GIG CYMRU NHS WALES
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.

Contents

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.

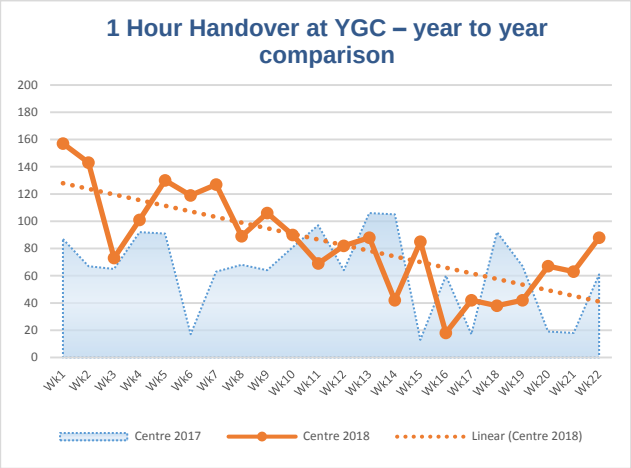
Comprehensive Seasonal Infections Plan in which we actively managed the vaccination of both staff and high risk groups of the population. Whilst our vaccination plan was a success the speed with which we are able to complete diagnostics and confirm diagnosis was not quick enough. We are already engaged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

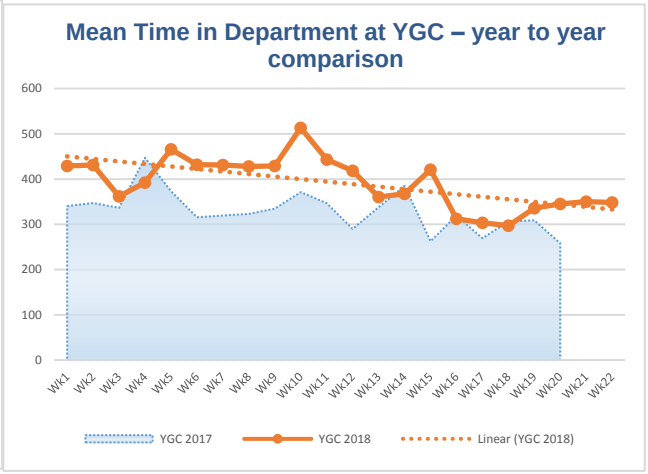
Frailty Assessment including a trial at Ysbyty Gwynedd in which a Care of Older Peoples Assessment (COPA) unit which led to a reduction in Length of Stay in the target cohort. This resulted in further capacity being identified at YGC and Maelor.

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





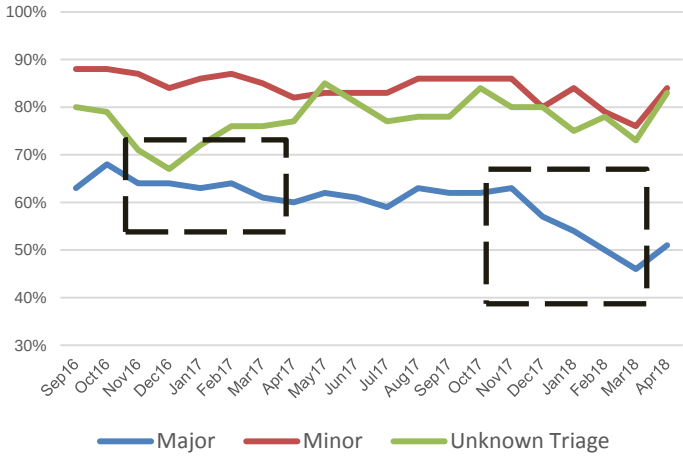
3.3) Opportunities for Development

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.

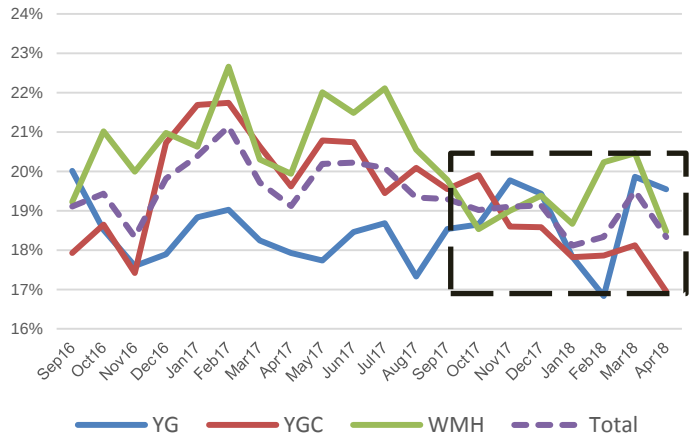
Fig 2. BCU 4Hr ED Performance By Triage Category



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.

Fig 3. % of Patients Discharged before Midday
Regular Inpatients Only



4) Delivering Objective 1 – Immediate Actions In Secondary Care

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) Delivering Objective 2 – System Level Service Improvement

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.

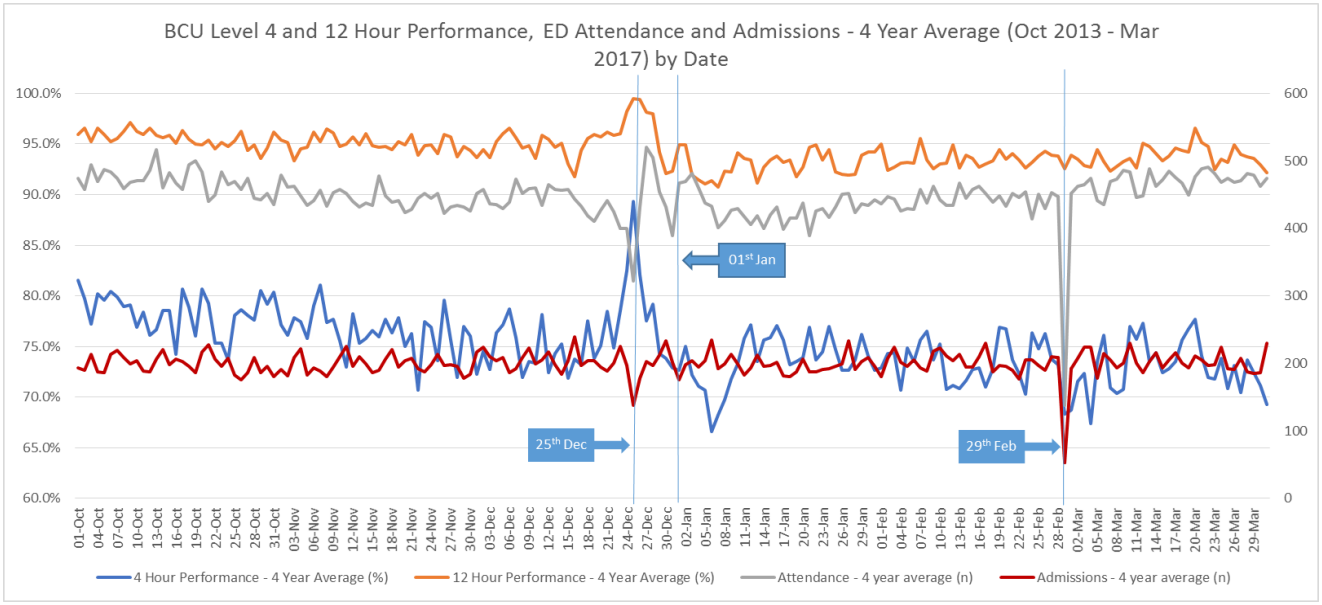
Fig 4 Areas of Resource Risk to Delivering BCUHB Resilience Plan

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.

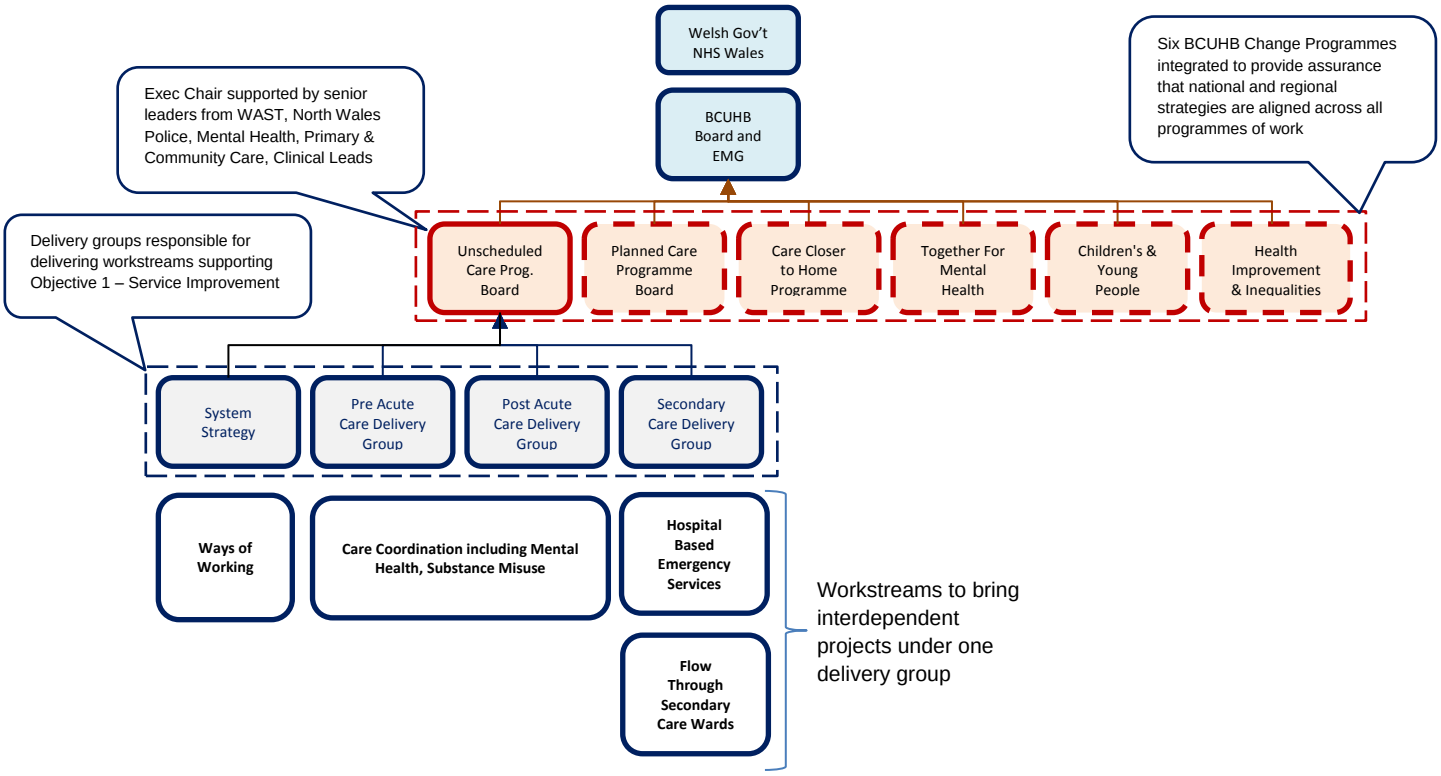
7) Managing Delivery – Governance and Assurance

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

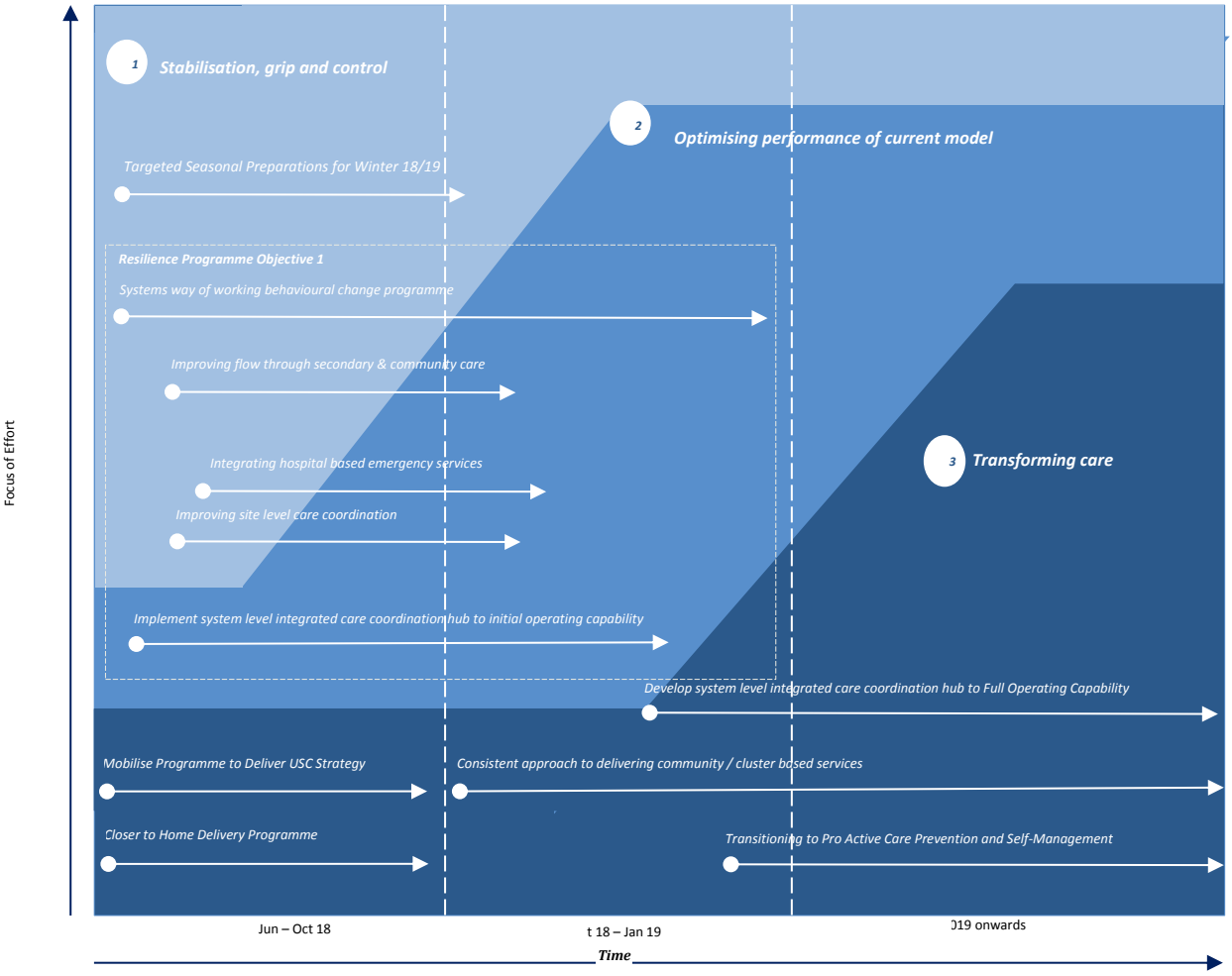


8) Linking Resilience to wider North Wales Care Strategies

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.