yw hyn yn benodol ar gyfer y gaeaf hwn, efallai y bydd y Pwyllgor yn ymwybodol bod Llywodraeth Cymru'n ddiweddar wedi cyhoeddi y bydd yr elfen gyfalaf o'r Gronfa Gofal Integredig wedi cynyddu o £10 miliwn y flwyddyn i £105 miliwn dros dair blynedd er mwyn helpu i ddarparu gofal mwy cydgysylltiedig yn agosach at gartref, ynghyd â helpu i adeiladu tai a fydd yn galluogi pobl i fyw yn annibynnol yn eu cymunedau'u hunain. Y nod yw creu tai ar raddfa fwy sy'n integreiddio gofal cymdeithasol yn ogystal â dulliau arloesol eraill. Mae'r cyllid cyfalaf hwn yn ychwanegol at yr elfen refeniw o £50m yn y Gronfa a gyhoeddwyd ym mis Ebrill eleni. Bydd y gronfa yn cefnogi amcanion 'Cymru Iachach', sy'n cydnabod y cyfraniad o bwys y gall tai addas ei wneud wrth ddod â gwasanaethau iechyd a gwasanaethau cymdeithasol yn nes at gymunedau.

Gall tai addas helpu pobl i gadw eu hannibyniaeth a rhoi'r amgylchedd iawn i bobl sy'n gadael yr ysbyty – gan leihau oedi wrth ryddhau cleifion. Gall hyn hefyd helpu pobl hŷn, pobl sydd â dementia neu anableddau, neu bobl sydd ag anghenion cymhleth, gan alluogi gwasanaethau cymdeithasol i roi gofal mwy effeithiol iddynt. Gall y cyfan helpu'r GIG a gwasanaethau cymdeithasol i weithio'n fwy effeithiol.

Effaith mentrau penodol Llywodraeth Cymru, fel yr arian ychwanegol ar gyfer y byrddau iechyd i leihau amseroedd aros rhwng atgyfeiriadau a thriniaeth, ac effaith hyn wrth ymdrin â phwysau gaeaf.

Ar gyfer 2017/18, buddsoddodd Llywodraeth Cymru yn drwm er mwyn helpu gwasanaethau iechyd a gofal cymdeithasol i ddarparu gwasanaethau diogel a phroffesiynol dros y gaeaf a'r tu hwnt. Roedd hyn yn cynnwys:

- bron i £43m yn 2017/18 drwy'r Gronfa Gofal Sylfaenol er mwyn helpu gwasanaethau gofal sylfaenol i ddarparu mwy o wasanaethau iechyd lleol yn y cartref neu'n nes at gartref, gan ymyrryd yn gynnar i osgoi problemau a allai arwain at dderbyn pobl i'r ysbyty i gael gofal heb ei gynllunio

- £60m drwy'r Gronfa Gofal Integredig yn 2017/18 i helpu i roi gofal a chymorth yn nes at gartref ac atal derbyniadau heb fod angen i'r ysbyty, ynghyd â mynd i'r afael ag oedi wrth drosglwyddo gofal – gan wella llif cleifion drwy'r system.

- £19 miliwn yn ychwanegol o gyllid rheolaidd i helpu i reoli effaith y cynnydd i'r Cyflog Byw Cenedlaethol er mwyn gwella amodau'r gweithlu a chreu mwy o sefydlogrwydd a gwydnwch yn y sector gofal cartref.

- Ym mis Awst 2017, rhoddodd Llywodraeth Cymru £50 miliwn yn ychwanegol i GIG Cymru ar gyfer pwysau'r gaeaf er mwyn helpu i gydbwyso'r modd y gwneir gwaith dewisol a gwaith brys a gwella amseroedd aros erbyn diwedd mis Mawrth 2018, gan leihau nifer y cleifion sy'n aros dros 36 wythnos, y rheini sy'n aros dros 8 wythnos am ddiagnosteg a'r rheini sy'n aros dros 14 wythnos am wasanaethau therapi yn enwedig. Golygodd y buddsoddiad hwn bod Byrddau Iechyd Lleol wedi gallu cynyddu capasiti eu hadnoddau mewnol (gan gynnwys defnyddio darparwyr allanol annibynnol) a chyfeirio cleifion at ddarparwyr eraill yng Nghymru a GIG Lloegr er mwyn lleihau'r amser y mae cleifion yn ei aros am lawdriniaethau.

  O ganlyniad, o'u cymharu â ffigurau mis Mawrth 2017, roedd ffigurau mis Mawrth 2018 ar gyfer amseroedd aros rhwng atgyfeirio a thriniaeth, amseroedd aros am ddiagnosteg ac amseroedd aros am therapi wedi gwella 2% o ran aros 36 wythnos drwy Gymru gyfan, wedi gwella 69% o ran aros wyth wythnos am ddiagnosteg, ac wedi gwella 90% o ran aros 14 wythnos am therapi.

Er gwaethaf y gwelliant hwn yn ystod y flwyddyn, ni wnaeth tri Bwrdd Iechyd Lleol gyflawni'r ymrwymiadau a roddwyd pan gafodd y £50m ei roi. Y rhain oedd Abertawe Bro Morgannwg, Aneurin Bevan a Betsi Cadwaladr. O ganlyniad, ni wnaeth y Byrddau Iechyd Lleol hyn gael y symiau llawn a neilltuwyd (sef £7.4 miliwn, £2.9 miliwn a £3.13 miliwn yn y drefn honno), sef cyfanswm o £13.43 miliwn.

- darparwyd bron i £700,000 i Wasanaethau Ambiwlans Cymru i gynyddu nifer y clinigwyr yn eu canolfannau cyswllt o 18 i 30. Cynyddodd hyn eu capasiti i drin cleifion yn ddiogel dros y ffôn neu i'w cyfeirio i wasanaethau eraill, gan arwain at ostyngiad sylweddol (tua 10%) yn y teithiau diangen mewn ambiwlans i'r ysbyty.

- Er mwyn cydnabod rhywfaint o'r cynnydd sylweddol mewn galw, yn gynnar ym mis Ionawr cytunais ar £10m ychwanegol i helpu gwasanaethau rheng flaen i gymryd camau ar unwaith i wella gofal i gleifion. Bu gofyn i bob ardal Bwrdd Iechyd Lleol ddatblygu cynllun amlinellol a hwnnw'n cynnwys manylion ynghylch sut y byddent yn targedu eu dyraniadau a gweithiodd tîm y Rhaglen Genedlaethol ar gyfer Gofal Heb ei Drefnu gyda'r gwasanaethau i ganfod sut yr oedd yr arian ychwanegol yn cael ei wario, ynghyd ag edrych ar effaith y gwariant hwnnw wrth gyflwyno gwelliannau a rhoi gwerth am arian. Er mwyn helpu gyda'r broses hon, datblygodd y tîm dempled safonol y gallai gwasanaethau ei ddefnyddio i roi gwybodaeth.

  Roedd y wybodaeth a roddwyd yn cyfeirio at 159 o wahanol gynlluniau, a'r rheini'n canolbwyntio'n bennaf ar ofal eilaidd ac adnoddau a oedd yn gwella gwasanaethau a fodolai'n barod. Dyma enghreifftiau o sut y cafodd y cyllid hwn ei ddefnyddio:

  - Ehangodd Cwm Taf oriau agor practisau meddygon teulu ar benwythnosau er mwyn helpu'r Gwasanaeth y Tu Allan i Oriau;
  - Cynyddodd Hywel Dda adnoddau therapi, gweithwyr cymdeithasol ac ymgynghorwyr er mwyn helpu i ryddhau cleifion dros y penwythnos;
  - comisiynodd Caerdydd a'r Fro welyau adsefydlu ychwanegol er mwyn helpu cleifion gyda'u hanghenion gofal parhaus.

  Bydd yr hyn a ddysgir o'r gwerthusiad hwn yn cael ei ddefnyddio i helpu gyda phrosesau cynllunio ac arferion yn y dyfodol o ran gwrthsefyll pwysau yn y gaeaf a'r Cynllun Tymor Canolig Integredig.

- Ar 13 Chwefror, cyhoeddais hefyd £10 miliwn yn ychwanegol i awdurdodau lleol er mwyn rhoi sylw i'w blaenoriaethau mwyaf, a'r rheini wedi'u canfod ar ôl trafodaethau â Chymdeithas Llywodraeth Leol Cymru a Chymdeithas Cyfarwyddwyr Gwasanaethau Cymdeithasol Cymru. Targedwyd yr adnoddau ychwanegol ar gyfer darparu pecynnau gofal cartref; gwasanaethau gofal a thrwsio er mwyn gallu rhyddhau pobl yn gynt o'r ysbyty a'u helpu i fod yn annibynnol gartref; a gofal preswyl tymor byr a llai dwys. Rydym wrthi'n casglu gwybodaeth gan awdurdodau lleol ynghylch nifer y pecynnau, y gwasanaethau a'r llefydd gofal tymor byr a ddefnyddiwyd, ond mae'r dangosyddion cynnar yn awgrymu bod hyn wedi bod yn llwyddiannus wrth alluogi mwy o bobl i barhau i fyw yn eu cartrefi eu hunain, osgoi derbyniadau i'r ysbyty a chartrefi gofal, a hwyluso rhyddhau pobl o'r ysbyty.

“Fy Adran Damweiniau ac Achosion Brys i”:

Ar y cyd â'r GIG, mae Llywodraeth Cymru wedi datblygu adnodd ar y we, 'Fy Adran Damweiniau ac Achosion Brys i'. Adnodd yw hwn sy'n rhoi gwybodaeth ddefnyddiol i'r cyhoedd ynghylch faint y gallant ddisgwyl ei aros am ddiagnosis, am driniaeth, ac i gael eu

rhyddhau, ynghyd â mwy o wybodaeth am eu hadran damweiniau ac achosion brys leol a'r Uned Mân Anafiadau leol. Y prif nod oedd 'helpu' defnyddwyr i ddewis yn ddoeth drwy ddefnyddio gwirwyr symptomau a gwneud y dewisiadau iawn am y gwasanaeth i'w ddefnyddio ar sail eu hanghenion.

Cyflwynwyd yr adnodd ym mis Tachwedd 2017 ac mae Iechyd Cyhoeddus Cymru wedi cynnal gwerthusiad cynnar. Rhoddwyd croeso i'r syniad a dywedodd bron i 80% o'r rheini a ymatebodd y byddent yn defnyddio'r wefan yn y dyfodol. Dywedodd nifer o bobl iddynt gael rhywfaint o anawsterau wrth ddefnyddio'r wefan ac y byddent yn fwy cyfforddus yn defnyddio 'apiau' ar ffôn. Mae'r gwerthusiad wrthi'n cael ei ystyried ac mae cynlluniau i wella'r adnodd yn cael eu datblygu.

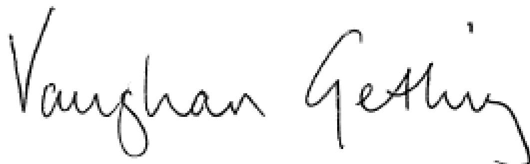
Yn ogystal â'r uchod, ac ystyried y pwysau a wynebwyd yn 2017/18, a oedd yn cynnwys ambell gyfnod prysur iawn o ran galw, a rhai o'r rheini y tu hwnt i'r hyn y gellid bod wedi'i ddisgwyl, blaenoriaeth er mwyn gwella gwydnwch a rheoli risg yn effeithiol yn 2018/19 yw'r angen i wella rheolaeth weithredol a grymuso rheolaeth ysbyty sy'n canolbwyntio ar elfennau clinigol.

Rhaid i'r pwyslais fod ar gydweithio a gweithredu'n gynnar drwy'r holl system pan fydd uwchgyfeirio'n digwydd, er mwyn gallu ysgafnhau pwysau'n gyflym a gwella llif cleifion. Mae rhai byrddau iechyd a'u partneriaid wedi cyflwyno ymyriadau neu gamau lleol sy'n canolbwyntio ar adegau penodol, fel 'Torri'r Cylch' yn syth ar ôl cyfnod gwyliau'r Nadolig yn enwedig.

Mae 'Torri'r Cylch' yn golygu canolbwyntio ar y camau a fydd yn cael yr effaith fwyaf; gweithredu fformat uwchgyfeirio Efydd, Arian ac Aur; gohirio'r rhan fwyaf o gyfarfodydd nad ydynt yn rhai brys; cynyddu cyfraniad timau gweithredol, rheoli a chlinigol at lwybr y claf; dull aml-ddisgyblaethol sy'n cynnwys gofal cymunedol a gofal cymdeithasol; a datblygu amcanion clir a mabwysiadu dull system gyfan o sicrhau bod llif cleifion yn fater sy'n gyfrifoldeb i bawb.

Mae sefydliadau wedi adolygu sut y maent wedi gweithredu eu hymyriadau llwyddiannus dros gyfnod y gaeaf gan gynnwys cydweithio'n well, gwneud penderfyniadau prydlon, a chryfhau cefnogaeth glinigol yn ystod cyfnodau o bwysau ac uwchgyfeirio trwm. Bydd disgwyl i sefydliadau ystyried y gwersi a ddysgwyd a defnyddio hynny i wella'r modd y gallant ymateb i bwysau tebyg yn y dyfodol a gwella profiadau a chanlyniadau i'r claf.

Yn gywir,



Vaughan Gething AC/AM
Ysgrifennydd y Cabinet dros Iechyd a Gwasanaethau Cymdeithasol
Cabinet Secretary for Health and Social Services

Atodiad A

Diweddariad Llywodraeth Cymru am yr argymhellion a wnaed yn Adroddiad y Pwyllgor Iechyd, Gofal Cymdeithasol a Chwaraeon ym mis Rhagfyr 2016: Ymchwiliad i barodrwydd ar gyfer y gaeaf 2016/17 (ac eithrio'r argymhellion a wrthodwyd).

Argymhelliad 1. Dylai Ysgrifennydd y Cabinet a'r Gweinidog, fel mater o flaenoriaeth, ganolbwyntio ar integreiddio'r sector iechyd a'r sector gofal cymdeithasol yn well, o ran sut y mae'r sectorau hynny'n cynllunio ac yn darparu gwasanaethau. Rhaid i'r GIG, y sector gofal cymdeithasol a'r sector annibynnol fod yn rhan bwysig o'r gwaith hwn.

Mae Llywodraeth Cymru eisoes wedi darparu ar gyfer sefydlu byrddau partneriaeth rhanbarthol statudol o dan Ddeddf Gwasanaethau Cymdeithasol a Llesiant (Cymru) 2014, a hynny fel un o gyfres o gamau sy'n cael eu cymryd i ddarparu gofal iechyd a gofal cymdeithasol integredig. Mae'r byrddau hyn yn dod â gwasanaethau iechyd, gwasanaethau cymdeithasol, y trydydd sector a phartneriaid eraill ynghyd er mwyn gwella canlyniadau i bobl a'u llesiant. Mae gofyn i bartneriaid asesu anghenion gofal a chymorth eu poblogaeth a chreu cynllun gyda'r nod o wella pa mor effeithlon ac effeithiol yw'r gwasanaethau a ddarperir.

Mae Llywodraeth Cymru wedi dweud bod yn rhaid i fyrddau partneriaeth lleol flaenoriaethu integreiddio gwasanaethau mewn meysydd amrywiol, gan gynnwys pobl sydd ag anghenion cymhleth, ac rydym yn dal i'w helpu i wneud hyn.

Mae byrddau partneriaeth lleol yn goruchwylio'r Gronfa Gofal Integredig a sefydlwyd i ddatblygu modelau newydd ac arloesol ar gyfer gweithio'n integredig. Mae £50 miliwn mewn cyllid refeniw a £30 miliwn mewn cyllid cyfalaf wedi'i neilltuo yn 2018-19 ac mae'r Rhaglen Lywodraethu yn cynnwys ymrwymiad i barhau i ddarparu'r gronfa bwysig hon.

Roedd gofyn i fyrddau partneriaeth rhanbarthol sefydlu cyllidebau cyfun ar gyfer darparu llety gofal cartref i oedolion o fis Ebrill 2018. Bydd y cyllidebau cyfun hyn yn gymorth i gomisiynu'n integredig, gan alluogi awdurdodau lleol a byrddau iechyd i ganolbwyntio ar wella ansawdd ynghyd â sicrhau gwell gwerth am arian.

Mae Deddf Llesiant Cenedlaethau'r Dyfodol yn creu disgwyliad newydd ar gyfer cynllunio'n integredig a hynny ar sail anghenion y boblogaeth, gan fynd y tu hwnt i ffiniau gwasanaethau iechyd traddodiadol drwy gynnwys meysydd fel tai ac addysg. Pan fydd y byrddau iechyd ac awdurdodau lleol ill dau'n asesu anghenion gofal a chymorth, gan gynnwys anghenion cymorth gofalwyr, rhaid iddynt hefyd ganfod y canlynol:

- i ba raddau nad yw'r anghenion hynny'n cael eu hateb;
- ystod a lefel y gwasanaethau y mae eu hangen i ateb yr anghenion hynny;
- ystod a lefel y gwasanaethau y mae eu hangen i ddarparu'r gwasanaethau ataliol sy'n ofynnol o dan y Ddeddf; a
- sut y bydd y gwasanaethau hyn yn cael eu darparu drwy gyfrwng y Gymraeg.

Er mwyn cyflawni hyn, mae angen i sefydliadau'r GIG barhau i ddatblygu a chryfhau eu perthynas â phartneriaid allweddol, y trydydd sector, gwasanaethau cymdeithasol ac eraill sy'n rhan o'r gwaith o ddarparu gofal o ansawdd da i gleifion.

Mae Cynlluniau Tymor Canolig Integredig y byrddau iechyd ac ymddiriedolaethau'r GIG yn allweddol er mwyn integreiddio gwasanaethau iechyd a gwasanaethau gofal yng Nghymru. Mae ein trefniadau ar gyfer cynllunio yn rhoi cryn bwyslais ar sicrhau bod cynlluniau wedi'u creu i ddarparu gwasanaethau yn lleol ac ar y cyd i gleifion yng Nghymru, ac mae proses i graffu ar hynny'n bodoli hefyd. Mae disgwyl i fyrddau iechyd ymwneud yn rheolaidd â'r sector gofal cymdeithasol a'r sector annibynnol wrth ddatblygu eu Cynlluniau Tymor Canolig Integredig. Pan na fydd modd i sefydliadau greu Cynllun Tymor Canolig Integredig sydd wedi'i gymeradwyo, byddant yn darparu cynlluniau gweithredu blynyddol i helpu i wella pethau'n gyflym yn eu sefydliadau, gan gynnwys y modd y maent yn ymwneud â sectorau eraill.

Cyhoeddodd Llywodraeth Cymru 'Cymru Iachach: ein Cynllun Iechyd a Gofal Cymdeithasol' ar 11 Mehefin, ac mae'r model trawsnewidiol cenedlaethol ar gyfer gofal sylfaenol a gofal cymunedol yn sail i hwn hefyd. Mae'r Cynllun yn cyflwyno model ar gyfer darparu gofal a chymorth di-dor ar sail 24/7 er mwyn atal yr angen i roi gofal heb ei gynllunio ar gyfer anghenion iechyd a llesiant. Pan fydd anghenion o'r fath yn bodoli, mae'r model yn darparu ar gyfer ateb y rheini yn y ffordd iawn, ar yr adeg iawn, yn y cartref neu mor agos â phosibl at gartref. Mae Clystyrau a Byrddau Partneriaeth Rhanbarthol yn parhau i aeddfedu fel dulliau o gynllunio a darparu gwasanaethau ar y cyd, a hynny gan fyrddau iechyd, awdurdodau lleol a darparwyr gwasanaethau annibynnol ac yn y trydydd sector.

Argymhelliad 2. Dylai Ysgrifennydd y Cabinet edrych ar yr opsiynau ar gyfer creu trefniadau gweithio mwy effeithiol rhwng meddygon teulu a fferyllwyr er mwyn osgoi cystadleuaeth wrth roi cynlluniau ataliol cenedlaethol ar waith, fel brechu rhag ffliw.

Ym mis Gorffennaf 2017, llofnodwyd cytundeb gan bwyllgor meddygon teulu BMA Cymru Wales a Fferylliaeth Gymunedol Cymru er mwyn annog cydweithio, gyda'r nod o gynyddu'r nifer sy'n cael eu brechu rhag ffliw yn y GIG.

Mae'r 'Memorandwm Dealltwriaeth' wedi'i ddatblygu er mwyn cynyddu nifer y cleifion cymwys sy'n defnyddio gwasanaethau brechu rhag ffliw presennol y GIG ac annog dull o gydweithio, lle bydd meddygon teulu a fferyllwyr yn cydweithio i sicrhau bod pawb sy'n gymwys i gael eu brechu rhag ffliw yn cael eu brechu, gan ysgafnhau'r pwysau ar bractisau meddygon teulu ar yr un pryd.

Mae'r nifer a gafodd eu brechu rhag ffliw gan y GIG mewn fferyllfeydd wedi cynyddu 34% y llynedd, i fymryn dros 36,000 o frechiadau. Mae hyn yn ddatblygiad ar gynnydd dros dymhorau blaenorol. Bydd y nifer sy'n cael eu brechu'n parhau i gael ei fonitro yn y dyfodol er mwyn sicrhau bod mwy o unigolion sy'n wynebu risg yn gallu cael eu brechu.

Gofynnwyd i fyrddau iechyd sicrhau bod Cyfarwyddiadau ar gyfer Grwpiau o Gleifion yn cael eu cyhoeddi'n brydlon yr haf hwn er mwyn galluogi fferyllwyr cymunedol i gynnig brechiadau rhag y ffliw drwy'r GIG mor gynnar â phosib yn y tymor.

O 2018-19, bydd yr holl staff sy'n gweithio mewn cartrefi gofal preswyl a chartrefi nyrsio i oedolion yng Nghymru yn gymwys i gael eu brechu rhag ffliw yn rhad ac am ddim, heb fod unrhyw gostau iddynt hwy eu hunain nac i'w cyflogwyr, a hynny mewn fferyllfeydd cymunedol sy'n cynnig gwasanaeth brechu rhag ffliw y GIG. Wrth benderfynu cynnig brechiadau drwy fferyllfeydd, roeddwn yn ymwybodol o'r angen i beidio ag ychwanegu at faich gwaith meddygon teulu yn ystod y gaeaf.

Tan hyn, cyflogwyr unigol fu'n gyfrifol am gynnig y brechiad rhag ffliw i staff gofal cymdeithasol. Er gwaethaf y ffaith bod cyfraddau brechu rhag ffliw yn uchel ymhlith preswylwyr, gall ffliw ledaenu'n rhwydd mewn cartrefi gofal a gall staff ei drosglwyddo i breswylwyr pan fydd ganddynt symptomau ysgafn neu hyd yn oed ddim symptomau o gwbl. Gwelwyd bod brechu staff yn effeithiol wrth rwystro'r afiechyd rhag lledaenu ac wrth leihau cyfraddau marwolaeth ymhlith cleifion mewn cartrefi gofal. Gall hefyd helpu i sicrhau parhad busnes drwy leihau achosion o salwch ymhlith staff yn sgil ffliw, a lleihau'r angen am staff locwm yn eu lle.

Bydd cyllid ar gyfer y rhaglen ar gael drwy'r contract fferylliaeth gymunedol presennol, a hwnnw wedi'i addasu'n ddiweddar er mwyn helpu i gomisiynu gwasanaethau ychwanegol. Bydd cyllid newydd o £112,800 yn cael ei neilltuo i dalu am gostau caffael y brechlyn.

Argymhelliad 3. Dylai Ysgrifennydd y Cabinet sicrhau bod trefniadau ar gael i werthuso pa mor effeithiol yw holl ymgyrchoedd Llywodraeth Cymru sy'n ymwneud ag iechyd dros y gaeaf, gan gyhoeddi'r gwersi a ddysgir yn fuan. Dylai hefyd sicrhau bod trefniadau ar gael i sicrhau bod yr holl system yn dysgu o'r gwaith gwerthuso hwn.

Gallwn gadarnhau i ymchwil cymdeithasol gael ei gynnal gan Beaufort Omnibus, sefydliad ymchwil annibynnol sydd wedi hen ennill ei blwyf a sefydliad sy'n arbenigo mewn cynnal ymchwil marchnad ac ymchwil gymdeithasol. Mae ganddo brofiad helaeth o ddarparu ymchwil cymdeithasol o ansawdd da i'r sector cyhoeddus. Cafodd yr ymchwil a gynhaliwyd gan Beaufort Omnibus ei seilio ar 1,000 o gyfweliadau gydag oedolion 16+ oed yng Nghymru i fesur eu hymwybyddiaeth o'r ymgyrch gyfathrebu ac effaith yr ymgyrch honno. Ceir hefyd nifer o ffynonellau gwerthuso presennol a fydd yn cael eu defnyddio i fesur llwyddiant yr ymgyrch wrth ddarparu'r canlyniadau a fwriadwyd. Dyma'r rhain:-

- Y cyfryngau – lefel y sylw yn y cyfryngau gan gynnwys cyhoeddiadau gan randdeiliaid a'r cyfryngau arbenigol;
- Y cyfryngau ar-lein a'r cyfryngau cymdeithasol - nifer y trawiadau ar wefannau / ymweliadau â gwefannau a'r nifer sy'n lawrlwytho deunydd ac yn rhyngweithio ar Twitter; a

- Sianeli partneriaid – partneriaid sy’n rhoi sylw i negeseuon yr ymgyrch a’r wybodaeth ddiweddaraf ac yn eu rhannu ar eu sianeli eu hunain, gan gynnwys y cyfryngau cymdeithasol.

Cynhaliwyd gwerthusiad ym mis Mawrth 2018 a rhoddodd hyn wybodaeth am yr ymgyrch gyfathrebu ‘Dewis Doeth’. Gellir gweld o ddata am y gwasanaethau a ddewisir bod mwy o waith o hyd i’w wneud wrth sicrhau bod y cyhoedd yn dewis y gwasanaeth cywir i’w hanghenion. Wrth rannu’r data yn ôl anhwylderau, gwelwyd y dylai ymgyrchoedd y dyfodol ganolbwyntio ar anhwylderau penodol. Er enghraifft, er ei bod yn ymddangos bod pobl sydd â'r ddannodd yn gwybod y dylent fynd i weld y deintydd, nid yw pobl yn gwybod cystal pa wasanaeth i’w ddefnyddio pan fydd plentyn yn sâl, a gellid targedu hyn. Dangosodd yr ymchwil i’r ymgyrch gael rhywfaint o effaith ar ddewisiadau cadarnhaol ynghylch gwasanaethau, a bydd yr hyn a ddysgwyd o’r gwerthusiad hwn yn cael ei ddefnyddio a’i ymgorffori wrth gynllunio drwy gydol y flwyddyn yn y dyfodol, gan gynnwys yr ymgyrch ar gyfer y gaeaf nesaf.

Mae mwy o wybodaeth am newid ymddygiad hefyd wedi’i rannu â’n tîm Cyfathrebu o Optometreg Cymru ac Iechyd Deintyddol Cyhoeddus ym Mwrdd Iechyd Prifysgol Caerdydd a’r Fro, a bydd y wybodaeth hon yn cael ei defnyddio yn sail ar gyfer ein hymgyrch a’n gwaith i gynllunio ar gyfer gwrthsefyll pwysau yng ngaeaf 2018/19.

Mae canolfan gyfathrebu GIG Cymru wedi trefnu sesiwn i edrych yn ôl ar y gwaith cyfathrebu ar gyfer ymgyrch 2017-18, ac wedi cytuno i gynnal gweithdy ym mis Gorffennaf neu fis Awst pan fydd yn defnyddio’r ymchwil a’r dadansoddiad o newid ymddygiad i gynllunio'r gwaith cyfathrebu ac i helpu i gynllunio at y gaeaf yn y flwyddyn sydd i ddod.

Bydd hyn yn cael ei ymgorffori yng nghynllun cyfathrebu Dewis Doeth/gwrthsefyll pwysau yn y gaeaf, sef cynllun a gaiff ei ddatblygu dros yr haf.

Argymhelliad 7. Dylai Ysgrifennydd y Cabinet a’r Gweinidog ystyried, a hynny’n ddiymdroi, yr angen am well hyfforddiant, datblygu sgiliau a goruchwyliaeth drwy’r holl sector iechyd a gofal cymdeithasol. Dylid rhoi mwy o bwyslais ar gydweithio rhwng y sectorau wrth wneud hyn.

Mae Llywodraeth Cymru yn ariannu Cyngor Gofal Cymru i hyrwyddo a chynnal safonau uchel wrth hyfforddi gweithwyr gofal cymdeithasol, ac o ganlyniad mae ganddo rôl bwysig wrth ddatblygu a sicrhau ansawdd hyfforddiant a chymwysterau ar gyfer gweithwyr gofal cymdeithasol. Mae’r Cyngor Gofal yn gweithio’n agos gyda Cymwysterau Cymru a rhanddeiliaid eraill i fwrw ymlaen â’r gwaith o ddatblygu cyfres o gymwysterau newydd i weithwyr yn y maes iechyd a gofal cymdeithasol, a’r rheini i’w rhoi ar waith yn 2019. Bydd y gyfres newydd hon o gymwysterau iechyd a gofal cymdeithasol yn rhoi pecyn cynhwysfawr o addysg a dysgu parhaus sy’n galluogi gweithwyr gofal cymdeithasol i wneud cynnydd drwy eu gyrfaoedd. Bydd Gofal Cymdeithasol Cymru hefyd yn arwain y gwaith o ddatblygu ymgyrch farchnata, recriwtio a chadw staff er mwyn creu delwedd gadarnhaol o swyddi yn y maes gofal cymdeithasol.

Newidiodd y Cyngor Gofal i ddod yn Gofal Cymdeithasol Cymru ym mis Ebrill 2017 a bydd yn defnyddio cyfuniad grymus o swyddogaethau i wella gwasanaethau a’r

gweithlu sy’n darparu’r rheini. Un o’i dasgau cyntaf fydd paratoi at ehangu cofrestr y gweithlu er mwyn cynnwys gweithwyr gofal cartref, a hynny yn 2020. Bydd hyn yn golygu helpu’r gweithlu i gyflawni’r lefel berthnasol o gymwysterau gan ddefnyddio cyllid o’r grant datblygu gweithlu sylweddol sydd wedi’i roi gan Lywodraeth Cymru i’r sector.

Mae Llywodraeth Cymru yn rhoi grant blynyddol o £8m i’r sector gofal cymdeithasol er mwyn helpu i hyfforddi a datblygu staff. Mae’r grant ar gael yn sgil y cynlluniau hyfforddi a datblygu rhanbarthol y mae’r partneriaethau gweithlu rhanbarthol wedi’u creu. Mae’r partneriaethau rhanbarthol yn golygu bod modd i awdurdodau lleol a’r sector annibynnol gydweithio i ddatblygu’r gweithlu.

Mae fframwaith datblygu sgiliau a gyrfaoedd ar gyfer gweithwyr cymorth gofal iechyd clinigol wedi’i ddatblygu i’r GIG. Diben y fframwaith hwn yw rhoi dull o lywodraethu ar gyfer datblygu sgiliau a gyrfaoedd y gweithlu Gweithwyr Cymorth Gofal Iechyd yn GIG Cymru. Bydd yr adnodd hwn yn berthnasol i Weithwyr Cymorth Gofal Iechyd yn y meysydd nyrsio, bydwreigiaeth, a Gweithwyr Proffesiynol Perthynol i Iechyd. Bydd yn helpu i ddatblygu swyddi presennol ac yn y dyfodol drwy safoni cwmpas swyddi a datblygu llwybrau addysg sy’n rhoi’r wybodaeth a’r sgiliau i ymarfer yn ddiogel. Bydd y fframwaith hwn yn hwb i yrfaoedd Gweithwyr Cymorth Gofal Iechyd ac yn gwella pa mor broffesiynol yw’r gweithlu craidd hwn, gan ddatblygu ar y gwasanaeth o ansawdd da sydd eisoes yn cael ei ddarparu i unigolion. Rydym yn ystyried integreiddio’r fframwaith hwn gyda’r fframwaith sy’n cael ei ddefnyddio ar gyfer staff gofal cymdeithasol.

Bydd fframwaith dysgu a datblygu tebyg ar gyfer Therapyddion Galwedigaethol mewn Gofal Cymdeithasol wedi’i greu i gyd-fynd â’r holl fframweithiau eraill sy’n bodoli, gan gynnwys fframwaith Gweithwyr Proffesiynol Perthynol i Iechyd y GIG, “Modernising Allied Health Professional Careers in Wales”, y fframwaith Llwybr Gyrfa ac Addysg a Dysgu Proffesiynol Parhaus i weithwyr cymdeithasol, a’r fframwaith gyrfa cyffredinol sydd wrthi'n cael ei ddatblygu gan Goleg Brenhinol y Therapyddion Galwedigaethol. Mae’r fframwaith yn ddogfen a gafodd ei chreu ar y cyd o dan arweiniad Alison Strode, cyn-Brif Gynghorydd Therapïau Cymru, mewn ymgynghoriad â rhanddeiliaid allweddol, gan gynnwys Coleg Brenhinol y Therapyddion Galwedigaethol, Cymdeithas Cyfarwyddwyr Gwasanaethau Cymdeithasol Cymru a Gofal Cymdeithasol Cymru. Bydd y fframwaith yn adnodd defnyddiol i gyflogwyr er mwyn gweld sut y gellir defnyddio sgiliau therapyddion galwedigaethol orau wrth ateb eu hanghenion penodol, yn enwedig wrth inni ddatblygu gweithlu hyblyg mewn system iechyd a gofal cymdeithasol mwy integredig.

Mae nifer o ddogfennau canllaw wedi’u cyhoeddi er mwyn hwyluso cyd-hyfforddi a chydweithio rhwng staff iechyd a gofal cymdeithasol, a hynny er budd cleifion a chleientiaid. Mae'r rhain yn cynnwys canllawiau ar ddirprwyo i drydydd partïon a chanllawiau ar fwydo drwy endosgopi.

Mae byrddau iechyd wedi sefydlu fforymau metronau gofal cartref er mwyn helpu i ddysgu a datblygu yn y sector hwn. Mae nifer o fyrddau iechyd hefyd wedi rhoi gwahoddiadau agored i staff gofal cartref i ddefnyddio rhaglenni hyfforddiant mewnol y byrddau iechyd.

Mae Llywodraeth Cymru wedi cyflwyno dwy set o reoliadau o dan Ddeddf Rheoleiddio ac Arolygu Gofal Cymdeithasol (Cymru) 2016, a'r rheini'n ceisio atal y potensial i gamddefnyddio contractau oriau heb eu gwarantu yn y maes gofal cartref. Roedd y rheoliadau cyntaf yn ei gwneud yn ofynnol i ddarparwyr gwasanaethau gofal cartref gyhoeddi manylion am drefniadau contract eu staff (gan gynnwys contractau oriau heb eu gwarantu) yn eu hadroddiadau blynyddol cyhoeddus. Serch hynny, roedd Llywodraeth Cymru yn cydnabod nad oedd gofyn am dryloywder yn sicrhau newid ymddygiad ynddo'i hun, ac y gallai rhai cyflogwyr barhau i ddefnyddio contractau o'r fath mewn ffyrdd sy'n niweidiol i'w staff. O ganlyniad, datblygwyd cyfres bellach o reoliadau gennym a oedd yn ei gwneud yn ofynnol i gyflogwyr gynnig dewis o gontract i'w staff (contract oriau sefydlog neu barhau â chontract dim oriau) ar ôl cyfnod o dri mis o weithio. Roedd y rheoliad hwn yn ymateb i alwadau gan randdeiliaid, gan gynnwys rhai gweithwyr, am gadw'r hyblygrwydd y gall contractau o'r fath ei roi, ond gwneud hyn yn opsiwn yn hytrach na'r norm.

Daeth y cyfresi hyn o reoliadau i rym ym mis Ebrill 2018. Disgwyliwn i ddarparwyr sydd wedi cofrestru ar gyfer 2018-19 gwblhau'r gyfres gyntaf o wybodaeth flynyddol erbyn diwedd mis Mai 2019. Bwriadwn adolygu effaith y ddeddfwriaeth maes o law i weld a yw'r cynigion wedi cyflawni'r amcanion a fwriadwyd, gan edrych ar yr adroddiadau blynyddol newydd i ddeall i ba raddau y mae darparwyr gofal cartref yn defnyddio contractau dim oriau.

Argymhelliad 8. Dylai'r Gweinidog wneud a chyhoeddi trefniadau i rannu arferion da mewn ffordd strwythuredig mewn perthynas â chynlluniau llwyddiannus sy'n cael eu darparu drwy'r Gronfa Gofal Canolraddol.

Drwy gyfres o ddigwyddiadau penodol, mae Llywodraeth Cymru wedi ceisio sicrhau bod gan ranbarthau gyfle i rannu'r arferion gorau o ran cynlluniau sy'n cael eu datblygu drwy'r Gronfa Gofal Integredig. Bu gwaith yn mynd rhagddo hefyd i rannu gwybodaeth ac arferion da yn fwy anffurfiol, a hynny'n uniongyrchol rhwng y rhanbarthau a swyddogion yn Llywodraeth Cymru. Er nad ydym yn derbyn bod angen cyhoeddi'r trefniadau'n ffurfiol, byddwn yn parhau i hyrwyddo diwylliant o rannu arferion gorau drwy'r canllawiau diwygiedig a gaiff eu cyhoeddi cyn hir ar gyfer y byrddau partneriaeth rhanbarthol, a hynny er mwyn helpu i ddefnyddio'r Gronfa Gofal Integredig a drwy ragor o ddigwyddiadau cenedlaethol.

Mae Archwilydd Cyffredinol Cymru wrthi'n cynnal adolygiad o'r Gronfa Gofal Integredig. Bydd yr adolygiad yn ystyried a yw'r Gronfa yn cael ei defnyddio'n effeithiol i ddarparu gwasanaethau cynaliadwy sy'n sicrhau gwell canlyniadau i ddefnyddwyr gwasanaethau. Bydd adroddiad cenedlaethol terfynol yn cael ei gyhoeddi ym mis Ionawr 2019, a hwnnw'n cyflwyno'r prif ganfyddiadau a'r argymhellion drwy Gymru.

Er mwyn sicrhau'r defnydd gorau o adnoddau ac osgoi dyblygu gwaith, mae'r Gweinidog wedi penderfynu na fydd adolygiad arfaethedig sydd i'w gomisiynu gan Lywodraeth Cymru o'r Gronfa Gofal Integredig yn cael ei gynnal tan y bydd Archwilydd Cyffredinol Cymru wedi cyhoeddi ei adroddiad yntau. Bydd unrhyw adolygiad a gomisiynir gan Lywodraeth Cymru yn datblygu ar ganfyddiadau adolygiad Swyddfa Archwilio Cymru ac o bosibl yn edrych yn fanylach ar y rhain.

At hynny, yn y gynhadledd gofal sylfaenol cenedlaethol ym mis Tachwedd 2017, lansiwyd adnodd cenedlaethol i rannu dysgu arloesol ac arferion da o bob rhan o Gymru a hynny mewn ffyrdd newydd a gwell er mwyn rhoi'r gofal iawn ar yr adeg iawn o'r ffynhonnell iawn yn y cartref neu'n agosach at gartref.

Bydd y Pwyllgor yn gwybod ein bod yn awyddus i'n gwasanaethau iechyd a gofal cymdeithasol fesur effaith cynlluniau neu fodelau gofal lleol a chenedlaethol, gan rannu arferion da mewn ffordd systematig drwy Gymru. Pan fydd hynny'n briodol, dylid rhoi'r arferion hyn ar waith yn eang a'u defnyddio ar raddfa fwy er mwyn ateb anghenion cleifion. Mae cynnydd yn cael ei wneud ac yn ogystal â'r uchod, mae'r Pwyllgor Gwasanaethau Ambiwlans Brys wedi sefydlu is-grŵp, sef y Grŵp Cynllunio, Datblygu a Gwerthuso.

Diben y Grŵp hwn yn wreiddiol oedd rhoi cyngor a sicrwydd i'r Pwyllgor ynghylch a oes trefniadau effeithiol wedi'u sefydlu i gyflawni amcanion y Pwyllgor, gan helpu i gynllunio, datblygu a gwerthuso. Mae'r elfen o werthuso yn cynnwys sicrhau bod unrhyw newidiadau arfaethedig i wasanaethau neu 'gynnyrch' yn cael eu gwerthuso'n gadarn, ac wedi'u seilio ar waith ymchwil a datblygu credadwy – gan rannu unrhyw wersi a ddysgir a thystiolaeth. Fel rhan o'n gwaith i rannu a lledaenu arloesi llwyddiannus ac arferion da, mae cylch gwaith y grŵp wedi'i ehangu i helpu'r gwaith cenedlaethol a wneir fel rhan o ofal heb ei drefnu i werthuso arloesi mewn ffordd safonol a chyson.

Argymhelliad 9. Dylai Ysgrifennydd y Cabinet a'r Gweinidog egluro'r sefyllfa ynghylch rhoi cyllid hirdymor i gynlluniau llwyddiannus o dan y Gronfa Gofal Canolraddol. Dylent hefyd amlinellu'n glir sut y bydd y buddsoddiad ychwanegol yn y Gronfa fel rhan o gyllideb ddrafft 2017-18 yn cael ei ddefnyddio, a beth fydd yr effaith ddisgwyliedig.

Ers ei sefydlu yn 2014, mae'r Gronfa Gofal Integredig wedi cael ei defnyddio i ddatblygu modelau newydd ac arloesol ar gyfer gweithio'n integredig rhwng gwasanaethau cymdeithasol, gwasanaethau iechyd, y maes tai, y trydydd sector a'r sector annibynnol. Yn y flwyddyn ariannol hon, mae cyllid o £50 miliwn wedi'i roi i barhau i gefnogi ystod eang o waith sy'n mynd rhagddo i osgoi derbyniadau i'r ysbyty yn ddiangen, osgoi derbyniadau i ofal preswyl yn ddiangen, ac osgoi oedi wrth ryddhau pobl o'r ysbyty.

Mae *Symud Cymru Ymlaen* yn cynnwys ymrwymiad i gadw'r gronfa hon. Rydym ar hyn o bryd yn ystyried yr amcanion a'r blaenoriaethau ar gyfer y gronfa yn y dyfodol, a byddwn yn sicrhau bod hyn yn eglur i'r rhanbarthau cyn y flwyddyn ariannol newydd.

Bydd y byrddau partneriaeth rhanbarthol yn parhau i reoli'r gronfa bwysig hon. Maent hefyd yn gallu sicrhau bod partneriaid yn defnyddio cyllidebau a ffrydiau cyllido'n effeithiol, gan gynnwys y Gronfa Gofal Integredig a'r Gronfa Gofal Sylfaenol, er mwyn cydlynu'r modd y caiff cyllid ei wario a sicrhau'r buddion gorau posibl i ddinasyddion wrth ymateb i'r asesiad o'r boblogaeth sy'n ofynnol o dan y Ddeddf.

Cafodd cwmpas y Gronfa Gofal Integredig ar ei newydd wedd ei ehangu'n sylweddol y llynedd ac mae bellach yn cynnwys meysydd blaenoriaeth y bwrdd partneriaeth rhanbarthol ar gyfer integreiddio. Mae'r rhain yn cynnwys gwasanaethau i bobl hŷn, gwasanaethau i blant sydd ag anghenion cymhleth, gwasanaethau i bobl sydd ag anableddau dysgu a gwasanaethau i ofalwyr. Drwy wneud hyn, mae'r gronfa bwysig hon wedi dod yn fodd i gyflawni gofynion y Ddeddf Gwasanaethau Cymdeithasol a Llesiant (Cymru).

Bydd Llywodraeth Cymru yn ystyried yn ofalus ganfyddiadau'r adolygiad sydd ar y gweill gan Archwilydd Cyffredinol Cymru o'r Gronfa Gofal Integredig, gan gynnwys pa mor effeithiol yw'r gwaith o brif ffrydio prosiectau'r Gronfa.

Elfennau'r Model Trawsnewidiol ar gyfer Gofal Sylfaenol a Gofal Cymunedol (y fersiwn y cytunodd y Bwrdd Gofal Sylfaenol Cenedlaethol arno ym mis Mawrth 2018)

Mae rhaglen i drawsnewid gwasanaethau gofal sylfaenol a gofal cymunedol yn mynd rhagddi er mwyn gwella iechyd a llesiant pobl Cymru, gan ddatblygu ar y gwasanaethau rhagorol sydd eisoes yn cael eu darparu gan weithwyr proffesiynol ledled y wlad. Mae'r model newydd yn edrych ar y system gyfan er mwyn ail-ddylunio gwasanaethau, gan seilio hynny ar safonau ansawdd cenedlaethol ond gyda'r hyblygrwydd i ymateb i anghenion cymunedol lleol (gweler y diagram yn Atodiad 1).

1. Egwyddorion y Model Trawsnewidiol ar gyfer Gofal Sylfaenol a Gofal Cymunedol

Mae'r dinesydd yn ganolog i'r model newydd, gan gynnwys pobl o bob oed a demograffeg. Bydd hyn yn sicrhau bod y gofal iawn ar gael ar yr adeg iawn o'r ffynhonnell iawn, yn y cartref neu'n agosach at gartref. Mae'r model wedi'i seilio ar y canlynol:

- Datblygiadau i wasanaethau ar sail anghenion y boblogaeth, gyda chlystyrau gofal sylfaenol lleol yn arwain y gwaith cynllunio a thrawsnewid
- Hyrwyddo byw'n iach a dadfeddyginiaethu llesiant
- Pwyslais ar y boblogaeth fel sail i gynllunio a darparu gwasanaethau mewn cymunedau lleol
- System gofal sylfaenol fwy ataliol a rhagweithiol sydd wedi'i chydlynu'n well, a honno'n cynnwys darpariaeth ymarfer cyffredinol a gwasanaethau cymunedol drwy dimau adnoddau cymunedol neu wasanaethau eiddilwch
- Dull system gyfan drwy integreiddio gwasanaethau iechyd, gwasanaethau awdurdodau lleol a gwasanaethau'r sector gwirfoddol, wedi'i hwyluso gan gydweithio ac ymgynghori
- Gofal holistaidd i ddinasyddion sy'n ymgorffori llesiant corfforol, meddyliol ac emosiynol, gyda chysylltiad rhwng hynny â dewisiadau byw'n iach
- Gofal integredig wedi'i symleiddio ar sail 24/7, gan ganolbwyntio ar y cleifion mwyaf sâl y tu allan i oriau
- Mwy o wydnwch cymunedol drwy rymuso dinasyddion a rhoi mynediad i ystod o asedau cymunedol
- Cyngor a chymorth ar gael i helpu pobl i fod yn iach, gyda mynediad rhwydd i wasanaethau gofal lleol pan fydd angen y rheini ar bobl
- Arweinyddiaeth amlbroffesiwn cryf ar draws sectorau ac asiantaethau i wella ansawdd
- Atebion technolegol i wella pa mor hygyrch yw gwybodaeth, cyngor a gofal a chymorth ar gyfer hunanofal

2. Cyhoedd gwybodus

Er mwyn llwyddo, mae'n hanfodol rhannu dealltwriaeth ynghylch yr achos dros newid, gan ddangos beth sy'n dda ac esbonio'r manteision. Mae angen gwybodaeth, addysg, cymhelliad ac ysbrydoliaeth ar y cyhoedd er mwyn cyflwyno newid diwylliannol a'u grymuso i berchnogi eu hiechyd eu hunain. Mae angen pwyslais cryf ar ofal sylfaenol a gofal cymunedol mewn strategaethau cyfathrebu, a hynny er

mwyn rhoi gwybodaeth i'r cyhoedd a gweithwyr proffesiynol ynghylch y modelau newydd a datblygiadau i wasanaethau. Efallai y bydd angen dulliau gwahanol er mwyn newid ymddygiad pan fydd gwahaniaethau diwylliannol rhwng ardaloedd daearyddol. Mae sicrhau bod plant a phobl ifanc yn deall pwysigrwydd ysgwyddo cyfrifoldeb yn un o'r prif bethau a fydd yn galluogi newid yn y dyfodol. Mae gweithwyr gofal iechyd proffesiynol yn defnyddio dulliau ac ymyriadau byr gan gynnwys sicrhau bod pob cyswllt yn cyfrif er mwyn cael effaith ar ymddygiad a dewisiadau sy'n ymwneud â ffordd o fyw

3. Dinasyddion sydd wedi'u grymuso

Mae cynnwys pobl wrth gynllunio'u gwasanaethau lleol, defnyddio adborth ynghylch profiadau defnyddwyr a rhoi rôl weithgar i bobl yn y broses newid i gyd yn gymorth i rymuso'r cyhoedd. Gall hyrwyddwyr lleol rannu gwerth arloesi mewn gofal sylfaenol a gofal cymunedol drwy eu profiadau cadarnhaol eu hunain. Mae technegau hyfforddi a chyfweld sy'n cymell pobl wedi bod yn effeithiol wrth eu helpu i newid eu hymddygiad. Mae cleifion a defnyddwyr gwasanaethau'n cael eu hannog i wneud dewisiadau gwybodus gyda'u gweithwyr iechyd a gofal cymdeithasol proffesiynol.

4. Cymorth ar gyfer Hunan-ofal

Mae pobl yn cael cymorth i ysgwyddo cyfrifoldeb dros eu hiechyd eu hunain drwy wella eu gwybodaeth, eu sgiliau a'u hyder. Mae hunanofal ac ysgwyddo cyfrifoldeb yn allweddol i drawsnewid pethau, ac mae'n golygu cynnwys pobl a gofalwyr yn y penderfyniadau a wneir am ofal pobl, a rhoi ystod o adnoddau lleol i hyrwyddo hunanofal a hunangyfeirio. Mae technoleg glyfar yn gymorth wrth fonitro, rhoi hunanofal a chyfathrebu.

5. Gwasanaethau Cymunedol

Mae'r model yn ymgorffori gallu gweithwyr gofal iechyd proffesiynol mewn ymarfer cyffredinol i gyfeirio pobl at ystod ehangach o wasanaethau a llwybrau cymunedol, gan roi'r wybodaeth a'r cyngor diweddaraf am iechyd a llesiant. Mae'r model hefyd yn cynnwys gofal a chymorth anghlinigol yn ogystal â gwasanaethau clinigol. Mae ystod gynyddol o opsiynau ar gyfer rhoi cymorth a chyngor yn cynnwys sgyrsiau gyda thimau iechyd lleol dros y ffôn, drwy e-bost neu drwy alwadau fideo. Mae'r systemau wedi'u dylunio i helpu pobl i wneud penderfyniadau a sicrhau bod y gweithiwr proffesiynol neu'r gwasanaeth gorau ar gael pan fydd angen hynny. Gellir defnyddio adnoddau cymunedol drwy hunangyfeirio neu drwy frysbennu dros y ffôn, a hynny ar ffurf dull presgripsiynu cymdeithasol, gan ddefnyddio Gweithwyr Cyswllt, Presgripsiynwyr Cymdeithasol a thechnoleg er mwyn helpu i gyfeirio pobl. Mae'n hanfodol bod y gwasanaethau lleol hyn yn hygyrch, yn gynaliadwy ac yn ateb anghenion y gymuned.

6. Gweithio mewn clwstwr

Mae cyflogi staff i weithio mewn clystyrau yn cynyddu effeithlonrwydd ac yn sicrhau bod y boblogaeth leol yn gallu manteisio'n rhwydd ar arbenigedd glinigol, arbenigedd gymdeithasol ac arbenigedd rheolwyr. Bydd timau clwstwr yn recriwtio gweithwyr proffesiynol gan gynnwys fferyllwyr, ffisiotherapyddion, gweithwyr cymdeithasol, parafeddygon, cymdeithion meddygol, therapyddion galwedigaethol, cwnselwyr iechyd meddwl, dietegwyr, gweithwyr y trydydd sector ac aelodau eraill o staff awdurdodau lleol er mwyn cynyddu capasiti wrth reoli anghenion y boblogaeth leol o ddydd i ddydd.

Mae sefydlogrwydd ymarfer cyffredinol yn ganolog i'r model newydd ac mae'n hanfodol er mwyn sicrhau bod gwasanaethau iechyd lleol yn gynaliadwy ac yn gallu ymateb i alwadau'r dyfodol. Mae cefnogaeth leol gan y byrddau iechyd yn helpu i sefydlogi practisau meddygon teulu bregus a bydd cynllunio'r gweithlu lleol yn effeithiol yn sicrhau cynaliadwyedd y rhain yn y tymor hwy.

Mae timau clwstwr yn cael gwared ar y rhwystrau artiffisial mewn systemau iechyd a gofal cymdeithasol lleol er mwyn hyrwyddo gofal integredig sy'n cyd-fynd ag anghenion y boblogaeth leol. I hwyluso gweithio integredig a newid diwylliannol, ceir contractau ar y cyd, sesiynau i rannu gwersi a ddysgir, cydleoli staff a chyfleoedd i weithwyr proffesiynol symud o un sector i'r llall. Mae datblygiad y gwahanol fodelau sy'n hyrwyddo cydweithio mewn clystyrau, fel Ffederasiynau, Mentrau Cymdeithasol a Chanolfannau Gofal Sylfaenol yn cyd-fynd â'r dull aml-broffesiwn integredig hwn.

6. Brysbennu Clinigol / Systemau Ffôn yn Gyntaf mewn Ymarfer Cyffredinol
Mae systemau brysbennu clinigol a systemau i ddelio'n ddiogel ac yn effeithiol â galwadau cychwynnol mewn gofal sylfaenol yn ceisio cyfeirio pobl at y gwasanaeth neu'r gweithiwr proffesiynol mwyaf addas, gan symud oddi wrth y system bresennol lle bydd meddygon teulu yn gweld y rhan fwyaf o gleifion i ddechrau. Mae cyngor dros y ffôn yn addas i gyfran uchel o anghenion pobl, ac os bydd gweithiwr proffesiynol profiadol yn rhoi'r cyngor hwnnw, gall hyn leihau nifer yr ymgynghoriadau wyneb yn wyneb mewn ffordd ddiogel ac effeithiol. Mae gan y model ffôn yn gyntaf hwn, sy'n ymgorffori delio â galwadau (neu lywio gofal) a brysbennu clinigol, y potensial i gyfeirio pobl y tu hwnt i'r gweithwyr proffesiynol amrywiol sy'n gysylltiedig â'r meddyg teulu.

Mae'r model ffôn yn gyntaf / brysbennu hefyd yn golygu sicrhau bod modd i bobl gael y gofal iawn gan y gwasanaeth iawn yn brydlon, gan gyfeirio pobl at y canlynol:

- Gweithwyr clinigol proffesiynol sydd wedi'u hintegreiddio yn y tîm clwstwr aml-broffesiwn lleol, gan gynnwys gweithwyr optometreg a deintyddol proffesiynol er mwyn rheoli problemau llygaid, dannedd ac iechyd y geg; fferyllwyr cymunedol i reoli anhwylderau cyffredin a phroblemau sy'n gysylltiedig â meddyginiaethau; a ffisiotherapyddion i reoli problemau cyhyrysgerbydol
- Gwasanaethau anghlinigol cymunedol pan fydd hynny'n briodol, gyda gweithwyr cyswllt neu bresgripsiynwyr cymdeithasol sydd wedi'u hintegreiddio yn y tîm aml-broffesiwn lleol yn helpu i atgyfeirio

Gofal 111 a'r tu allan i oriau
Mae'r gwasanaeth 111 ar ei newydd wedd yn sicrhau bod pobl sydd ag anghenion brys yn y cyfnod y tu allan i oriau yn cael eu rheoli'n briodol, gyda systemau cyfathrebu da i sicrhau bod timau proffesiynol yn gallu gweld y cofnodion clinigol diweddaraf. Mae hyn yn hanfodol er mwyn rhoi gofal di-dor yn ystod oriau a'r tu allan i oriau, yn enwedig i gleifion sydd ag anghenion cymhleth ac/neu ar ddiwedd eu hoes.

Mae 111, gyda chymorth cyfeirlyfr rhithiol cenedlaethol o wasanaethau, hefyd yn gweithredu fel dull o bresgripsiynu cymdeithasol er mwyn cyfeirio pobl at wasanaethau lleol a ffynonellau cymorth ar sail 24/7.

8. Mynediad uniongyrchol
Gall pobl ddefnyddio ystod o wasanaethau iechyd lleol yn uniongyrchol, gan gynnwys: fferyllwyr cymunedol i gael cyngor a thriniaeth am ystod o anhwylderau cyffredin; optometryddion i roi cyngor ac i drin problemau llygaid cyffredin a brys; deintyddion i drin y ddannodd ac iechyd y geg; ffisiotherapyddion i drin problemau cyhyrysgerbydol; ac awdiolegwyr i drin problemau clyw. Efallai na fydd rhai o'r gwasanaethau hyn ar gael ym mhobman ar hyn o bryd, ond maent yn datblygu ac yn cael eu trawsnewid dros gyfnod o amser.

9. Pobl sydd ag anghenion gofal cymhleth
O ganlyniad i frysbennu effeithiol a mwy o weithio mewn clystyrau amlddisgyblaeth, mae gan feddygon teulu ac uwch ymarferwyr fwy o amser i fod yn rhagweithiol wrth ofalu am bobl sydd ag anghenion mwy cymhleth yn y cartref neu yn y gymuned - sef yn aml yr henoed sydd â chyd-afiacheddau. Mae angen amser ymgynghori sylweddol hwy i asesu, cynllunio a chydlynu gofal a rag-gynllunnir.

Gall timau adnoddau cymunedol, timau eiddilwch neu dimau integredig lleol eraill roi gofal di-dor i bobl sydd ag anghenion iechyd a gofal cymdeithasol ill dau. Gall dull system gyfan, aml-broffesiwn weithio'n well i reoli problemau cymhleth sy'n deillio o broblemau'n ymwneud â lles, tai a chyflogaeth. Mae'r tîm clwstwr hefyd mewn sefyllfa dda i helpu gyda gofal pobl sydd â salwch difrifol mewn Wardiau Rhithiol a Chanolfannau Cymunedol, gan weithio ochr yn ochr â chydweithwyr arbenigol i ofalu am y rheini a fyddai fel arall yn cael eu derbyn i'r ysbyty ac yn wynebu risg o golli'u hannibyniaeth. Gall timau cymunedol hefyd helpu i ryddhau pobl yn gyflym o'r ysbyty.

Mae'r model amlddisgyblaethol holistaidd hwn felly yn rhoi dull mwy rhagweithiol ac ataliol o ddarparu gofal, gan reoli pobl yn gynt ar eu llwybrau gofal pan fyddant yn ymateb yn well i addysg a chymorth i roi hunanofal. Y canlyniad yw gwell canlyniadau a phrofiadau i bobl a'u gofalwyr.

Mae gan y model hwn y potensial i ddarparu ystod ehangach o ofal wedi'i gynllunio yn y gymuned, gan gynnwys apwyntiadau a thriniaethau i gleifion allanol, a phrofion diagnosteg. Gallai hyn hefyd leihau nifer yr atgyfeiriadau i ofal eilaidd a derbyniadau ar gyfer gofal heb ei drefnu, gan alluogi staff ysbytai i ganolbwyntio'u hadnoddau ar bobl sâl iawn a gofal arbenigol sydd wedi'i gynllunio.

10. Seilwaith i helpu gyda'r broses drawsnewid
Mae angen seilwaith sy'n addas i'w ddiben yn gefn i'r model ar gyfer trawsnewid gofal sylfaenol, a hwnnw wedi'i gynllunio i helpu pobl i weithio mewn timau aml-ddisgyblaeth. Mae angen i gyfleusterau iechyd lleol, gwasanaethau gwybodeg a systemau ffôn fod yn hyblyg a rhaid iddynt allu ymateb i newidiadau yn y dyfodol, gan helpu gyda gwaith aml-broffesiwn ac elfennau ffôn yn gyntaf/brysbennu. Mae angen i opsiynau digidol i ofyn am ofal ac i gael gofal fod yn gyffredin. Mae'n hanfodol rhoi mynediad uniongyrchol i wasanaethau diagnosteg yn y gymuned, a hynny gan glinigwyr clwstwr, er mwyn darparu gofal o ansawdd da yn agosach at gartref.

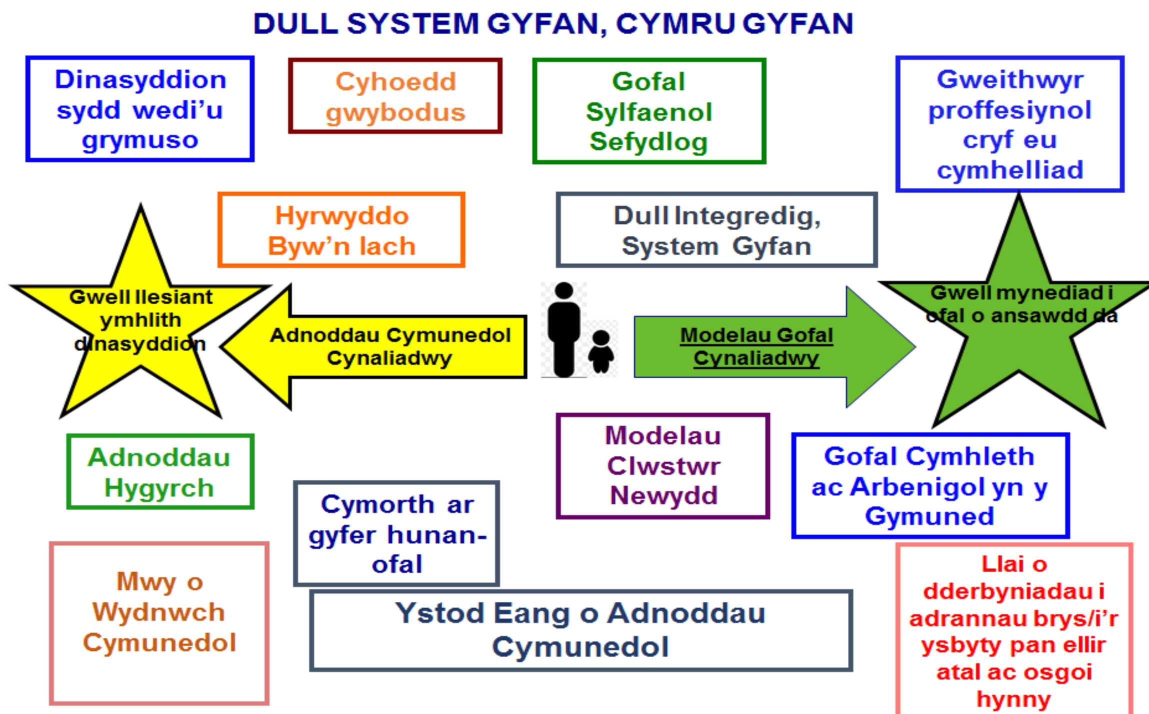
11. Y canlyniadau disgwyliedig

Atodiad B

Mae ymchwil cenedlaethol a rhyngwladol, ochr yn ochr â'r dystiolaeth sy'n deillio o'r Rhaglen Pennu Cyfeiriad, yn dangos manteision posibl y model trawsnewidiol ar gyfer gofal sylfaenol a gofal cymunedol:

- Gwell iechyd a llesiant ymhlith dinasyddion
- Mwy o wydnwch cymunedol
- Gwell ysbryd, cymhelliant a llesiant ymhlith ymarferwyr
- Mwy o recriwtio a chadw staff gofal sylfaenol a staff cymunedol
- Modelau gofal cynaliadwy

Atodiad 1



THE WELSH NHS CONFEDERATION
CONFFEDERASIWN GIG CYMRU

	The Welsh NHS Confederation response to the Health, Social Care and Sport Committee inquiry into winter preparedness.
Contact:	Nesta Lloyd – Jones, Policy and Public Affairs Manager, the Welsh NHS Confederation. [redacted] Tel: [redacted]
Date:	20 June 2018

i) Introduction

1. The Welsh NHS Confederation represents the seven Health Boards and three NHS Trusts in Wales. The Welsh NHS Confederation supports our members to improve health and well-being by working with them to deliver high standards of care for patients and best value for taxpayers' money. We act as a driving force for positive change through strong representation and our policy, influencing and engagement work.

2. We welcome the opportunity to contribute to the Health, Social Care and Sport Committee inquiry into winter preparedness. Operational planning processes need to be in place all year round however experience demonstrates that the winter months pose particular challenges for health and care organisations. During the winter the unscheduled care system is faced with increasing activity, patient acuity and complexity of health and social care needs, which is compounded by workforce supply pressures. However, when the Committee considers these pressures and challenges it is vital that the whole health and care service, and not only the acute hospital services, are considered. Unscheduled care performance is a whole-system issue that is significantly affected by community, social care, primary care, domiciliary and residential home care and preventative care services.

ii) Background

3. This winter there has been exceptionally high levels of demand on the NHS across the UK. Winter is always a challenging time for our health and care service and pressures are apparent across the whole system, in GP practices and community services as well as in our hospitals.

4. This winter has been particularly challenging with significant peaks in demand at secondary and primary care levels. While some of this was forecast, several other factors have contributed to demand pressure. The numbers of people with significant flu and flu-like symptoms has added a level of demand which has been difficult to predict; there has been a rise in the number of people presenting at A&E with complex and acute needs; the age of people attending hospital has increased; the number of people with infectious diseases has gone up; and the ability to transfer patients safely from hospital to their place of residence has led to some difficult periods in our Emergency Departments and Medical Assessment Units.

5. These added pressures inevitably mean that patients, and carers, have had to wait longer which impacts on the patient and carers experience and NHS staff morale because it is

much more difficult to deliver the high quality and timely care staff want to provide. Despite these pressures it is testament to the dedication and commitment of all staff that the vast majority of patients have continued to receive the care they needed in a professional and timely manner.

iii) Exceptional levels of demand

6. This winter has been very challenging with our services seeing some exceptional levels of demand. For example:

- December 2017 was the busiest December on record for A&E attendances, with 82,370 patients attending A&E Departments across Wales;
- The average number of A&E attendances per day in February 2018 was 4.5% higher than February 2017 (116 more attendances per day on average);
- Patients waiting over twelve hours in an A&E department before being admitted or discharged in January 2018 was at its highest on record;
- There was an average of 4,773 outpatient referrals per working day in February 2018;
- In February 2018 there was a 13% increase in patients over 75 at A&E compared to the same time last year;
- 999 call demand was 18% higher in January 2018 compared to January 2017 and 9% higher in February 2018 compared to February 2017 (114 more calls per day on average);
- In December 2017 the Welsh Ambulance Services NHS Trust (WAST) received the highest number of Red calls since the ambulance clinical model was introduced in October 2015. January 2018 was the second highest;
- In February 2018 there were 38,323 emergency calls to the WAST, an average of 1,369 per day, which is the second highest average on record;
- Over the Christmas period GPs and primary care services across Wales saw approximately 100,000 patients per day, around double the normal activity;
- There was a reported increase of between 4 – 5% in out of hours activity;
- This flu season has seen the highest rate of illness since 2010/11, increasing pressures on GPs and hospitals; and
- There was a 13% increase in the number of gastrointestinal outbreaks in hospitals and care homes in December and January compared to the same period last winter. Staffing capacity has been affected at times by viral and respiratory illness.

7. Despite the exceptional pressures on the system:

- Over the winter months A&E activity has increased with more patients treated, admitted or discharged within four hours. Whilst activity increased and performance against the 4-hour national A&E target fell in December 2017 when compared to the same month in 2016 – more patients were treated, admitted or discharged within 4 hours than in any of the previous December months going back to 2014;
- Therapy waiting times have improved in February 2018, with the number of people waiting over 14 weeks now at its lowest since October 2011;
- WAST has continued to exceed the 65% national target for Red calls;

- The number of Delayed Transfers of Care (DToC) decreased by 11% in February 2018 compared to January 2018. The total number of delays during 2017 were the lowest since records began 12 years ago; and
- In terms of postponed procedures, the total number of non-clinical postponements was 5% lower in December 2017 than in December 2016.

There are many examples of good practice and initiatives in place across the system, utilising the significant investment made by the Welsh Government through the Integrated Care Fund (ICF), Primary Care Fund, additional winter pressure monies, etc. which are clearly having a positive impact. Some examples are included in the Appendix to this submission on page 13.

iv) Why is this year different?

8. Planning for this winter has been more comprehensive than in previous years and the health and care sector were better prepared going into this winter than in previous years. However, the demands across the whole system have been considerable and this has affected performance.

A&E demand

9. December 2017 was the busiest December on record (since the NHS began reporting differently in 2011) for A&E attendances with 82,370 patients attending A&E Departments across Wales, a 5.4% increase on attendances in December 2016. For January 2018, 81,050 patients attended A&E departments across Wales, a 2.9% increase on January 2017, and for February 2018 76,010 patients attended A&E departments, 4% higher than February 2017.

10. February 2018 also saw a 13% increase in patients aged over 75 at A&E compared to the same time last year. Older patients will often have more complex needs, requiring longer periods of assessment in A&E and if admitted are more likely to have a longer stay in hospital. Over 54% of elderly people who attended A&E have been admitted so far this winter.

11. The number of people calling 999 resulted in a increase in patients arriving at A&E by ambulance, many of which requiring admission and causing added bed pressures across the system. There were nearly 700 ambulance arrivals at A&E departments on 31st December 2017, approximately 15% higher than the average daily number of ambulance arrivals across Wales.

A&E performance

12. While the performance against the 4-hour A&E target to be treated, admitted or discharged within four hours of arriving at A&E has deteriorated, it should be noted that more patients were admitted or discharged within four hours in December 2017 than in any of the previous December months going back to 2014. In December 2017, over 2,100 more patients were admitted or discharged within four hours compared to December 2016. In January 2018, 1,007 more patients were admitted or discharged within four hours

compared to January 2017. In February this year, 1,142 less people were seen than February last year.

13. While performance is disappointing, in view of the substantial and unrelenting pressure, it is testament to the dedication and skill of all A&E staff that the vast majority of patients were treated, admitted or discharged within four hours. The typical time spent in A&E before admission or discharge was just over two hours.

Acuity of patients

14. The pressure on the system is also due to the fact that patients being admitted to hospital are sicker than in previous years and have complex health and social care needs. This is due to the increase in the number of over 85 years old being admitted and the increase in care that they require. As a result, patients are needing to stay in hospital longer, which reduces patient flow through the hospital making it harder to find beds for new admissions.

15. The ageing population has a significant impact on demand for health and social care services all year round, but particularly during winter months. The ageing population, accompanied by increasing co-morbidity, medicalisation, dementia, frailty and social isolation, is a long-term driver of unscheduled care demand. As people live longer but have fewer children, there is an increased proportion of the population who are dependent on care. On average, older people have lower baseline functions, greater frailty and lower resilience. This leads to greater need for support for the activities of daily living, tipping over into acute ill health at a lower threshold, and slower recovery from illness, which places increased demand on health and social care services.

Ambulance Service

16. For the first three months of the winter period, October to December 2017, 999 call demand was 14.4% higher than the previous year. December 2017 was the highest month for Red demand since the new model was introduced in October 2015. The average daily number of red calls in February was 70, the third consecutive month that it has been 70 calls or more. However, it must be noted that during this time the number of conveyances WAST took to District General Hospitals reduced.

17. In January 2018 there was more lost ambulance hours due to handover delays (9,970) than any other month going back to April 2015. There were 39% (2,819) more lost hours in January 2018 than in the same month last year. This recognises the complexity of the patients needing to be seen in hospitals and the variation in activity and processes across hospital sites.

Infrastructure constraints

18. One key aspect of winter planning for this year is the ability to manage surges in activity from the heralded emergency caseload whilst maintaining levels of elective activity. Most hospitals in Wales have very few surge areas available to them during the winter. This limits both the creation of additional bed capacity for winter and the options for managing infection prevention and control outbreaks.

19. Within acute services, difficulties can be encountered with the number of acute emergency admissions presenting and as a consequence the ability to accommodate this caseload alongside planned elective activity. Furthermore, available bed capacity often becomes compromised by bed closures resulting from infections, particularly of a viral gastrointestinal nature.

Influenza and infection control

20. Hot and cold weather are both associated with increased demand for unscheduled care services. Respiratory illnesses have a distinct seasonal pattern, with an increase in winter largely due to influenza infection leading to hospital admission and excess winter mortality. Other viral infections, such as norovirus, are also common in the winter. Both viruses can place significant short-term strain on unscheduled care services.

21. This flu season has seen the highest rates of illness since 2010/11 which has placed extraordinary demands on the NHS. While not quantified, this will have inevitably impacted on the availability of beds in wards and specialist critical care, and may have affected the speed with which beds can be accessed from A&Es. Flu also affected staff in care homes and the community as well as NHS Wales and Local Authority staff.

22. Winter stomach bugs such as Norovirus place additional strain on the NHS and this winter has been no different. There was a 13% increase in the number of gastrointestinal outbreaks in hospitals and care homes in December and January compared to the same period last winter.

Primary care

23. It is well recognised that GP services, both in and out of hours, and primary and community services are under increasing pressure. The period following Christmas was particularly challenging with anecdotal information indicating that GPs and primary care services across Wales had seen approximately 100,000 patients per day. This was a significant spike and around double the normal activity. Action has been taken to relieve pressure on GPs by relaxing the Quality and Outcomes Framework (QOF) element of the GP contract. The action enabled GPs and practice nurses to manage their most vulnerable and chronically sick patients during the winter period.

24. Pressures on GP Out of Hours Services is a UK wide issue. The majority of Health Boards experienced increased activity over the winter period but they all adopted strategies to mitigate the impact e.g. using nurses who are able to prescribe to provide cover, nurses and paramedics to cover home visiting and drawing in additional vehicles, call handlers etc.

Workforce

25. The NHS ability to respond to winter challenges is constrained by a number of factors, including the NHS workforce. Recruitment issues exist within all staff groups and core medical, nursing and therapy workforce capacity impacts on the NHS ability to find the increase in the workforce required during the winter. In some Health Boards workforce

capacity remains fragile in areas such as ED, Acute Medical Services and District Nursing, despite proactive recruitment at home and overseas, and introducing changes to workforce models to provide sustainability.

26. While workforce strategies, including overseas recruitment for nursing/therapies, are in place recruitment and employment processes have been, and continue to be, challenging. For example, nursing and senior nurse cover are co-ordinated to ensure robust arrangements are in place, however this is always challenged by sickness and vacancy impacts, and can lead to an increased use of agency and bank staff. The availability of bank and agency staff can be limited during peak holiday periods and experience has proven that the reliability of agency staff attending for their shifts can be problematic for some Health Boards.

Social care provision

27. A great deal of social care resource has also been targeted at enabling people to return home or to a care home following admission to a hospital bed. This has, at times, meant there has been additional pressure on social care capacity in the community.

28. In order to ensure a smooth flow of people through the care system (primary, community and acute health and social care), it is imperative that all patients are able to be transferred or discharged in a timely fashion when their episode of care is complete. Winter demand for social care, particularly home care services, has been very high. Social services are supporting people through interim arrangements, either reablement services or step-down beds, wherever this is feasible, and right for the individual.

29. One way of measuring flow efficiency, particularly between various parts of the care system, is to measure delayed transfers of care. Increased delays due to patients awaiting social care arrangements accounted for 31% of all delays in February 2018. However, delayed transfers of care (DToC) has reduced. From a full year perspective, the total number of DToC in 2017 was 750 (13%) lower than in 2016 and the lowest full year total recorded in the 12 years that DToC statistics have been collected. In February, DToC decreased by 11% in February 2018 compared to January 2018. A key priority for next winter will be a specific focus on Health Boards working with Local Authorities to increase access and availability of domiciliary care packages to enable people to leave hospital and return home without delay.

30. What was very clear in December 2017 and January 2018 census periods was that the problems in meeting demand for home care packages in several Health Board areas had worsened despite the improvement that followed from remedial action taken when the issue first became apparent in late summer. The indications are that the Local Authorities concerned are not failing to meet previous levels of demand but are experiencing difficulties with the pace of increased demand, coupled with some instability in the domiciliary care market. There has been a high demand for domiciliary care, especially where both formal and informal carers have been impacted by flu and other sickness.

v) Key actions taken by the NHS

31. NHS Wales is better placed to deal with these challenges. We take a systematic and collaborative approach, operating in an environment of integration, robust common commissioning structures with more information available to inform decisions, than any other part of the UK.

Winter planning

32. As part of their Integrated Medium-Term Plan (IMTP) process, Health Boards and Trusts review previous winter plans and performance each year and then develop plans for the forthcoming winter with Local Authority partners. This includes implementing their unscheduled and urgent care improvement plans and considering the priorities that have been confirmed as part of their individual IMTP process for 2017/18.

33. The health and social care sector have continued to work closely together, and with Welsh Government, in preparation for winter, including holding national planning events where key NHS Wales and Local Authority staff met to discuss their plans, share learning and examples of best practice to inform planning. Similar to recent years, NHS Wales and Local Authorities developed integrated winter plans with an emphasis on collaboration and taking a whole-system approach.

34. This year, the Welsh Government developed an Integrated Winter Resilience Planning Checklist, which was distributed to all relevant organisations as an aide-memoire to support local integrated planning.

Programme for Unscheduled Care

35. The National Programme for Unscheduled Care is working in partnership with Health Boards, WAST, Public Health Wales NHS Trust and Welsh Government. Together they have developed a strategic programme of work aimed at reducing the demand of the top five unscheduled care conditions, promoting resilience and the use of community services in line with prudent healthcare, and supporting the population of Wales to live happier, healthier lives.

36. The programme has supported NHS Wales in alleviating some of the pressures on unscheduled care, through a stepped patient pathway that recognises that actions taken outside of an emergency facility impact on the demand for, and use of, the facility. This reflects the approach that Health Boards have adopted in recent years where their Unscheduled Care Improvement Plans have prioritised:

- Providing services that reduce unscheduled care demand in the first place, especially for emergency care; and
- Ensuring that once an acute episode of care is complete, the transfer back to the community is timely and safe.

37. Increased collaboration has also been key to ensuring improvements. Overall, Health Boards and Trusts have a positive track record of joint working to manage the pressures facing health and social care during winter. Collaboration takes place throughout the year

to enhance joint activities to support and improve service delivery and reduce system pressures. Through working collaboratively Health Boards and Trusts have ensured that actions within the plans are implemented to manage surges and variation in demand, enable improved flow across the system, and maintain service levels in all areas to improve access for patients.

Bed capacity

38. A wide range of positive actions have been planned to further improve local and national resilience, including an increase in available bed capacity both in hospital and in the community to mitigate against the anticipated rise in the number of patients with multiple conditions who require admission to hospital over winter. Across Wales, there are almost 400 additional beds or bed equivalents identified for last winter.

Elective activity

39. In anticipation of increased pressures and as part of their planning Health Boards will often consider reducing their elective inpatient activity, over the festive period in particular, to create capacity to meet the increase in urgent and emergency demand. These planned reductions in elective activity will often be in relation to routine elective inpatients, and not those requiring urgent or emergency treatment such as people needing cancer treatment or day surgery where a bed is often not required.

Postponed operations

40. The number for non-clinical postponements at short notice was 1% lower in December 2017 than in December 2016 and the total number of non-clinical postponements was 5% lower in December 2017 than in December 2016. During December 2017, more than half of all postponements were by the patient and a further 9% were by the hospital for clinical reasons.

Virtual wards

41. Almost all Health Boards are working to some degree on Virtual Ward based services to improve patient experience, helping people to be successfully treated in their own home and reducing the need for them to be admitted into hospital.

42. The Virtual Wards have been created after it was noted that patients were being unnecessarily admitted to hospitals as emergency and that earlier support and treatment was needed to prevent these admissions occurring. Virtual Wards tend to be focussed on conditional specific populations, such as respiratory disease. Virtual Wards brings health, social services, GPs and the voluntary sector together to ensure seamless services to help people in their own homes.

My A&E Live

43. The ‘My A&E Live’ online tool went live on 12 December 2017 and Google analytics data indicates that the live A&E waits page had almost 2,000 hits up until 3rd January. An evaluation of the tool will be undertaken by 1000 Lives during 2018.

The ambulance service (WAST)

44. The ambulance clinical response model was designed to ensure that those patients with the greatest clinical need received a response first. This prioritisation is essential when demand outstrips the availability of resource, when resources are lost to hospital handover delays, and the clinical model has achieved this for the WAST. While the 95th percentile response time for Amber calls is gradually increasing, WAST has ensured the appropriate prioritisation of Amber 1 patients.

45. Significant additional resources have been invested in the ambulance service in the last few years and these have been targeted at ensuring that the number of frontline staff are increasing both in the control centres and on the road. There are a record number of staff employed in the service.

46. The ambulance service has put additional hospital ambulance liaison officers at seven major A&E departments in March and April 2018 to help reduce handover delays. Ambulance liaison officers were at the University Hospital for Wales, Princess of Wales, Morriston, Royal Gwent, Ysbyty Gwynedd, Ysbyty Glan Clwyd and Wrexham Maelor hospitals. The role of the ambulance liaison officer is being evaluated currently.

WAST Hear and Treat

47. The Hear and Treat service means clinicians in WAST control rooms (clinical desk, NHS Direct Wales, 111) assess patients over the telephone, giving them advice or directing them to alternative healthcare providers such as GPs, community nurses or pharmacies. Clinicians use their expertise to reassure patients and make sure they get the right care for their condition. If working effectively, the Hear and Treat service should also release emergency ambulance capacity for those patients who are seriously ill or are suffering life-threatening conditions, with ambulances more readily available to respond.

48. There has been a marked increase in Hear and Treat since the implementation of the new Computer Aided Dispatch (CAD) system. This is due to clinicians working from a set queue which is only visible to the Clinical Support Desk. Clinicians have more time to triage calls that have been deemed as appropriate for secondary triage without the inappropriate dispatch of emergency resources. This has led to improved efficiencies and a increase in the number of patients being discharged with self-care advice over the phone, the number of patients referred to primary care, the number of patients advised to make their own way to hospital and the number of taxis arranged as alternative transport.

Escalation levels

49. The escalation levels reported provide a clear indication that hospitals are under a great deal of pressure, and more so than last year. The hospitals reported escalation level 4 for 21.3% of December 2017, an increase of just over 2% when compared to December 2016. Escalation levels for Decembers 2016 and 2017 were significantly above the level reported in December 2015.

50. Despite these increased levels of pressure and additional challenges, the services have indicated that the protocols have supported them in their response to escalating and de-

escalating pressures. The implementation of their winter resilience actions has supported resilience and while there were times of high escalation, services found that they would recover from significant spikes in pressure more quickly.

Immunisation

51. The table below highlights that uptake of flu vaccination rates in at-risk groups has improved on last year.

Key Group	At 31/01/17	At 30/01/18
Over 65 years	66.1%	68.3%
Under 65 years at risk	46.2%	47.6%
Pregnant women (number)	12,098	12,470
NHS staff (direct contact)	48.6%	56.7%
Children 2 & 3 years	44.9%	49.2%
Children in primary school	65.8% -67.8%	67.0% - 69.9%

111 and NHS Direct Wales

52. The NHS 111 Wales telephone helpline for people needing access to urgent health care advice and support is an example of the provision of a more modern approach to healthcare provision. 111 currently operates in the ABMU and Carmarthenshire area and will be rolled out across Wales by 2021.

53. NHS Direct Wales provides health advice and information service 24 hours a day, seven days per week. During the quarter ending 31 December 2017, 76,200 calls were made to NHS Direct Wales and 1,787,884 visits were made to the NHS Direct Wales website during January – March 2018.

Choose Well campaign

54. The Choose Well campaign was developed in 2011 and aims to help people get the best treatment, in the right place and at the right time to improve experience and outcomes, and ease pressure on ambulance services, GP services and A&Es.

55. In November 2017, a new element to the Choose Well campaign, My Winter Health Plan, was launched. My Winter Health Plan is a simple person-centred document that helps people share key information about their health condition and support network with attending health and care staff. It can be used by anyone but is particularly beneficial for those living with a chronic condition; mental health needs; older people with health needs or anyone who may need support from visiting practitioners over the winter period.

56. In addition to the Choose Well campaign, the Welsh Government has introduced Choose Pharmacy. Choose Pharmacy has already highlighted several positive outcomes, including improved patient access, better use of pharmacists' skills and resources, and improved public understanding of the support available at their local pharmacy.

NHS Wales Employers

57. New Health and Wellbeing guidance has been developed in collaboration with Trade Unions and was launched in January 2018. The guide provides practical materials to encourage staff to improve their health and wellbeing and helps to promote healthy lifestyles and prevent ill health. In addition, the guides recognise that it is the joint responsibility of managers and individual employees to work together to encourage healthier lifestyles and life choices and support each other in the work place.

Social care

58. The additional £19 million recurrent funding from the Welsh Government is supporting the provision of good quality social care services and to help manage the impact of the increase to the National Living Wage (NLW). This is intended to improve workforce conditions and build increased stability and resilience into the home care sector, which should reduce the incidence of patients who are delayed in hospital, while waiting for home care services.

Integration and collaboration

59. Integration across health and social care is key. The health and well-being of the population is not the sole responsibility of the NHS - everyone must come together to play their part. To provide patient-centred care, collaborative working is vital. Integration needs to happen, both within and outside the health service. The NHS will not be able to rise to the challenges it faces without the help of our colleagues in other sectors, including housing, education and, in particular, those in social services.

60. The Public Service Boards (PSBs), introduced as part of the Well-being of Future Generations (Wales) Act 2015, enable public services to commission and plan collaboratively, ensuring that services are integrated and that care and support provided improves health and well-being outcomes for the local population through the PSBs Well-being Assessments and Well-being Plans.

Self-care

61. The vision for unscheduled care in Wales is that people should be supported to remain as independent as possible, that it should be easy to get the right help when needed and that no one should have to wait unnecessarily for the care they need, or wait to go back to their place of residence. The NHS in Wales will achieve this by working with patients and carers as equal partners to provide prudent care.

62. We need a much more sophisticated and long-term conversation with the population of Wales to understand expectations, inform service design, affect behaviour change and truly coproduced sustainable unscheduled care services. Self-care plays an important role in helping to reduce demand on over-stretched primary care and emergency departments during periods of increased demand. Self-care can prevent ill-health in the long-term, and can help reduce the burden on general practice in the winter. Furthermore, there is a need for an open and honest conversation with the public about what the NHS can provide in the future. While the NHS is free at the point of contact, it is not free of obligation, and the public will need to be supported in taking more responsibility for their own health. Patients need to become partners in managing and improving their health,

rather than passive recipients of healthcare. However, increased use of self-care and its promotion should only be one of many measures taken to increase the resilience of the NHS to beat the effects of winter pressures.

vi) Conclusion

63. Demand has increased across the system and the NHS has responded to this through planned work and by working in partnership. However, lessons from this winter need to be considered to inform planning for future winters, improve patient care and experience, reduce the pressure on staff, and deliver improved and sustainable levels of performance.

64. The NHS in Wales continues to work in an integrated and planned way to alleviate the pressures and challenges that it faces, especially during the winter period. In order to adequately respond to the pressures that health and care services are facing, it is vital that there is sufficient capacity across the entire health and social care system, including accident and emergency departments, general practice and social care provision.

APPENDIX

Good Practice on improving patient flow and managing emergency demand pressures

Abertawe Bro Morgannwg University Health Board (ABMU)

Improving Patient Flow and Discharge: **Transfer of Care and Liaison Service (multi-disciplinary) – TOCALS**

The aim of the project was to improve the flow of patients across ABMU;

- To promote direct discharges from the acute site within ABMU; and
- To maximise capacity and through put via the assessment beds at Plas Bryn Rhosyn, (PBR - POBL facility).

The TOCALS project meant that the assessment of patients with a Neath Port Talbot (NPT) address were transferred to Neath Port Talbot Hospital (NPTH) for ongoing medical care, complex discharge planning or ongoing occupational therapy (OT) and physiotherapy. This included direct discharging from the acute sites through liaising with Local Authorities, 3rd sector and families. The Health Board identified safe and timely pathways to discharge and the OT assessment and follow up occurred on discharge. This service was successful when implemented in Morriston in June 2017 and was rolled out to Singleton as part of the winter plan.

The outcomes of TOCALS included:

1. Decreased total length of stay in hospital - reduced Average Length of Stay from 43 to 33 on medical wards;
2. Increased numbers of patients discharged from the acute sites – from 24 per month to 80;
3. Reduction in bed days lost for patients requiring transfer to NPTH – from 24 per week to 16 per week;
4. Reduced demand on domiciliary care packages against baseline at the project initiation; and
5. Improved utilisation of the assessment beds and a reduced length of stay whilst at the unit.

Aneurin Bevan University Health Board (UHB)

Discharge Co-ordinators-DisCos

The aim of the project was to improve the patient pathway and create capacity in a time responsive way through the development of Discharge Co-ordinators. This is a non-clinical bespoke role to complement and enhance the multidisciplinary team at ward level. Whilst managed centrally by the Patient Flow Team they have been allocated to specific wards (1-2 wards per DisCo) and are directed on a daily basis by clinical teams. The purpose of the role is to minimise delay in the patient pathway utilising a check, chase and challenge approach to the discharge plan.

There are many things which have the potential to cause delay and unnecessarily prolong a patient's stay in hospital. Standardising the approach to the organisation and delivery of care for every patient every day must be adopted consistently to manage a patient's hospital stay safely and efficiently. A safe, effective and timely discharge with minimal delay is the optimal quality outcome for all patients.

The measures of success for the DisCo have been identified as reduction in the length of stay and an increase in the number of patients discharged before noon. The average reduction in the length of stay across wards with discharge co-ordinators has seen a reduction of 17%. The average early in day discharge has seen a reduction of 4%.

Betsi Cadwaladr UHB

Patient Safety Huddle

The aim of the project was to ensure health system risks were understood and mitigated each morning, and to have a plan for the day to provide safe, timely patient care by expediting flow. The Patient Safety Huddle implementation in Fife was explored in detail, and the lessons learnt incorporated into a model for North Wales.

Training was provided for all senior staff identified to chair the Safety Huddles, as well as those managers designated as 'controller' to oversee the daily plan, and for senior nursing staff responsible for providing daily information on ward status and discharges. A comprehensive information pack was developed and rolled out to all Betsi Cadwaladr UHB hospital sites, including information and guidance, templates for ward information, and standardised documentation/templates for the morning huddle meeting. Early Safety Huddle meetings were used as a proof of concept, with changes made as necessary to the script/structure of the meeting, templates and information packs, and method if information sharing, to ensure the model works as effectively as possible for Betsi Cadwaladr UHB.

The Safety Huddle model is now embedded successfully on all three major acute sites in North Wales, and forms a cornerstone of managing operational risk and service delivery. Meetings are held daily to identify and mitigate risk, discuss patient flow, and a plan developed and overseen by the daily controller. There is an increased emphasis in all wards on ensuring obstacles to timely patient discharge are discussed, alleviated and escalated where necessary. The Safety Huddle model provides the mechanism for this, by ensuring representation from all staff groups involved in patient care to ensure a solution is quickly identified.

Cardiff and Vale UHB

Cardiff Community Assessment Unit (Residential Discharge to Assess), Cardiff & Vale University Health Board.

The aim of the project is that this Unit provides additional capacity within a care home setting by which to support patient discharge and/or divert Emergency Unit (EU) admissions for patients whose ultimate aim is to remain in their own home (e.g. not for patients requiring long term care home placement). The Unit was originally opened in December 2016 and is funded via Integrated Care Fund (ICF).

Across the year, 6-8 beds are used, profiled to meet anticipated growth in demand over Winter period. A further 2 beds were commissioned (e.g. 10) from November 2017 to March 2018. The Unit is intended to provide short stay (up to 14 days) accommodation for patients on transition from hospital/EU to their own home. The key aim of the unit is to provide an additional discharge route for patients (aligned to the Cardiff Community Resource Team (CRT)) and provide an environment where their ongoing support needs can be better assessed before final discharge home. It also provides an opportunity to divert admissions where clinically appropriate. The Unit also helps the Cardiff CRT to manage its demand better and maintain response times at peak periods.

As part of the Cardiff and Vale UHB:

1. Scoped capacity in the care home market to develop the unit;
2. Met with interested parties and identified a home;
3. Jointly developed an operational policy;
4. Identified key staff to manage the project from within Cardiff CRT;
5. Commissioned GP support to the Unit;
6. Prepare information for patients and ward staff re the unit;
7. Arranged transfer transport in conjunction with Patient Access;
8. Opened the unit on a phased basis over the course of 4 week;
9. Arranged monthly review meetings; and
10. Re-tendered for the beds as required.

The outcomes included;

- 182 patients admitted to the unit April 2017- March 2018;
- 44% of patients were from Medicine Clinical Board and 45% were from Surgical Clinical Board;
- Average length of stay was 13.5 days;
- 70% of patients who completed their stay in CAU, had either no ongoing care needs or reduced care needs based on the anticipated levels of support needs as identified on referral to the unit;
- 17 admission avoidance patients;
- 17 readmissions over course of the 12 months- new acute problems; and
- CRT response time remained reasonably static over Winter period.

Cwm Taf UHB

Stay Well @ Home Team

The aim of the project was 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 and provides a 4-hour response between the hospital based team, support @ home/initial response and nursing @ home. Below outlines the different services areas and their phased implementation during the first 12 months:

The scheme is delivered by the following areas of service which have been operational since April 2017:

- SW@H hospital based team (RGH & PCH);
- Nursing @Home;
- RCT Support @Home;
- Initial Response MTCBC
- Medication Support @Home has required an incremental implementation but will be fully operational by June 2018; and
- Third Sector - Age Connect Supported Discharge Service.

The outcomes were

- There has been a slight increase in the total number of emergency admissions for patients aged >61+ over the last three years. This is consistent with patients aged >75.
- There has been measurable improvement for patients aged > 61 who have a zero length of stay. 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 length of stay.
- There has been measurable improvement for patients aged over 75 who have a 1-2 day length of stay which demonstrates a change in the system. Therefore, in relation to the over 75 who have a zero length of stay it may be that for this more elderly cohort, the benefit of SW@H service is being felt slightly later in the pathway.
- There has been measurable improvement for patients aged>61 who have a 5+ day length of hospital stay (LOS).
- There has been measurable improvement for patients aged over 75 who have a 5+ day LOS.
- There has been a measurable improvement (reduction) in average LOS for patients aged >61 who stay more than 5 days.
- There has been little change in the numbers of patients being placed on the transfer list for community hospitals; although we note two months of special cause variation in July/August 2017. This will need further analysis over a longer period of time.

Hywel Dda UHB

Prince Philip augmentation of the Transfer of Care and Liason (TOCALS) & Daily Frailty clinics.

The aim of the project was to improve the quality of care for complex frail patients admitted to Prince Phillip Hospital increasing the number of frail patients discharged in 3 days or less. The Hospital has benefited from a Transfer of Care and Liaison Service (TOCALS) for 3 years which provides OT, Physio and social work assessment and intervention at the front door to avoid admission to a ward bed.

During the pilot project this service the TOCALS service was augmented with additional consultant, therapy and community input for a 2-week period starting 8th January. Consultant led Multi-Disciplinary Team Frailty clinics were held daily to allowed frail patients to be discharged with a consultant follow up later in the week.

During the pilot period there was in increase in the proportion of over 75 year old patients discharged within 3 days, from 35% to 47%. Other benefits include the number of unnecessary capacity assessments and social worker referrals avoided

Powys Teaching Health Board

Joint Powys Health & Care Coordination Hub

The purpose of the Health & Care Co-ordination Hub is to facilitate the overall coordination of patient flow for Powys residents, working in partnership with Social Services and the Third Sector to improve admission, discharge, inter-hospital transfers and case management. Previously the coordination of patient flow was managed in two localities. In situations of high escalation and unscheduled care pressures, however, a centralised approach is activated, as per the Powys response action cards.

Through a centralised approach in high escalation, it was recognised that having a daily visual log of available beds within the County and demand internally and externally there was more effective management and prioritisation of patient flow, taking account of national pressures and the escalation levels for English partners.

The idea of a permanent joint Health & Care Hub was crystallised and the additional funding available from Welsh Government to support patient flow was utilised to set up a joint hub, in a three-month timescale.

A Clinical Lead was identified, with project management support. A physical space for the hub was sourced, kit ordered and the recruitment process activated to appoint a Hub Coordinator. In tandem, a tendering exercise was completed to secure support for the improvement in patient flow, embracing Lean methodology.

The project has two distinct phases:

- Improve Hospital Flow & inter-hospital transfers; and
- Improve Care Coordination and community care.

The specific benefits for phase 1:

- An effective visual hospital approach to effectively manage patient flow, demand and capacity based on risk and clinical prioritisation.
- Improved repatriation time for Powys residents and prioritised inter-hospital transfers from Welsh providers.
- Maintenance of low levels of unscheduled care pressures and escalation levels.

Phase 2 will involve multi-agency care coordination, working jointly with Adult Social Care and the Third Sector to promote safe admission avoidance with a home first ethos, together with Virtual Wards & identification of community capacity.

The Health and Care Coordination Hub commenced on 12th March 2018. It is too early to provide validated data but improvements have been noted to include:

- Early indication show an increase in discharges and admissions for April 2018.

Month	Discharges	admissions
Nov 17	94	115
Dec 17	82	110
Jan 18	126	138
Feb 18	87	102
March 18	110	141
April 18	130	149

- Feedback from Executive Team and Senior managers is that the information for the all Wales National Unscheduled Care Call is more robust with accurate demand and capacity identified.
- Improved communication and working relationships with neighbouring District General Hospital's (DGH's).
- The length of delay for DToC has reduced and numbers of DToC has reduced in April 2018 and May 2018.
- Powys remained at low escalation levels, mostly Level 2, during the significant national pressures.

WAST

Betsi Cadwaladr UHB Area and Welsh Ambulance Services Advanced Paramedic Pilot Scheme

Recognising the pressures in Secondary Care the WAST tested an innovative framework that supported the effective utilisation of Advanced Paramedic Practice (APP) resources. The framework placed APPs within a rotational model, of operational delivery and clinical despatch within the Clinical Contact Centre (CCC). The aim of which was to safely reduce conveyance to Emergency Departments through the effective use of extended skills and alternative pathways. Validation was necessary to show that the model worked as intended and that the setup properly supported the process within WAST and the Betsi Cadwaladr UHB area.

Over the five-month period of the pilot the team of 10 Advanced Paramedic Practitioners worked 12 hours 7 days per week, and were targeted at calls where it was believed they could positively impact on patient outcomes using their extended skills.

The 10 APP's, rotated between working on two Rapid Response Cars and then spent time despatching their colleagues of the same skill set within the CCC. They attended a total of 1045 incidents.

The following results were evidenced at the end of the pilot.

- Only 30% of patients attended the Emergency Department (ED) compared to pre-intervention of the norm of 69%.
- Of the 70% of patients who did not attend the ED, 33% of these cases were closed with no further referral to other healthcare resources.
- Of the 1045 patients attended, only 13% were subsequently transported to the ED.
- Compared to the standard management the additional 307 patients managed at home by the APP's saved 732 ambulance hours.
- Patient's satisfaction was very high with the average patient's satisfaction score of 9.82/10.
- Re-contact rates remained below 5% after a 48 hours period.

In terms of a safe and sustainable reduction in conveyance rates to Emergency Departments from WAST resources the pilot has been seen as a great success and has exceeded the expectations from the trial.

Bwrdd Iechyd Prifysgol
Betsi Cadwaladr
University Health Board

North Wales Health and Social Care Integrated Resilience Plan 2018-19

BRIEFING NOTE

DRAFT WORK IN PROGRESS

Purpose. This document has been prepared as a briefing document to provide the Health, Social Care and Sport Committee with an analysis of winter 2017/18 and to outline what preparations Betsi Cadwaladr University Health Board (BCUHB) are making for winter 18/19. This is a summary briefing document and greater analysis will be available in the Health Board's Annual Operational Plan and the detailed Winter Resilience Plan that is currently being prepared.

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1) Introducing Resilience Planning at BCUHB

At BCUHB we have conducted a review of performance over winter 17/18. This review has concluded that meeting the demands of winter 18/19 will require both service improvement in advance of winter and a robust seasonal plan to protect services and the population as winter pressure increase. Consequently our resilience plan has three objectives.

Objective 1 – Immediate Actions in Secondary Care
There are a number of immediate actions that BCUHB will implement in Secondary Care and Primary Care services to enable further improvements at system level.

Objective 2 – System Level Service Improvement
A system resilience programme that will improve the quality of planned and unplanned care across the BCUHB Health and Social Care system before the onset of winter 18/19. This plan is well-developed and delivery is being managed by BCUHB's Unscheduled Care Programme Board.

Objective 2 – Seasonal Plan
Secondly to make targeted winter 18/19 preparations that will allow the Health Board to manage expected increases in demand for which we have no accurate timelines. This objective includes initiatives such as managing the impact of influenza; vaccinations programmes and preparing for serious weather events. These plans will build on the success of last year and BCUHB have started a planning process that will report to the BCUHB Board in early September 2018.

2) Developing the North Wales System Resilience Plan

In order to achieve our two objectives BCUHB has further embedded the whole system approach adopted during winter 17/18. The continued development of our System Resilience Plan will draw on a number of reference points and data sources, these will include:

- An internal review of performance data and qualitative review of systems working.

- A review of exemplar Welsh and English Resilience Plans including Cwm Taf and Hwyel Da, Airedale and Barts Health resilience plans.

- A review of wider planning guidelines and winter resilience specific planning frameworks.

This plan builds on the lessons from winter 17/18 and a whole system unscheduled care design event on 21 and 22 May. This design event was attended by over eighty delegates from across the public and third sector in North Wales. The outputs from the event are a long term strategy for unscheduled care and short term, quick wins that will impact in year performance. These quick wins have been included in both this briefing document in support of objective 1 and our 18/19 operational plan.

Detailed planning for Objective 2 – Seasonal Preparations are underway and will complete in late August. The completed plan covering both Objectives 1 and 2 will be circulated to BCUHB and WAST and Local Authority Boards for review and comment in early September. The completed and aligned system plan will then be presented to the North Wales Partnership Board in November 2017.

3) A Review of BCUH Winter Resilience in 17/18

3.1) Overview

The Winter Resilience Plan for 17/18 focussed on eleven core areas:

1. Communication
2. Primary Care
3. Pharmacy
4. Dental Services
5. Seasonal Influenza Planning
6. Norovirus
7. Community – Minor Injury Units
8. Reducing Ambulance Conveyances
9. Escalation
10. Ring Fenced Capacity
11. Discharge

3.2) Areas of Success

In reviewing our performance in winter 17/18 there have been some areas of success, these include:

The use of a standing System Gold Command in which BCUHB executives worked daily with WAST, Local Authority and North Wales Police Gold Commands to manage specific periods of high pressure.

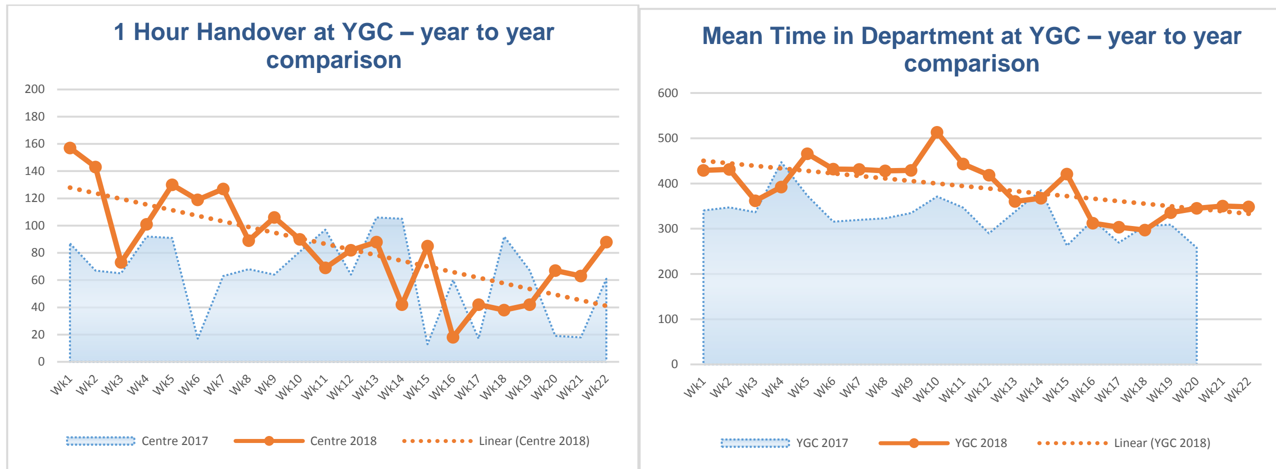
Comprehensive Seasonal Infections Plan in which we actively managed the vaccination of both staff and high risk groups of the population. Whilst our vaccination plan was a success the speed with which we are able to complete diagnostics and confirm diagnosis was not quick enough. We are already engaged with Public Health Wales to discuss how to reduce time to diagnosis and release isolation facilities in a timely way.

Frailty Assessment including a trial at Ysbyty Gwynedd in which a Care of Older Peoples Assessment (COPA) unit which led to a reduction in Length of Stay in the target cohort. This resulted in further capacity being identified at YGC and Maelor.

Operational Service Improvement. We have worked with partners to deliver a number of service level operational improvements that have made significant improvements in operational metrics, including 1hr ambulance waits; site risk indicators and reduced mean time in the department. The unanticipated benefit of working collaboratively with partners has been the bringing together of people experience and expertise from a range of sectors.

Use of 24/7 Distinct Nursing. During the winter of 16/17 we expanded our district nursing support to become a 24/7 service. We have maintained this through the year and strengthened pathways for catheter management and IV administration to avoid admission.

Fig 1. Example of Service Level Performance Improvement – Year on Year performance for 1hr Ambulance Handover and Mean Tine in the ED Department at Ysbyty Glan Clwyd

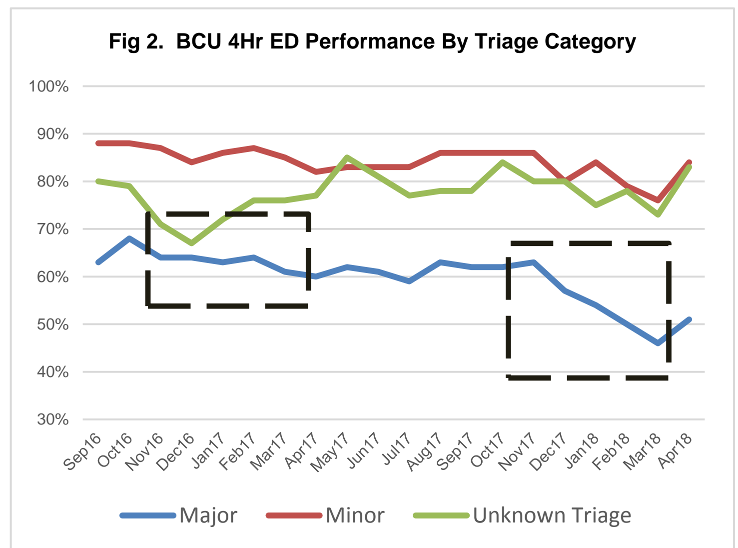


3.3) Opportunities for Development

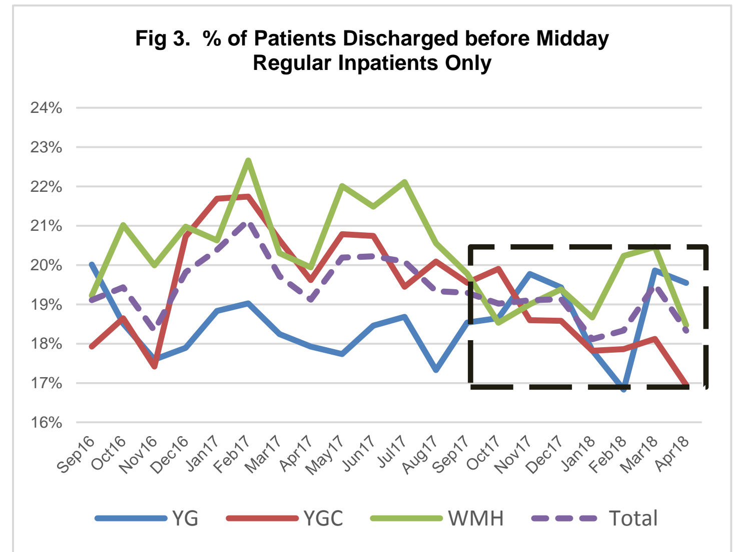
Alongside these successes there were opportunities to learn and improve in anticipation of winter 18/19. There is a significant opportunity to build on the lessons of Gold Command to deliver greater integration across all care sectors. Similarly we have learnt that greater standardisation and a focus on process level performance will drive system level improvements. From a performance perspective our data provides key insights that are supported by qualitative reviews.

4Hr Performance

Average year on year 4hr performance of major patients between October and March fell by 9%. This matched by a corresponding drop in 12hr performance figures for major patients. Our review concluded that flow through both hospital and community wards was a major impact on this specific area of performance. Minors performance experienced a similar drop in performance which can often be attributed to major patients being placed in minors assessment areas overnight.



Discharge Performance
The average monthly percentage of our inpatients discharged before midday in the winter of 17/18 was between 1 and 3% lower than in 16/17, subject to site and month. Typically 18% of our patients are discharged before midday, however, 27% of patients attend ED between 4am and midday. This discrepancy between arrival and discharge profile creates pressure in ED as patients awaiting admission are blocked by those awaiting discharge from the ward. Aligning key staffing skills with demand through detailed service planning is key.



4) <u>Delivering Objective 1 – Immediate Actions In Secondary Care</u>

Working with clinical and operational leads across our three hospitals we have identified five actions that are specific to Secondary Care and will be delivered in line with objective two. These quick win areas are:

1. Reviewing and tracking consistency of our internal professional standards, particularly in the way we manage flow in ED departments, e.g. triage within 15minutes and first doctor review within 1 hour.

2. Consistent approach to how secondary care sites manage escalation and de escalation to protect services that have greatest impact on performance including minor non admitted patients and paediatric capacity.

3. Achieving ten discharges before 10am.

4. Modified boarding processes in which we transfer patients from ED to wards in anticipation of planned discharges.

5. Daily review of EDD and discharge plans.

5) <u>Delivering Objective 2 – System Level Service Improvement</u>

5.1) Underlying Challenges

Learning from last year has enabled BCUHB to identify four underlying challenges that make a major contribution to the quality of care we provide. Addressing these is fundamental to the Health Board achieving Objective 2 – System Service Improvement. Our four challenges and a short summary of the headline interventions that will address each challenge Annex 1.

1. **Systems Ways of Working**
   Secondary Care clinical and specialty teams are making significant progress in improving individual pathways and linking WAST, primary, community and social care services together. Our intention is to develop a behaviours based approach to embed these ways of working and support teams to develop more collegiate, systems ways of working. In this model teams will work together to manage risk and performance holistically across organisational boundaries. Key to this change is improving the way in which we share key data around pathway performance. We will make pathway dashboards available to colleagues across the system to inform collective decision making.

2. **Flow through Secondary Care Wards**
   The variation between attendance and discharge profiles is exacerbated by BCUHB having a higher than national average length of stay. Improving flow will not only allow us to manage seasonal demands in unscheduled care but also to deliver a greater pro portion of our planned case load before Winter. In order to address this we will continue to expand and embed our operational tools such as SAFER, Red 2 Green and End PJ Paralysis across all of our wards. The impact of these nationally recognised schemes will be further enhanced by community based services such as Discharge to Assess consistent application of the choice policy and the re focussing of escalation capacity into therapy led assessment wards ensuring We will focus on the areas of greatest opportunity to deliver a phased implementation.

3. **Improving Care Coordination**
   We have learnt from the winter Gold Command that we implemented with WAST and the North Wales Police during the winter of 17/18. We will further embed this level of partnership working to improve care coordination at both hospital and system level. At the specialty and ward level we will continue to develop our approaches to integrated discharge planning and the proactive use of EDD as a means of forecasting bed availability. During the winter of 17/18 we Ysbyty Glan Clwyd developed a Discharge Planning Tool to create the ability to plan tomorrows discharges today. We will continue to refine this and roll out across all specialties. Doing so will enable us to place patients with the most appropriate care provider and in doing so improve access for all categories of patients. This will be particularly relevant to patients with mental health and substance abuse.

4. **Integrating Hospital Based Emergency Service**
   Our trial of Direct Access Pathways and the Frailty Units across all acute sites has yielded a number of important lessons for how we collaborate to deliver hospital based emergency services. As part of objective 2 we will improve the collaboration between ED, assessment units, ambulatory care, frailty teams and mental health at each of our hospital sites. We will also conduct detailed clinical service reviews to align staffing profiles with demand. We will develop a multi-disciplinary management structure to promote systems working and collective performance management.

5.2) Objective 2 - Resources

Successful delivery of Objective 1 – Service Improvement across BCUHB in time for winter 18/19 is a significant undertaking. BCUHB and system partners are currently identifying the internal capacity required to deliver the change. There are areas of risk in which BCUHB may require temporary programme capacity to deliver the plan.

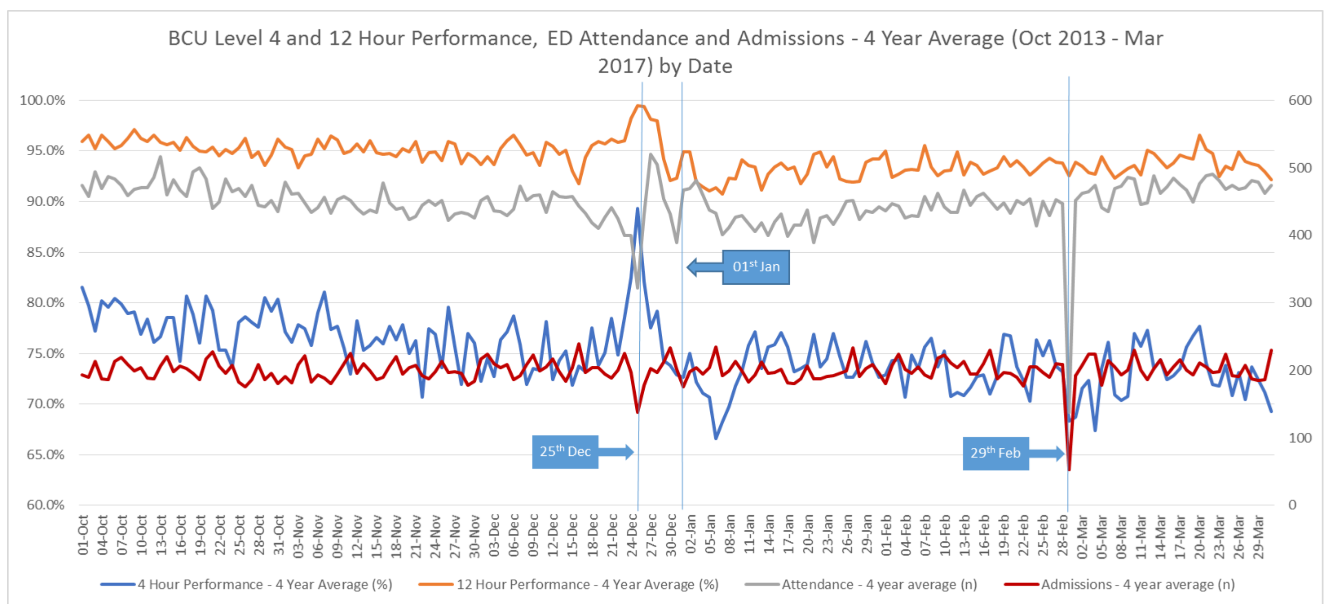
Fig 4 Areas of Resource Risk to Delivering BCUHB Resilience Plan

Resource Risk	Demand / Description
Substantive Operational Capacity	• Additional capacity for service improvement at Secondary Care Site level • Additional leadership capacity to reduce clinical variation across Secondary Care • Additional clinical and operational leadership to develop Emergency Care triumvirate at each site
Temporary Programme Capacity	• Capability to design and capacity to implement a behavioural change programme • Capability and capacity to design and implement near real time performance dashboards • Capacity to implement SAFER and Red 2 Green across all wards • Capability to develop the business case, target operating model and information systems for a single system care coordination hub across North Wales • Capacity to support Emergency Care triumvirates to lead integration projects across all secondary care unscheduled care services

6) Delivering Objective 3 – Seasonal Preparation

Our review of demand and performance across recent years indicates that demand and performance will vary significantly from day to day. Our seasonal preparations will focus on managing those factors that we know will impact our population, however, the timing of that impact is subject to a wide range of factors.

Fig. 5 BCUHB Demand, Performance and Admissions Oct 2013 – 2017



Building on the lessons from 17/18 our seasonal resilience plan will continue to be developed in preparation for reporting to the BCUHB Board in September. Early stages of planning indicate that it will include the following core components:

1. **A comprehensive Public Health communication strategy** that will target vulnerable and hard to reach population groups using the Choose Well messages and symptoms checker. We will continue to promote use of our Live Waits App and communicate across multiple channels including Facebook and Twitter.

2. **A Primary Care strategy** developed jointly with our GP cluster groups that builds on our roll out of the Primary Care Dashboard in 16/17 and the Keeping Well Campaign that will increase the number of primary care appointments available from November onwards.

3. **Infection prevention and control campaign.** This will prioritise preventative influenza and norovirus measures. Specifically we will target information and awareness campaigns to both health and social care staff and the population. Specifically in the work place we will promote a staff vaccination programme and a hand cleansing campaign. We will be equipping staff to manage outbreaks more effectively with enhanced procedures and personal protective equipment. Our community teams will focus vaccinating the patients and their carers in the home to prevent community based spread.

   Safe, Clean, Care Campaign has been introduced since January 2018 that has led to a reduction in the spread of infections which will impact on capacity. A named cohort area has been identified for use should infection levels increase beyond isolation capacity to prevent unplanned bed closures.

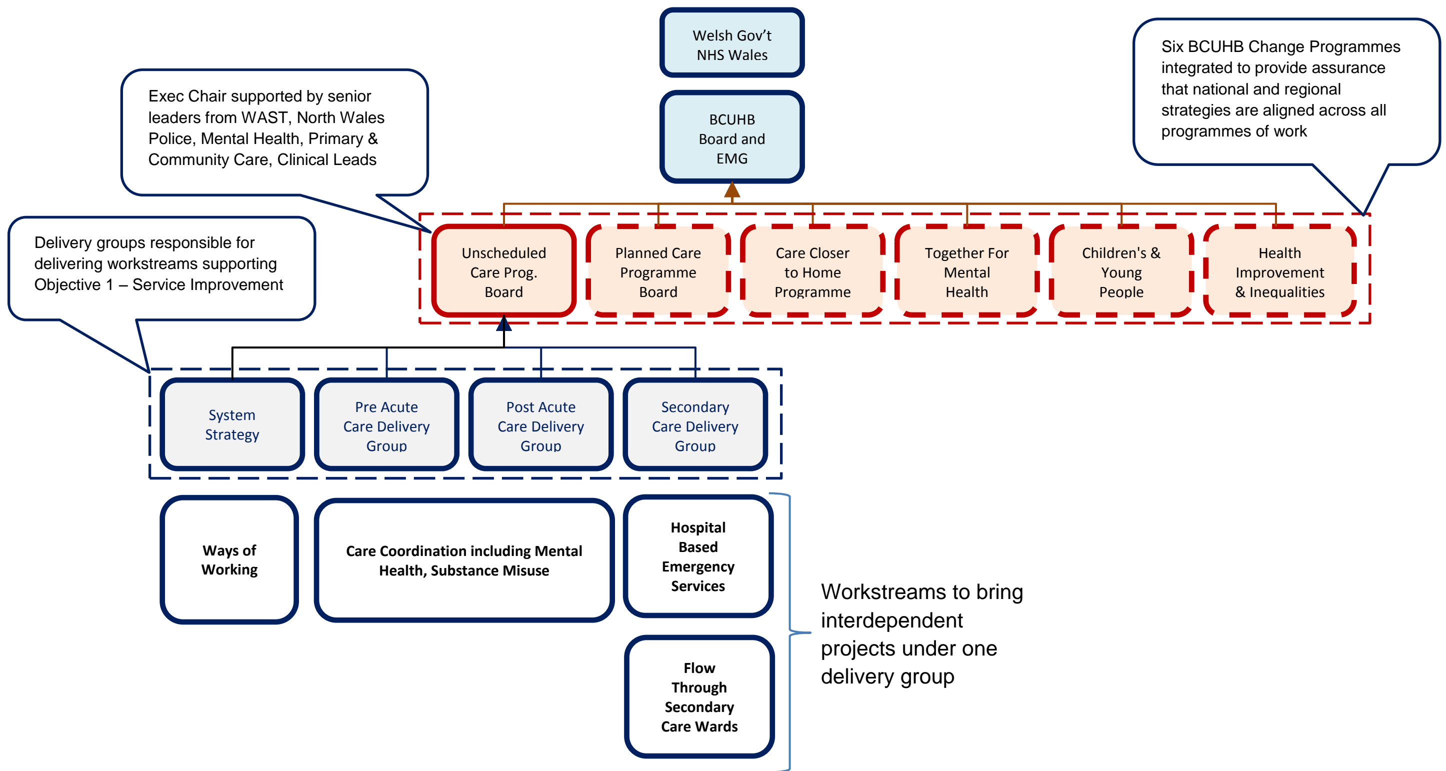
7) Managing Delivery – Governance and Assurance

Our plan is challenging but as a Health and Wellbeing System we recognise the significant risks posed by under performance. The programme of service improvement to achieve objective one and the detailed planning for the seasonal preparations described in objective two will both be overseen by our Unscheduled Care Programme Board.

This Programme Board is chaired by a BCUHB Executive and includes senior representation from WAST, North Wales Police and North Wales public sector partners. Programme level dependencies are managed horizontally across the six BCUHB change programmes to provide assurance that mental health, childrens' and public health strategies are included in the resilience programme.

Programme delivery is managed through four delivery groups each of which are responsible for addressing the challenges identified in our review of 16/17 performance.

Fig. 5 BCUHB Programme and Resilience Governance

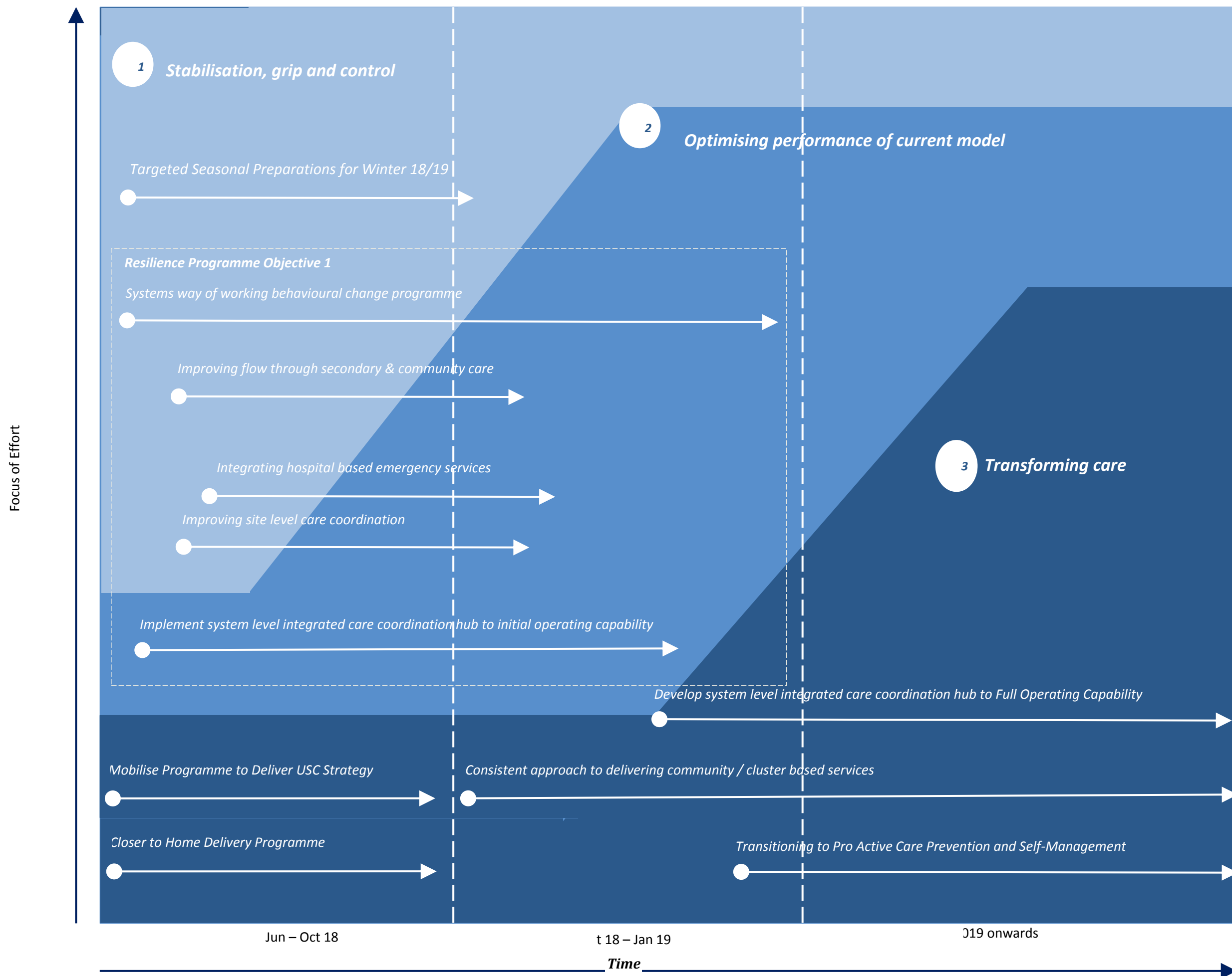


8) Linking Resilience to wider North Wales Care Strategies

We recognise the significant benefits available from linking in year service improvement initiatives with longer term strategies. We have therefore linked our resilience plan to wider strategies to ensure interventions are complimentary.

We use our Stabilise, Optimise and Transform stages of change as a framework for delivering programme. During the stabilise phase we must deliver the quick wins that will minimise risk and improve performance at a service or site level. In the phase we will also be preparing to optimise services and transform care. During the optimise phase we will improve the integration of services and decision making to drive system improvement which paves the way for a move to preventative care and self-management in the transform phase.

Fig. 6 Stabilise Optimise and Transform Stages of Change



Annex 1. System Improvement Plans on a Page

9) Plan on a Page – Systems Ways of Working

a. Overview	A behaviours based approach to embedding the benefits of greater collaboration across pathways and organisational boundaries.
b. Case for Change	Embedding partnership ways of working and behaviours will allow clinical and operational leaders to manage resource and performance across the pathway for greatest patient impact.
c. Interventions	• Behavioural change project: ➢ Development of a Betsi Way of Working, principles, approach, success criteria and performance criteria at a pathway level to improve pathway performance ➢ Diagnostic to assess maturity against target behaviours. ➢ Train site and service specific teams to deliver implementation through waves; with each wave implementation team grows ➢ Support to clinical and operational teams to transition to new ways of working and embed behaviours ➢ Continuous impact assessment through use of clinical leads and divisional champions. • Operational Dashboard project: ➢ Define information requirements at system, site, ward and departmental levels. ➢ Develop baseline of information architecture and define integration requirements. ➢ Define information hierarchies to enable effective decision making at the appropriate levels. ➢ Develop future information architecture and implementation plan. ➢ Development and operational trials. ➢ Roll out across in scope sites.
d. Performance Impact	This project will improve pathway performance and make significant improvements to staff engagement and lead to reductions in KPIs including 4hr Performance, LoS and Discharge.
e. Quality Impacts	This project will encourage and champion the use of outcomes based decision making for patients and lead to increased use of care closer to home and self care initiatives.
f. Risks & Dependencies	• The success of this project is dependant upon integration of performance and quality data across multiple existing platforms. • There is a risk that the "All Wales" strategy for IT solutions impacts on project delivery and reduces potential benefits.
g. Clinical Risks	• No perceived changes to clinical practice or governance.
h. Stakeholders	• BCUHB Primary, Secondary and Community Care
i. Critical Enablers	• Technology enablers to deliver consistent near real time performance data across BCUHB sites • Capacity to implement a new way of working across all care settings.

10) Plan on a Page – Flow through our Hospital Wards

a. Overview	Flow through our secondary care wards has a major impact on the quality of care we provide. It impacts both on how we manage admitted unscheduled demand and on how we discharge patients back to their communities and families.
b. Case for Change	• Over the last two years BCUHB Average Length of Stay is typically 0.5 days longer than the All Wales position. • The pre midday discharge profile is 18% which does not meet the demand of the 27% of patients attending ED between 4am and midday. • Use of reported EDD fell to an average of 18% during the between Oct 17 and Mar 18.
c. Interventions	• Implementation of the SAFER bundle of interventions consistently across all secondary and community care wards. • Implementation of the "Red 2 Green" protocol consistently across all secondary and community wards. • Development of nurse and therapy led discharge wards for Medically Fit patients. • Consistent use of Discharge Planning Tools and EDD as a means of forecasting bed availability. • Development of a flow centre of excellence to support implementation and transfer learning and best practice across BCUIHB. • Consistent implementation of the BCUHB choice policy
d. Performance Impact	• A reduction in Length of Stay of 0.5 days would lead to significant increases in both planned and unscheduled care capacity and lead to 4hr performance improvements. • Increasing AM discharges by 9% through better discharge planning would lead to significant improvements in the performance of ED Major admitted patients.
e. Quality Impacts	• Reductions in Length of Stay and am discharge would be a significant impact on the quality of care for patients. This applies to both in patients and those awaiting admission in ED.
f. Risks & Dependencies	• Successful implementation of process level changes will be dependant upon the systems working workstream to reinforce embedding of processes to become adopted behaviours. • There is a risk that a lack of consistency in approach and adoption of processes leads to complexity in managing system performance. • Delivery of LoS and Discharge benefits are dependent upon flow through both secondary and community care settings.
g. Clinical Risks	• No perceived changes to clinical practice or governance.
h. Stakeholders	• BCUHB Secondary Care divisional, specialty and wards teams • Community Resource Teams • Primary Care • Local authority social care • North Wales Police • Mental Health Teams
i. Critical Enablers	• Capacity to implement and embed behavioural change. • Communications plan to manage public expectations of choice policy.

11) Plan on a Page – Integrated Care Coordination

a. Overview	**Improving Care Coordination.** We will further embed the foundation of partnership working established during our Gold winter group in the winter of 17/18. Implementing a consistent approach at both system and hospital level will enable us to place patients with the most appropriate care provider and in doing so improve access for all categories of patients. This will be particularly relevant to patients with Social Care, Mental Health and Substance Abuse needs.
b. Case for Change	Allocation of health and well-being support, including physical health treatments, social care and mental health care is typically managed in line with organizational priorities rather than the needs of the patient. Greater care coordination will provide the opportunity for a more holistic assessment of needs and for pressure to be managed across the system.
c. Interventions	• Single System Level Care Coordination Hub to bring visibility and active management of system wide demand and capacity. • Site Care Coordination hubs to support prioritise firstly the flow of patients from secondary care to community and social care setting and secondly to deflect in appropriate ED demand to other care settings. • Development of Discharge to Assess models of care to facilitate quicker discharge and improved access to community and social care services in the normal place of residence. • Use of social care, mental health and frailty teams in community and secondary care to support navigation to the most appropriate care setting where acute care may not have the best outcome. This relates to both prevention of admission and expediting discharge. • Greater coordination of WAST, North Wales Police, Social Care and the Third Sector to provide a quicker and more effective response to mental health and substance abuse demand across the BCUHB planning footprint.
d. Performance Impact	• A reduction in Length of Stay of 0.5 days would lead to significant increases in both planned and unscheduled care capacity and lead to 4hr performance improvements. • Increasing AM discharges by 9% through quicker allocation of community and social care packages of care would lead to significant improvements in the performance of ED Major admitted patients.
e. Quality Impacts	• Better coordination of services will lead to improved care outcomes for patients across a number of cohorts specifically COTE, Mental Health and substance abuse patients.
f. Risks & Dependencies	• The scale of change envisaged is significant and will create complexity; this should be mitigated through a phased implementation. • Successful implementation and benefits realisation is dependant up alignment across multiple organisational boundaries.
g. Clinical Risks	• No perceived changes to clinical practice or governance.
h. Stakeholders	• BCUHB Secondary and Community Care • Primary Care • WAST / 111 • AHPs • Social Care • Nursing and Residential Care • Third Sector
i. Critical Enablers	• Specialist capability and capacity to develop operating model and OD solution • Technology solution to create near real time visibility of care assets and resources. • Single North Wales protocol for allocating assets and resources against triage profiles • Capacity for patients and care professionals to access the Single Integrated Hub • Access to profession or organisational IT / Information Systems

12) Plan on a Page – Integrating Hospital Based Emergency Care

a. Overview	As part of objective 1 we will improve the collaboration between ED, assessment units, ambulatory care, frailty teams and mental health at each of our hospital sites. This will include putting these services under a single operational management structure to promote systems working and collective performance management.
b. Case for Change	Year on year average monthly 4hr performance between Oct and Mar fell by 9% for major patients and 4% for minor patients between the winters 16/17 and 17/18. This equates to
c. Interventions	• Creation of an Emergency Care Clinical Directorate led by a triumvirate in all Secondary Care sites. This brings ED, Assessment Units and Ambulatory Care under one leadership team and will drive to improve quality and performance. • Use of streaming nurses at reception to divert inappropriate demand. • Protection of minors service to increase 4hr performance in minor non admit patients • Implementation of performance tracking of all patients through chasers and the use of white boards / information systems. • Clinical Service Planning to develop demand driven staffing models in ED, Assessment and Ambulatory Care departments. • Increased "horizontal" leadership to reduce variation in key services – planned care; unscheduled care; and the four pan N Wales specialties. • Consistency of approach to recording and reporting performance to support
d. Performance Impact	• Increase minor non admit 4hr performance to 100% leading to a 5% improvement in overall 4hr performance. • Increase performance of pediatric 4hr performance to 100% to deliver a 2% improvement in overall 4hr performance.
e. Quality Impacts	• Improvements in ED performance will reduce the risk faced by patients waiting for triage or subsequent admission to secondary care wards. • Treatment of inappropriate ED attendances in community / social care settings will lead to better care outcomes for patients.
f. Risks & Dependencies	• Dependant upon availability of triumvirate resource. • Dependant upon alignment with integrated care coordination project and flow projects
g. Clinical Risks	• No perceived changes to clinical practice or governance.
h. Stakeholders	• BCUHB Secondary Care
i. Critical Enablers	• Additional substantive resource to deliver the capacity to improve horizontal integration across secondary care sties.

BRIEFING PAPER FOR THE HEALTH, SOCIAL CARE AND SPORT SELECT COMMITTEE OF WELSH GOVERNMENT

19 JULY 2018

WINTER REVIEW 2017/18 AND PREPAREDNESS 2018/19

1) INTRODUCTION

This briefing paper provides an overview of Hywel Dda University Health Board's experiences in managing care services through winter 2017/18 and the planning direction being employed in preparation for the winter period 2018/19.

2) WINTER 2017/2018

a) General

The Health Board's winter planning round for 2017/18 commenced when it undertook a rapid review of the previous winter's experience in order to inform preparations for 2017/18. Guidance on resilience was issued by WG in the summer and the integrated winter plan was finally submitted to the Board in October 2017.

b) Planning and Preparation

<u>Learning from Experience</u>
Planning for winter 2017/18 started with an evaluation of the Health Board's experiences of 2016/17 using rapid review techniques which involved collecting submissions from each of the four acute hospitals operating within the Health Board together with the same for the county based community teams. Added to this the Health Board commissioned an independent review from its University partner at Swansea University which aimed to test the planning assumptions employed in preparation

for 2016/17 and in particular the bed modelling and demand projections used to inform the plan.

Financial Assumptions

Throughout the planning process confirmation of external financial support specifically to tackle winter pressures remained absent and hence the winter plan was developed using two approaches.

The first assumed no targeted financial support and hence scope to identify effective additionality became limited as a consequence. The Health Board was however able to make limited internal financial support available and this was targeted for use at Withybush Hospital based on the experiences of winter 2016/17. Given this support was made available early it was activated in readiness for the demand intensification that manifested in October.

The second assumed that capacity shortfalls identified in the plan's capacity/demand analysis would be met through targeted external support.

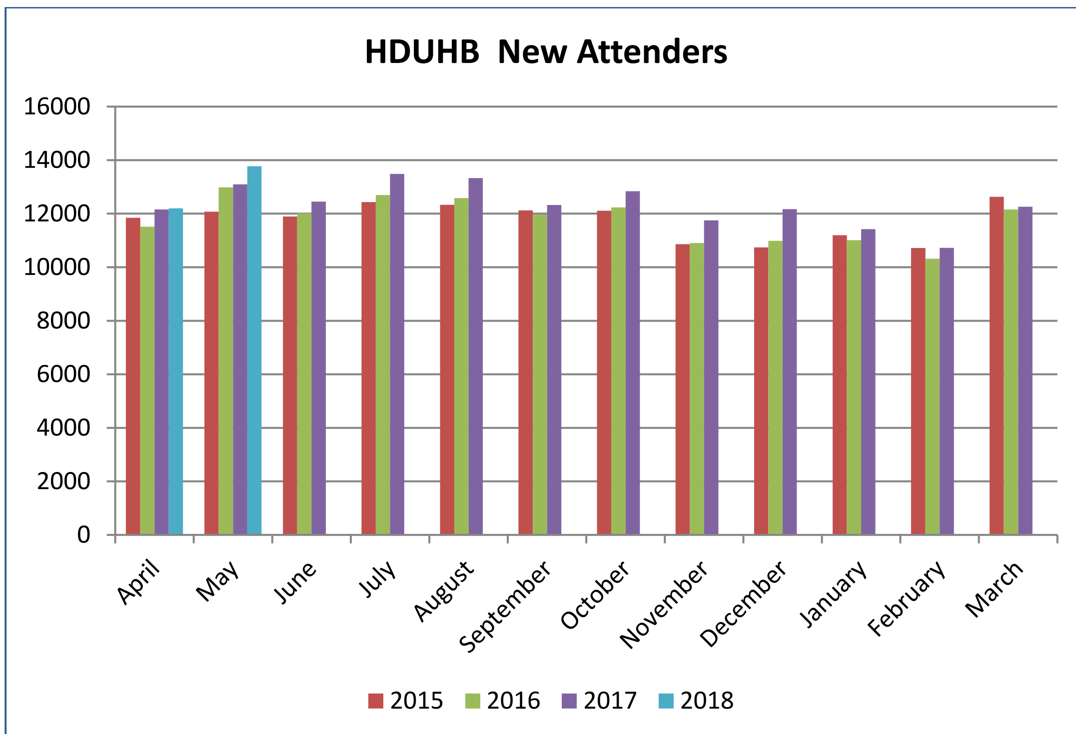
Demand/Capacity Planning

The bed modelling approach employed for winter 2016/17 left the Health Board with an unrealistic deficit to understand and manage and the learning from this was applied to the 2017/18 winter plan. The approach to demand/capacity planning used in 2017/18 therefore used the actual data seen in the previous three years' winters. This approach was endorsed by the Swansea University evaluation work.

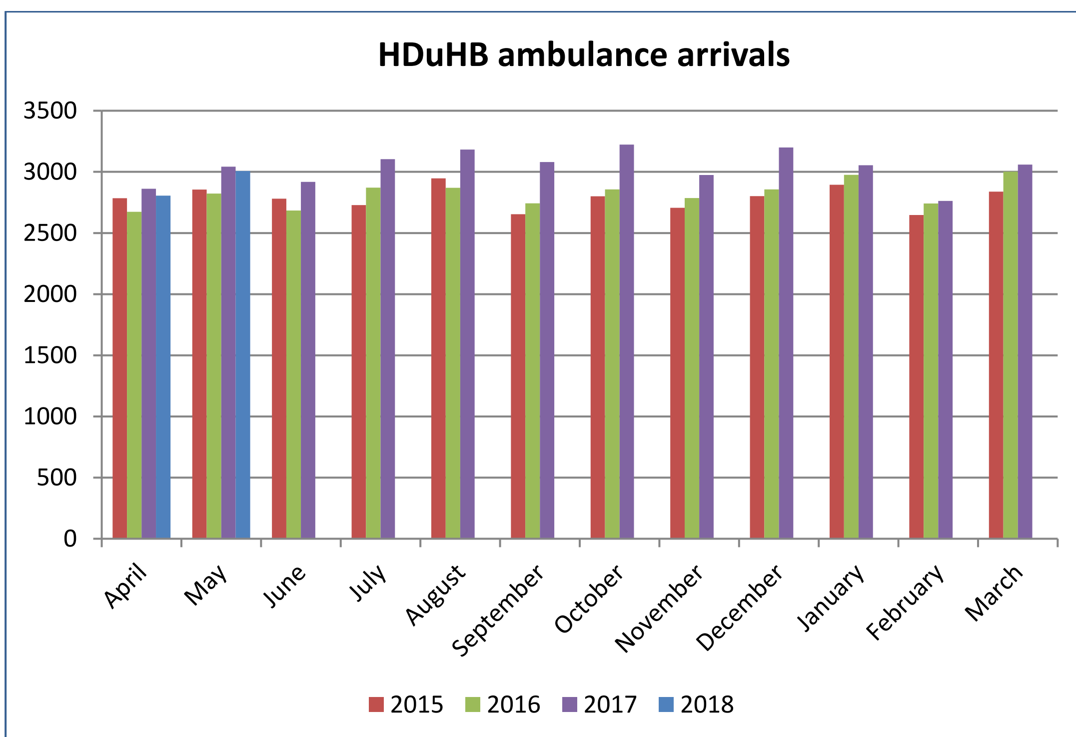
c) Emergent Themes from Winter 2017/18

Demand at Acute Hospitals

Evaluation of 2017/18 data shows that the Health Board's emergency departments' new attenders at its four acute hospitals, over the period October 2017 to March 2018, were 5% higher than the same time in the previous year. This profile aligns with the same increase seen over the full year. However, the daily fluctuation in numbers attending emergency departments was notably different and it is this variation, it is believed, was at the centre of the most severe winter pressures. This is continually witnessed, on all sites throughout the year.



During the same period, ambulance arrivals showed an increase of 6%, marginally less than the year-on-year increase of 8%. Likewise, the number of ambulance delays over 1 hour almost tripled to 1,368 during winter 2017/8 compared to 550 in the previous year.



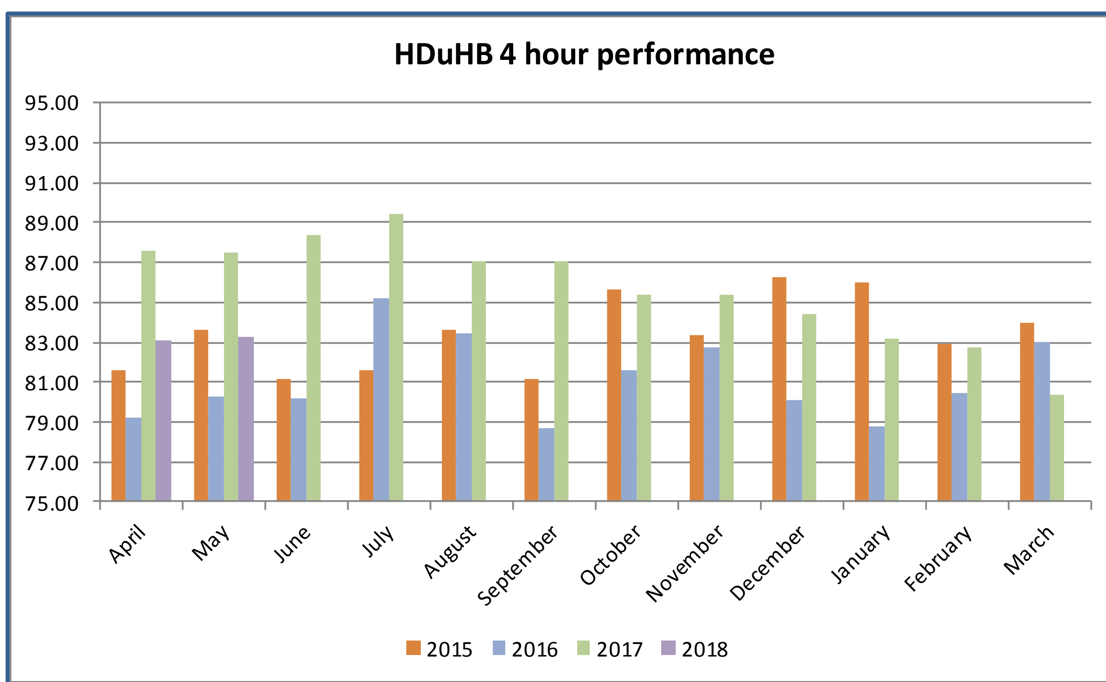
The GP out of hours service saw higher levels of calls during the winter period; 2,691 more than the same period in the previous year equating to

a 10% increase, with high points in December 2017 (17%) and March 2018 (22%). It should be noted that Carmarthenshire Clinical Advice includes calls advised by both '111' clinicians and HDUHB doctors. Analysis shows that the number of advice consultations satisfied by Health Board clinicians increased considerably in Carmarthenshire since the inception of '111' which was as a direct consequence of reductions in home and face to face visits.

Performance

The 4-hour performance showed signs of decline as early as October 2017 and this compared unfavourably with the previous two years; this trend continued throughout the winter period and is continuing into early summer.

The 12-hour performance followed a similar pattern with breaches increasing significantly compared to the previous two years from October and this pattern has continued. 12-hour breaches over the winter period showed a 53% increase with 1,480 breaches compared to 951 the previous year.



Influenza

The volume of influenza cases and the intensity of activity in 2017/2018 was higher than in any season since the 2010/2011, with more time spent above low levels of activity than any time since that year. It was also the only season since 2010/2011 where GP consultations reached the highest

levels of intensity nationally in relation to flu (almost exceeding the threshold for very high levels at the peak of the season).

In primary care there were 2,083 Hywel Dda patients diagnosed with influenza like illnesses. 513 of these were confirmed with influenza at Hywel Dda hospitals and 40 with confirmed influenza in intensive care unit settings.

Medically Fit

The number of patients occupying in-patient beds and no longer requiring medical care (medically fit patients) significantly increased over the 2017/18 winter period.

Bronglais Hospital

Medically fit patients peaked at 22 patients, compared to a daily average of 12, over the winter period, representing 22% of the unscheduled care bed base.

Glangwili Hospital

Medically fit patients rose to a peak of 83 patients at the end of January before settling back again to around 60 patients, with a daily average of 50 patients, which represents 16% of the overall bed numbers for Glangwili Hospital.

Prince Philip Hospital

Medically fit patients peaked at 50 patients, with a daily average of 37 patients, representing 18% of the bed base.

Withybush Hospital

Medically fit patients peaked at 44 patients, with a daily average of 22 patients, representing 11% of the bed base.

Medically fit numbers remain high within the Health Board. Analysis suggests this is for a number of reasons including:

Therapies provision

Therapies capacity on wards remains sub optimal, and during the winter period the situation became further impaired due to the number of additional patients at hospitals. It is well-evidenced that delays in therapy assessments results in longer patient lengths of stay.

Social services provision

Patients experienced delays waiting for packages of care and re-ablement services. Every effort was made during the winter period to alleviate this. Perfect weeks in the lead up to the Christmas holiday

identified those who may require support on discharge, this fully utilised all available capacity and resulted in a lack of re-ablement and domiciliary care services for patients identified early in the New Year. Capacity challenges remain for all Local Authority partners.

Care home Provision for 'elderly mentally infirm' (EMI)
A lack of EMI beds led to extended waits resulting in longer lengths of stay for patients. It was recognised that activity was far higher than in the previous winter with added increases in acuity. Often these were patients with complex needs for which residential beds were not suitable and nursing/stroke EMI beds were required to support these patients whilst ongoing full assessment.

Cardiac Waits
Over the last financial year the number of patients, awaiting transfer to Morriston Hospital increased significantly. The most significant impact was in March 2018 with numbers increasing across all acute hospitals. Withybush Hospital experienced the largest increase with 5 patients waiting for angiography at Morriston Hospital at the start of the winter period to 18 patients by March. 90%, of the Withybush Hospital Cardiology Ward, (ward 8) beds were consumed with patients waiting for transfer to ABMU Health Board; the longest being 34 days for a transfer to Morriston Hospital.

Impact on Elective Work
Demand pressures and the lack of bed availability, led to the Health Board cancelling not insignificant amounts of elective activity over the winter period. Elective weekend work was also affected due to beds being taken up by medical patients resulting in further lost opportunities. At Prince Philip Hospital the elective orthopaedic ward (28 beds) was converted into an emergency medical ward for a 2-3 week period and these remained unavailable, in part, to surgery well into March 2018. A number of outpatient clinics were also cancelled to enable consultants to focus on in-patient care.

Workforce
It could not be said that staff did not surpass expectations in fulfilling their duties over the winter period. The extended Christmas holiday weekend added further pressure to the system but staff made themselves available for the sake and safety of patients.

Managers working on-call were doubled up to add further resilience and this offered much needed support during the most pressured of times. An arrangement which made provision for continuity of the executive on-call over the first two weeks in January had a definite positive impact on managing pressure in the system.

Nurse Staffing

Workforce issues directly affected the discharge profile, over the winter period. The principle of planning for how and when a patient leaves hospital should begin on the day of admission. The biggest factor that inhibits this is staffing levels on the wards. Ward sisters who are pivotal to ensuring discharge plans are in place, were left with little or no management time as they covered front line nursing vacancies on their respective wards. The impact of these vacancies meant that staff were fatigued and morale was affected negatively.

During the winter period acute hospitals faced staffing deficits in their emergency departments and acute wards and surge that was opened in response to high demand remained a constant in an effort to maintain some level of flow.

Bronglais Hospital had 60 WTE registered nurse vacancies across its acute wards, with 3 wards (1 of which was surgical) having a vacancy rate of over 45%.

Glangwili Hospital had 62 WTE registered nurse vacancies within unscheduled care.

Prince Philip Hospital had 22 WTE registered nurse vacancies across its wards.

Withybush Hospital had 66.76 WTE registered nurse vacancies.

Medical Staffing

Glangwili and Withybush Hospitals continued to experience staffing deficits in both medicine and emergency units at middle grade and consultant level. Whilst every effort was made to recruit to the posts, the majority of candidates were from overseas and the recruitment process was not helped by the very lengthy process of Visa application and GMC registration. This resulted in several posts remaining vacant over the winter period.

Prince Philip Hospital had issues with staffing of its GP rota in the minor injuries unit. The GP rota is designed so that there are two GPs available in the afternoon when demand peaks. Due to difficulties in recruiting enough GPs to fully staff the rota it was not possible to

always have two GPs working the afternoon shift. This resulted in considerable waits for patients whose needs were beyond the competencies of the ENP role.

GP Out of Hours experienced gaps throughout the winter period, and this continued into spring / early summer 2018. These staffing deficits are not just a factor within Hywel Dda but are consistent with GP out of hours services across Wales. The impact of these gaps is a demand increase in both ambulance conveyance and emergency department attendance. March saw particular difficulties with gaps in service; there were ongoing gaps in Carmarthenshire including one Sunday when there was no service at either Llanelli or Carmarthen. Bronglais was adversely affected by GP gaps in Gwynedd, (Dolgellau out of hours service).

Patient Experience

Whilst it is not always straightforward to categorise complaints due to their complexity the number of complaints across the Health Board relating to issues linked to the seasonal pressures reduced from 189 in the previous year to 99 over the winter period 2017/2018; a reduction of 48%.

At times of highest escalation and to alleviate the impact on patients who might have found themselves in less than favourable environments additional hotel services support was provided.

Complaints specifically related to unscheduled care services also reduced during the same period from 18 in the previous year to 10 in 2017/18; a reduction of 45%.

However, the number of serious incidents reported was marginally higher with 15 in 2017/18 compared to 13 in the previous year. This increase was in the main due in-patient falls which increased to 10 from 4 in the previous year; an increase of 250%.

WG Targeted Financial Support

On the 10th January 2018, NHS Wales received an allocation from a £10m budget provided by the Cabinet Secretary in recognition of the exceptional demands being placed on health and social care services over the immediate preceding weeks. The Hywel Dda University Health Board received £1.05m. Each county was awarded an allocation based on additional actions that could be put in place from January 2018 until the

end of March 2018 to help alleviate winter pressures coming to bear on frontline staff across the health and social care system.

All acute hospitals were able to put in place additional actions, in the main to support an increase in timely discharge from acute in-patient beds. The enhanced levels of service remained in place through to the Easter weekend at the end of March.

The themes targeted for financial support included:

- Additional resources provided at weekends, on all acute sites, to support safe discharge and to provide additional senior review at the front-door, which did in-turn, reduced admissions;
- Increased pharmacy/phlebotomy/ therapies support, at Glangwili and Withybush Hospitals over the weekend period to increase discharges and hence avoiding bottlenecks on Sundays;
- Dedicated and additional senior doctor – focused on weekend discharges at all sites where internal locums could cover;
- Glangwili Hospital positioned a Respiratory / Acute Medicine Consultant into A&E, from January to March 2018, with the provision of hot clinics. Respiratory Specialist Nurses provided in-reach to the Clinical Decision Unit over the bank holiday period;
- Prince Philip Hospital augmented the Transfer of Care and Liaison service (TOCALS) with an additional consultant, therapies and community input for a 2 week period starting 8th January 2018. In addition daily frailty clinics allowed frail patients to be discharged with a consultant follow up later in the week. Initial analysis shows that there was an increase in the number and percentage of over 75s discharged within 3 days;
- 7-day turnaround services Multi-Disciplinary Assessment and Support Team (MAST)/ Assessing Alternative to Admissions (AA2A) services at the front doors of Withybush and Bronglais Hospitals;
- Spot purchase of additional community beds where capacity was available in all 3 counties.

<u>Additional Capital Monies</u>
Capital investment was made into the hospital estate across three of the acute hospitals during the last winter period with the following projects coming on line before the end of the winter period:

Glangwili Hospital Minors Area
A new minors area for the Emergency Department opened 4th December 2017 and operates 10am until 10pm. This has provided an

additional dedicated space for patients in the category to be seen. However due to the acuity of patients seen over the winter months the facility had little impact on the overall 4 and 12-hour wait performance. However there have been no minors' breaches during the opening hours of the unit and it is believed that without the new unit there would have been a far worse 4-hour breaches position. An average 45-50 patients are seen in this unit each day.

Withybush Hospital Ambulatory Emergency Care Unit (AEC)
The Ambulatory Care Unit in Withybush opened on the 15th January 2018 and is a newly developed area alongside the existing Acute Clinical Decisions Unit, which is adjacent to the Emergency Department. The unit has 6 stations and a designated treatment room that is open from 10am to 6pm Monday to Friday. The unit operates using identified pathway protocols that both push and pull through from the Emergency Department. The Unit has proved enormously successful with 72% of admissions being discharged directly from the unit on the same day. The pathways and operating procedures are developing daily and have been refined to improve the patient experience and outcomes.

The impact of the unit on winter demand and the continuing site pressures has proved invaluable and will further improve as the model develops.

Bronglais Hospital Y Banwy Surge Area
The Y Banwy escalation unit opened in January 2018. The intention was for the dedicated 6-bedded escalation area at Bronglais to replace existing, sub optimal escalation options, which were necessary prior to the dedicated area coming on line.

The unit provided some additional capacity, though in addition, the site has also at times escalated overnight in to the minors department in A&E and day surgery unit. The level of day surgery unit escalation has however been less than previous years.

Given the higher demand and acuity seen throughout the winter and the incidence of flu, which occurred earlier in Ceredigion, it is believed that the situation could have been worse had this surge capacity not been available

Summary

a. Demand increased significantly on previous years. The system had no capacity to cope with such variability in demand. Escalation levels were higher than expected.
b. Performance significantly deteriorated and manifested acutely in 12-hour waits and ambulance delays.
c. Acuity was anecdotally higher.
d. Influenza was higher than in any season since 2010/2011.
e. Medically fit patients were significantly higher and options to tackle these numbers outside of hospital, through assessment beds, packages of care etc. were inadequate due to capacity challenges.
f. Delays in cardiac patients awaiting transfer to ABMU Health Board increased.
g. Elective cancellations were excessive.
h. Workforce gaps continued to run at high levels and recruitment of overseas doctors resulted in inevitable delays in the recruitment process.
i. Out of hours was significantly more fragile than it was the same time in 2016/2017 with a number of shifts/ and sometimes centres not covered.
j. Complaints related to unscheduled care reduced by 45%, however a number of patients were bedded in escalation areas. Serious incidents relating to falls increased.

3) PLANNING FOR WINTER 2018/19

a. General

Planning for winter 2018/19 commenced in May when an internal lessons learnt exercise was undertaken on the experiences of managing unscheduled care in through the winter 2017/18. The learning from this work will be added to the documented learning that emerged from winter 2016/17. A WG event hosted by the Delivery Unit was provided in May and brought all Health Boards and Welsh Ambulance Service Trust together to help set the scene.

Following the May event further information has been provided to the Welsh Confederation on initiatives undertaken within the Health Board that have had a proven impact on delivery of USC services during a winter of particular high demand. These include:

- Introduction of iStumble falls assessment algorithm across nursing and care homes throughout HDUHB in partnership with colleagues at Welsh Ambulance Service Trust.
- Augmentation of the Transfer of Care Advice and Liaison Service and daily frailty clinics at Prince Philip Hospital
- Senior consultant physician input at the front door in Glangwili Hospital.

More generally, the Health Board plans to work closely with the Welsh Ambulance Service with a renewed focus around ambulance handovers, as improving this will unlock several opportunities to do things better for our patients.

The quality and safety agenda will also need to factored into the planning and be adequately calibrated against the other competing priorities.

Escalation plans will remain a key feature of the winter preparations and will form the basis of a fall back position should demand outstrip capacity beyond the Health Board's scope of planning.

b. Planning Process

The Health Board's winter plan will maintain the additionality only factor that was applied in 2017/18 and rationalise the initiatives within a manageable cohort of themes. As with the 2017/18 plan the approach follows two financial scenarios; being zero targeted support and full support to cover the capacity deficits identified.

Locally a draft format based on last year's plan has been developed and aligned to the unscheduled care 7-component pathway. This draft format was presented to the integrated winter planning group, on the 22nd June 2018, with representation from acute, community primary care, public health and local authority services, for discussion. Further engagement with partners including primary care clusters will follow.

The preparatory work in drafting this year's plan has included the following;

- Review of actions from the last 2 years' plans, 2016 and 2017; agreement of those actions of most benefit that will be applied in 2018
- Review of key risks; ensuring consistency with unscheduled care risk register and actions to mitigate risks;
- Review of key data sets;

- Updating of the communication plan with lessons learnt from previous winters aligning with other major communication initiatives for example the flu immunisation programme.

The planning approach also includes a simpler form of risk based planning as the risk themes remain broadly consistent year on year. The key to this will be through review of lessons learnt from the 2016/17 and 2017/18 years which will include determining those initiatives that worked well and discounting those that did not.

Key lines of approach incorporated into the plan include:

Integrated Pathways for Older People (IPOP)
Hywel Dda University Health Board, in partnership with social care colleagues, is currently piloting the **I**ntegrated **P**athway for **O**lder **P**eople (IPOP) on behalf of the National Programme for Unscheduled Care (NPUC).

In the context of winter the Health Board believes that to effectively manage seasonal demand when it is at its greatest the plan must ably cater for the over 75s. The IPOP pathway supports this.

The national IPOP is a six component pathway and the first pathway for integration developed as a part of the NPUC and the NPUC Board. It has been developed by an expert reference group (ERG) and been supported by the National Director for Primary Care and the Primary Care Reference group for the National Primary Care Board.

A integrated seven component pathway has been used as the foundation framework within our Health Board as a part of our local Unscheduled Care Programme for the last 2 years; with the addition of a component 7 '*Continue to care for me'* and the acute component 5 broken down further to components '*Front door'* (5a) and *'inpatient services'* (5b).

The winter resilience planning cycle provides an opportunity for the integrated Unscheduled Care Programme to utilise this framework as the single mechanism for service planning, winter resilience planning, reporting and performance management across the 'whole system'; this seven component pathway has already been used as part of the annual plan and is work is ongoing to utilise this framework as part of the integrated medium term plan (IMTP).

As such, the detail of the winter resilience plan is tied back to the relevant component steps within the pathway to ensure that any additional actions address all the components.

Influenza Plan

The Seasonal Influenza Plan for 2018/2019 has highlighted a strategic aim of preventing respiratory illness in the Hywel Dda population; this requires that the Seasonal Influenza Plan and Winter Resilience Plan be closely aligned to ensure a consistent and robust approach to addressing winter pressures. A first meeting has been held and joint actions agreed.

Unscheduled Care Programme

The draft winter resilience plan was discussed at the integrated Unscheduled Care Programme Board in June and agreement given that the Health Board with local authority partners and Welsh Ambulance Service Trust would co-produce a regional integrated winter resilience plan. This plan would then be approved by all parties through the regional partnership board.

This Unscheduled Care Programme Board have agreed to focus on a limited number of high impact actions, delivered in partnership, that address all the component steps within the USC pathway. These include:

Admission Avoidance - components 4 & 5

- Home First – a 'hearts and minds' campaign to encourage all staff to be thinking about home first option for patients, this will ensure that expectations are correctly set at the outset of the patient journey throughout our services. This work will be delivered with support from colleagues from the Welsh Government Delivery Unit and Emergency Care Improvement Programme.
- Alternative pathways – working with community, 111, GP Out of hours and Welsh Ambulance Service Trust colleagues to ensure

utilisation of current pathways is optimised and wherever possible development of new pathways.

- Acute Frailty Network Project – implementation of the principles of the Acute Frailty Network, part of NHS Elect in England at Withybush Hospital, supporting people with frailty and urgent care needs to get home sooner and healthier. This will be the first acute site in Wales to implement these principles that are focused on the first 72 hours of the elderly persons' pathway in an acute setting.
- Health Care Professional conveyance rates by GP cluster / practice – working with Welsh Ambulance and Primary Care colleagues to undertake a full evaluation of the conveyance rates to understand the variance, if any, between clusters and roll out examples of best practice to other clusters.

Making Every Contact Count - components 1, 2 & 3

- Flu immunisation campaign – working with public health colleagues to ensure a consistent and robust approach to addressing winter pressures.
- Choose Well – further development of our Choose Well campaign, helping the population of our region to make informed decisions when seeking medical attention.

Bed Configuration - component 5

- Elective capacity – understanding the demands on the elective bed base, ensuring alignment to the Health Board's RTT plans.
- Critical care capacity - understanding the demands on our critical care bed base, and what actions that can be taken to ensure capacity throughout the winter period
- Community care capacity - understanding the demands on the critical care bed base, and what actions that can be taken to ensure capacity throughout the winter period.

Discharge to Assess – component 6

Development of the Health Board's discharge to assess model; ensuring that patients who no longer require an acute hospital bed receive their assessment for longer-term care and support needs in the most appropriate setting and at the right time for the person.

The Health Board is also changing the way our Long Term Care Specialist Nurses deliver care to patients. The support they provide will start as soon as a patient is identified as requiring Long Term Care and the Specialist

Nurse will then be supporting and advising staff, patients and their families through this complex process. With their extensive knowledge and experience of the independent care home sector they will be able to offer the patient and families in-depth knowledge about the care home chosen, what to expect when they move in and the finer details that really matter to patients to support a structured and well controlled transition in partnership with the Independent Care Home. This will ensure that patients requiring long term care planning are identified at the earliest stage of admission.

Other Actions

An evaluation of the effectiveness of the perfect week initiatives that Glangwili and Withybush Hospital undertook in the weeks leading up to and post the Christmas holiday period demonstrated the value of this initiative and recommended that this was undertaken again in the lead-in to Christmas and that there would be value in undertaking a perfect week in the 2nd week of January.

Last year saw annual leave restrictions in place over the Christmas and New Year period and it is recommended that this be implemented again this forthcoming year, with a view to extending the period to the first 2 weeks of January, as this historically has been a period of higher escalation.

This winter resilience group will now continue to meet regularly in the run up to the commencement of winter to develop more detail around these high impact actions and ensure robust integrated county operational plans are in place. The Health Board will also continue to work with Welsh Government and other Health Boards to implement identified best practice where possible.

Powys Teaching Health Board

Briefing for the Health, Social Care & Sport Committee: Winter Preparedness, Resilience and Forward Planning

Introduction:

The 2017-18 winter period saw what has been described as 'unprecedented demand' on all NHS systems and services, across the UK. Whilst PTHB's daily reporting of Risk Status remained at a fairly constant Level 3 during the months of December to March, whilst Wales remained at a high risk Level 4, with some Health Boards reporting Level 5 for a few days in December and January.

The Welsh NHS Confederation has reported All Wales performance during the winter to Welsh Government. Their summary provides a useful 'scene setting' into the pressures felt across Wales on all services, and is outlined below:

- December 2017 was the busiest December on record for A&E attendances, with 82,370 patients attending A&E Departments across Wales;
- The average number of A&E attendances per day in February 2018 was 4.5% higher than February 2017 (116 more attendances per day on average);
- Patients waiting over twelve hours in an A&E department before being admitted or discharged in January 2018 was at its highest on record;
- There was an average of 4,773 outpatient referrals per working day in February 2018;
- In February 2018 there was a 13% increase in patients over 75 at A&E compared to the same time last year;
- 999 call demand was 18% higher in January 2018 compared to January 2017 and 9% higher in February 2018 compared to February 2017 (114 more calls per day on average);
- In December 2017 the Welsh Ambulance Services NHS Trust (WAST) received the highest number of Red calls since the ambulance clinical model was introduced in October 2015. January was the second highest;
- In February 2018 there were 38,323 emergency calls to the WAST, an average of 1,369 per day, which is the second highest average on record;
- Over the Christmas period GPs and primary care services across Wales saw approximately 100,000 patients per day, around double the normal activity;
- This flu season has seen the highest rate of illness since 2010/11, increasing pressures on GPs and hospitals; and
- There was a 13% increase in the number of gastrointestinal outbreaks in hospitals and care homes in December and January compared to the

same period last winter. Staffing capacity has been affected at times by viral and respiratory illness.

Data analysis has shown that for many years rising demand is resulting in increasing hospital activity – from A&E attendances and emergency admissions to referrals to outpatient services, diagnostic tests and elective admissions. There is also evidence that other parts of the health service are facing similar challenges, including general practice (Baird et al 2016) district nursing services (Maybin et al 2016) and mental health (Gilburt 2015), although the demand for mental health services is not seasonal. There is persuasive evidence of a health system that is challenged in trying to meet increasing demand within constrained resources.

Patient acuity contributes directly on system pressures as patients being admitted to hospital are notably sicker than in previous years. This is due to the increase in the number of over 85 year olds being admitted and the increase in care they require. As a result, patients are needing to stay in hospital longer, which impacts on patient flow.

The ageing population has a significant impact on demand for health and social care services all year round, but particularly during winter months. The ageing population, accompanied by increasing co-morbidity, medicalisation, frailty and social isolation, is a long-term driver of unscheduled care demand. As people live longer but have fewer children, there is an increased proportion of the population who are dependent on care. On average, older people have lower baseline functions, greater frailty and lower resilience. This leads to greater need for support for the activities of daily living, tipping over into acute ill health at a lower threshold, and slower recovery from illness, which places increased demand on health and social care services.

Much of the literature on emergency pressures underlines the importance of the NHS and partners focusing on finding ways of meeting and moderating rising demand for hospital care. As identified in the Powys Health & Care Strategy, the focus needs to shift to upgrade prevention and to increase investment in services in the community, to avoid hospital use where possible and provide more care in people's homes or closer to home. Continued actions in these domains will help to transform the delivery of health and social care to better meet the needs of the population and secure improved patient experience. Aligning primary care, community care, social care and third sector services in cluster areas provides a real possibility of moderating rising demand for hospital care, providing care in communities locally and safely.

The following presents an overview of performance for provided services in Powys against a range of metrics, to include: Delayed Transfers of Care (DToC), MIU 4 hour transit time, MIU breach rates, WAST Red Call performance & RTT performance during the Winter period 2017/'18. The

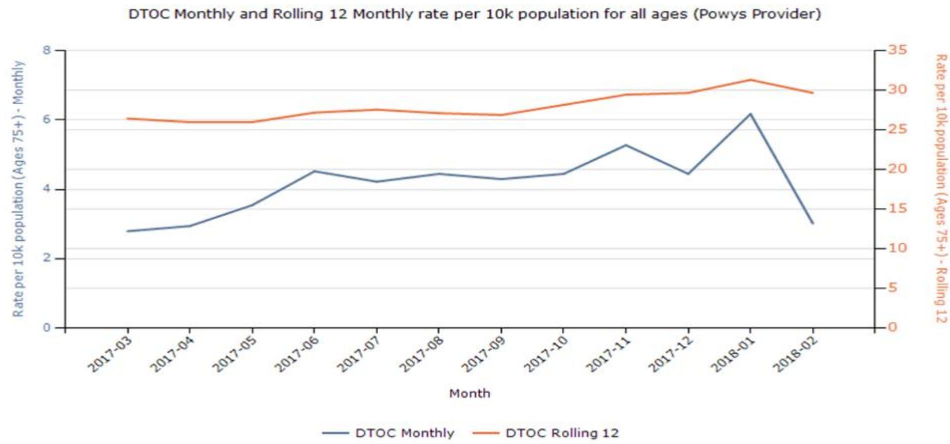
briefing also identifies what worked well for Powys, providing operational examples aligned to the Winter Plan 2017/'18 and the intended approach for Winter 2018/19.

Metrics:

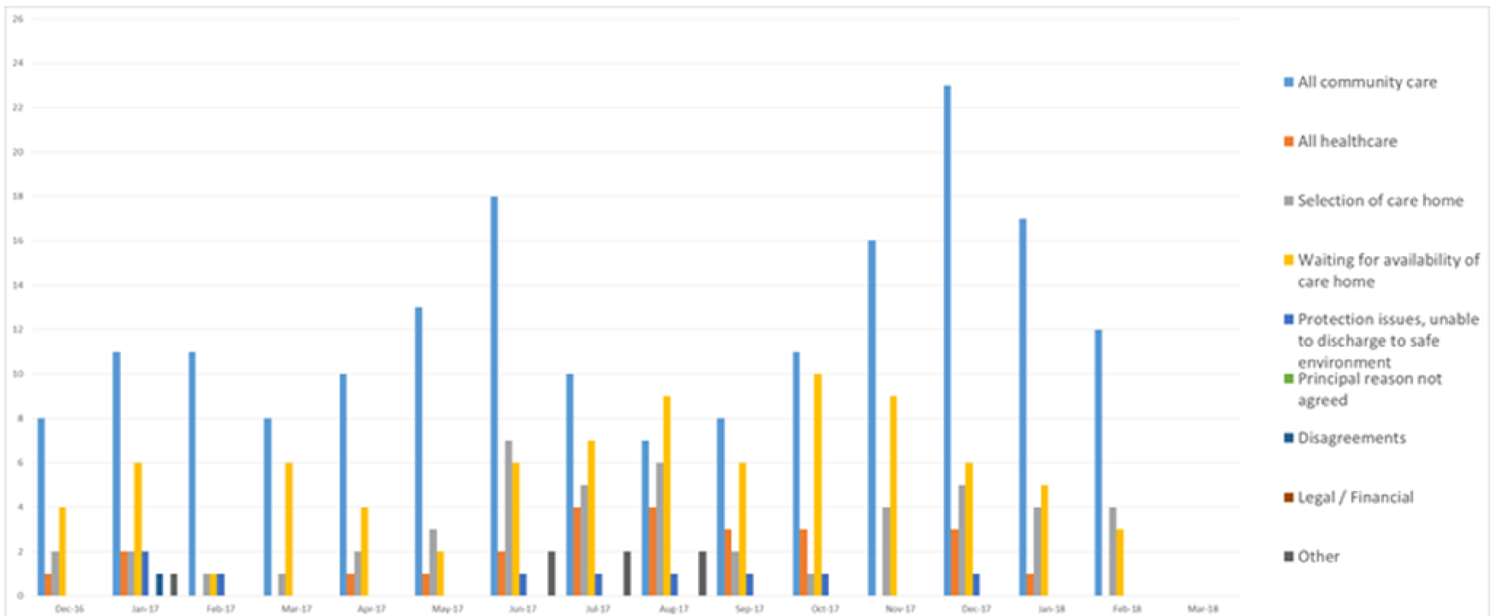
- **DToC**

Whilst there was a spike in the number of non-mental health DToCs in Community Hospitals in December 2017 and January 2018, the figures below demonstrate that a reduction is evident in February, closer to the lowest total number of 18 at census seen over the year. The numbers of Delayed Transfers of Care remains variable and this is an area for focused attention during 2018/'19, influenced by the Delivery Unit SAFER Discharge Principles review.

Source: StatsWales												
	03/17	**04/17**	**05/17**	**06/17**	**07/17**	**08/17**	**09/17**	**10/17**	**11/17**	**12/17**	**01/18**	**02/18**
Number of Non Mental Health +75 years DToC's Powys	18	20	24	30	24	24	18	25	31	34	24	19
Number of Non Mental Health +75 rolling 12 rate per 10K Powys	171.0	163.4	158.3	162.1	164.7	170.5	168.6	168.6	174.3	186.6	185.3	187.2
Number of Non Mental Health +75 years DToC's (All Wales)	300	306	339	333	328	342	370	366	355	332	354	311
Non Mental Health +75 years Rolling 12 Rate Per 10k DToC (All Wales)	151.1	147.1	145.6	145.4	144.1	143.5	143.2	141.9	140.6	140.4	142.7	143.1



The graph below, which details the DTOC reason (on census day each month), shows a peak in December followed by the start of a reduction, in particular of note is the reduction in 'healthcare' category.



- **MIU attendances**

During the period from October to February, the attendance pattern for new presenters across MIUs remained fairly static. There were no significant attendance impacts for MIUs during the winter period despite introducing a model to divert ambulances to MIU in the North, as opposed to neighbouring DGHs.

Source: Myrddin							
HOSPITAL	ATTEND TYPE	2017-10	2017-11	2017-12	2018-01	2018-02	Total
Casualty Dept - Brecon Hospital	NEW	565	502	428	508	449	**2452**
Casualty Dept - Llandrindod Wells	NEW	475	430	428	388	416	**2137**
Casualty Dept - Welshpool	NEW	362	294	290	322	296	**1564**
Casualty Dept - Ystradgynlais	NEW	186	172	143	162	186	**849**
Total		**1588**	**1398**	**1289**	**1380**	**1347**	**7002**

- **MIU Breaches:**

The MIU target for patients to be seen, treated and discharged in an MIU department within 4 hours is 95%. Throughout the past year, including the winter pressures period, all 4 of the PTHB MIUs have performed at a minimum of 99.0%.

There were no significant delays for patients waiting longer than the 4 hour target in MIUs during the winter period.

- **WAST Performance:**

From a national perspective, for the first three months of the winter period, October to December 2017, 999 call demand was 14.4% higher than the previous year. December 2017 was the highest month for Red demand since the new clinical model was introduced in October 2015. The average daily number of red calls in February was 60, the third consecutive month that it has been 60 calls or more.

In January 2018 there was more lost ambulance hours due to handover delays (9,970) than any other month going back to April 2015. There were 39% (2,819) more lost hours in January 2018 than in the same month last year. This recognises the complexity of the patients needing to be seen in hospitals and the variation in activity across sites.

In terms of Powys:

MIU Over 4 Hour Breach Rate

Ambulance waits

Source: Myrddin	2017-03	2017-04	2017-05	2017-06	2017-07	2017-08	2017-09	2017-10	2017-11	2017-12	2018-01	2018-02
Casualty Dept - Brecon Hospital	99.6%	99.6%	99.7%	99.7%	99.5%	99.3%	100.0%	100.0%	99.6%	99.8%	99.2%	99.3%
Casualty Dept - Llandrindod Wells	100.0%	100.0%	100.0%	100.0%	100.0%	99.6%	100.0%	99.8%	99.5%	99.3%	99.0%	99.5%
Casualty Dept - Welshpool	100.0%	100.0%	99.6%	100.0%	100.0%	99.5%	99.7%	100.0%	100.0%	99.7%	99.7%	100.0%
Casualty Dept - Ystradgynlais	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

Emergency ambulance calls and responses to red calls, by LHB

Source: http://gov.wales/statistics-and-research/ambulance-services/?lang=en

Feb-18	Red calls	Red calls resulting in an emergency response at the scene	Red calls resulting in an emergency response at the scene within 8 minutes	Red calls - % of emergency responses arriving at the scene within 8 minutes	Amber calls	Green calls
WALES	1952	1930	1331	68.94	26971	9400
Betsi Cadwaladr	380	373	266	71.31	6734	2548
Powys	60	60	43	71.67	1069	389
Hywel Dda	258	255	167	65.49	2997	1175
Abertawe Bro Morgannwg	399	392	270	68.88	4531	1412
Cwm Taf	178	177	126	71.19	2561	881
Aneurin Bevan	359	355	218	61.4	5013	1634
Cardiff & Vale	318	318	241	75.79	4066	1361

Ambulance services: mean response times (minutes and seconds)

Source: *Ibid*

Area	Sep '17	Oct '17	Nov '17	Dec '17	Jan '18	Feb '18
Betsi Cadwaladr	06:46	05:18	06:00	06:35	06:57	06:55
Powys	05:43	07:08	08:42	06:50	06:22	06:59
Hywel Dda	06:22	06:56	07:26	07:32	07:16	07:28
Abertawe Bro Morgannwg	04:51	05:43	06:27	06:40	06:43	06:26
Cwm Taf	05:52	05:56	05:52	07:00	06:36	06:22
Aneurin Bevan	05:23	05:36	06:18	07:05	06:06	07:07
Cardiff & Vale	04:52	04:56	05:47	05:37	05:51	06:16
WALES	**05:40**	**05:41**	**06:22**	**06:42**	**06:34**	**06:47**

The performance for Ambulance response is reported weekly and Powys has seen some mixed performance for red calls, which have been primarily attributable to geographical challenges. The previous table shows mean Powys response time by month and it can be seen Powys missed the 8 minute target for November but this did not adversely affect the National position.

The following outlines the joint working approach between PTHB and WAST to reduce demand and conveyance:

- Collaborative operational working with WAST, to support the clinically appropriate divert of patients to Powys MIU's, as opposed to transporting to DGH's;
- Contact made with PAVO to identify potential community transport options to relieve pressure on WAST/NEPT requests;
- Consideration given to additional support from Clinicians for WAST call-handling;
- District Nurse and Specialist Nurse Teams worked more closely with WAST to support the triage of patients and provide increased support at home to facilitate admission avoidance

The Winter impact:

PTHB plays a key role in supporting neighbouring Health Boards and English NHS Trusts to maintain timely flow through A&E departments and acute beds, in light that there is no DGH provision in Powys itself. During January

& post the Christmas period, the Community Directorate prioritised unscheduled care and patient flow.

Business Continuity Plans exist in all Community Hospitals and community services, and are reviewed in the Locality Management Team meetings regularly.
Over the seasonal period this included:

- Inpatient services
- Staffing availability across all departments
- All DN caseloads reviewed to ensure priority delivery initiated
- Therapist workloads evaluated and reassigned where possible
- Outpatient and theatre staffing and services
- Medicines Management
- Facilities - to include bedding, food supplies & cleaning capacity
- Estates - to include heating, fuel & power supplies
- Administration and support services, including Switchboard

Sit-reps were prepared by Heads of Service daily and submitted to the Business Managers to inform the daily situation call. This facilitated oversight of the pan-Powys position, to include demand and capacity, enabling targeted intervention and prioritisation of action.

Staff briefings were provided daily to ensure effective communication and awareness of the Powys status and the national position. Staffing levels across all essential services were monitored and maintained with additional deployment where necessary to address unplanned gaps.

During the snow episodes, the professionalism and dedication of staff, frequently working extended hours, some up to 24 hours was considerable. Staff travelled into work ahead of their planned shifts, anticipating the expected heavy snowfall, in order to be available for shifts the following day and nights. Temporary accommodation was sourced to ensure business continuity, including on-site within Hospitals but also negotiated rates within local B&B establishments. The accommodation provision plus the exceptional planning, long hours and commitment of staff resulted in there being no agency nurses being used for the February and March snow episodes in Brecon, Bronllys, Newtown or Llanidloes.

Transport for staff was offered by members of the public and other staff with 4x4 vehicles. Several ward staff were transported to and from sites in this way and the District Nursing teams were also assisted to remote areas.

The Hospital Emergency Control Centre was opened on 2 occasions during the winter to facilitate increased collaboration with partners and co-ordinate patient flow. This enabled:

- The activation of additional internal bed management calls.
- All managers reporting twice daily on respective sites and services.
- The Care Transfer Coordinators working more proactively and on site with neighbouring Health Boards and Trusts to expedite transfers, including non-Powys patients.
- Daily multidisciplinary review of all patients to expedite discharge.
- The extension of opening times in Ystradgynlais MIU with Radiology support.
- The opening of additional beds on most wards to increase capacity.
- The co-ordination of escalation calls to Social Services and Primary Care.
- Access to mental health capacity.
- Coordinated liaison with the Temporary Staffing Unit, enabling prioritisation of available staff.

The following table is an example of the impact of the MDT approach re:

- Admissions avoided to DGHs
- Facilitated discharges
- Transfers from DGH into Community Hospital beds.

ADMISSION AVOIDANCE, TRANSFERS FROM DGH & FACILITATED DISCHARGE			
TIME	LOCATION	DETAIL	No.Pts
WEDNESDAY 7 MARCH 2018			
10.01	Mid	Palliative care patient admitted to hospice instead of Community or DGH.	1
10.15	Mid	PURSH & DNs	1
11.4	North	1 patient transferred from SATH to Welshpool	1
12.45	Mid	Patient transferred from Ross on Wye to Glan Irfon to release bed.	1
12.45	Mid	Patient transferred from Leominster to Llandrindod to release bed	1
12.45	North	1 discharge from Mach with POC	1
12.45	North	2 discharges from Llanidloes	1
12.45	North	1 patient admitted to Llandidloes to avoid DGH admission	1
11.48	North	Admission to Llanidloes to avoid DGH admission	1
12.57	South	2 patients admitted to YCH to avoid DGH admission	2
12.57	South	1 patient discharged from YCH with POC to release bed	1
12.57	South	1 patient discharged to Nursing Home from YCH to release bed	1
12.57	South	2 patients discharged from YCH with reablement to release beds	2
17.25	North	1 patient assessed by Powys OT in Bronglais discharged	1
17.25	North	Patient assessed by Powys OT in Bronglais. Transferred to Newtown to release DGH bed.	1
17.25	North	Patient assessed by Powys OT in Bronglais. Transferred to Newtown to release DGH bed.	1
THURSDAY 8 MARCH 2018			
9.01	North	Patient assessed by Powys OT in Bronglais. Discharged with Reablement	1
09:01	North	Patient assessed by Powys OT in Bronglais. Transferred to Newtown to release DGH bed.	1
9.36	North	Patient assessed by Powys OT in Bronglais yesterday. Discharge today with reablement.	1
10.35	South	1 patient to return to Epynt from Nevill Hall	1
10.35	Mid	1 patient transfer from Llandrindod to Glan Irfon to release bed.	1
10.35	Mid	2 discharges today with 2 patients returning from Hereford	2
10.35	North	1 patient in Bronglais for discharge with reablement	1
		TOTAL	26

Specific additional actions were taken with English NHS Trust partners and WAST, to include: 5 bed calls per day maintained throughout December with WVT, Herefordshire CCG, 2gether NHS Trust, Herefordshire Social Care Services, NHS England, NHS Improvement, WMAST, Primecare OOH service and Taurus GP Collaborative, 2 x CTCs trained as 'trusted assessors' to support Social Services capacity issues and promote patient flow, Operational Flow workshops, facilitated by Herefordshire CCG, have been held by operational teams across PTHB and WVT in order to address

challenges with discharge pathways and promote more effective collaborative working, participation and engagement with NHS Improvement who are working collaboratively with the senior management team in SATH to improve patient flow.

- **Patient Experience:**

Reported Incidents

Ref	Date	Location	Incident
WEB34920	06/03/2018	Bronllys	Car Park not accessible. Snowy/icy pavements not cleared.
WEB34913	05/03/2018	Brecon	Flooding of Radiology * Department due to frozen pipes.

*Brecon x-ray was affected by flooding due to a ruptured heating coil that forms part of the air exchange system to the department. This resulted in disruption in service delivery due to water damage and subsequent risks to patients and staff.

A full Business Continuity Plan was put into action immediately, resulting in:

- Set up temporary USS room within X-Ray Department to maintain delivery of ultrasound service;
- Set up temporary X-Ray facilities in Cardiology consultation room;
- Effective communication with patients;
- Effective communication with GPs and DGHs;
- Collaborative working with Estates and Health & Safety within PTHB and external Contractors.

Remedial works initially estimated to take approximately 3 weeks (due to ordering of replacement components) were completed by Estates within 1 week and due to the remarkable teamwork the patient disruption was kept to an absolute minimum.

Reported Complaints

No concerns or complaints were received by PTHB relating to winter pressures, although there was awareness of the increased complaints to WAST and an offer of assistance from PTHB to support complaint coordination.

Welsh Government funding to support flow

In January 2018, Welsh Government allocated additional funding to support NHS Wales to deliver improved patient experience and meet unscheduled care targets. PTHB received £380,000 enabling a number of initiatives to be introduced. The below table summarises the projects which were approved and initiated:

Action	Outcome	Resource Required	Partners
1. Increased therapy input into Community Hospitals and DGH's	Intensive rehab to facilitate earlier and less dependent discharge	Therapist with Acute Experience based in Community Hospitals or within the DGH – to include 1 in each of: Llandrindod, Brecon, Bronllys, Welshpool, Newtown, Bronglais / Mach, Llanidloes, WVT , Morriston	DGHs
2. Adult Social Care (ASC) Additional Capacity	Reduced LoS in acute care Reduce DToCs Early repatriation	Social work capacity to undertake assessments on Powys Patients in WVT (including travel) Additional agency support to provide more Dom Care provision Agincare Brokerage agency support admin 10K	Powys County Council ASC
3. Increased short term urgent domiciliary care	Reduced LoS in acute /community hospital care Reduce DToCs Early repatriation 'Home First'	Increased short term urgent domiciliary care services in people's own homes 24 hours a day, seven days a week by securing additional capacity within existing PURSH / Red Cross provision	Third Sector
4. Transforming flow	Diagnosing and transforming the system issues re flow across Health & ASC	Procuring independent Lean intervention	Independent Contractor

Action	Outcome	Resource Required	Partners
5. Health and Care Flow Hub	Track patients centrally co-ordinate discharges from the Health Boards across NHS Wales together with the two main provider trusts on the border with England	Short term consultancy resource Short term admin support to set up and establish Health & Care Flow Hub	Independent Contractor Powys County Council ASC

The following provides an overview of the impact of therapists as part of **action 1** above.

Occupational Therapist and Physiotherapists working with Plas Cae Crwn Residential Home, Newtown to review and assess residents who are frequent fallers. Interventions have started and reviews will take place looking at the outcome measures.

Current falls: Location of falls: Mainly in bedrooms and overnight	
December 2017	20 falls documented
January 2018	12 falls documented
February 2018	10 falls documented

Locums working in the community have supported rehabilitation for patients to remain in their own home preventing further decline in patient's condition.

Substantive staff have worked more closely with the Virtual Ward and have utilised the Powys Urgent Response Service at Home (PURSH).

The use of Occupational Therapy and Physiotherapy locums in Newtown, Welshpool and Glan Irfon has:

- Enabled the teams to be more responsive to referrals in the community. The majority of new referrals have been seen within 1/52.
- Enabled the teams to be more responsive to referrals for rehab assessments and interventions on the wards.
- Enabled the teams to support discharge with timely follow ups post discharge.
- Enabled Reablement referrals to be responded to faster or within recommended time frames and allowed prompt reablement assessment to be completed.
- Enabled cover for unplanned gaps enabling continuity of service provision for patients.

- The locum support enabled OT presence in Glan Irfon Monday to Friday. This supported a daily handover of information and discussions regarding referrals and current service user plans.

Occupational Therapists and Physiotherapists have been piloting weekend working in Newtown and Welshpool Hospital, starting on Saturday 10 March 2018.

To date, having the extra therapy provision available over the weekend has:

- Enabled initial assessment to be completed in a timely manner
- Enabled discussion with Occupational Therapist regarding discharge and support at home, enabling plans to be put in place sooner.
- Enabled the therapy staff to continue rehab over the weekend to improve endurance with mobility.
- Enabled the therapy staff to complete reablement referral earlier which allowed it to be processed and screened sooner in preparation for discharge
- Enabled the patients to be mobilised to the day room 7 days a week e.g. for lunch and to watch the rugby, enhancing social interaction.

Additionally,

- The in-reaching Occupational Therapist into Hereford Hospital has supported patients being discharged on the right pathway and reducing their length of stay in hospital. This role supports the District General Hospital with local knowledge of the community and patient and improves communication with the care transfer co-ordinator.
- Increase capacity within the services has enabled the Occupational Therapy and Physiotherapy teams to attend and respond to Virtual Ward requests. Attendance by a registered member of staff has strengthened the role and expectations of each service.

In terms of **action 4 and 5** - a joint Health & Care Coordination Hub was established. The purpose of the Health & Care Co-ordination Hub is to facilitate the overall coordination of patient flow for Powys residents, working in partnership with Social Services and the Third Sector to improve admission, discharge, inter-hospital transfers and case management. Previously the coordination of patient flow was managed in two localities. In situations of high escalation and unscheduled care pressures, a centralised approach is activated, as per the Powys response action cards.

Through a centralised approach in high escalation, it was recognised that having a daily visual log of available beds within the County and demand

internally and externally there was more effective management and prioritisation of patient flow, taking account of national pressures and the escalation levels for English partners (ie SATH & WVT).

The idea of a permanent joint Health & Care Hub was crystallised and the additional funding available from Welsh Government to support patient flow was utilised to set up a joint hub, in a three month timescale.

A Clinical Lead was identified, with project management support. A physical space for the hub was sourced, kit ordered and the recruitment process activated to appoint a Hub Coordinator. In tandem, a tendering exercise was completed to secure support for the improvement in patient flow, embracing Lean methodology. The project has two distinct phases:

- Improve Hospital Flow & inter-hospital transfers; and
- Improve Care Coordination and community care.

The specific benefits for phase 1:

- An effective visual hospital approach to proactively manage patient flow, demand and capacity based on risk and clinical prioritisation.
- Improved repatriation time for Powys residents 'stranded' in SATH & WVT & prioritised inter-hospital transfers from Welsh providers.
- Maintenance of low levels of unscheduled care pressures and escalation levels.

Phase 2 will involve multi-agency care coordination, working jointly with Adult Social Care and the Third Sector to promote safe admission avoidance with a home first ethos, together with Virtual Wards & identification of community capacity. The Health and Care Coordination Hub commenced on 12th March 2018. It is too early to provide validated data but improvements have been noted to include:

- Early indication show an increase in discharges and admissions for April 2018 both higher than any month in financial year 2017/18.

Month	Discharges	admissions
Nov 17	94	115
Dec 17	82	110
Jan 18	126	138
Feb 18	87	102
March 18	110	141
April 18	130	149

- Improved communication and working relationships with neighbouring DGH'S.

- The length of delay for DToC has reduced and numbers of DToC has reduced in April & May.
- Repatriation time is currently being analysed but the number of 'stranded' Powys residents in WVT & SATH have reduced.
- Powys remained at low escalation levels, mostly Level 2-3, during the significant national pressures.

- **Cancellation of Services**

It was necessary to cancel a number of clinics through the winter pressures across Powys Teaching Health Board due to other HBs and NHSTs managing their own internal pressures, plus the adverse weather conditions, resulting in patients, consultants and other clinicians being unable to travel. Over the 4 days of snow in Feb/Mar, 60 theatre and outpatient sessions were cancelled, affecting 544 patients.

In addition, 1 x scheduled Oral Surgery theatre session was prevented from going ahead due to a recurrence of the heating and air exchange system malfunctioning in low temperatures, affecting 4 patients who were provided with alternative appointment dates prior to their departure on the day. All subsequent sessions were cancelled as a short-term solution was not possible. As the second episode of snow in March occurred over the weekend, there was minimal impact upon Outpatient and Theatre services. It should be noted due to the constant re-planning of sessions and allocation of room space, plus the negotiation with other HB colleagues for replacement sessions, only 2 patients breached in Urology as the Consultant was unable to travel from Herefordshire due to adverse road conditions on 26th March. The table below illustrates the number of clinics cancelled.

Day	Site	Patients	Clinic	No.Session	Sess total	Pts Total
TUES 27/02	BWM	4	Theatre	1		
	BWM	7	Endoscopy	2		
	LWM	8	OPC	1		
	BWM	34	OPC	3		
	YCH	55	OPC	4	**11**	**108**
WED 28/02	BWM	4	Theatre	1		
	LWM	3	Theatre	1		
	LWM	45	OPC	4		
	BWM	55	OPC	6		
	YCH	23	OPC	4		
	Welshpool	6	OPC	1	**17**	**136**
THURS 01/03	LWM	6	Theatre	1		
	LWM	58	OPC	4		
	BWM	81	OPC	7		
	LWM	2	Theatre	1		

	YCH	28	OPC	3	**16**	**175**
FRI	BWM	6	Theatre	1		
02/03	BWM	9	Endoscopy	2		
	LWM	33	OPC	3		
	BWM	40	OPC	4		
	YCH	12	OPC	2		
	Mach	8	OPC	1		
	Mach	8	OPC	1		
	Newtown	9	OPC	1	**15**	**125**
				TOTALS	**59**	**544**

- **Summary:**

Demand increased across the care system and the NHS has responded to this through a planned approach and by working in partnership with key stakeholders. Lessons from this past winter are being considered to inform planning for future winters, improve patient care and experience, reduce the pressure on staff, and deliver improved and sustainable levels of performance.

The Powys reflection is that a positive contribution was made locally and nationally in NHS Wales & NHS England, as hopefully illustrated by some of the data and operational narrative. With no acute provision/DGH in Powys our role is seen more as a supportive partner, but ensuring a full and proactive contribution for the benefit of the Powys population and performance across NHS Wales.

- **Reflections:**

- Earlier planning with partners, specifically Adult Social Care & Third Sector.
- Focused work with WAST to manage conveyance rates to DGH's.
- More focus on support for GP's to manage increased demand.
- Investment/redeployment during the winter in terms of the MDT.
- Proactive staff profiling to gear up the Temporary Staffing Unit.

Work is on-going to finalise the PTHB Unscheduled Care Plan and commence winter preparedness in July for 2018/'19. This will include Discharge to Assess models and a Lean approach to patient Flow. Additionally, the Health Board is exploring the further evolution of cluster-based modelling of services and structural alignment as a real possibility to moderate rising demand for hospital care, providing care in communities locally and safely.

**ABMU Health Board Written Submission:
Health, Social Care & Sport Committee Inquiry into Winter Preparedness
Thursday 19th July 2018**

ABMU Summary

Despite a comprehensive winter planning process which included partner organisations in WAST, our three Local Authorities and the third sector, the winter period of 2017/18 was particularly challenging, with some services seeing exceptional levels of demand and reported increases in patient acuity.

There were a number of factors which represented a change in the demand experienced in the winter of 2018/19.

Although the overall number of attendances to our Accident & Emergency departments and minor injuries units was largely consistent with the demand presenting the previous winter, variation in daily demand was a challenge at times in terms of our ability to respond within the staffing resource and capacity available.

The prolonged winter was a key factor, which continued well into April, and which tested the resilience of services and staff across the system.

Flu prevalence was significantly higher than in previous years and had a significant impact on patient flow and capacity from January onwards. At the same time we had our highest recorded ambulance red conveyance demand - a 24% increase in red conveyances to our hospitals through the winter. We also saw during times of exceptional system pressure, an increase in the number of patients who self-presented at our emergency departments.

In spite of these challenges, our staff worked extremely hard over the prolonged winter period to maintain services across the whole of the unscheduled system, and the flexible use of surge bed capacity supported flow across all acute sites. We maintained our ability to perform elective operations for the vast majority of patients, reducing cancellations for bed capacity reasons by 19% on the previous year.

The Health Board used the winter period to test new pathways and models of care to improve patient flow and patient outcomes. For example, pilots in Singleton and Princess of Wales Hospitals avoided hospital admissions and delivered reductions in lengths of stay; and the joint working between our Acute Clinical Response Team and WAST enabled patients to be treated at home, avoiding unnecessary hospital admissions.

The Health Board has started to plan for the next winter period using a multi agency approach. This includes learning lessons from 2017/18, as well as the development of more sustainable models of care and capacity to respond to the changing demands on the wider unscheduled care system all year round. We will focus on maintaining patient safety and patient flow using the SAFER bundle approach and will continue to develop our frailty services with therapy and reablement resources to support admission avoidance and more timely discharge. We will continue to prioritise early intervention by developing models that deliver care closer to home by an appropriate care professional at the time it is needed.

A more detailed report evaluating winter 2017/18 and describing how we intend to develop our 2018/19 plans has also been provided.

ABMU Health Board Written Submission:
Health, Social Care & Sport Committee Inquiry into Winter Preparedness
Thursday 19th July 2018

Winter 2017/18 Evaluation / Winter 2018/19 Planning

Introduction

1. The Welsh NHS confederation has prepared a paper on the key issues and challenges faced by NHS Wales over the winter of 2017/18, as part of the evidence gathering process to feed into the Health and Social Care and Sport Committee inquiry into winter preparedness on 19th July 2018. As part of the development of this paper by the NHS confederation, the Health Board submitted examples of the positive impact of its approaches implemented over winter 2017/18, some of which are included in the paper.

2. The Chief Operating Officers for ABMU University Health Board and Cardiff and Vale University Health Board will be representing their respective Health Boards at the inquiry on 19th July 2018, and have a shared time slot for this purpose. This paper forms the ABM University Health Board's written submission to the inquiry, presenting key messages and learning from the evaluation of the winter of 2017/18, together with outline plans to enhance system resilience within ABMU Health Board for the forthcoming winter.

Background

3. Despite a comprehensive winter planning process which included partner organisations in WAST, our three Local Authorities and the third sector, the winter period of 2017/18 was particularly challenging and prolonged. The Health Board experienced significant patient flow pressures, significant variation in demand, high flu prevalence, and the adverse weather conditions experienced at the end of February and into early March, presented further challenges to the unscheduled care system which was already under considerable pressure.

4. The Health Board allocated £1.2million to support the winter pressures experienced in 2017/18. The Health Board also received confirmation in January 2018of £1.7million additional Welsh Government non-recurrent funding, to support the management of winter pressures.

Demand

5. The Health Board experienced a challenging winter with some services seeing exceptional levels of demand and increase in patient acuity. For example:
   - The GP out of hours/ 111 service across ABMU Health Board saw an 8.5% increase, equating to 4,585 patients, during November 2017 – March 2018 when compared to the same period the previous year.
   - Although the overall number of attendances to our Accident & Emergency departments and minor injuries units was consistent with the demand presenting the previous winter, there were a number of factors which represented a change in the demand we saw last winter and impacted upon our performance.

- Attendances at our two major emergency departments between November 2017 and March 2018 increased by 2.2% compared with the previous year, whilst attendances at our minor injuries units reduced by 7.7%.
- Daily variation and unpredictable peaks in demand were difficult to respond to within the physical environmental and staffing capacity available in our emergency departments.
- The number of patients who were conveyed by ambulance in the red or life threatening category between November 2017 and March 2018 increased by 24% when compared with the previous year, whilst our amber and green categories conveyance reduced by 10% and 15% respectively. March 2018 saw the highest recorded red conveyance demand for ABMU Health Board.
- Emergency medical admissions in the >80 age group increased by 10.8% in February 2018 and by 8.6% in March 2018 when compared with the same months in 2017.
- The bed days lost associated with delayed transfers of care in non-mental health services increased by 3% between November 2017 and March 2018 when compared with the same period in the previous year.
- Flu prevalence was significantly higher during the winter of 2017/18, which has a significant impact on patient flow and capacity.
- High demand and ongoing growth for cardiology and stroke services was experienced across the Health Board.

6. Despite the significant pressures on the system:
   - Cancellation of patient operations for bed reasons reduced by 19% between October and March compared to the same period in 2016/17.
   - There was a reduction of 9.5% in the number of medical outliers in 2017/18 compared to 2016/17.
   - Our staff vaccination rates were the highest achieved with over 9500 (58.5%) of our staff vaccinated across the Health Board, making this our most successful campaign to date.
   - Our increased focus on delivering higher levels of activity through ambulatory and day of surgery models of care contributed to reduced lengths of stay.
   - A surgical assessment area trialled in Princess of Wales Hospital's Emergency Department demonstrated performance gains (5% against 4hrs) and also reduced emergency surgical admissions.
   - In Singleton Hospital an acute frailty model was piloted which resulted in 38% of patients being discharged directly from the assessment unit, and a 9.55 day reduction in average length of stay for patients.
   - Neath Port Talbot Hospital (NPTH) implemented a range of measures which enabled increased patient flow from acute sites by 20%.
   - The Gold Command arrangements implemented in response to the adverse weather conditions at the end of February and early March demonstrated strong multi-agency working and a positive whole system responses at times of exceptional pressures.
   - The implementation of good infection control measures and practice contained the spread of infection for patients attending our hospitals with suspected and confirmed flu.

Performance

7. Following improved 4 and 12 hour performance in the summer of 2017, the 4 and 12 hour A&E performance for the Health Board deteriorated during the winter period. There was a particular increase in the additional time patients spent in our Emergency Departments resulting in an increase in the number of patients who were treated and also discharged from the Emergency department due to unavailability of beds within our hospitals.

8. Our ambulance handover times also deteriorated over the winter months and contributed to increased ambulance lost hours. At times of exceptional system pressures it was also noted that there was an increase in the number of patients who self-presented at our emergency departments, as a result of prolonged ambulance response times.

Acuity of patients

9. Whilst the overall number of emergency medical admissions in the >80 age group was comparable with the previous winter, the number increased by 10.8% in February 2018 and by 8.6% in March 2018 when compared with the same months in 2017.

10. The number of patients who were conveyed by ambulance in the red or life threatening category between November 2017 and March 2018 increased by 24% when compared with the previous year, whilst amber and green categories conveyance within ABMU Heath Board reduced by 10% and 15% respectively. In relation to the amber conveyances however, data suggests that amber 1 conveyances are seeing an increasing trend whilst amber 2 conveyances are reducing.

11. Our critical care units in Morriston and Princess of Wales Hospitals treated 6.5% more patients in the period between November 2017 – January 2018 than they did in the same months during 2016/17.

12. The number of stroke admissions presenting at our major hospital sites increased by 9% between November 2017 and March 2018, when compared with the same period in the previous year.

13. High demand and ongoing growth for cardiology services was experienced at Morriston hospital in particular.

Ambulance Service within ABMU Health Board.

14. There has been a changing dynamic in relation to the prioritisation of patients conveyed. The number of patients who were conveyed by ambulance in the red or life threatening category between November and March 2018 increased by 24% when compared with the previous year, whilst our amber and green categories conveyance reduced by 10% and 15% respectively. In relation to the amber conveyances data suggest that amber 1 conveyances are seeing an increasing trend whilst amber 2 conveyances are reducing.
15. A joint programme of work implemented with WAST during 2017/18 resulted in a reduction in lower acuity conveyances. This programme of work involved:

- NPT and Swansea Acute Clinical Teams based in the community responding to appropriate patients who entered the 999 system. This project resulted in most of the patients who were seen by the ACT avoiding admission to hospital unnecessarily through timely access to the provision of the appropriate support in the community, as well as releasing ambulance personnel/capacity. 92% of patients treated remained at home (average age 81 years).
- The i-stumble training programme being delivered to care homes in the three localities to avoid and reduce the number of falls conveyances to hospital.
- Frequent attender work has continued and continually reduces the unnecessary impact on both WAST and ABMU Health Board Emergency Departments. Within ABMU Health Board, the percentage of frequent attenders reduced from 11.1% in January 2018 to 7.1% in March 2018.
- The compliment of Advanced Paramedic Practitioner (APP) within the Health Board increased to 3 at the early part of 2018, resulting in an increase in the number of patients who were not conveyed to hospital following the assessment and intervention of these health care professionals. By April 2018 71.32% of patients were not conveyed to hospital following an assessment by APPs.
- WAST worked closely with GPOoH/111 service whereby paramedics attended to patients on behalf of the GP. As a result of the positive impact of this model, the Health Board has now funded 3 posts to support the recruitment / provision of paramedics in the OOH service 7 nights a week.

Influenza & Infection Control

16. The 2017/18 winter period saw higher rates of influenza activity compared with previous influenza seasons. The number of cases identified within the Health Board during January 2018 was four times higher than the previous year. This significant level of influenza activity had a direct impact on daily operational service delivery across all of the acute hospital sites.

17. A structured debrief on the influenza season was undertaken in April 2018. This debrief looked at the challenges experienced over the winter in detail, it considered how we responded and the impact of the season on our services. The debrief enabled us to capture the learning from the full influenza season which has informed the development of a plan in preparation for the next flu season.

18. Appendix 2 provides graphical information to demonstrate the operational impact of flu over the last winter.

Primary Care

19. The GP out of hours/ 111 service across ABMU Health Board saw an 8.5% increase, equating to 4,585 patients, during November 2017 – March 2018 when compared to the same period the previous year.

20. The GP OOH workforce was more fragile than in previous years. However the service worked increasingly closely with the 111 service to jointly manage service / sustainability challenges through further workforce redesign and increased use of other health care professionals to support and manage appropriate calls, such as paramedic and pharmacist roles.

21. Working with voluntary organisations, Primary Care services in ABMU were able to commission Community Companion schemes, Red Cross initiatives to support discharge of patients and to provide supportive equipment in frail older peoples' homes.

22. Around 2500 "My Winter Health" packs were issued to citizens/patients within the Health Board.

23. Close working between acute and community staff at every level resulted in increased patient throughput at our 2 community hospitals compared with the previous winter.

24. Increased community pharmacy capacity was implemented to improve access to advice and treatment for patients with minor illnesses and ailments.

Workforce

25. Workforce was a risk identified within our winter plans and capacity has been a key constraint and challenge in key areas - across medical, nursing and therapies, primary and hospital services and in domiciliary care as a result of recruitment and also retention issues .

26. Whilst the Health Board continues to develop different approaches and new workforce models to mitigate some of these challenges, some of our services remained fragile over the winter period as a result of workforce capacity issues.

27. In spite of these challenges our staff worked extremely hard over the prolonged winter period to maintain services across the whole of the unscheduled system.

Social care provision

28. Domiciliary care provision within parts of the Health Board continues to be fragile, and was identified as a risk in our winter plans. As an example of this one of the care providers in the Health Board area handed back their contract to the Local Authority prior to Christmas, which impacted on overall capacity.

29. The Breaking the Cycle (BTC) period involved our local authority partners who fed back significant improvements in communications and the value of senior social services managers to be on site forging closer links and support to manage pressures across the whole system of health and social care, including flexing capacity to respond to increased demands where possible.

30. Local Authorities received separate WG non recurrent investment to support the winter pressures in early 2018, which was targeted at supporting additional packages of care where possible and also in providing equipment to support hospital discharge and to prevent hospital admission.

Winter planning 2017/18

31. The winter plan for 2017/18 is attached in Appendix 1.

32. The plan was developed on the basis of the emerging themes from the National evaluation of the winter in 2016/17, our own learning within ABMU Health Board from previous winters, from shared learning from other Health Boards within Wales, and on the principles agreed by the Executive team to focus on targeting frailty services, enhancing ambulatory care services, strengthening pre-hospital pathways and services, and implementing the Breaking the cycle approach in early January, as previous experience and data suggested that this was one of the most challenging periods across the unscheduled care system.

33. Our plan built upon the changes implemented earlier in the financial year in relation to the development of frailty and ambulatory care models and improvements in pre –hospital pathways, and pathways to improve patient flow across the unscheduled care system. The plan also recognised the need to allocate additional resource to enable temporary increases in bed capacity to be implemented over the winter months, in recognition of expected changes in our demand profile.

34. A number of actions were implemented to reduce the demands on our acute services over the winter months. These included:

- Development of a comprehensive flu plan which further engaged primary care and local authorities in promotion of uptake of the flu vaccine. 58.5% of our front line staff received the vaccination.
- Targeted use of additional Intermediate Care Funding to increase support and capacity for our frailty services through the development of the acute clinical response teams and the development of the frail older persons pathway in Neath Port Talbot.
- Continuing to maximise the benefit of the urgent Primary care service (111/ out of hours) within ABMU. As described above, the winter period saw much higher patient numbers being seen by the OOH service and greater support from the 111 service.
- Various additional measures were planned and implemented in primary care – including the roll out of the telephone first model to practices, implementation of the directed enhanced service for Care Homes, implementation of a new community based IV pathway in community hospitals, and increased community pharmacy capacity.
- Various joint initiatives with WAST as outlined earlier.

35. The following measures were implemented and specifically targeted at the “Big 5” demand areas:

<u>Health Care Professional (HCP) referrals to hospital</u>

- TOCALs team from NPT discharged an increased number of frail older people from the ED at Morriston – including non-injury falls patients.
- Strengthened frailty models at the front doors of Princess of Wales and Singleton Hospitals.
- Acute Care Teams supported admission avoidance – see joint working with WAST below.
- Green HCP call conveyances within ABMU reduced compared with the same period in 2016/17, indicating the alternative pathways developed to respond to minor calls were implemented and successfully avoided hospital attendances.

People who have fallen

- Winter plan – additional monies plan led to RN and OT support within the community team in the management of non-injury falls patients.

People who are experiencing chest pain

- There was a planned change to the duties of cardiology nurse practitioners at the Princess of Wales Hospital to reduce the amount of co-ordination of ward flow activity. Redirecting these staff to the front door for early assessment of patients/triage of patients needing to be seen by a cardiologist and those who need to be seen in emergency access cardiology clinic. This was to enable quicker discharge of patients earlier in the day.

Respiratory complaints

- At the Princess of Wales Hospital changes took place to secure additional equipment and staffing to ensure specialist expertise was available for patients with respiratory conditions who were previously receiving non-invasive ventilation.
- Additional "hot clinics" were implemented to improve access to specialist advice and input.
- GP practices and community pharmacies prioritised all at risk groups to target vaccination.

Mental Health

- A mental health pathway with WAST is in place, enabling direct conveyance to mental health units.
- Health Care Support Workers were provided by Mental Health services to support patients with dementia on acute hospital sites – for example where additional 1:1 nursing support was required.
- Extended hours of psychiatric liaison support were provided within the two major acute sites.

36. The initial winter plans identified potential additional bed capacity of 66 beds (+14 at weekends) across all sites. Based on the pressures experienced during November and December 2017, it was necessary to bring forward the additional capacity plan and implement the extra capacity earlier than planned on all sites.

37. Additional bed capacity plan was reviewed again in mid-December 2017 and further adjustments were subsequently implemented to respond to the pressures at the time. This resulted in changes being made to the Singleton hospital capacity plan and also access to 10 additional beds in Tonna hospital above our planned winter capacity to support the interim placement of patients pending discharge. A ward at Singelton Hospital was re-designated a swing ward which helped to better manage/balance elective and emergency pressures, and a Theatre admission unit was created at this hospital to increase day of surgery admissions, and to support elective activity.

38. As part of the learning taken from the national evaluation of the winter plan for 2016/17, the Health Board adopted the Executive led 'breaking the cycle' approach between 8th -22nd January 2018. A full evaluation of the impact of this was undertaken and the benefits included:

- Engaging and enlisting support from staff who would otherwise not be involved in patient flow;

- Releasing staff time through cancelling non-urgent meetings, to provide increased leadership and support to staff at ward and departmental level;
- Improved communication and greater understanding of roles, services and processes across the system.
- Reduced levels of escalation across the unscheduled care system and improved recovery times following periods of high demand.

39. Other key actions taken by the Health Board, and by Local Authority partners to improve resilience and flow included:
    - Increased non-emergency patient transport capacity.
    - Increased access to the community equipment store.
    - Communications with carers association and 3rd sector to support winter plans.
    - Ongoing and rapid reviews of packages of care.
    - Introduction of new flexible resource service in mental health services to support patients with mental health issues on acute hospital wards in Swansea.
    - Increased hours of the acute psychiatric liaison teams in our emergency departments.
    - Targeted increased support from therapies to support the front door.
    - Additional CEPOD capacity being implemented in Morriston and Princess of Wales hospitals to support emergency flow in surgical specialities.
    - Strengthened weekend pharmacy cover at Morriston and Princess of Wales hospitals.
    - Review of consultant job plans to enhance consultant presence on ward rounds and to support the front doors of our hospitals.
    - Improved escalation and management on call arrangements and capacity.

40. The winter period also demonstrated joint working with other Health Boards – for example, through the Critical Care Network during periods of pressure in units along the M4 corridor, during times of high pressure there was regular communication around management of ambulance flow across health board boundaries, and regular communication to support the timely repatriation of patients between Health Boards. However capacity challenges experienced across all Health Boards in Wales hampered the opportunities for mutual support at times.

41. The Health Board's 2017/18 winter plan identified key risks as workforce and system capacity, and the impact of infection on capacity and patient flow. These were risks which all materialised over the course of the winter period with varying degrees of impact on patient flow. Further consideration around reducing the impact of these risks is included within the 2018/19 winter planning section later in this document.

Unscheduled care - Planning for Next Winter

42. An evaluation of the winter plan for 2017/18 has been undertaken on a lessons learnt basis, and this information was shared with WG colleagues in February and April 2018. Additionally, separate feedback was also provided to Welsh Government colleagues on the impact of the Breaking the Cycle approach that was implemented across the Health Board in early January 2018, as this was an approach that was promoted and encouraged by WG as part of the learning from the winter of 2016/17.

43. ABMU Health Board was well represented at the National Winter planning event arranged by Welsh Government on 1st May 2018, and the ABMU team also included representatives from WAST and the three local authorities. This event was positively received in that it:

- provided opportunities to share learning from organisations across Wales,
- provided time for the ABMU HB team to discuss and reflect upon the learning from our winter plans, to inform the development of plans for 18/19,
- reinforced the need for a system wide approach to managing the additional seasonal pressures which the winter months bring,
- reinforced the need to move away from pilots and to focus on a smaller number of priorities that increase resilience across the system all year round, and not only for the winter months.

44. As a result of the learning from 2017/18, the Health Board has supported the development of front-door frailty models that were introduced at Singleton and Princess of Wales Hospitals during the last winter period. These models are now being implemented on a sustainable basis. Further service change projects being progressed ahead of the next winter period include:

- A COPD early discharge scheme which will support the discharge of respiratory patients from Morriston and Singleton Hospitals into the community.
- Further implementation of SAFER flow bundles.
- Remodelling and enhancing the frailty service at Singleton and Gorseinon hospitals.
- Roll out of Transfer of Care and Liaison Service at Neath (TOCALS) to Singleton Hospital.

45. The increased prevalence of influenza in our communities in the 2017/18 winter, and the snow/ adverse weather experienced at the beginning of March, both had a significant impact on the resilience of our unscheduled care system. Consequently separate de-briefing sessions have taken place on the Health Board's flu plan and the adverse weather plan. Lessons learnt from both sessions are being fed into the development of our winter plans for 2018/19.

46. An ABMU multi agency winter planning group, chaired by the Chief Operating Officer, has already met to start the development of the winter planning response for 2018/19, recognising that winter planning is one part of the development of all year-round sustainable and integrated care models to improve patient flow across the unscheduled care system.

47. The following areas have already been highlighted as having the potential to increase system wide resilience and will developed as part of our planning:

- The ongoing implementation and development of models of care in our frailty services together with increased capacity to support more timely patient discharge for the frail older person. Learning from within our own Health Board and from other organisations, has demonstrated that these models have resulted in improved patient flow, patient access and patient outcomes. This includes reviewing our therapy and reablement resources to support admission avoidance and more timely discharge.

- The Bevan exemplar pilot implemented between WAST and our acute clinical response teams in the winter months, evidenced a reduction in the conveyance of frail older people to hospital. The pilot demonstrated the potential to make a significant impact on reducing demands on our hospital system through earlier intervention, and by supporting this group of people at home, with the right care, at the right time by an appropriate care professional. Constraints on the capacity within the Acute clinical response team affected their ability to support additional numbers of patients during the pilot, and will be considered by the Primary and Community services delivery unit as part of the wider service redesign proposals.
- The learning from the Breaking the Cycle approach will also be incorporated into our winter plans for 2018/19, with a key focus on maintaining patient safety and patient flow using the SAFER bundle approach. The Health Board is also currently working with the Delivery Unit on the implementation of the Safety Huddle approach over the summer months which will compliment and enhance the SAFER bundle model of care.
- It is intended to repeat the Breaking the Cycle approach in the early part of January 2019.
- To reduce the risks associated with domiciliary care providers over the winter period, our plan for 2018/19 and beyond, includes exploring the development of different models of care to provide more resilience with this sector, and will also include opportunities to increase the support of the Third sector, particularly during the Christmas and New Year period when domiciliary care capacity is at a premium.
- Our plans for 2018/19 will reflect the benefits associated with implementing Gold Command and the multi-agency response implemented at times to deal with exceptional pressures in the winter of 2017/18, alongside a review our escalation processes across primary and community and local authority services to provide earlier warnings and responses to changes in demand.
- ICNet enabled earlier access to flu test results which informed quicker actions to be taken, and aided patient flow.
- Greater involvement of Public Health colleagues in anticipating changes in demand.
- A wider communications strategy for the public on the unscheduled care system and managing patient expectations.
- Improved operational processes particularly where patients are transferred between statutory organisations to reduce patient transfer times.
- Continued development of pathways and services that improve the management of patients in the 'Big 5' category.
- Joint work between ABMU and Hywel Dda Health Boards has commenced to review capacity, demand and solutions to manage the ongoing growth for cardiology services within Morriston Hospital.
- Planning for the provision of additional short term bed capacity above our baseline bed compliment to manage the predicted change in the demand for inpatient services over the winter months.

48. The Health Board's RTT delivery plans factor in the need to maximise efficiency from our core capacity, and also recognise the potential impact of winter pressures on elective activity. Our previous winter plans have included plans to mitigate the impact of winter pressures on elective activity, and as a result the Health Board has been able to evidence a year on year reduction in elective cancellations as a result of bed pressures over the winter months. However, our RTT delivery plans

for 2018/19 also include bringing forward elective activity where possible into the first 9 months of this financial year.

49. Clinical and managerial colleagues from the Health Board, Local Authorities and WAST will also be meeting with WG colleagues in two winter resilience summits – one in August and one in November. The aim of these summits is to review lessons learnt, to discuss the development of our plans for 18/19, and to identify any support required from national organisations to assist in the preparation of our winter plan.

50. One of the key learning points however was that whilst the additional non recurrent winter pressures funding received in January 2018 was welcomed, the confirmation of this funding late in the financial year did not enable Health Board to realise the full potential of this resource before the end of March 2018, due to lead in times to implementation and workforce capacity and constraints. Should this central funding be available in 2018/19, the earlier notification and allocation of funding would be particularly helpful in planning and shaping our arrangements for 18/19.

Appendix 1 – ABMU Winter Plan September 2017

Winter Plan
September update 2

Appendix 2 – Operational Impact of Influenza

Operational Impact
of Influenza in ABM

Cardiff & Vale University Health Board Submission to the Health, Social Care and Sport Committee Inquiry into Winter Preparedness

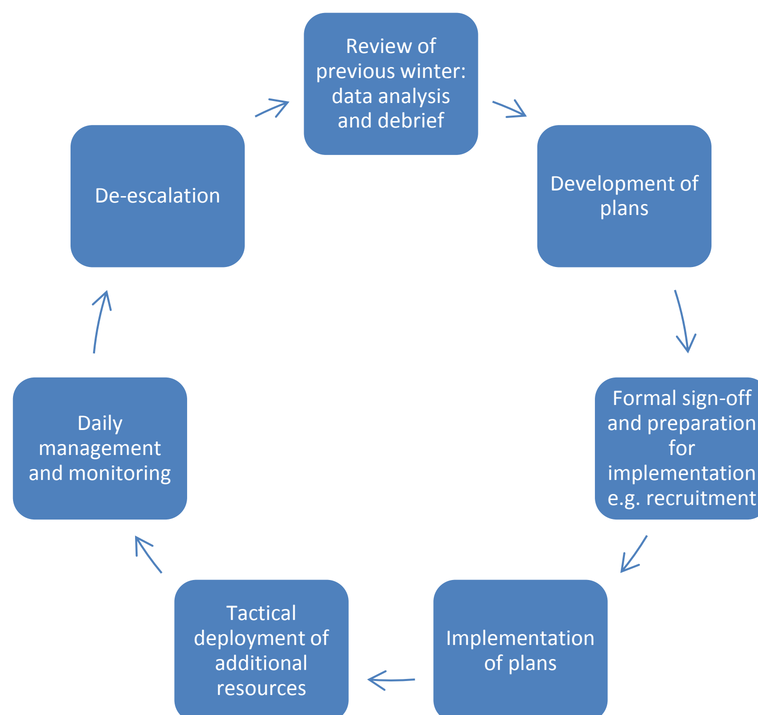
1. Introduction

1.1. The Chief Operating Officers for ABMU University Health Board and Cardiff and Vale University Health Board will be representing their respective Health Boards at the inquiry on 19th July 2018, and have a shared time slot for this purpose. This paper forms the Cardiff and University Health Board's written submission to the inquiry, presenting key messages and learning from the evaluation of the winter of 2017/18, together with outline plans to enhance system resilience within the Health Board for the forthcoming winter.

1.2. The UHB has contributed to and received the NHS Confederation response to the committee. This submission therefore supplements that response with a local perspective and has avoided repeating observations where possible.

2. Background

2.1. Three years ago the UHB introduced a planning cycle for winter preparedness designed to bring forward the design and implementation of winter plans, enhance governance, maximise opportunities for integrated working with partner organisations, and promote learning. A high-level diagram of this planning cycle is shown below:



2.2. This continues to be the approach taken by the UHB with refinements and improvements made each year. This methodology has supported an overall improvement in both unscheduled care performance and specifically winter resilience up to winter 2017/18.

2.3. Our experience of planning for winter is that there are a number of essential components, all of which are connected by the common theme of the UHB's design principle 'home first':
- GP out of hours (OOH) resilience particularly over the Christmas and New Year period
- Promotion of flu vaccination
- Additional senior decision-makers at the 'front door' (the Emergency Unit and Assessment units, both adults and paediatrics), to promote early assessment and treatment to minimise the need for admission
- Enhanced support for patient flow management and discharge
- Resilient domiciliary care services
- Plans developed in partnership working with WAST, the local authorities and the third sector
- Increased medical bed capacity, particularly on the acute sites, and equivalent bed capacity in the community (e.g. CRT capacity, discharge to assess units etc.)
- Effective internal and public communication strategies

3. Unscheduled Care Performance ahead of winter

3.1. Winter preparedness is of course not an isolated task, it forms part of a wider programme of improvement for the unscheduled care system. The UHB and partners introduced a wide range of service initiatives over the past 12 months to support resilience and efficiency in the unscheduled care system, which contributed to the region's preparedness for winter. These included:
- Remodelling of the Emergency General Surgery
- Investment in and redesign of the GPOOH service
- Establishment of a Community Assessment Unit (residential discharge-to-assess unit)
- Establishment of an ambulatory emergency care unit
- Development of pathways with WAST
- Work with care homes to reduce unplanned hospital admissions
- Focused piece of work on reducing medical length of stay at UHL

3.2. These improvements were reflected in the UHB's activity and performance statistics up to the end of November 2018, demonstrating that despite sustained growth in demand performance had improved against all the key metrics:

Pre-Winter activity and performance *(April-November)*	**2016-17**	**2017-18**	**Year on year change**
EU attendances (total)	93548	97207	3.9%

EU attendances (majors)	44677	48008	7.5%
4-hour performance	84%	86%	1.5%
Number admitted or discharged within 4 hours	78885	83233	5.5%
Number over 12 hours in EU	354	278	-21%
Ambulance lost hours	4950	3768	-24%
Delayed Transfers Of Care (number)	651	473	-27%
Delayed Transfers Of Care (bed days)	17719	13008	-27%

4. Winter Planning 2017/18

4.1. A comprehensive review of winter 2016/17 was undertaken along with a multiagency winter debrief session which enabled the Health Board to evaluate what went well and identify the key learning points to inform the development and improvement proposals for the 2017/18 integrated winter plan.

4.2. The initial winter schemes were developed and approved early in the year (July 2017) and included:

- Increased capacity of the GP OOH service aligned to peaks in demand over Christmas and New Year
- Additional Acute Care Physician sessions
- Additional Paediatric consultant
- Extra Trauma SPR in the Emergency Unit on weekends
- Enhanced site management
- 24 additional medical beds
- Dedicated medical outlier team
- Additional two discharge to assess beds
- Transfer team and discharge lounge extended opening
- ‘My winter health’ & ‘Choosewell’ advertising
- 7 days no delays

4.3. Following notification of the additional winter funding available from Welsh Government the UHB introduced a number of further initiatives including:

- ACS pathway
- Additional trauma and emergency surgery list at weekends
- St John’s clerical support in discharge lounge
- Dedicated senior nurse for stroke
- Flu based molecular point of car testing
- Additional SHO cover (medicine)
- Emergency Unit and WAST hospital avoidance team
- Additional therapies support

5. Key reflections 2017/18

5.1. A comprehensive review of winter has been completed and presented to our

Board. The review is part of our regular planning cycle for winter and summarises some of the key activity and performance measures for the 2017/18 winter period with comparisons to previous years. The review is also informed by a multi-professional and multi-agency debrief of winter, conducted in May, to gather feedback from clinical boards and partners on their experience of the 2017/18 winter, the effectiveness of the various initiatives and to inform the development of the 2018/19 integrated winter plan.

5.2. The UHB's key reflections on last winter are as follows:

a) ***Advanced Planning -*** Our internal preparations for winter began early, with the development and sign-off of the winter initiatives completed in July 2017. This allowed the maximum time for implementation and consequently, despite significant workforce and infrastructure challenges, the UHB was able to implement all of its original schemes as planned and on time. The additional funding received from Welsh Government in January was welcome and allowed the UHB and partners the opportunity to test new initiatives which we will consider as part of future winter plans and the development of our unscheduled care system.

b) ***Demand Increases and levels of acuity -*** The challenge of winter is not so much anticipating an increase in demand but the variability of that demand change from one year to the next. It is clear from our local data and the pattern across NHS Wales that the December to March period saw unusually high levels of demand, combined with higher levels of acuity.

c) ***Variability in the demand pattern -*** The *volume* of demand is clearly an important metric for each part of the unscheduled care system, however the timing of when that demand occurs can be equally important. The UHB flexes its capacity on a daily basis, anticipating the likely demand patterns for each service. In the pre-Christmas period winter was following a fairly typical pattern and the UHB was utilising its capacity accordingly, including where possible 'flexing down' or delaying the deployment of capacity (e.g. beds) in preparation for the January surge. Consequently the UHB was approximately where it expected to be heading into the Christmas period, including having 66 beds empty in addition to the 24 dedicated winter beds and a further 12 surge beds available, i.e. a total of 102 beds available to be deployed. The UHB then experienced two atypical periods, firstly between Christmas and New Year, followed by an unusually busy February.

d) ***Sequence of Exceptional Circumstances*** – The high levels of demand and acuity coincided with the highest influenza rates since 2010 and extreme weather conditions, testing the resilience of the system to the limit.

e) ***Reduced Unscheduled Care Performance -*** For Cardiff and Vale UHB the trend over recent years has been one of improving winter performance, reflecting a combination of greater preparedness and comparatively mild winters. However this winter the UHB had, in general, lower performance than the 2016/17 winter but improved performance on 2015/16.

f) ***Areas where performance continued to improve*** - It is important to acknowledge that, despite the significant challenges this winter, the UHB and partners maintained or improved performance in a number of areas:
   - GPOOH urgent calls responded to within 20 minutes
   - WAST 8-minute performance
   - Cancer performance
   - RTT performance
   - Diagnostics performance
   - Therapies performance
   - Delayed Transfers of Care
   - Postponed Operations

g) ***Resilience of our staff -*** Despite the exceptional pressures our staff remained resilient and continued to deliver high levels of care in very difficult circumstances. This was particularly evident during the extreme weather conditions.

6. Demand and Acuity

6.1. The UHB experienced significantly higher demand in most areas this winter. GPOOH calls were 4% higher than last year; the Emergency Unit (EU) attendances increased by 3% overall; and Medical admissions were up 4% (December to March). The two significant exceptions to this were ambulance conveyances (see section 11) and surgical admissions (down 7%). The reduction in surgical admissions follows a significant redesign of the Emergency General Surgery model from October 2017.

6.2. In addition to an increase in the volume of demand there were indications that the acuity of patients also increased this winter: referrals from GPOOH to secondary care were up 5%; EU 'majors' attendances increased by 6% and critical care bed days increased by 9%.

6.3. During winter 2017/18 fewer patients over the age of 65 were admitted per head of population compared to 2016/17 and 2015/16. Despite this the combination of a growing and ageing population meant 40% of emergency medical beds were occupied by patients over 85 years, an increase of three percentage points compared to the same period last winter.

7. Variability in the pattern of demand

7.1. In the pre-Christmas period the Health Board's preparations for winter were progressing as planned – all the winter schemes were in place or ready to be deployed, demand had followed a relatively familiar pattern and the hospital bed position was ahead of the bed capacity deployment plan (66 beds empty on 24th December, plus 24 'winter' beds and the option of a further 12 surge beds).

7.2. As described above the UHB experienced significantly higher demand across the whole winter period, but in addition to this the UHB saw two periods of

atypical demand patterns – firstly between Christmas and New Year and secondly during the month of February.

7.3. Between the 24th December and the 2nd January there were 289 (9%) more EU attendances than the same period in 2016/17, of which 201 were in the 'majors' category, an 11% increase. Three days in particular stand out – the 24th (22% increase), 30th (14%) and 31st December (26%). This increase in attendances translated in to an increase in medical admissions, 46 (12%) higher than the same period last year. Critically this meant that the number of beds occupied by a medical patient increased by 135 in this nine day period, subsequently peaking at its highest point for three years on the 8th January.

7.4. The typical pattern of winter is that the first week of January is the most challenging with gradual easing of the pressure from that point onwards (however there is often variation from this general trend). This year, as stated above, the first week of January proved to be a very difficult period followed initially by some improvement. The month of February however saw significantly higher demand and acuity, summarised in the table below:

Emergency Department Attendances	**Feb-17**	**Feb-18**	**+/-%**
Total ED Attendances	10664	11412	7.0%
Resuscitation Cases	487	552	13.3%
Majors	5518	6107	10.7%
Minors	2850	2878	1.0%
Paediatric	2296	2427	5.7%
Resus/Majors cases Age 65+	1693	1923	13.6%
Resus/Majors cases Age 85+	478	549	14.9%
Emergency Admissions Activity			
Emergency Medical Admissions	1464	1634	11.6%
Emergency Surgical Admissions	608	593	-2.5%
ITU Bed days utilised	848	926	9.2%
Total Elective Activity			
Total Elective Procedures	5958	5907	-0.9%
GP OOH Activity			
Calls to OOH	8641	8978	3.9%

8. Performance

8.1. Following significant year-on-year improvement up to November 2017 the 4-hour, 12-hour and ambulance lost hours performance deteriorated from December-March. As a result the full-year performance of the UHB ended as no change against 4-hour performance, a deterioration in 12-hour performance

and a 5% improvement in ambulance lost hours. The “Did not wait” performance was 4.5% for January-March, a small increase on the rest of the year but below the 5% target overall. These performance figures are in the context of 2017/18 being the busiest year ever for EU attendances, a 3.2% increase on 2016/17 and 5.9% increase on 2015/16.

8.2. Other unscheduled care process indicators showed greater resilience. The proportion of urgent GPOOH calls responded to within 20 minutes increased by 7% on 16/17; the number of DTOCs was on average 29% lower; length of stay reduced for surgical emergencies and there were fewer delays in discharge from critical care.

8.3. Despite the significant pressure on the unscheduled care system, it is testament to the professionalism and commitment of our staff that the UHB maintained and improved performance in many of the planned care services. The number of RTT patients waiting over 36-weeks continued to reduce throughout the winter period, reaching the lowest point since August 2010. Similarly the number of patients awaiting a diagnostic over 8 weeks reduced to its lowest point since May 2010. Overall, the total waiting lists reduced by 8000 patients between October 2017 and March 2018. 31-day cancer performance improved on winter 2016/17 and exceeded the Welsh Government target, whereas 62-day performance remained at the same level.

8.4. In summary, the UHB’s mitigating actions allowed elective services to continue to function throughout the period (with the exception of the days affected by heavy snow). This was in contrast to many other parts of the UK where elective surgery was cancelled on mass, delaying vital operations. Nonetheless, we did not reach the level of unscheduled care performance we expect as a Health Board and there are important lessons for us to consider in our planning for future winters.

9. Influenza and infection control

9.1. This year Cardiff & Vale community flu vaccine uptake exceeded the Wales average for both under and over 65s with levels slightly higher than last year (this year <65 at risk was 49.0% and >65 was 71.0%).

9.2. The uptake for frontline staff saw an 11.7% improvement on 2016/17. Feedback suggests the rise may be due to the increased use of Flu Champion Peer Vaccinators model and weekly reporting of statistics at Clinical Board level.

9.3. This season the circulation of flu was high intensity and the highest since 2010-11. The peak for first GP consultation was seen in the second half of January after which intensity did not decline to low intensity until March. Flu was therefore a significant contributing factor to February being a particularly challenging month.

9.4. Despite high levels of flu and diarrhoea and vomiting during winter 2017/18, the number of bed days lost was minimised through cohorting patients to avoid bed

closures. This was helped by the 'flu based molecular point of care testing' which allowed patients tested positively for flu to be cohorted as appropriate. The scheme also allowed a quicker risk assessment enabling wards to be reopened earlier and beds to be used which would previously have been closed as a precaution.

9.5. Whist the organisation was successful in minimising the number of beds days lost, the closure of beds inevitably places restrictions on where patients can be placed adding an additional complexity to managing flow through the hospital. This contributed to a significantly higher volume of 12-hour breaches seen this year.

10. Primary care and Community

10.1. Following investment into GPOOH services there was overall improvement in the percentage of urgent OOH calls logged and returned within 20 minutes, with a 7% increase from 2016/17 and a 13% increase from 2015/16. The percentage of routine OOH calls logged and returned within 60 minutes was broadly consistent with last winter but a significant increase of 16% from 2015/16.

10.2. A Community Pharmacy Common Ailment Service was established ahead of this winter. This is a scheme encouraging patients to consult a community pharmacy rather than their GP for a predefined list of common ailments. The pharmacist will then supply medication, advice or a referral to the GP if necessary.

10.3. The Community Resource Teams consistently achieved 35-40 new patients per week, albeit overall slightly below the weekly target of 40 slots. For the past two winters this service has been operational seven days per week, supporting flow across the critical weekend period.

10.4. As part of the ICF investment the region has invested in residential discharge to assess beds in both Cardiff and the Vale of Glamorgan. During the winter period an additional two beds were commissioned, supporting the early discharge of patients.

11. Ambulance services

11.1. The total number of lost ambulance hours was 5% higher than 2016/17 but 3% lower than 2015/16. Lost hours peaked in February but there was significant recovery in March.

11.2. 8-minute performance did reduce over the winter months but remained above the Welsh Government target.

11.3. As part of the additional Welsh Government funding the UHB and WAST piloted a Hospital Avoidance Project. The review of the project identified a reduction in conveyances and work is now ongoing to consider how this can be developed into a core part of the unscheduled care service.

12. Social care provision and DTOCs

12.1. 2015/16 saw significant issues in the domiciliary care market in Cardiff. Following ICF investment into the Bridging Team, domiciliary care was less problematic this year.

12.2. Delayed Transfers of Care (DTOCs) decreased in December and reached 39, the lowest figure for the two previous years. The number of DTOCs increased slightly between January to March but remained 23% below the year previous and 28% fewer bed days lost.

12.3. Local Authorities received separate Welsh Government non-recurrent investment to support the winter pressures in early 2018, which was targeted at supporting additional packages of care where possible and also in providing equipment to support hospital discharge and to prevent hospital admission.

13. Post-winter

13.1. The winter challenges continued into April before improving throughout May. The UHB de-escalated all of its winter plans in line with the original schedule.

13.2. Most recently the unscheduled care performance has returned to an improving trend, with the four-hour performance currently above 90% for the month of June, the highest performance since January 2014.

14. Preparations for Winter 2018/19

14.1. Preparations for winter 2018/19 commenced immediately following the end of winter 2017/18. In May the UHB formally reviewed last winter and all Clinical Boards were requested to develop their plans for 2018/19. The first drafts of these plans were received on 4th June 2018 and have been refined through June. The proposals will be taken to the UHB's Management Executive over the next few weeks for formal approval and will form the basis of the UHB's winter plan. The full integrated plan will be developed with the support of partners including WAST, social care services and third sector organisations, and be presented to the UHB Board in September. The timetable of planning activities is shown at the end of this document.

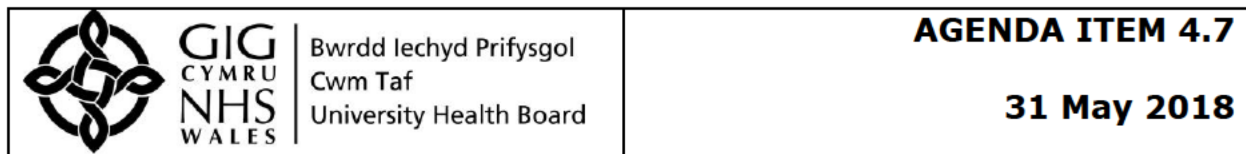
14.2. It is likely the winter plans for 2018/19 will include additional resilience for the GP out of hours service, senior decision makers at the front-door, additional critical care and ward bed capacity, and enhanced CRT and discharge-to-assess capacity. The UHB will continue to work with WAST to develop alternative pathways.

14.3. In addition to the specific winter plans, the UHB and its partners are working on broader system improvements for implementation through the summer and autumn of 2018 which will add resilience through the winter period. These include:

- the roll-out of multi-disciplinary teams to add capacity and resilience to primary care
- the development of a domiciliary discharge-to-assess service in Cardiff
- the expansion of the First Point of contact service to support early hospital discharge
- length of stay reduction initiatives at both acute sites and community hospitals to reduce the requirement for beds
- implementing a live ‘patient flow’ information system for unscheduled care – to identify constraints in key patient streams at the earliest opportunity
- maximising the benefits from the new Emergency General Surgery model
- review of the Emergency Unit flows

SEASONAL PLANNING CYCLE

Activity	March 2018				April 2018				May 2018				June 2018				July 2018				August 2018				September 2018			
	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4
Revise and agree winter planning cycle		■																										
Data analysis completed on previous winter					■	■	■																					
Organise and communicate winter debrief event						■																						
2017-18 review paper drafted								■	■	■																		
Hold debrief of previous winter (multi-agency)									■																			
Request winter plans from each Clinical Board										■																		
2017-18 review paper finalised and discussed at Management Executive											■																	
2017-18 review paper submitted to Board												■																
2017-18 review paper considered at Board													■															
First draft Clinical Board (and other) plans submitted													■	■														
Initial consideration of submissions by COO at OPG														■														
Feedback/further discussion on first draft plans - discussion in OPG														■	■													
Final draft proposals submitted by Clinical Boards (and other areas)																■	■											
Finalise and submit paper to ME on winter schemes 2018/19																		□	□									
Formal approval provided to Clinical Boards																			□									
Integrated winter plan considered at Board																												□



University Health Board Report
WINTER PLANNING EVALUATION REPORT 2017/18 AND PREPAREDNESS FOR WINTER 2018/19

Executive Lead: Chief Operating Officer
Author: Deputy Chief Operating Officer / Assistant Director of Operations (Medicine) & Head of Business Support (Operations)
Contact Details for further information: [redacted] or [redacted]

Purpose of the University Health Board Report
The purpose of this report is to provide the University Health Board (UHB) with an evaluation of the robustness of the winter plan for 2017/18 and to set out the next steps to ensure that lessons are learnt in readiness for next year.

Governance	
Link to Health Board Strategic Objective(s)	The Board's overarching role is to ensure its strategy outlined within 'Cwm Taf Cares' 3 Year Integrated Medium Term Plan and the related organisational objectives aligned with the Institute of Healthcare Improvement's (IHI) 'Triple Aim' are being progressed, these in summary are: • To **improve** quality, safety and patient experience. • To **protect** and **improve** population health. • To **ensure** that the services provided are accessible and sustainable into the future. • To **provide** strong governance and assurance. • To **ensure** good value based care and treatment for our patients in line with the resources made available to the Health Board. This report focuses on outlining the operational impact of all of the objectives above.
Supporting evidence	This report is prepared in light of a recent multi-agency review of the UHB's winter plan to determine areas of success and where modifications may be required in advance of next year.

Engagement – Who has been involved in this work?							
Deputy Chief Operating Officer, Welsh Ambulance Services NHS Trust, Rhondda Cynon Taf Local Authority, Merthyr Tydfil Local Authority, acute, locality and primary care staff and a representative from Cwm Taf Community Health Council.							
University Health Board Resolution To:							
APPROVE		**ENDORSE**		**DISCUSS**	✓	**NOTE**	✓

Recommendation	The University Health Board is requested to: • **DISCUSS** and **NOTE** the content of the report.

Summarise the Impact of the University Health Board Report	
Equality and diversity	There are no specific equality and diversity issues highlighted within this report
Legal implications	There are no legal implications highlighted within this report.
Population Health	This report does link to population health.
Quality, Safety & Patient Experience	Unscheduled care pressures during the winter months have a huge impact on all sections of the health care system and this can impact of the quality and safety of the patient experience.
Resources	Increases in unscheduled care attendances, alongside an increase in the number of patients attending acute services with multiple core morbidities, challenge the system during the winter months. The Welsh Government made additional resources available this year as set out in the report.
Risks and Assurance	The report highlights a number of risks related to the operational delivery of services at times of increased pressure.
Health & Care Standards	The 22 Health & Care Standards for NHS Wales are mapped into the 7 Quality Themes: Staying Healthy, Safe Care, Effective Care Dignified Care; Timely Care; Individual Care; Staff & Resources http://www.wales.nhs.uk/sitesplus/documents/1064/24729_Health%20Standards%20Framework_2015_E1.pdf The work reported in this summary takes into account many of the related quality themes including safe and effective care.
Workforce	A number of workforce challenges were experienced during the winter period and action was taken to mitigate the associated risks as far as possible.
Freedom of information status	Open

WINTER PLANNING EVALUATION REPORT 2017/18 AND PREPAREDNESS FOR WINTER 2018/19

1. SITUATION / PURPOSE OF REPORT

The purpose of this report is to provide the University Health Board (UHB) with an evaluation of the robustness of the winter plan for 2017/18 and to set out the next steps to ensure that lessons are learnt in readiness for next year.

2. BACKGROUND / INTRODUCTION

The annual winter delivery plan sets out the UHB 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 winter period.

The plan is intended to 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 was developed in collaboration with key partners including the Welsh Ambulance Services NHS Trust, Merthyr Tydfil County Borough Council and Rhondda Cynon Taf County Borough Council. It aims to demonstrate how joint plans will ensure the delivery of safe, high quality services to the population during potential periods of increased pressure.

The Winter Planning and Preparedness Plan:

- reflects a whole system approach to the delivery of services over the 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 aimed 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.

This paper reflects on the winter delivery plan for 2017-18, highlighting areas where there has been success and areas where there is a need to refocus when setting out the UHB plan for the next winter period.

3. ASSESSMENT / GOVERNANCE AND RISK ISSUES

The key risks 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
- 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.

There are a number of policies and procedures in place to mitigate against these known risks, which are tested each year and amended as a result of any learning. The following sections provide a summary of a collaborative review of the 2017-18 winter plan, which in the main has delivered against the key aims set out above.

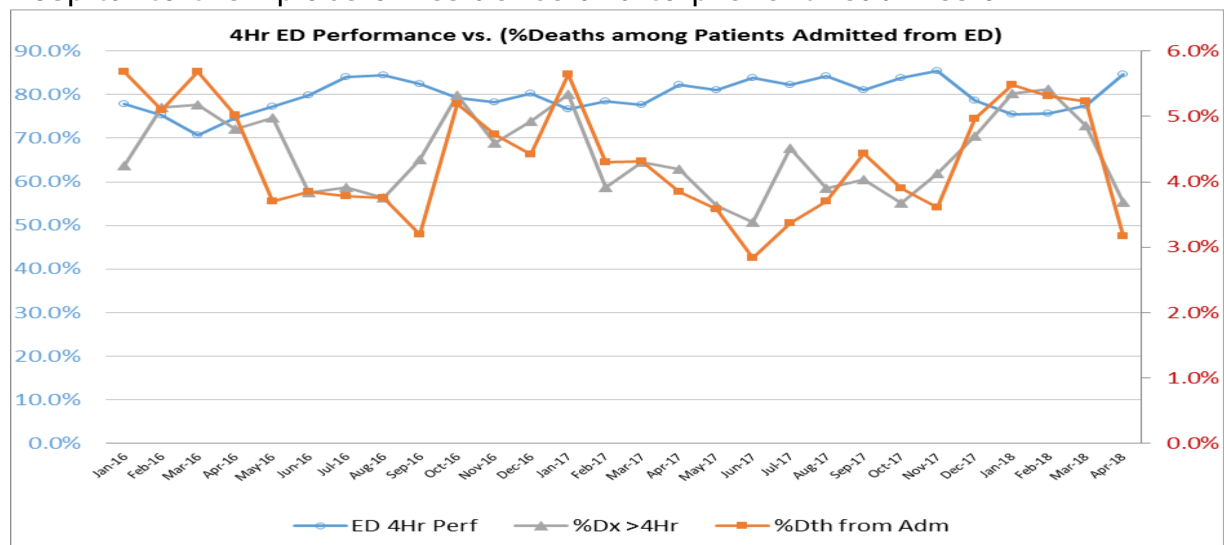
WINTER PLANNING EVALUATION REPORT 2017/18

Volume and Acuity Challenges

Colleagues will be aware from recent media stories that the first week after Christmas saw the pressure on services reach extreme levels across the UK. For Cwm Taf UHB this meant that we had over 500 additional attendances at the emergency departments and from 8 January to the end of the month, there were an additional 244 major cases. GP urgent cases tripled during this first full week in January with high levels of A&E attendances. This increase in attendances equates to more than 32 additional patients each day and we have seen the main increase in the 65-85 age group.

More patients have been admitted during this winter period compared to last. We can show improvements in the length of stay throughout the last year linked to our improved productivity, however average length of stay increased in January and February due to the increased demand.

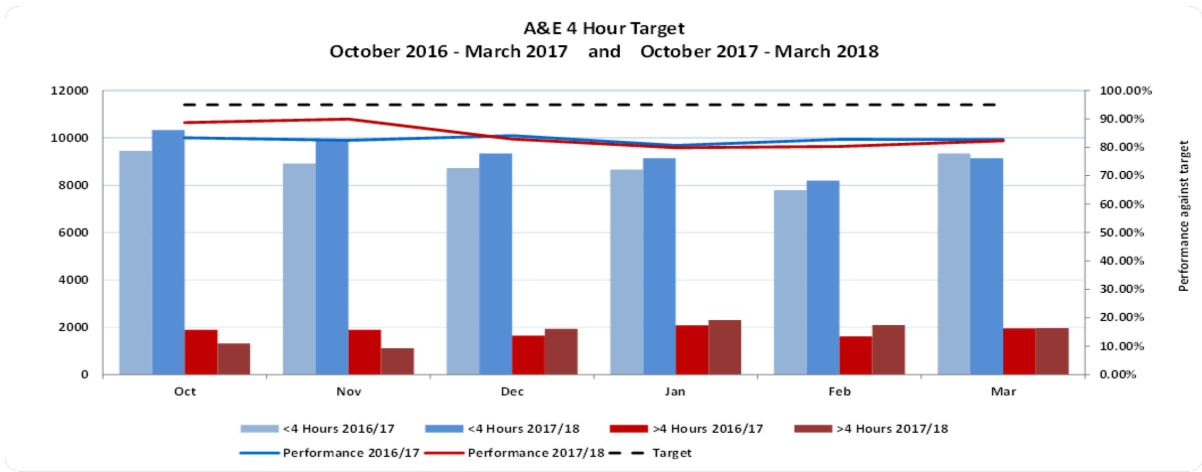
There are a number of challenges in meeting high levels of demand, especially during winter months where many of the patients who require care, treatment and support have increasingly complex needs and acuity. The most significant issue is not always the numbers of people presenting at emergency departments but also the complexity and severity of conditions of those admitted, the ability to transfer patients safely from hospital to their place of residence and to prevent readmission.



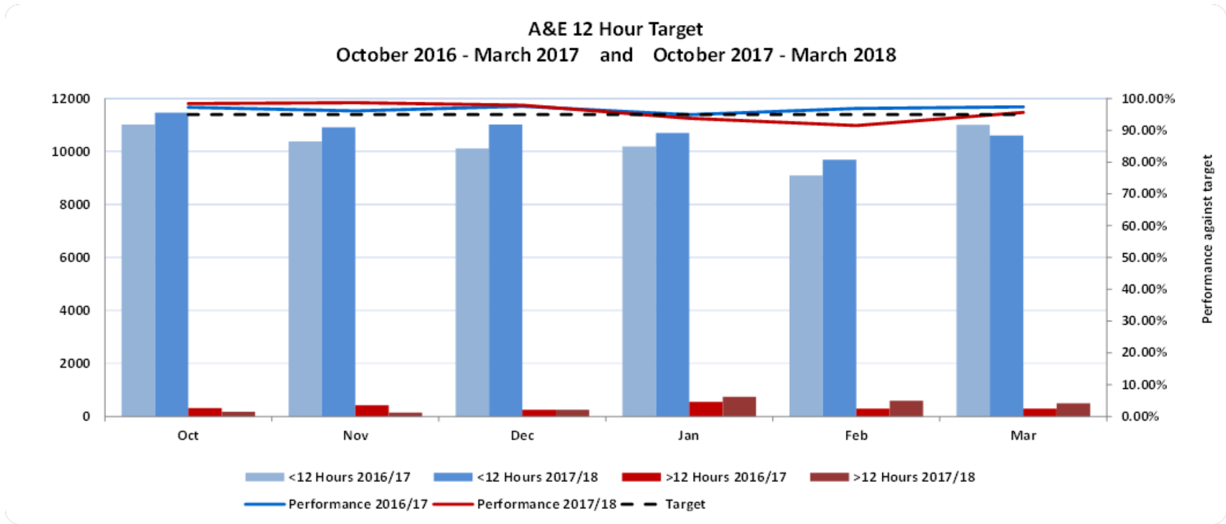
The above Warwick chart is reviewed on a monthly basis, and compares mortality rates against 4 hour performance on the date of attendance at the emergency departments. Over the past three years the mortality rate has reduced in overall terms but clearly demonstrates seasonal variation. The above also appears to reflect the acute nature of the winter pressure encountered this year across Cwm Taf.

During this time the UHB has maintained its zero tolerance approach to ambulance handover delays at our emergency departments. The UHB continues to perform well in this area, which in turn supports the Welsh Ambulance Services NHS Trust (WAST) with its ongoing delivery of red 1 calls performance within the Cwm Taf UHB area. Our continued zero tolerance approach to ambulance handover delays has been kept under constant review with daily operational management and improvement reviews where necessary. Our approach continues to be recognised as best practice across NHS Wales by WAST and the Welsh Government (WG).

Performance against the tier 1 targets for the emergency departments has deteriorated during the winter months with a significant dip in achievement of the 4 hour performance target during January and February 2018. The performance prior to December remained well above the previous year's performance reflecting a more resilient system, which is in part as a result of the integrated service developments we have implemented with local authority colleagues. This also appears to be influencing the UHBs ability to return to a stable state of delivery post the winter period.



Performance against the 12 hour performance target was also maintained in the later months of 2017, with performance dipping in February as a result of the acute level of pressure at this time. The UHB continued to undertake a senior review on a case by case basis of all patients who remained in the emergency department over 12 hours to ensure care and treatment was delivered in line with medical and nursing plans.



As mentioned above, the UHB has now returned to a stable state of delivery post the winter period and the first 18 days of May saw 91% performance against the 4 hour target (2017 was 85.4%) and 98.98% performance against the 12 hour target (2017 was 98.8%). The number of 12 hour breaches has reduced from 89 patients in 2017 to 70 patient this year and this is against an increase in attendances. The contribution of our winter plan to this ongoing sustained improvement should not be underestimated.

Managing Demand at the Front Door

A number of key initiatives were in place across Cwm Taf to manage the high levels of demand and complexity of the patients attending our emergency departments during winter and these included:

- Increase in the hours covered by acute physicians to integrate with the emergency departments to support more effective front-door decision making
- Dedicated space on each district general hospitalsite to protect minor injuries stream
- Ambulatory care facilities aligned with the emergency departments on both acute sites with read across to the Stay Well @Home services
- Pilot project with St John’s Practice in Aberdare and the WAST for the virtual ward
- Development of a number of cluster schemes around chronic conditions management
- Patient pathways in place with the WAST to reduce the ambulance conveyance rates
- Psychiatric liaison and crisis resolution services.

The **Stay Well at Home Team** was established in April 2017. The SW@HT includes a skill mix of social workers, occupational therapists, occupational therapy technicians and physiotherapists, working 7 days a week to undertake assessments at the emergency departments and support individuals to be discharged home. The SW@HT can access a four hour response from social care and the nursing @home service to ensure appropriate support can be provide in the community to ensure a safe and timely discharge. This service has been incrementally implemented across the CTUHB footprint with some aspects of the service yet to be rolled out fully e.g. medicines @ home.

The **Early Supportive Discharge Support Service** provided by Age Connect Morgannwg is in operation across two district general hospital sites to assist in unlocking additional capacity by speeding up hospital discharge, in a supportive way for patients and families. This service links seamlessly with the Stay Well @ Home service.

The **Virtual Ward** concept at St Johns Surgery in Aberdare continues to be developed with proactive support from community paramedics, occupational therapists, physiotherapists and other key professionals and discussions are underway to develop the next phase of this initiative for roll out across the Cwm Taf area.

In the cohort of 150 complex patients identified within the ward there was a 60% decrease in GP appointments, 80% decrease in hospital admissions and a 90% reduction in OOHs demand (currently being validated).

Robust plans were implemented to ensure the provision of **GP Out of Hours Services** with additional GP support over Christmas / New Year and other peak times during the winter. New clinical roles, such as advanced nurse practitioners and community paramedics were developed and worked alongside the GPs in the clinical team. The Christmas shift fill stabilised at over 80%, with 4,500 patients seen over three weekends with an average of 3.5% conversion to A&E. Where the GP fill rate was not 100% we secured additional Advanced Nurse Practitioner and Specialist Training Year 3 (ST3) doctor cover and increased coverage in other areas to compensate.

Delayed Transfers of Care (DToC)
The DToC position in Cwm Taf saw a dramatic reduction from 43 cases reported in October 2017 to just 16 cases identified in March 2017. The total number of delays during 2017 were the lowest on record since records began 12 years ago and the DToC figure in January 2018 was the third lowest January in the last 13 years. This can in part be attributed to the focused efforts during the period of Gold Command as set out later in the report.

Infection Prevention and Control
An increase in Influenza cases was evident this year in particular across the Merthyr Tydfil and Cynon area during January and February. We saw a sharp increase in admissions with suspected influenza in January and a cohort area consisting of 2 bays and 3 side rooms was introduced on ward 11 on the 15 January 2017. Ward 11 was used as a cohort area and was needed until 5 February with suspected and confirmed cases of influenza admitted to this area. The plan worked well and prevented the spread of cases across the hospital site. The admissions were also kept to a minimum with most patients being managed in a primary care setting.

From 1 January to 31 March 2018, we had a total of 109 suspected cases of influenza who attended the emergency department and paediatric ward or were admitted to PCH - 64 of those were confirmed influenza. Influenza has caused less disruption at the Royal Glamorgan Hospital and we did not need to cohort patients in one area and managed to isolate patients in single rooms. From 1 January – 31 March 2018, 84 patients attended the emergency department and paediatric ward or were admitted with suspected influenza – 28 of those were confirmed.

Flu vaccination rates
The school vaccination programme saw the highest percentage uptake in Wales during 2016/17, and the UHBs nursery pilot moved the vaccination of 3 year olds to an increase in uptake of almost 30%. The pilot won the Beat the Flu Award for most innovative flu campaign.

This year saw the implementation of a scheme where midwives vaccinated pregnant women in one of our community hospitals.

The pilot commenced very late in the season (January) with 20+ women project vaccinated and the results are awaited. Frontline staff uptake decreased by 3% this year, which was disappointing and plans are underway to increase this rate for the forthcoming winter and to also consider a joint approach with key partners such as the local authorities and WAST.

Maintaining our Capacity for Elective Operations
During the winter period – 1 October 2017 to 31 March 2018 - 167 elective cases were cancelled due to winter bed pressures. This was an improvement on last year and the lowest number of cancelled operations in the last 7 years as illustrated below.

2011/12	361
2012/13	886
2013/14	176
2014/15	605
2015/16	1114
2016/17	399
2017/18	167

It is clearly evident that there has been a significant reduction in cancellations this year, enabling achievement of the scheduled care year end position.

Staffing Profile and Surge Capacity
The availability and sustainability of staff over the winter period was a key challenge for the UHB and workloads were prioritised on a daily basis to ensure that patient flow was maintained. We continued to engage with staffing agencies to ensure that areas were staffed appropriately however on occasion our challenging staffing position worsened due to lost agency shifts.

The availability of suitable staffing also impacted on our ability to increase the level of surge capacity on our acute and community hospital sites and this, on occasion, had an impact across the whole of the system.

Due to extreme pressure on the emergency departments we utilised all additional surge capacity during the winter period including the use of treatment rooms and day rooms, additional patients into clinical decisions units and opening additional areas. Despite this we remained at high levels of escalation for a number of weeks with the demand for inpatient beds far outreaching our capacity at certain points during the period.

Snow Plans and Adverse Weather

The significant snowfall in early March had a big impact on access for all of our hospital sites. Whilst the demand pressures on our district general hospitals settled down as a result of the snow, increased efforts were needed using the combined resources of the WAST, Mountain Rescue Services, Fire & Rescue and Police Services and some volunteers to help us discharge medically fit patients and to move staff off or onto the sites.

We cancelled some outpatient and elective activities although we managed to complete urgent cancer electives and some other procedures. Remarkably we managed to avoid losing too much referral to treatment time target (RTT) activity through rebooking and the shifting of some activities into next weekend, thanks to the efforts of our management teams and the support of our clinicians.

Primary care demand was down and about half of our practices and community pharmacies remained open during the snow and our district nursing teams made home visits on foot throughout the region. Local authority services and domiciliary care services were heavily compromised by the weather, but colleagues were supportive in continuing to review care packages and also in terms of targeting gritting and supplementary transport activities to help us.

Our support services teams in catering, housekeeping, transport and other estate and facilities functions were absolutely remarkable in the way they sustained their support for colleagues. We have completed a robust review of the plans in place to respond to adverse weather events such as snow and the agreed actions have been incorporated into the overall plans for the next winter period.

Allocation of Additional Funding

In January 2018, the Director General of NHS Wales advised all health boards of the allocation of additional funding in recognition of the exceptional levels of demand on unscheduled care services. The UHB allocated this money to some additional measures to enable greater resilience across the unscheduled care pathway over winter including:

- Opening surge capacity across both acute sites
- Increased nurse staffing levels to care for corridor waits
- Increased medical cover for the emergency departments out of hours
- Increased occupational health physician cover
- Additional funding to Care & Repair for small adaptations
- Continued provision of local authority reablement services
- Extended pharmacy provision on Sundays
- Employment of additional clinical support staff such as phlebotomists
- Commissioning additional transport services for hospital discharges and transfers.

Operating a Gold Command
In early February 2018, the Chief Operating Officer instigated a Gold Command group for the Cwm Taf unscheduled care system. This group involved representatives from both local authorities plus officers from the acute, community, primary care, mental health and operational teams. The decision to enact a Gold Command sought to restore sustainable operational flow across the whole system.

A daily tasking environment was established by:

- Including community and primary care colleagues in the routine 10.30am daily conference calls
- Running an end of day call at 5pm every week day with local authority extended membership
- Running a daily deep dive meeting with local authority colleagues to ensure that we were expediting care packages
- Holding a weekly face to face meeting on a Wednesday to review the first half of the week and prepare for the second half
- Deploying senior executive and management leads to sites to provide leadership and support.

We ensured that key officers within the health board and local authorities had senior management contact details to facilitate the early resolution of any challenges and we ensured that robust on call arrangements were in place including arrangements to enhance the senior nurse presence on our acute sites at the weekend. The evaluation of the period of Gold Command is included in the next section that sets out the plans to ensure additional resilience in the system as we approach the next winter period.

WINTER PLANNING AND PREPAREDNESS FOR WINTER 2018/19

Following the winter period and the adverse weather we have completed a number of review meetings with colleagues from the local authorities, Welsh Ambulance Services Trust and Community Health Council. These reviews have been consolidated into the following key themes with clear actions identified in preparedness for the next winter period.

Communications and Co-ordination
Communication is key during periods of continued high escalation and adverse weather events and as always this is an area that can be improved.

The following actions are being taken to ensure that system and process issues are refined:

- Establish Gold Command earlier following consistent deterioration in the levels of escalation and increasing number of 12 hour waits in the emergency departments. Gold Command will include the establishment of clear communication protocols with local authority and WAST colleagues utilising social media and innovative channels where

possible; establishment of a recognised hub on each site with dedicated senior manager support; senior deep dives on each acute and community hospital site; clear communication protocols (automated where possible) to relay key messages across the sites and to receive early escalation of issues.

- Escalate and plan earlier when there is a "red" weather alert and this should include the instigation of a Gold Command.

- Update the staff policy related to adverse weather conditions and include a one page briefing note to clarify staff expectations re attendance at other sites, ability for agile working, and accommodation options.

- Implementation of an automated emergency department system to facilitate live date input and the sharing of "live" situation reports across the organisation.

Redesigning Service Delivery
During the 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. Key actions include the following:

- Phase 1 of the Stay Well @Home service (SW@H) has been in place for the last year and evaluation has shown that it has been successful in improving discharges from the emergency departments and supporting earlier discharge following admission by providing responsive community services and avoiding unnecessary admissions. As part of the planned roll out of this initiative, phase 2 is a proposal to respond to community professionals (GPs, GP out of hours, WAST and district nurses) to provide them, following their assessment, with an alternative to sending people to A&E. Providing a rapid community response service to maintain people in their own homes. The introduction of phase 2 of the SW@H is a key priority for preparedness prior to the next winter period.

- Redesign of primary care and community based services needs to take into account the roll out of the virtual ward model, full utilisation of the @home IV service, maximised use of advanced care planning, enhanced support for care homes, development of a community communications hub for co-ordinated triage, full utilisation of WAST care pathways, review of multi-disciplinary working, robust arrangements for the GP out of hours service, and the development of step up capacity in the community hospitals.

- Clarification of the roles and responsibilities of the discharge co-ordinators, discharge liaison nurses, senior nurses and social workers

to ensure that the patient flow processes are clear particularly in relation to implementation of the Choice Protocol and interim placements for patients in dispute or going to Court of Protection for a decision.

Transport Arrangements
Transport was a key challenge over the winter period and this was heightened during the snow period. The WAST was unable to prioritise inter hospital transfers due to the high levels of escalation within the Trust and the need to respond to red emergency calls. During the snow transport was key to allow staff to get to the sites to maintain services. The following key actions are now being taken forward in readiness for next winter:

- Commission non-emergency transport services from additional providers and ensure that plans are in place to facilitate the discharge and move of patients between sites during times of high escalation and adverse weather.

- Each directorate needs to identify a list of 'essential' and non-essential staff for transport prioritisation during adverse weather and this needs to be discussed with the facilities team. The plans need to take into account the need to utilise locally based staff where possible, special needs of individuals due to a disability, pregnancy or home location; the ability for agile working; and the skeleton staffing profile needed to maintain essential services.

- Continue to develop and train the network of drivers who can be called upon for support during adverse weather and consider the establishment of a combined public sector fleet in the Cwm Taf area with a 5th transport hub based at Ty Elai.

Cross Boundary Working
Further thought needs to be given to the opportunities for joint working initiatives across organisational boundaries prior to the next winter period and areas for consideration include the following.

- Impact of the proposals to change the boundary alignment of Bridgend County Borough Council and the management responsibility for the Princess of Wales Hospital.

- The ability to utilise staff from other Health Boards who present at our sites during severe weather conditions.

- Robust processes for the repatriation of patients back to Cwm Taf and back to the local areas with particular issues identified for residents from the Gwent valleys and Creigiau area of Cardiff.

CONCLUSION

Whilst this report focusses on an evaluation of the plans in place for winter 2017/18 and the organisational readiness as we approach the next winter period it is important to note that many of the process issues and planned service redesign are not specifically related to the winter.

Many of the identified actions will improve the system resilience and ensure that patients flow across the whole integrated pathway in a timely manner and therefore have been adopted into current mainstream operational working.

The Health Board can be proud of the improvements made in this cycle of winter planning and is very grateful for the huge commitment of its staff and many peer and supporting organisations across the public and voluntary service that worked with us throughout winter 2017/18.

4. RECOMMENDATION

The University Health Board is requested to:

- **DISCUSS** and **NOTE** the evaluation of the robustness of the winter plan for 2017/18 and the plans in place to ensure that lessons are learnt in readiness for next year.

Freedom of information status	Open

Health, Social Care and Sport Committee – 19 July 2018

Winter Preparedness

Aneurin Bevan University Health Board Response

A) Background

1. The Health Board welcomes the opportunity to provide evidence to the Health, Social Care and Sport Committee on our analysis of our Winter Plan for 2017/18 and describe how we are preparing our plan for 2018/2019.

2. The Health Board, together with Welsh Ambulance Services NHS Trust, the five Local Authorities, voluntary and independent sectors collaborated in the production of a single plan aiming to use data intelligence and learning from previous years to ensure robust arrangements for winter 2017/18.

3. The Health Board's Winter Plan set out the key partnership actions, timescales and resource requirements to effectively manage the predicted challenges associated with the winter period and build on the integrated approach to winter planning that has been used by the health community in recent years.

4. The Winter Plan set out a range of key objectives, such as:

   a) Improving access to services and ensuring effective communication with patients to ensure they have clarity about different entry points and options to access services.

   b) Pre-planned system escalation – (Breaking the Cycle events) clear focus on increasing bed capacity, reducing diagnostic delays for primary care and integrated management of heath professional calls.

   c) Prioritising more clinical capacity in our whole system to the urgent care pathway at forecasted times of increased pressure.

   d) Clear pathway of care for patients not requiring an acute hospital stay through alternative use of increased community beds and 'Green to Go' wards.

e) Improved access to social and community services through development of local integrated plans and care capacity.

5. The plan also identified high level risks around extreme demand pressures, particularly out of hours/weekend, nurse staffing, Local Authority capacity, achievement of Referral to Treatment (RTT), extreme weather and the impact on staff.

B) Evaluation

Urgent and Unscheduled Care Demand

6. A review of urgent and unscheduled care demand activity and performance for the winter period identified the key indicators and trends which have enabled us to better understand the impact of our actions and also the causes of pressure in the system.

7. Key headlines:

a) Emergency Department attendances continued the trend we have seen over the past few years which is an overall decrease.

b) Despite an overall decrease we continued to see an increase in those patients assessed in the Emergency Department as 'major cases' and 'resuscitation cases' (the most unwell patients).

c) Ambulance arrivals were 15.5% lower than the same time period in 2016/17, again this is a trend we have seen over the past year. However numbers of 999 calls increased by 3.4%.

d) Whilst we have seen a 2% reduction in overall attendances, we have seen 3% increase in self presenting patients, and admissions from this group of self-presenting patients has increased by 15% (730 additional admissions).

e) Emergency medical admissions ie patients admitted to a hospital ward (regardless of route of referral) increased by 7.7% when comparing February 2018 with the same period last year.

f) Over the past year GP referrals into assessment units have been fairly static, but increases were reported in demand in both January and February.

g) The presentation times at our acute hospitals showed a shift in attendance to weekends and evenings. This presents a further challenge for us as we try to reshape our system and redeploy our resources across the 24/7 period.

h) The Quality Improvement Measure for 4 hour stroke compliance (a measure which combines admission to a stroke bed and swallow screen within 4 hours) showed a deterioration in performance, against an increased number of patients admitted to hospital with confirmed strokes.

i) A number of events were held over the winter period to coincide with expected peaks in demand, these included a full audit of patient pathways and removing barriers to discharge or pathway continuation. We also reintroduced a practitioner team to improve the Elderly Frail Unit pathway to avoid unnecessary stays within the Emergency Department.

Primary Care Out of Hours

8. The actions outlined in the Winter Plan focused on delivering a service that resulted in increased access for patients and improvement to the timeliness of responses, providing a more sustainable service in the Out Of Hours period.

9. Implementation of the overnight nursing team continued to support the Urgent Primary Care Out-of-Hours Service during a period of significant difficulty in filling medical rotas. The overnight nursing team responded to circa 500 calls per month, a number of which would otherwise require attendance from a GP. The increase in total activity between 2016/2017 and 2017/2018 represents a 10% growth which is a significant increase for our Primary Care services.

Health Care Professional Calls and District Services

10. As well as hospital site pressures, we placed operational support nurses to work alongside the Welsh Ambulance Service Trust (WAST) Clinical Team Leaders. Primary Care nurses worked alongside the Out Of Hours and WAST teams, reviewing jointly the WAST Waiting Queue within the Clinical Support Desk. From this review, patients who could potentially be triaged/seen by nurses were allocated. For example, on one afternoon, 6 cases were seen. One case was a pre-arranged ambulance admission, one required hospital admission and the nurses arranged non-WAST transport, and the remaining four were assessed by the nurses and avoided WAST response/admission.

11. This arrangement was considered to be very successful as an escalation measure and further work is being undertaken with WAST to consider how this approach might be deployed on a more regular basis. There is also work being undertaken by the Emergency Ambulance Services Committee to identify other learning from winter initiatives that could help provide an appropriate response to demand.

Performance

12. Achieving the Welsh Government access targets for patients in our urgent care system was a key focus for the Winter Plan. However, overall performance across 4 hour performance, patients waiting more than 12 hours and ambulance waits declined considerably in the period January to March 2018. Whilst overall activity was not above last year's levels, there have been significant changes in both the patterns of demand and the acuity of patients who self-presented to the Emergency Departments to include Stroke patients and those requiring Critical Care.

13. The Winter Plan had identified key pinch points in terms of activity and performance in the latter parts of the winter period and we initiated a number of actions to mitigate this. The plan had highlighted the risks associated with extreme weather and periods of prolonged cold weather which were then experienced during the January to March period. This had a significant impact on activity within the emergency and assessment areas with high levels of acuity and peaks in demand for services following the extreme weather events.

14. Despite the great efforts of all of our staff, we experienced significant staffing challenges throughout the winter and staff sickness, associated with coughs, colds, flu and respiratory issues, was higher than predicted and higher than in previous winter months.

15. The additional actions put in place to overcome the impact of demand and the consequences of the bad weather included:

    a) Changes to management and senior nurse rotas to support business as usual approach to Out Of Hours periods and improve the operational management of the sites. There was an increase in the junior medical staffing cover at all of our acute sites alongside additional nursing cover within the Emergency Department and Medical Assessment Unit to enhance patient safety. There was a further roll out of the discharge co-ordinators across all acute sites to support clinical teams to plan and drive discharges in a timely and effective manner.

    b) Winter incentive payments to encourage our staff to care for our patients by working additional shifts and/or working hard to fill shifts.

    c) Between the period December 2017 and end of March 2018, an additional 100 beds were opened as planned to respond to the demand. However, for long and sustained periods, the Health Board was in the highest level of escalation which did not allow us to manage the patient flow or de-escalate fully.

d) This level of bed occupancy and escalated bed state had a significant impact on the ability of the Health Board to continue to provide elective surgical services through January to April 2018. This enabled us to focus services on emergency patients and maintaining cancer treatments.

Integrated Care Fund (ICF)

16. During the Winter period we saw official Delayed Transfer of Care numbers at levels which were 26% above last year, accounting for around 95 beds over the period. This had been highlighted as a risk within the plan. Through the Integrated Care Fund (ICF) partners developed a programme of integrated activity to support winter resilience and these included the following:

    a) Discharge to Assess at Nevill Hall Hospital - the service has been provided by an independent care provider adding additional assessment and discharge capacity within the system. During the winter period the service discharged 52 patients within 8 hours of referral back to their home with a time limited package of care.

    b) Increased Social Assessment and Support Capacity - provided additional capacity over weekend periods for assessment and carer support in order to expedite discharge.

    c) Care Home In Reach Service - support has taken a number of different forms, most notably the further development of the i-stumble risk tool and the Falls Response Service (FRS). The FRS has continued to work with care homes to provide initial response to those that have fallen ensuring that citizens receive care in the least restrictive place. The FRS had involvement with 177 patients who had fallen during the winter period and who had contacted 999, of which 32% of patients required admission into MAU, this is compared to 78% for the previous year.

    d) Therapy Led Ward in Newport - developed within St Woolos Hospital, providing additional rehabilitation services within a community hospital setting. Ensuring that patients who no longer required acute care within a District General Hospital had clear care pathways, supporting the patient flow.

Quality and Patient Safety

17. Despite the pressures experienced, departments have worked hard to maintain the key safety quality indicators such as the prevention of falls, pressure ulcers and sepsis. Falls and fractures associated with falls have been reducing through 2017 and did not show an increase through the winter period which demonstrates the focus of clinical teams on safe care.

Patient Experience

18. Delays caused by ambulance handover, waiting for a bed, delayed discharges meant that experience for these patients and their families was not the experience we would want for our patients. We have reviewed both the complaints and compliments to ensure we learn the lessons and listen to the voice of the patient.

Seasonal Influenza Vaccination Programme

19. From January 2018, we carried out 989 flu samples, 380 were for inpatients and we had 141 confirmed flu cases. Flu vaccination uptake in the community increased across all ages compared with the end of the flu season last year. However, more work is needed to reduce the inequality in uptake. For example, this year the uptake in 2 and 3 year olds ranged from 37.6% in Blaenau Gwent East to 58.9% in Torfaen South.

20. The Health Board uptake of the Staff Flu Immunisation Programme amongst all staff was 58%, this represents considerable improvement on the previous season of 52% and saw initiatives to recognise the best performing Divisions and strong visible senior leadership.

21. However, despite the improving level of staff immunisation, we saw significantly higher levels of staff absence during the winter period for reasons related to colds, coughs and flu. We also saw a 13% increase in those staff who were absent from work due to sickness. We typically report 63% of staff with no sickness, this year our performance reduced to 50%.

Financial Resources

22. An allocation of £0.55m was funded from reserves to support the increase bed capacity on all hospital sites for January – March 2018. Welsh Government also allocated £10m of winter monies in January of which £1.818m was allocated to the Health Board. Funding was used for additional Emergency Department cover, increased beds, discharge and home support and other preventative measures.

Communications

23. The Health Board developed a strategy for keeping staff and public informed of this year's plans. The 'Be Winter-Wise' campaign is a campaign that uses existing national level communications and literature related to winter advice and incorporates them into a single area. Central to the communication message is the 'Choose Well' Campaign, which is a national approach to informing patients of how to best access healthcare. All elements of the communication plan

were delivered successfully. In addition to the winter plan communications programme, the supplementary £25k Primary Care monies that was provided by Welsh Government supported a very successful social media campaign with new videos, road maps, leaflets and new infographics and reached 2.1 million social media users.

C) Winter Planning 2018/2019

Approach

24. The Health Board will take a collaborative approach to this year's plan alongside our partners in the Welsh Ambulance Services NHS Trust, the five Local Authorities, voluntary and independent sector to produce a single plan using evidence, data and learning from previous years to ensure robust arrangements for Winter 2018/19.

25. A number of the schemes from last year were assessed as essential to supporting core delivery and as such are now embedded into core service. These include the Discharge Co-ordinators (DISCOs), the Transfer Team, Safety Huddles ED and Board Rounds. These schemes will be revisited though the summer months to assess their effectiveness and maximise their potential for Winter.

26. The Health Board will use the learning from last Winter to inform the plan going forward. The structure of our plan will be in line with our priority areas within the IMTP and in particular around our Service Change Plans.

27. The Health Board will use a planned Executive led Winter Planning Workshop on 24 July 2018 to discuss learning from 2017/18, but also to share some wider learning from other Health Boards. This will allow for discussion, the generation of ideas and our proposals for this coming Winter. The Aneurin Bevan Continuous Improvement Team (ABCi) and Service Planning will support to ensure that we have a project management approach and that we develop a suite of measures to understand the impact of the actions. We will also review our plans against the best practice set out in Good Practice Compendium produced by the Welsh NHS Confederation.

28. Some of the schemes which we will explore are listed below. These will developed into a first cut plan for submission to the Executive Team by the first week of September and will set out the financial impact assessment, deliverability, risks to implementation and success measures.

Strategic Change Plan 1 – Improving Population and Wellbeing

a) Working with Primary Care and Public Health colleagues to develop schemes for the continued focus on flu vaccination for at risk

patients, staff, particularly those in the front line and vulnerable inpatients.

b) Explore point of care testing for early diagnosis and infection control management of any cases of flu.

c) Using our Communication Strategy for Winter, we will assess the impact of last year's messages and build on those with the most successful impact (Dr Olivia videos, Choose Well).

Strategic Change Plan 2 - Delivering Integrated System of Health Care and Wellbeing

a) Work with the Neighbourhood Care Network (NCN) we will be preparing winter resilience plans which will include additional support and increased community resilience.
b) Primary Care nursing teams will work more closely with WAST and Out of Hours, and we will build on the learning.

c) We will explore the Stay Well at Home service used in other health boards to work alongside the new Elderly, Frail Unit (EFU) which will maximise care closer to home reablement.

d) The Health Board will review the potential to purchase step up/step down beds in available nursing and residential care homes with appropriate protocols for access by community services and Primary Care.

e) During the Winter, we will look to extend the capacity and scope for the Discharge to Assess project which will have been in place with Local Authority colleagues.

f) As in last year's plan, we intend to increase Social Assessment and Support Capacity to provide additional resources over weekend periods in order to expedite discharge.

Strategic Change Plan 3 - Management of Major Health Conditions

a) Revisit the virtual inpatient ward model and capacity and consider whether they can support additional patients with exacerbation of chronic conditions.

b) We are currently working with WAST to review the scope of the Falls Service and building on the success to explore opportunities for maximising the impact and reach of this service.

Strategic Change Plan 5 - Urgent and Emergency Care

a) The Health Board will explore how the public can access information about current waiting times in the Emergency Departments and

Minor Injury Units so that they can make choices about when and where they access care.

b) We have already undertaken some early collaborative planning with WAST colleagues to understand data around conveyances, Hear and Treat and "scheduling" unscheduled care demand. Exploring the impact of the role of the Advanced Paramedic Practitioner based in the Emergency Department at times of peak demand and also the role working on the Clinical Desk and the Physician Response Unit.

c) We are planning work with WAST and community teams to explore pre-screening of the Health Care Professional calls on the WAST stack.

d) We will ensure early planning for the resourcing of additional inpatient capacity in both the acute sites and community hospitals, using the successful staffing model delivered this year.

e) An urgent action is to review whether additional Assessment Unit/ambulance space to off load can be made available on the ground floor at Royal Gwent Hospital, based on the fact that we are an outlier with regards to trolley and cubicle facilities per 100,000 population.

f) Clinical streaming of patients at the front door is part of our Urgent Care Plan to reduce variation, waste and double handling of patients and getting them to the right specialty first time.

g) We are currently exploring the implementation of direct admissions from the Emergency Department for accepted conditions (by pathway and protocol), e.g. Paediatrics.

h) Our Breaking the Cycle programme has continued to be successful and will be refreshed and reintroduced. A Breaking the Cycle rota will be prepared in advance of Winter to ensure maximum impact and resilience in both acute and community settings.

i) Our Senior Nurse and Senior Management support will be strengthened to cover Out of Hours and weekends.

j) Our Infection Control Team will refresh training and processes which are in place to identify any early potential infectious outbreaks with robust infection control measures.

k) Where possible, support Emergency Departments and Assessment Units with additional junior doctors.

l) We are seeking to secure additional Clinical Site Manager cover to support operational flow which should be in place before winter.

D) Summary

29. The Winter of 2017/18 was extremely challenging for the Health Board. Despite proactive planning of innovative and successful initiatives to manage the known risks, the change in demand and acuity, as well as the patterns of presentation there were times when the Health Board was compromised and there were unacceptable delays for patients and our partners in accessing our services.

30. The extreme weather saw significant dips in temperature and given that we know this contributes to a whole range of health conditions and together with our population demographic, this resulted in older and frail patients presenting with more complex needs and a higher level of demand for hospital services.

31. Our quality markers evidence that we did keep patients safe and incidents have been appropriately reviewed by the Health Board and WAST colleagues.

32. The planning is well underway for the coming Winter and the Health Board will work in partnership with colleagues to improve the robustness of our approach this year.

National Assembly for Wales: Health, Social Services and Sport Committee
Inquiry into Winter Preparedness Summer 2018
Evidence Submission: Welsh Ambulance Services NHS Trust

Introduction

1. The Welsh Ambulance Service welcomes both the opportunity to contribute to Committee's inquiry into winter preparedness and also its commitment to supporting NHS Wales by instigating the inquiry in order that learning from the recent winter of 2017/18 can be captured and recommendations made.

2. It is universally acknowledged that the winter of 2017/18 was one of the most challenging experienced by NHS Wales. While the reasons for this are many, complex and various, it is important for the Welsh Ambulance Service that a system wide review of those reasons, and possible solutions, is undertaken.

3. As an ambulance service working within the wider NHS system in Wales, it is acknowledged that there is a need to deliver different solutions to respond to the sustained increases in operational pressures, many of which are prevalent throughout the year, but are more acutely felt during the winter season.

4. Such pressures are well documented; a combination of an ageing, increasingly frail and/or health-compromised population, coupled with the real likelihood of adverse weather, seasonally more prevalent illness, for example flu, and the threat posed by a generally more unstable world, mean that the need to develop sustainable and responsive services has never been more necessary.

5. In this evidence submission, the Welsh Ambulance Service will provide an organisational perspective on winter preparedness 2017/18, together with an indication of the work already underway to ensure the service is as resilient as it can be to cope with, and respond to, organisational or system pressures, regardless of their cause or their timing.

Background: Commissioning Arrangements

6. Emergency ambulance services are commissioned on a collaborative basis by the seven local health boards through the Emergency Ambulance Committee (EASC) and the Chief Ambulance Services Commissioner (CASC), acting on their behalf. The Commissioning & Quality Delivery Framework for emergency ambulance services is the document which sets out what is expected of the ambulance service.

7. In collaboration with commissioners, five-step pathways for both emergency and non-emergency (NEPTS) services have been developed, which focus on delivering real improvements for patients.

Figure 1: Five-Step Emergency Ambulance Care Pathway

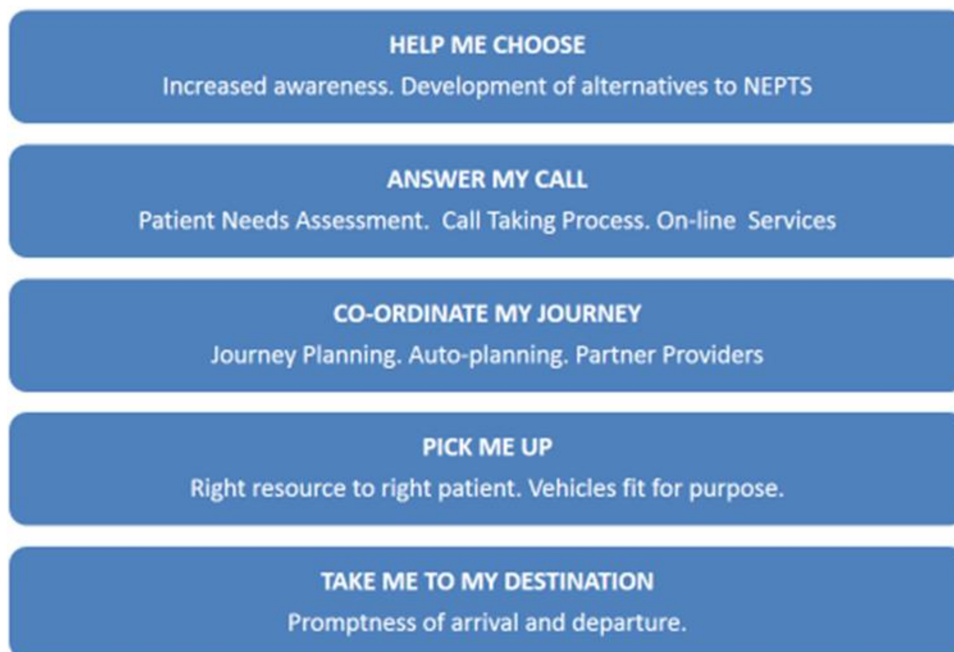
Designed with permission using the CAREMORE® 5 steps. Copyright, 2017 WAST

8. The focus of the pathway is to ensure that patients are supported to make the right choice for them and receive the care most appropriate to their needs.

9. Step one supports patients to choose the service that most appropriately meets their immediate needs, which may not be an emergency ambulance, while step two focus on providing patients with the right advice when they call. Steps three and four focus on ensuring that more patients can be treated at scene or referred to other services if that would be more appropriate for them, while step five makes sure only those patients who absolutely need to be conveyed are taken to hospital.

10. The NEPTS Five-Step Model also shows what is expected of non-emergency transport services and became operational in shadow format from November 2017.

Figure 2: NEPTS Five Step Model



11. The organisation's clinical response model, which was confirmed as permanent in February 2017, provides the clinical basis on which calls are categorised.

12. The fundamental basis of the response model ensures that the care of the sickest patient is prioritised, as outlined in the paragraphs below.

13. The model has three types of call – red, amber and green.

14. Red calls are immediately life-threatening calls and are categorised as such when someone is in imminent danger of death, such as a cardiac arrest. In such cases, there is compelling clinical evidence to show an immediate emergency response will make a difference to a person's outcome. The eight-minute target has been retained for this group, with a target of 65% of calls receiving this level of response.

15. Amber calls refer to those patients with conditions that may need treatment and care at the scene and rapid transport to a healthcare facility, if appropriate. Patients are prioritised on the basis of clinical need and patients receive a fast, blue light response. There are no time-based target for amber calls; instead a range of clinical indicators (the Ambulance Quality Indicators) have been introduced to measure the quality, safety and timeliness of care being delivered, alongside patient experience information, which is published every quarter.

16. Green calls are non-serious calls, which can often be managed by other health services, including by providing healthcare advice or through self-care. This category also includes many calls from healthcare professionals.

17. The clinical response model and the ambulance care pathway, taken together, provide the basis of the Welsh Ambulance Service's operational approach in respect of emergency medical services.

Planning for Seasonal Pressures

18. The Welsh Ambulance Service, in line with other NHS organisations across Wales, makes detailed plans for seasonal pressure, using learning from previous experience and modelling to inform its approach.

19. The organisation takes the process of winter planning very seriously, recognising that having a well thought through and executed plan is key to maintaining high levels of care for patients at times of increased pressure across the health system, such as those which inevitably come with winter.

20. Similarly, plans are not developed in isolation from the wider system, and colleagues spend a considerable amount of time and effort in working with health board partners to ensure plans are aligned and that organisations are cognisant of each other's proposals.

21. The Board of the Welsh Ambulance Service takes an equally robust approach to planning for winter, with the Board having considered and approved the organisation's winter plan at its meeting in September 2017.

22. In addition to discrete initiatives (detailed below), the Trust also has a Resource Escalation Action Plan (REAP) plan, which outlines measures to be taken at differing levels of pressure in the system. This enables the service to respond more appropriately to demands across the wider NHS system, ensuring ambulance resources are preserved for those in most acute need of help, in line with the organisation's clinical response model.

23. It is indicative of the severity of the winter of 2017/18 that, in response to the challenges across NHS Wales, the Trust needed to respond with its highest level of escalation, Reap 4; the first time this has been deemed necessary.

Seasonal Interventions

24. As part of its planning for the anticipated increase in demand during the winter and, to an extent, in response to those subsequently experienced, the Welsh Ambulance Service introduced a number of initiatives within its gift of control as mitigation against those pressures. These included:

- The piloting of the use of 10 Advanced Paramedic Practitioner **(**APPs – MSc-educated paramedics) working across two Rapid Response Vehicles (RRVs) and rotating into the Clinical Contact Centre, in the Betsi Cadawaladr University Health Board area. The APP within the CCC tasked the two responding RRV APPs to incidents where it was felt that there was an opportunity for patients to be appropriately managed and cared for in a way that did not necessitate conveyance or an admission to an Emergency Department (ED).

  The impact of this initiative on conveyance and patient care has been significant, with the initial data analysis being based upon 636 patients attended.

  The data illustrated an indicative rate of 69% ED avoidance, with 37% of cases being closed at scene without further referral, negating the requirement for additional pathways. This remained constant throughout the pilot. The re-contact rate within 48 hours was circa 5%. Of the patients that were conveyed to the ED, the majority (51%) were not conveyed by emergency ambulance.

- A "falls assistant" pilot in collaboration with St John Cymru began on 1 February 2018. This team provided cover between 0700 and 1900, seven days a week. The Falls Assistant was qualified to the level of a Welsh Ambulance Service Urgent Care Assistant and responded to non-injured fallers, or fallers who had sustained minor injuries. The team was based in Cardiff, but could be asked to support surrounding health board areas. Assistants were deployed to more than 200 incidents. Ways of securing such a service longer term are currently being explored.

  Similarly, given the volume of calls to lift uninjured patients who have fallen, 20 "Mangar Camel" lifting devices were placed with Community First Responder (CFR) teams in South East Wales to provide a different resource to support patients, thus negating the need for an emergency ambulance and its skilled crew.

- Significant focus was placed on the use of social media as a sign posting and information sharing mechanism, in particular to position NHS Direct Wales' online "symptom checkers" as the first point of reference for people feeling unwell but unsure about the right NHS service to meet their needs. The aim was to alleviate demand and to provide advice and

guidance in an immediately accessible format, thus reducing unnecessary call volume, either to NHSDW's 0845 number or to 999.

Between October – December 2017, there was a total of 943,303 visits to the NHSDW website. Between January-March 2018, this figure rose to 1,787,884.

The impact of being able to communicate via social media during periods of adverse weather also proved to be important in providing information to patients and the wider public. The Welsh Ambulance Service's Communications Team provided digital and media support throughout the extended periods of adverse weather on a 24/7 basis during the winter of 2017/18, with senior leaders being visible through the media in discussing pressures and providing advice and support to the public.

- Our Non-Emergency Patient Transport Service (NEPTS) enhanced its role in the discharge of patients from hospitals across Wales, to support improved flow of patients through the acute hospital system and to ensure patients who were medically fit for discharge and required ambulance transport could return home in a timely manner.

- Investment in the Trust's "hear and treat" provision to increase the capacity of the organisation's "clinical desk", which triages calls where clinical assessment and advice might negate the need for an ambulance and/or acts as a "safety net" for patients who have waited longer than anticipated for a face-to-face assessment.

25. These initiatives were implemented in part to anticipate, and to respond to the pressures being felt across the NHS Wales system during the winter of 2017/18, the detail of which is outlined below.

Winter 2017/18: A Brief Performance Analysis

26. While detailed planning for winter was undertaken as outlined above, highlighted below are some of the issues and impacts for the Welsh Ambulance Service related to sustained system-wide pressures, recognising that, despite these pressures, the Welsh Government and commissioning target of reaching 65% of red calls within eight minutes continued to be maintained.

27. The key points were as follows:

    - 999 calls answered increased by 16.01% during the winter of 2017/18, compared to the previous winter

    - Verified demand increased by 5.86% in 2017/18, compared to the previous winter (October to March)

    - 999 calls ended as a result of hear & treat (calls reviewed by a nurse or paramedic via NHS Direct Wales or the Welsh Ambulance Service's Clinical Desk, where following triage and advice, no ambulance was deployed) increased by 29.57% during winter 2017/18, compared with winter 2016/17

- While Red performance was maintained above 65% (it was 69.7% in January, 69% in February and 69.6% in March) in 2017/18, this became increasingly challenging, with performance declining compared to winter 2016/17

- Amber performance became particularly challenging during the winter period. While there is no delay built into the clinical model (amber calls receive a blue lights and siren response), pressures on the wider system, including resultant handover delays at hospitals, meant this was the category which saw the most obvious deterioration in performance, recognising that there are no formal response targets for the amber category. This meant that some patients waited significantly longer than would be desirable.

- Amber response activity accounted for 84% of response activity and was comparable with previous years

- Whilst there was clearly a significant challenge in terms of amber performance, (in some cases the 95th percentile performance for Amber exceeded five hours), the pan Wales amber median was in the range of 17 minutes – 34 minutes during the winter of 2017/18 and the 65th percentile was under one hour throughout the winter, in the range 25 minutes to 58 minutes)

- Red response activity also increased to 7.52% of response demand during winter 2017/18, higher than the c.5% at the start of the Clinical Response Model in October 2015 and 2.51% higher than the winter of 2016/17

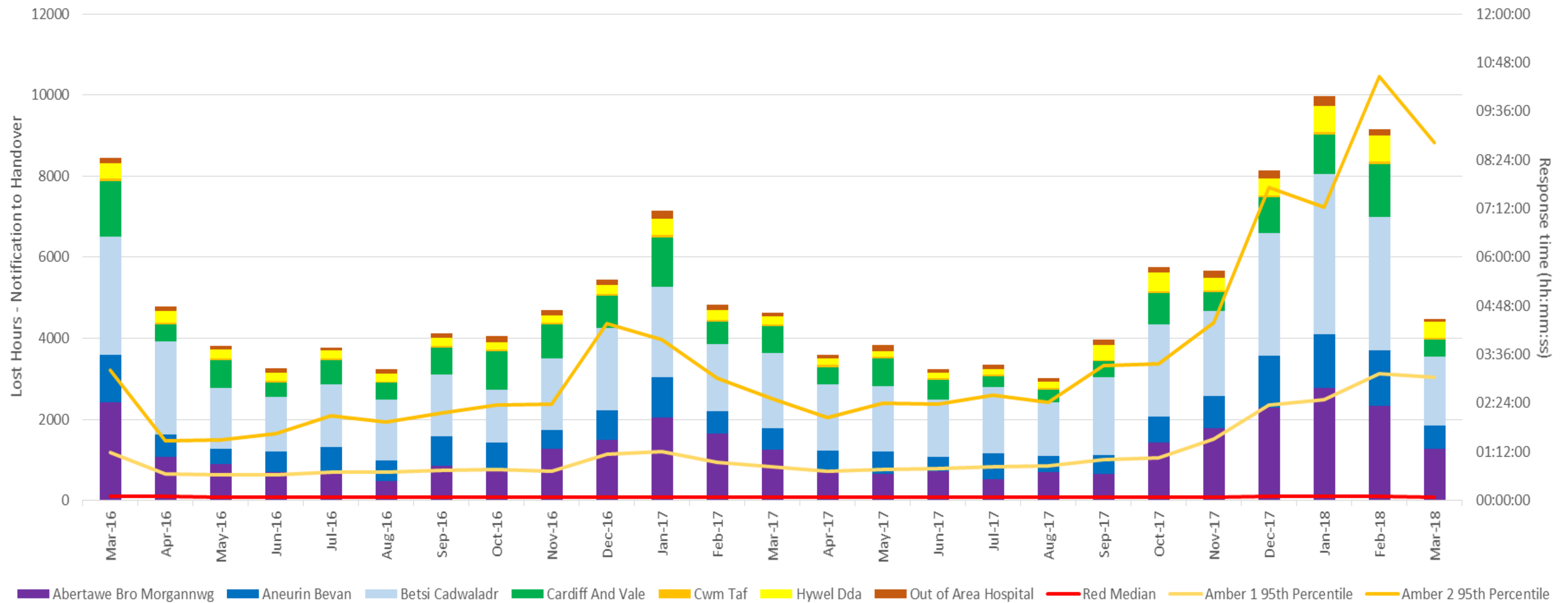
- Green response activity accounted for 9% of response demand, with hear and treat capacity contributing to a reduction in this figure based on previous years

- 9,494 (7.7%) fewer patients were conveyed to major A&Es during winter 2017/18 compared with the previous year (or 113,797 compared to 123,291). This is notable given the overall rise in demand and reflects the efforts made by the ambulance service to manage demand by using its hear and treat capacity effectively and by treating more patients at scene , thus avoiding unnecessary conveyance to hospital.

28. The impact of lost hours to handover has been a significant contributory factor to delayed responses, and there is a strong correlation between poor amber response time performance and lost hours.

29. The Trust notified to handover delays increased by 54% during winter 2017/18 compared with the previous year. This equated to 47,524 hours of lost production, 10% of the organisation's EMS conveying capacity or 3,960 shifts (an ambulance crewed for 12 hours) during the winter period. It should be noted that the Trust expects an ambulance to undertake around 7 incidents per 12 hours; this lost time equated to the chance to attend to circa 22,500 patients.

The following graph illustrates a strong correlation between amber performance and handover lost hours.



RED Median, AMBER1 & AMBER2 95th Percentile against Lost Hours - Notification to Handover Delays
Lost Hours - Notification to Handover
Response time (hh:mm:ss)
0
2000
4000
6000
8000
10000
12000
00:00:00
01:12:00
02:24:00
03:36:00
04:48:00
06:00:00
07:12:00
08:24:00
09:36:00
10:48:00
12:00:00
Mar-16
Apr-16
May-16
Jun-16
Jul-16
Aug-16
Sep-16
Oct-16
Nov-16
Dec-16
Jan-17
Feb-17
Mar-17
Apr-17
May-17
Jun-17
Jul-17
Aug-17
Sep-17
Oct-17
Nov-17
Dec-17
Jan-18
Feb-18
Mar-18
Abertawe Bro Morgannwg
Aneurin Bevan
Betsi Cadwaladr
Cardiff And Vale
Cwm Taf
Hywel Dda
Out of Area Hospital
Red Median
Amber 1 95th Percentile
Amber 2 95th Percentile

Patient Safety and Experience

30. The impact and consequences of the extended winter system pressures on the ability of WAST to respond to patients in the community have been of concern.

31. The strong correlation between delayed responses to patients awaiting a response in the community and hospital delays is evident in the significant reduction in amber performance. This may result in poorer outcomes for patients.

32. An increase in reported serious adverse incidents (SAIs) and concerns from patients, their families and politicians, was observed during the winter of 2017/18

Serious Case Incident Forums (SCIF), Serious Adverse Incident (SAI) Reporting

33. In relation to the reporting of potentially adverse incidents, cases are considered by the Trust's Serious Case Incident Forum (SCIF) for assessment prior to any submission reported to Welsh Government. There were 168 incidents considered by the SCIFs held relating to incidents over the winter of 2017/18 , of which 68 of were reported to Welsh Government as SAIs.

Complaints and Concerns

34. The number of concerns registered from December 2017 to April 2018 was 277, compared to 114 for the same period the previous year.

35. There has been a concomitant rise in the level of concerns raised by politicians on behalf of their constituents.

Impact on Staff

36. Periods of sustained and relentless pressure inevitably take their toll on ambulance staff. This has been true across all staff groups, but was of particular note among clinical contact centre staff, who were placed under considerable pressure in managing both an increased volume of calls and the impact of delays.

37. The Trust has a range of mechanisms to support the health and wellbeing of its staff, but also introduced some discrete interventions for those staff working within its clinical contact centres, which were universally welcomed by colleagues.

Winter 2018/19 and Beyond

38. As outlined at the outset of this evidence submission, the Welsh Ambulance Service can be viewed as a barometer for pressure across the entire unscheduled care system and does not operate in isolation from the rest of the NHS in Wales.

39. The use of ambulance imagery in media reports, print, online and broadcast, has become a metaphor for system pressure, something which the Trust has challenged as implying that the ambulance service bears a greater responsibility for those pressures. It does not. It is, however, perhaps the most visibly affected service when system pressures are at their most acute.

40. What is clear is that there needs to be change across the entire system if the winter of 2017/18 is not to be repeated. The demography of Wales is well documented, while additional potential

factors such as adverse weather, pandemic illness, such as flu, or other unforeseen events would place similar pressure on the NHS in Wales in future years.

41. With this in mind, and with a clear commitment to being at the forefront of the necessary change, the Welsh Ambulance Service is anxious that the learning from the winter of 2017/18 is captured and that new, collaborative and system-wide approaches are adopted.

42. To this end, the Executive Team, including the Interim Chief Executive, is already meeting pro-actively with individual health boards to share data, experience and ideas with a view to having more resilient and innovative solutions agreed and/or in place earlier in the winter planning cycle.

43. It is similarly working collaboratively through the Emergency Ambulance Services Committee (EASC) and the Chief Ambulance Services Commissioner (CASC) to deliver collaborative changes in the system.

44. In particular, the Trust has developed the following initiatives for 2018/19 designed to mitigate the impact of further system pressures:

- A focus on reducing sickness absence and reviewing rosters to ensure staffing is optimised
- Increasing the organisation's permanent establishment to provide greater resilience in areas where staffing is more fragile, to cover absences and to account (in advance) for the routine turnover of staff, lessening the impact of the latter and ensuring staffing levels are maintained. In part, this will be achieved by converting the current overtime budget (and other variable resource expenditure) to increase numbers of permanent emergency ambulance staff
- Further development of the response logic for the Clinical Response Model, in particular, what an "ideal" response is and whether this response is from the Welsh Ambulance Service or from the wider unscheduled care system
- Delivering further benefits of the new Computer Aided Dispatch system, in particular reduced time to allocation for red incidents
- Increasing hear and treat volumes
- Realising the benefits of the recent implementation of the Band 6 paramedic, which requires colleagues to have improved clinical skillsets
- Reducing multiple arrivals on scene; and
- Improving the "ideal" arrival on scene, where the resource is a WAST resource.

Concluding Observations

45. It is increasingly apparent that no part of the NHS Wales system operates in isolation from others – this is particularly the case for the Welsh Ambulance Service.

46. Following that logic, the need for collaborative solutions to increasing demand is obvious, else pressure is simply shifted from one organisation to another.

47. The need for primary and community care, including the pressure point of fragile GP out-of-hours services, secondary care and social services to work together has never been more acute. There is more to do to align and integrate the way in which these services operate, and the Welsh Government's recent health and care strategy "A Healthier Wales" is welcomed as a step forward in focusing on this important area.

48. However, the Welsh Ambulance Service would argue that the time for radical change in thinking is now and, as an NHS Wales system, we must grasp this nettle once and for all, in order that all organisations are better equipped to contend with the demands increasingly being placed upon them.

49. The Welsh Ambulance Service sees itself increasingly occupying different areas within the unscheduled care space.

50. Similarly, it recognises the need to work in tandem with all partners and patients on the prudent use of systems and services, in a bid to ensure patients understand, and use, the correct parts of the NHS system to meet their needs and develop individual and community resilience. This chimes with the organisation's commitments to the fundamental tenets of the Wellbeing of Future Generations Act.

51. The architecture for change and collaboration is in place across Wales, including through legislation. There can now be no further delay in realising the ambition of the Welsh Government outlined in its "A Healthier Wales" strategy.

52. The Welsh Ambulance Service will continue to be a committed and vocal contributor to driving change across the wider NHS system across Wales, recognising that it too will need to morph and change continuously to meet the evolving needs of the people and communities it serves.

Ends/EVH/July18

Mae cyfyngiadau ar y ddogfen hon

ADSS Cymru
Leading Social Services in Wales
Yn arwain Gwasanaethau Cymdeithasol yng Nghymru

Inquiry into Winter Preparedness 2017-18

Written Submission by ADSS Cymru

Authority	Jenny Williams, President of ADSS Cymru
Completed by	Paul Pavia, Policy and Research Lead
Date	12 July 2018

General Comment

1. The Association of Directors of Social Services (ADSS Cymru) is the professional and strategic leadership organisation for social services in Wales and is composed of statutory Directors of Social Services and the Heads of Service who support them in delivering social services responsibilities and accountabilities; a group of more than 80 social services leaders across the 22 local authorities in Wales.

2. As the national leadership organisation for social services in Wales, the role of ADSS Cymru is to represent the collective, authoritative voice of Directors of Social Services, Heads of Adult Services, Children's Services and Business Services, together with professionals who support vulnerable children and adults, their families and communities, on a range of national and regional issues of social care policy, practice and resourcing. It is the only national body that can articulate the view of those professionals who lead our social care services.

3. As a member-led organisation, it is uniquely placed as the professional and strategic leadership organisation for social services in Wales, to lead on national service development initiatives to ensure a consistent efficient and high standard of delivery for people who access care services across Wales.

4. ADSS Cymru is committed to using the wealth of its members' experience and expertise, working in partnership with other agencies, to influence important decisions around social care to the benefit of the people it supports and the people who work within care services.

5. ADSS Cymru welcomes the opportunity to submit written evidence to the National Assembly's Health, Social Care and Sport Committee on its inquiry into winter preparedness, both in regard to the evaluation of the delivery of operational plans last winter (2017-18) but also in regard to the operational plans being formalised for next winter (2018-19).

6. Much like other parts of the UK, urgent and emergency care services in Wales have experienced periods of significant pressure and demand and this is an issue that has now become a challenge for 52 weeks of the year, not just over the winter months. There has been a sharp rise in the number of people seeking treatment and care at emergency departments and a peak in ambulance arrivals at hospitals throughout Wales. Over recent years the NHS across Wales has seen an increased number of people being admitted with a complex range of medical conditions and consequently greater degrees of frailty. Because of the nature and acuity of their conditions, these people take longer to assess, diagnose and treat and may have ended up staying in hospital longer for their treatment;

they often need more support arrangements to be put in place to enable them to eventually be discharged.

7. However, experience demonstrates that the winter months pose particular challenges for health and social care organisations and unscheduled care services face further pressures during the winter months; an area which impacts on how patients and the public experience health and social care services. Yet, it should be stated that the winter of 2017-18 was particularly challenging, one of the most challenging on record, with significant peaks in demand at secondary and primary care levels. December 2017 was the busiest for attendance at emergency departments on record and was proceeded by the second busiest January to March on record, due primarily, to very high levels of flu and elderly admissions. The extreme weather in early March also made it extremely difficult for both NHS and social care workforces to operate, which clearly had an effect on both waiting and discharged times.

8. ADSS Cymru welcomed the Welsh Government's acknowledgement that the social care sector and its workforce, play an equally important role in delivering care and had faced the same considerable pressures last winter as workers in the NHS and recognised that fact by providing an additional £10 million to local authorities to address their most immediate priorities, which were identify as:
   i. Providing extra domiciliary care packages
   ii. Providing care and repair services to enable quicker discharge from hospital and maintain independence at home
   iii. Short-term and step-down residential care.

Where do the pressures reside in the system?

9. ADSS Cymru believes that the pressures on acute hospitals in winter come from many sources and are a symptom of wider issues in the local health and social care system, suggesting that a more sustainable response will be developed by looking at the whole system. Good flow across the system is key to creating and maintaining capacity.

10. In addition, we are now finding that problems that were usually confined to the winter months are now increasingly being experienced at other times of the year as well. Whilst there is a mixed picture across the Welsh authorities and regions there are a number of trends reported by local authorities in relation to unscheduled pressures. These include:

- The fragility in domiciliary care and re-ablement services, exacerbated by market capacity, volatility in demand and short-term problems, associated with sickness or leave at times of public holiday.
- Responsiveness and complexity of service required are significant issues, with recruitment and retention said to be challenging, particularly, though not exclusively, in rural communities.
- Capacity in traditional residential care has been relatively resilient, but many areas have reported a scarcity of specialist Elderly Mentally Infirm (EMI) and nursing care capacity (in part as a result of workforce issues and with a particular challenge with recruitment of nurses)
- Pressures on the hospital system, in particular increased admissions and people presenting with higher levels of acuity, coupled with the reduction of hospital beds.
- Patient/Family choice and expectations

Delayed Transfers of Care

11. Delays in hospital discharge and timely transfer of care to other secondary providers, primary care and community care (hospital and home) have a significant impact on patients, their carers and indeed for those patients requiring admission to hospital. Therefore, discharge and transfer of care planning and its effective implementation is everyone's business, with the Multi-Disciplinary Team (MDT) at both ends of the system being critical to its successful delivery.

12. Delayed transfers of Care (DToC) are seen as the main reporting mechanism for the sector and are the benchmark used by Welsh Government to determine how well a Health Board and Local Authority are performing. Over the past few years, there has been a great deal of work to both understand the issues and causes of DToC and poor patient flows, along with tools and resources to address these.

13. The varying complexity of DToCs require effective partnership working by health and social care organisations. Transferring patients from one care setting to the next relies on appropriate joint processes and a patient centred approach. Therefore, DToC can be an indication of ineffective collaboration, contributing to systemic failure rather, than the actions of individual parties, whether in social care or the NHS.

14. A DToC is a complex issue and ADSS Cymru strong believes that in pursuing a whole systems approach in the planning and delivery of services, to fixate on this one issue in isolation would be to miss the point. A DToC is just a symptom of a broken patient journey. For example, while historically, the majority of DToCs can be attributed to delays within the NHS (Annex. 1), within the last year, we have seen the proportion attributable to social care increase, reflecting pressures faced by local councils, where the capacity of the workforce is a major contributory factor and so too is the stability of the market.

15. In 2013, the Community Hospital Interface Group published its report on DToC and stated that if improving flow is to be assured on a sustainable basis, a three-stranded approach is needed:

    i. A preventative approach which identifies those at risk of being admitted to hospital and seeks to intervene to avoid this where it is appropriate to do so;
    ii. A proactive approach which identifies and manages those at risk of becoming delayed when in hospital;
    iii. Effective systems and processes to identify and manage those who experience a delay in their discharge or transfer to a more appropriate setting.

    Following on from that in 2016, the Social Services Improvement Agency also published a report entitled, *Delayed Transfers of Care: Informal Review to Identify Good Practice,* which focused on operational practice, systems and processes within local authority and health board partnerships under the four themes of – Capacity, Consistency, Communication and Culture.

16. The research found there has been a conscious move towards rebalancing provision towards primary and community led healthcare service. The move towards a more community driven NHS response has led to significant investments in community services, including the establishment of Community Resource Teams (CRTs). Local authorities in partnership with Health Boards have

developed the CRTs and have also provided a shared approach to re-ablement, in addition to the longer term domiciliary care provision. This reinforces the need for all responses to take a whole system approach.

17. A number of actions have been identified to improve performance in relation to DToC, these included:

    - Implementation of existing guidance - such as 'Passing the Baton' and the Ten High Impact Changes for Complex Care.
    - Avoiding unnecessary hospital admissions – working with GPs to identify key people at risk to target early intervention, use of specialist staff at the "front door", providing support and advice to care homes, use of third sector organisations in the provision of preventative services and support.
    - Choice – ensure implementation of existing guidance, ensure staff are "on message" i.e. hospital is not accommodation and need early discussions to plan discharge, use of intermediate care beds, step down beds, interim placements etc.

18. ADSS Cymru believes that the winter 2017/18 saw greater collaboration across services and organisations in support of improved patient flow through the hospital system and transferring care to the community. Most local authorities have integrated re-ablement teams who can 'pull' patients out of hospital by organising packages of care quickly and effectively. This includes homecare, meals, small adaptations, transport. It is really important that social care is recognised as coordinating this function as part of the whole system approach. Those collaborative partnerships continue to mature and again there was consensus that relationships between partners have continued to improve through 2018, particularly as the work of the Regional Partnership Boards takes further root; partners now jointly own DToCs and collective action is being taken to tackle the issue.

19. Progress is being made on reducing the levels of DToC in Wales and in some regions, they are at historically low levels. It should be noted that while demand for social care last winter was very high, particularly home care services, the sector was able to effectively respond and consequently, the overall DToC figure has reduced. From a full year perspective, the total number of DToC in 2017 was 750 (13%) lower than in 2016 and the lowest full year total recorded in the 12 years that DToC statistics have been collected. In February 2018, DToC decreased by 11% in compared to January 2018. Yet, it is evident that pressures continue to exist, particularly in relation to future funding arrangements for social care.

Unscheduled Care

20. Local authorities have and continue to work closely with local health boards, Welsh Government and other partners to plan for unscheduled pressures and design services to meet needs. Local authorities have utilised the funding streams available to them to support much of their work in helping to lessen the impact of winter pressures. For example, previously funding from the Regional Collaborative Fund (RCF) was used to support the development of new services across regions with a focus on priority areas, including winter pressures for social care and health services. While the Intermediate Care Fund (ICF) has also provided opportunities to achieve a further step change in the way services work collaboratively at both strategic and operational levels, there is a significant level of uncertainty that accompanies this sort of short-term funding provision, which does impact on

recruitment. ADSS Cymru believes that while local authority social services have fully utilised these investment streams to reduce DToC pressures, we feel this has to be placed on a more sustainable footing moving forward and we hope Welsh Government will acknowledge that fact in future budget arrangements.

21. Other work local authorities have been involved with include the development of unscheduled care plans and pilot projects, aimed at managing winter pressures. This has included elements such as:

    - An exploration of opportunities to jointly fund interim placements with the aim of improving the discharge process and reducing the number of delayed transfers of care
    - Improving GP access during core hours
    - Closer working with regard to escalation procedures at times of increased demand
    - Development of step up / down beds.
    - Expanding Intermediate Care Service (Social Workers, Therapists, District Nurses and generic workers) available over the weekend in order to increase the number of safe discharges during the Winter pressures period
    - Having social work presence within hospitals to help prevent avoidable hospital admissions and facilitate earlier discharge.

22. There are also examples of innovative approaches that have been developed, for example, Healthy Prestatyn/Healthy Rhuddlan Iach, an integrated model of primary care delivery. This aims to treat patients as full and equal partners in their health journey, applying an integrated MDT approach to primary care which makes maximum use of community assets to fully address patient need. The new primary care service is based on four elements - Same Day, for minor ailments and injuries; Elective Centre, for planned care including chronic conditions; Domiciliary and Care Home Support; and an Academy providing training for professionals and patients. This represents a more holistic approach, recognising that the way to avoid delayed discharges is to identify how people end up in hospital and tackling the problem at its source.

23. Whilst there are examples of good practice right across Wales and much progress has been made, a clear test in addressing the challenges presented by winter pressures and unscheduled care is the capacity of the organisations and resources available. Given the ever-growing pressure on services, partners need to work together across the statutory and third sector to ensure best use of scarce resources in a time of austerity.

How can the NHS and local government initiate further integration for future winters?

24. At the heart of the Parliamentary Review of Health and Social Care and the Welsh Government's response, *A Healthier* Wales, is service integration; integration across health and social care is key. The health and well-being of the population is not the sole responsibility of the NHS and everyone must come together to play their part, particularly within the spheres of prevention and early intervention; that's where local government social services can lead, if properly enabled. Integration and collaboration needs to happen, both within and outside of the health service. The NHS will not be able to rise to the challenges it faces without the help of colleagues in other sectors, including the third sector (a sector we feel was not properly valued in the Parliamentary Review) housing, leisure, education, and in particular, those in social services. Ultimately, local government wants to lead on

the well-being and prevention agendas and significantly reduce the flow of citizens entering the acute sector; that is the only way to take pressure off the system.

25. The Social Services and Well-being (Wales) Act has provided opportunities to support integrated working through the creation of Regional Partnership Boards and requirements to undertake joint population assessments and action plan. ADSS Cymru believe that we need to take a more radical approach to integration, with local government at its heart. This is critical if we are to shift focus and resources towards prevention and early intervention, rather than treatment or resolving crises in the acute sector. The ICF has provided regional health and social care collaboratives the opportunity to focus on projects that deliver safe and impactful services to people in their own homes, reducing hospital admissions and freeing up beds in the acute sector. Developing these new models of service delivery have involved 'out of the box thinking', with the integration of social care, health and housing, along with the essential contribution of third and private sector agencies.

26. We need to learn from this, as well as from the approaches in other countries, in order to be able to accelerate this agenda in Wales, making better use of all available resources to both health and social services, to drive this forward towards more meaningful integration and improved outcomes. In effect, what we need to see now, in line with *A Healthier Wales*, is those best practice prevention and early intervention services effectively scaled up to provide more help before hospital admission becomes the only solution.

27. ADSS Cymru is currently working with Welsh Government and other stakeholders on three crucial work streams, using Delivering Transformation funding, that will help facilitate further integration, particularly around the future financing of social care and the scaling up of new models of service delivery, as well as the further integrated development of pooled budgets; all work that underpins the Welsh Government's delivery of *A Healthier Wales.*

What are ADSS Cymru's Five Fundamental Asks?

28. **Put prevention at the forefront of the whole systems debate**
    Local Government social services would like to see the initial activity of implementing *A Healthier Wales* to focus on prevention and early intervention. The future integration of health and social care services should be devised around keeping people physically and mentally healthy, in their communities, for as long as possible. Because once there is pressure on services in the community, the consequential impact is that there is pressure on the acute sector. If a person cannot see their GP in a timely manner, or is able to attend a local Minor Injuries Unit for assessment, they will present to hospital A&E. Therefore, as part of the prevention approach, there needs to be more effective information, media coverage and advice from key service organisations as to how people can keep themselves well, as well as when to attend hospital and when not to. Primary Care has a fundamental roll in this regard and we would like to explore new ways of local government taking over some of the elements of strategic planning of Primary Care in the community.

29. **Define the real problem and measure it**
    As has been previously stated, ADSS Cymru believes that too much focus and importance is put on DToC, which is just one part of a whole systems approach of expediting the patient through secondary care and back into the community. We would recommend that Welsh Government identifies data that actually captures the real issue, rather than, as is seen by coordinators on the

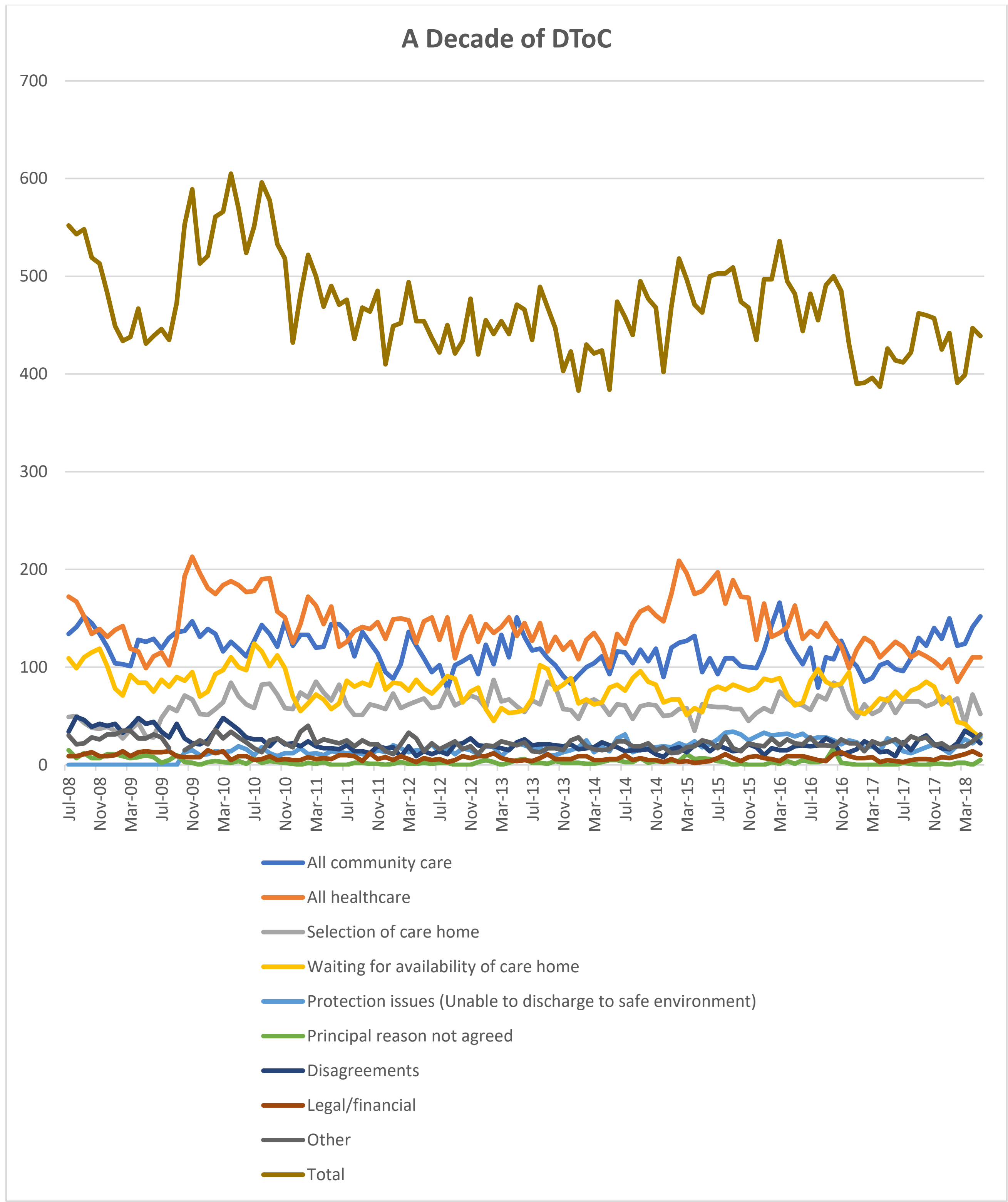
ground in local authorities, the current bureaucratic mechanism for allocating blame. We have discovered from studies in England – particularly the Nuffield Trust's examination of the New Cavendish Group of hospitals - the current system for reporting delayed discharges severely underestimates the numbers of patients in hospital who are ready to move elsewhere. In England, some hospitals have started to monitor the patients that could be cared for in other settings on a routine basis and are using this data to improve services.

30. **Operational improvements within organisations**
    There are many interventions that are known to reduce the numbers of patients waiting for discharge, ranging from simple process improvements to bigger policy changes. However, it is possible that hospitals and local authorities are so busy fire-fighting that they lack the capacity to implement these measures. Therefore, it is important that Regional Partnership Boards take a firm lead on this agenda and ensure that there is sustainability of best-practice through the use of pooled budgets and effective use of ICF funding.

31. **Improve the interface between hospitals and other services**
    Social care has had a role in increasing delays slightly this year and the timeliness of social care assessments is an important factor here. However, so is the interface between hospitals and community services, as is the availability of home support, therapies, access to diagnostics and other NHS services close to the patient. In driving forward *A Healthier* Wales and new models of integration, local authority social services have a real opportunity to lead this whole agenda – if properly supported and resourced – because of the networks it has already fostered with housing associations, the third sector and other agencies. These are extremely useful allies for local authorities but they often find dealing with the NHS very difficult and individually, they cannot solve the health sector's problems alone.

32. **Moving away from bureaucracy and duplication**
    The significant numbers of patients delayed in leaving hospital are both a cause and a symptom of problems in the smooth running of NHS hospitals. Yet, there is also a variation in local government and NHS performance in managing these delays. Learning from areas with fewer delays, improving systems and processes within hospitals and making better use of data can all help. For example, ADSS Cymru believes that while there is capacity in the discharge system, there is a lot of duplication of discharge co-ordination roles and functions, like Discharge Liaison Nurses, Patient Flow Co-ordinators etc.

ANNEX. 1



Y Pwyllgor Iechyd, Gofal Cymdeithasol a Chwaraeon

Ymchwiliad i atal hunanladdiad – trafodaethau gyda Tir Dewi, 21 Mehefin 2018

Trafodaethau gyda chynrychiolwyr Tir Dewi – Gareth Davies (cydlynydd); Eileen Davies (sylfaenydd); Rita Jones; Gill Gibson

Dai Lloyd AC (Cadeirydd); Angela Burns

Y cefndir

- Ffurfiwyd Tir Dewi yn 2015 gyda'r nod o ddarparu gwasanaethau gwrando i ffermwyr weithio drwy eu problemau a gwella eu lles;
- Ar hyn o bryd mae 19 o wirfoddolwyr hyfforddedig yn gweithio gyda Tir Dewi i gynorthwyo gyda gwaith achos ac ateb y llinell gymorth. Mae un gweithiwr rhan amser sy'n cydlynu gwaith y sefydliad;
- Mae'n cwmpasu ardaloedd Sir Benfro, Sir Gaerfyrddin a Cheredigion;
- Mae'r gwirfoddolwyr i gyd yn dod o gefndir ffermio;
- Ariennir Tir Dewi drwy ddau grant o Esgobaeth Tŷ Ddewi a chronfa gefn gwlad Tywysog Cymru, a chyfraniadau elusennol – mae'r cyllid o'r ddau grant i fod i ddod i ben yn fuan.

Pwysau ar ffermwyr

- Mae ffermwyr yn wynebu pwysau rheoleiddiol a gweinyddol o nifer o gyfeiriadau, gan gynnwys TB buchol, rheoliadau lles anifeiliaid, yr amrywiol gynlluniau talu ac ymchwiliadau fferm – gall pob un greu ofn ar ffermwyr ac effeithio ar eu lles meddyliol;
- Gall y cyfuniad o nifer o bwysau yn ogystal â beichiau arferol llwyth gwaith a phwysau ariannol arwain ffermwyr i ystyried ceisio cyflawni hunanladdiad;
- Cyfeiriodd un o'r cynrychiolwyr at hunanladdiad cyflawn lle'r oedd y ffermwr wedi llenwi ffurflen yn anghywir i gael grant, a cholli'r grant oedd ei diwedd hi;
- Gall yr unigrwydd o weithio ar eich pen eich hun hefyd fod yn ffactor sy'n cyfrannu at iechyd meddwl gwael;
- Pan fydd ffermwyr yn dioddef profedigaeth neu brofiad anffafriol, mae'n rhaid i waith y fferm barhau. Mewn termau ymarferol, mae unrhyw golled yn golygu un pâr o ddwylo yn llai i odro'r gwartheg neu i ofalu am yr anifeiliaid;

- Yn aml, mae ffermwyr yn ymdrin â nifer o adrannau ar draws Llywodraeth Cymru a llywodraeth leol. Gall cyfathrebu rhwng adrannau fod yn wael ac arwain at rwystredigaeth;
- Mae archwiliadau fferm yn amseroedd o straen arbennig i ffermwyr. Nid yw arolygwyr yn aml wedi'u hyfforddi i adnabod arwyddion o iechyd meddwl gwael mewn ffermwyr;
- Mae toriadau yng nghyllidebau archwilio a lles anifeiliaid wedi achosi i'r timau hynny ganolbwyntio'n unig ar waith gorfodi sy'n golygu bod ganddynt lai o amser i feithrin perthynas â ffermwyr.

Hunanladdiad ymhlith ffermwyr

- Dywedodd y cynrychiolwyr fod pob ffermwr yn gwybod am ffermwr a oedd wedi cymryd ei fywyd ei hun;
- Mae Tir Dewi wedi gweithio ar dros gant o achosion ers ei ffurfio, ac mae llawer ohonynt wedi teimlo'n ddigon anobeithiol i arwain trafodaethau ar hunanladdiad;
- Weithiau bydd Tir Dewi yn cael galwadau am gymorth i weithio ochr yn ochr â'r tîm argyfwng iechyd meddwl mewn achosion lle mae angen dealltwriaeth o ffermio ac amaethyddiaeth, ond nid yw hyn yn digwydd yn ddigon aml;
- Nid oes ystadegau penodol ar gael ar nifer y ffermwyr sy'n cyflawni hunanladdiad;
- Nid oedd y cynrychiolwyr yn ymwybodol o strategaeth Beth am Siarad â Fi 2 Llywodraeth Cymru;
- Mae angen strategaeth iechyd meddwl benodol i ffermwyr, wedi'i chynhyrchu gyda mewnbwn gan y rhai sy'n deall y pwysau sy'n wynebu ffermwyr.

Stigma

- Nid yw pobl yn sylweddoli bod iechyd meddwl yn salwch;
- Er bod mwy o ymwybyddiaeth o faterion iechyd meddwl nawr, nid yw pobl yn gwybod beth i'w ddweud, ac felly'n aml nid ydynt yn dweud dim;
- Gall fod yn anodd cael ffermwyr i siarad neu ofyn am help

Hyfforddiant i'r rhai sy'n gweithio gyda ffermwyr

- Roedd y cynrychiolwyr yn ymwybodol y byddai timau archwilio ffermydd o'r ardaloedd awdurdod lleol y mae Tir Dewi yn eu cynnwys, yn cael hyfforddiant iechyd meddwl wedi'i drefnu gan Sefydliad DPJ. Dylai staff yr holl sefydliadau hynny sy'n rhyngweithio â ffermwyr gael hyfforddiant iechyd meddwl;

- Roedd y cynrychiolwyr yn gwerthfawrogi gwaith gwasanaeth cyswllt fferm Llywodraeth Cymru, ond roeddent yn teimlo y gellid gwella'r dulliau cyfathrebu ag adrannau eraill ac ar draws adrannau eraill.
- Teimlwyd y dylai arolygwyr fferm fod â dyletswydd gofal i ffermwyr.

Atodiad

An answer for Angela Burns AM following a meeting in Carmarthen on 21st June 2018

WHY DO ISSUES SUCH AS SUICIDE, BEREAVEMENT AND ILLNESS IMPACT FARMERS MORE THAN OTHER PARTS OF OUR COMMUNITY?

Issues such as these have a serious impact on all parts of society, particularly bereavement and suicide, but the way in which it impacts a farm is often not thought through – it is easier to treat it in the same way as everyone else. We would like to point out a number of differences which make the impact much worse for a farmer and, then to give a real and current example to illustrate this.

I will use the example of bereavement but the points which I will make are equally applicable to suicide or serious illness. When a death occurs in a farming family it can have all of the impacts that it does elsewhere, plus the following:

- It may seem callous to regard a family death in this way but, when a member of a farming family dies it means that there is one less pair of hands to do the work on the farm. This is a very serious issue in the modern farming world as employed labour has been replaced with more automation and larger equipment. This means that a farm might be run entirely by the family with no external support. It also means that farms are leveraged to a greater degree with finance or leasing arrangements on the equipment needed to 'keep up' with the increasing move towards industrialisation of farming. It is not an exaggeration to say that farmers might be working 16 hours a day, 7 days a week already so how can they cope with this loss? The answer is too often that they can't… jobs get missed, the welfare on the farm drops, income reduces and the farmer becomes stressed; all of this on top of the fact that a family member just died.
- In other parts of our society, when a family member dies we might get compassionate leave from work, support from management, colleagues, HR and even friends, all of which helps. Some seek counselling to help them overcome the loss. When a death occurs on a farm, the cows still need to be milked this morning, and this evening and tomorrow…. There is no compassionate leave. Funerals are most often arranged for the middle of the day so that the farmer can do the milking before it and get home in time to milk again afterwards. Farmers work in isolation so there is no management from which to seek support, there are no colleagues and there isn't an HR department to provide support. Also, far too often, farmers don't have many friends as they work such long hours that there is not time for them. Finally, farmers are notoriously 'proud' and the idea of seeking counselling wouldn't sit well, even if they could find the time!

- It is often the case that fathers run the farm and the sons take over either when the father becomes too old or dies. Planned succession isn't always given much consideration. This means that the son might never have made decisions on the farm, never had financial responsibility, never have bought or sold livestock. There are so many aspects to farming that need to be dealt with that, particularly in the case of sudden death, the impact is completely overwhelming. The effect on mental health can be devastating. And it's not limited to the father, mothers are often the ones who do the accounts or ordering of supplies or the online animal movements and passport registrations. The same can apply in the case of a mother's death.
- A farm will have a Holding Number against which all of its registrations are held. This is needed for stock movements, purchases, sales and for the purposes of grant applications including the Farm Basic Payment. While different cases can differ, often a death can require a change in the registered holding. This is a complex process which can involve many steps including remeasuring the farm… If this process is ongoing when the Basic Payment is due then it can sometimes not be approved. The payment can make up a huge proportion of overall farm income so, at this difficult time for all of the above reasons a far could also find itself with 20, 30 or even 40% of its turnover missing!

I'm sure there are more ways in which impacts are felt but let me provide a brief, real and current example as an illustration. I will not mention the name or the area but this is still an unresolved case:

A farmer died in 2016 after a short, unexpected illness. Unfortunately, he died without a will. The family was complicated including two sons who each had farmed in partnership with their father on different holdings. There had also been a divorce and a subsequent long-term relationship. All of the above suddenly applied! Because probate was not granted, the basic payment was not made in 2017. As the estate was so complex, it was still ongoing 12 months later and the 2018 basic payment was also withheld. At last probate was granted but then a claim was made against the estate sending it back into a legal process.

OK, we could all say that it was the farmer's fault for not making a will, that they should have had a better lawyer… all sorts of judgements. But the impact on one of the sons has been enormous! He owes money to every supplier possible to an extent that people will only deal with him on a cash basis. He is working ridiculous hours to try to keep afloat and, all in isolation as his farming partner (his father) has died and he can't afford to pay wages. His mental health has suffered enormously but he doesn't have time to go to the doctor 'only to be told to rest'. In this case, suicide is a very real part of almost every discussion that we have with family members.

Forgive me for such a long answer; we encounter elements of this on such a frequent basis and it can all contribute to consideration of or even the action of suicide. Indeed, when my next-door neighbour, a dairy farmer died some years ago, his son committed suicide within days!

If you require any other information or elaboration, please do get in touch. We are only too happy to contribute to this important process.

Gareth Davies

Y Pwyllgor Iechyd, Gofal Cymdeithasol a Chwaraeon

Ymchwiliad i atal hunanladdiad – ymweliad â Sefydliad Jacob Abraham, 21 Mehefin 2018

Lynne Neagle AC; Dawn Bowden AC; Jayne Bryant AC; Julie Morgan AC

Y cefndir

Cafodd y Sefydliad ei sefydlu ar ôl marwolaeth Jacob Abraham ym mis Hydref 2015; Roedd Jacob yn 24 oed a chymerodd ei fywyd ei hun drwy hunanladdiad. Nicola a David Abraham, rhieni Jacob, yw ymddiriedolwyr sefydlol y sefydliad.

Nod Sefydliad Jacob Abraham yw helpu i atal hunanladdiad drwy ymyrraeth uniongyrchol â phobl sy'n agored i niwed, codi ymwybyddiaeth o iechyd meddwl / materion yn ymwneud â hunanladdiad, hyrwyddo iechyd meddwl cadarnhaol a chefnogi pobl sydd wedi cael profedigaeth drwy hunanladdiad yn ne Cymru.

Amcanion Sefydliad Jacob Abraham yw:

- Darparu hyfforddiant atal hunanladdiad ac ymyrraeth mewn cymunedau lleol.
- Cefnogi teuluoedd sydd wedi cael profedigaeth ar ôl hunanladdiad.
- Addysgu cymunedau ar faterion sy'n ymwneud â hunanladdiad ymhlith dynion, gan gynnwys taflenni, posteri ac arwyddion.
- Rhedeg rhaglenni / gweithdai ataliol ar gyfer pobl sy'n agored i niwed wedi'u targedu yn y gymuned.

Pwyntiau allweddol o drafodaeth â Nicola Abraham, Sarah Aitken a defnyddwyr gwasanaeth

Rhoddodd Nicola Abraham gyflwyniad i waith y Sefydliad. Dywedodd wrthym am farwolaeth ei mab, Jacob, drwy hunanladdiad, a sut y sefydlodd y Sefydliad wedyn i roi cymorth i bobl sydd mewn perygl o hunanladdiad neu sydd wedi cael eu heffeithio gan hunanladdiad.

Dywedodd Sarah Aitken, ymarferydd lles Sefydliad Jacob Abraham, wrthym fod y Sefydliad wedi rhoi cymorth cwnsela i 40 o unigolion agored i niwed a oedd mewn perygl o hunanladdiad yn ystod y flwyddyn ddiwethaf. Tynnodd Sarah sylw at yr arbedion posibl o'r math hwn o ymyrraeth, o ystyried yr amcangyfrifir bod cost pob marwolaeth drwy hunanladdiad yn £ 1.7 miliwn. Nid yw'r Sefydliad yn cael dim cyllid uniongyrchol ac mae'n dibynnu ar roddion a chodi arian ei hun.

Rhannodd pob cyfranogwr ei brofiad ei hun o golli aelod o'r teulu i hunanladdiad. Nid yw enwau na manylion achosion unigol wedi'u cynnwys yma o ran anhysbysrwydd, ond daeth nifer

o themâu i'r amlwg y bydd y Pwyllgor yn dymuno eu nodi. Bydd y dystiolaeth a gafwyd yn ystod yr ymweliad hwn yn werthfawr iawn i'r Pwyllgor wrth lunio ei argymhellion.

Cymorth i deuluoedd sydd wedi cael profedigaeth

Pwysleisiodd y cyfranogwyr i gyd y diffyg cymorth yn dilyn marwolaeth aelod o'u teulu drwy hunanladdiad. Disgrifiodd llawer sut y cawsant eu gadael ar eu pen eu hunain i ymdrin â'r canlyniad a cheisio ymdopi â'r sefyllfa, ar ôl yr ymweliad cychwynnol gan yr heddlu.

Teimlai'r cyfranogwyr yn siomedig; tynnwyd sylw at y ffaith bod pobl yn cael mwy o gymorth (yn cynnwys gan swyddogion cyswllt teuluoedd yr heddlu) pan gânt brofedigaeth mewn ffyrdd eraill, er enghraifft, o ganlyniad i ddamwain traffig ar y ffordd. Ymddengys nad yw hyn yn wir mewn achos o hunanladdiad.

Nid oedd unrhyw un wedi cael copi o Cymorth wrth Law Cymru. Dywedodd y cyfranogwyr y byddai hwn wedi bod yn adnodd defnyddiol iawn iddynt. Dywedodd Nicola Abraham wrthym fod y Sefydliad, er gwaethaf ymdrechion, wedi methu â chael copïau gan Iechyd Cyhoeddus Cymru i'w rhoi i ddefnyddwyr gwasanaeth. Mae wedi gorfod dibynnu ar fersiwn Lloegr sydd â llai o fudd i breswylwyr Cymru.

Soniodd rhai cyfranogwyr a oedd wedi gofyn am gymorth gan eu Meddyg Teulu am gael eu hatgyfeirio am sesiynau cwnsela ac at Gofal Mewn Galar Cruse. Pwysleisiwyd y rhestrau aros hir am y gwasanaethau hyn, gyda rhai unigolion yn dal i aros i gael eu gweld fisoedd yn ddiweddarach.

Roedd pob un o'r cyfranogwyr yn gwerthfawrogi'r cymorth a'r 'lle diogel' y daethant o hyd iddo yn Sefydliad Jacob Abraham. Mae Sefydliad Jacob Abraham ar agor i unrhyw un, ac mae pobl yn teithio o'r tu allan i Gaerdydd gan nad oes cymorth tebyg ar gael yn eu hardaloedd eu hunain. Mae angen mwy o wasanaethau yn y gymuned – mewn lleoliadau anfeddygol. Nodwyd bod adeiladau ym mhob cymuned gyda mannau y gellir eu defnyddio.

Tynnwyd sylw at bwysigrwydd y 'math iawn o gefnogaeth' – dylid hwyluso grwpiau cymorth yn briodol, ac ni ddylent ofyn i bobl rannu mwy o'u profiad nag y maent yn teimlo'n gyfforddus yn ei wneud ar unrhyw adeg benodol. Mae pobl yn profi'r galar cymhleth sy'n dilyn hunanladdiad mewn gwahanol ffyrdd, ac mae ganddynt wahanol ymrwymiadau gwaith a gofal a all fod yn rhwystr rhag cael mynediad at rai gwasanaethau cymorth presennol.

Mae angen cymorth ar blant ifanc sydd wedi cael profedigaeth drwy hunanladdiad hefyd, gan gynnwys mewn ysgolion. Tynnwyd sylw at fanteision therapi chwarae.

Ymwybyddiaeth/Hyfforddiant

Tynnodd y cyfranogwyr sylw at y stigma a'r ofn sy'n gysylltiedig â hunanladdiad. Yn rhy aml, mae ymateb y gwasanaethau cyhoeddus yn dangos diffyg ystyriaeth a thosturi lle mae ymddygiad hunanladdol neu hunanladdiad ei hun yn y cwestiwn.

Mae angen mwy o ymwybyddiaeth a hyfforddiant ymhlith y cyhoedd a holl staff rheng flaen, gan gynnwys sut i gyfeirio pobl yn effeithiol at wasanaethau priodol. Mae angen cyngor ar rieni / gofalwyr ynglŷn â chadw rhywun sydd â meddyliau hunanladdol yn ddiogel.

Cymorth i ddynion

Tynnwyd sylw at y ffaith bod dynion mewn llawer mwy o berygl o hunanladdiad na menywod, ond maent yn llai tebygol o ofyn am gymorth. Roedd yn nodedig bod pawb a gymerodd ran yn y drafodaeth grŵp yn fenywod, ac roeddent i gyd wedi colli perthnasau gwrywaidd. Mae angen ymagweddau newydd i annog ymddygiad o chwilio am gymorth ymhlith dynion, yn ogystal ag i gefnogi'r rhai sydd wedi cael profedigaeth drwy hunanladdiad.

Disgrifiodd Nicola Abraham ran y Sefydliad mewn prosiect a ariannwyd gan Comic Relief i ddarparu hyfforddiant atal hunanladdiad i datŵwyr. Gall tatŵwyr dreulio oriau gydag un cleient ac mae ganddynt berthynas o ymddiriedaeth. Mae'r prosiect yn ceisio manteisio i'r eithaf ar y cyfle hwnnw (mewn ffordd debyg i'r fenter 'Trust me I'm your barber').

Adrodd am hunanladdiad yn y cyfryngau

Roedd rhai o'r cyfranogwyr wedi profi ymddygiad ymwthiol gan y wasg yn dilyn marwolaeth eu perthynas. Roedd hyn yn cynnwys gohebwyr yn cysylltu'n uniongyrchol ag aelodau o'r teulu, cael lluniau Facebook, ac ysgrifennu'n helaeth ac weithiau'n anghywir am yr unigolyn dan sylw. Roedd yr adroddiadau'n aml yn canolbwyntio ar agweddau negyddol ar fywyd yr unigolyn (er enghraifft, defnyddio cyffuriau). Mae effaith adrodd anghyfrifol am hunanladdiad ar deulu a chyfeillion yr ymadawedig yn ddinistriol. Gall sylw yn y newyddion ar-lein - sy'n cael ei weld a'i rannu'n eang - fod yn arbennig o niweidiol, yn enwedig lle mae negeseuon yn agored i sylwadau gan y cyhoedd.

Camddefnyddio sylweddau

Cafwyd trafodaeth ynghylch a yw defnyddio cyffuriau yn ffactor sy'n cyfrannu at hunanladdiad. Roedd rhai cyfranogwyr yn ymwybodol bod eu perthynas wedi cymryd cyffuriau yn ystod y cyfnod yn arwain at ei farwolaeth drwy hunanladdiad. Roedd cocên yn gysylltiedig â nifer o achosion - roedd pryder bod y cyffur hwn yn hawdd iawn i'w gael. Mae ei ddefnydd yn cael ei normaleiddio, a gall yr amddifadedd cwsg sy'n gysylltiedig â chymryd cocên gynyddu'r perygl o hunanladdiad.

Cynulliad Cenedlaethol Cymru
Y Pwyllgor Deisebau

National Assembly for Wales
Petitions Committee

Pwyllgor Iechyd, Gofal Cymdeithasol a Chwaraeon
Health, Social Care and Sport Committee
HSCS(5)-23-18 Papur 14 / Paper 14

Dai Lloyd AC
Cadeirydd y Pwyllgor Iechyd, Gofal Cymdeithasol a Chwaraeon
Tŷ Hywel
Bae Caerdydd
CF99 1NA

13 Gorffennaf 2018

Annwyl Dai

Adroddiad ar ddeiseb P-04-682 Sgrinio Rheolaidd ar gyfer Diabetes Math 1 mewn Plant a Phobl Ifanc

Byddwch yn ymwybodol bod y Pwyllgor Deisebau wedi bod yn ystyried y ddeiseb uchod, a gyflwynwyd i'r Cynulliad yn dilyn marwolaeth athrist Peter Baldwin, a oedd yn 13 oed pan fu farw o ganlyniad i effeithiau diabetes math 1.

O gofio bod y Pwyllgor Iechyd, Gofal Cymdeithasol a Chwaraeon wedi ystyried y mater hwn yn flaenorol, roeddwn am eich hysbysu ein bod ni heddiw, 13 Gorffennaf 2018, wedi cyflwyno adroddiad ar y dystiolaeth a dderbyniwyd yn ystod ein hystyriaeth o'r ddeiseb. Ceir linc i'r adroddiad isod:

http://www.assembly.wales/laid%20documents/cr-ld11664/cr-ld11664-w.pdf

Cafodd y Pwyllgor dystiolaeth lafar ac ysgrifenedig gan nifer o ffynonellau. Rydym yn cydnabod y gall prinder cymharol diabetes math 1 ymhlith plant a phobl ifanc, ynghyd â'r symptomau cyffredinol sy'n aml yn bresennol yn y cyfnod cynnar, ei gwneud yn anodd cael diagnosis. Fodd bynnag, roedd yr hyn a glywsom fel Pwyllgor yn ein hargyhoeddi bod yna waith i'w wneud gan y llywodraeth, byrddau iechyd a chlinigwyr, tuag at wella diagnosis cynnar. O ganlyniad, rydym wedi gwneud 10 o argymhellion i Lywodraeth Cymru eu hystyried.

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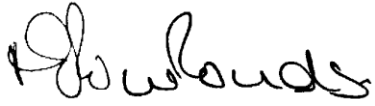
www.assembly.wales/SeneddPetitions
0300 200 6565

Rydym yn bwriadu i'r adroddiad gael ei drafod yn y Cyfarfod Llawn maes o law.

Yn gywir



David J Rowlands AC
Cadeirydd