FUTURE FIT PROGRAMME BOARD

REPORT COVER SHEET

Meeting Date:	Thursday 22 November 2018
Report Title:	**Powys Teaching Health Board Annual Plan 2018/19**
Presented by:	
Report for	Future Fit Programme Board
Purpose of Report:	This report provides an overview of the Powys Teaching Health Board priorities for 2018/19 and in the longer term, particularly in relation to out-of-hospital care, urgent & unscheduled care and care co-ordination.
Summary	Powys Teaching Health Board has set out a long term vision for integrated health and care in the Health and Care Strategy for Powys, agreed jointly between PTHB and Powys County Council. The delivery priorities are set out in more detail in the Health Board's Integrated Medium Term Plan 2018/19 to 2020/21. Whilst activities that support urgent and unscheduled care, care co-ordination and out-of-hospital care are embedded throughout the health board's plans, key delivery priorities are included within the section focused on Well-being Objective 4: Joined Up Care (pp 117-146). The key areas for delivery of Joined Up Care set out in the Health Board's three year plan include: • **Primary Care**: This includes GP Practices, Eye Care, Dental Care and Pharmacy. • **Care Co-ordination and Unscheduled Care**: Targeted support including a Care Co-ordination Hub, Virtual Ward, Integrated Teams, reablement, improvements to the flow of patients in and out of care pathways and a joined up approach for people with learning disabilities and children with disabilities. • **Planned Care**: Timely access to effective, high quality treatment. The development of Rural Regional Centres and Community Well-being Hubs within Powys. • **Specialised Care**: Ensuring that people can access the right care for more specialist needs. • **Quality, Safety and Patient Experience**: Continuing to strengthen all aspects of the experience of care; using agreed strategies for safeguarding, countering abuse or violence. The plan aims to ensure that people in Powys experience the following outcomes: • I have timely access to equitable services as locally as possible.

	• I am treated as an individual with dignity and respect. • My care and support are focused around what matters most to me. • I receive continuity of care which is safe and meets my needs. • I am safe and supported to live a fulfilled life. • I receive end of life care that respects what is important to me. The health board's aspirations in relation to care co-ordination and urgent & unscheduled care are set out in Appendix 1 below. The one-year delivery priorities are set out in more detail in the Health Board's Annual Plan 2018/19. The specific priorities in relation to care co-ordination and urgent & unscheduled care are asset out in Appendix 2 below.
Recommendation:	The NHS Future Fit Programme Board is asked to RECEIVE and NOTE the Powys Teaching Health Board Integrated Medium Term Plan 2018/19-2020/21 and Annual Plan 2018/19 priorities in relation to care co-ordination and urgent & unscheduled care.

Appendix 1: Extract from Powys Teaching Health Board Integrated Medium Term Plan 2018/19 to 2020/21

5.2.2 CARE CO-ORDINATION AND FLOW MANAGEMENT

There have been major challenges in key delivery areas during 2017/18, particularly with waiting times for treatment; cancer waits in some specialties; and in keeping pace with unscheduled care demand. These pressures are not unique to Powys, but experienced throughout the United Kingdom. Locally, much of this increased demand is generated by the system's inability to adequately care for the growing number of elderly frail patients. The impact on our ability to manage flow for all patients (planned, urgent and emergency care needs) across the system are significant. Some of the key areas to focus on in 2018/19 to deliver more timely access to services include:

- Reducing the number of patients being admitted to Acute Care/DGH's that could be managed via alternative pathways.
- Working with ambulance services to make sure patients are directed to the best place to meet their needs to reduce delays for ambulances at hospitals.
- Reducing waiting times for patients requiring outpatient assessment, diagnostic investigation or planned surgery.
- Reducing variation in cancer waiting times.
- Reducing the number of patients waiting for outpatient follow up:
    - Reducing the average Length of Stay in the Community Hospitals.
    - Reducing non-Mental Health Delayed Transfers of Care.
    - Improving care coordination and community flow, by measuring demand and capacity.

These challenges illustrate that current service models need to evolve to meet changing needs for health services, particularly reviewing traditional systems and approaches. These changes range from using key skills available in the primary care contractor professions such as Pharmacists, Optometrists, Dentists and Podiatrists, bespoke community models of care for elderly and frail patients and the application of prudent principles in supporting patients in accessing effective treatment. It also illustrates the need to modernise some services to make sure that patients can be seen by staff with the skills to deal with their issues safely and in a timely manner, maximising telehealth and information technology.

Integrated Teams

PTHB and Powys County Council have been focussing on the development of two Integrated Team pilot sites in South Powys, in Ystradgynlais and Brecon, through 2017/18. Considerable achievements in the delivery of care have been gained, through improved communication, coordination, knowledge and skills. It is widely acknowledged that integrated care is highly beneficial to the patient and carer and remains the model by which PTHB & Powys County Council wish to operate.

It is recognised that there is great potential to deliver further improvements, and a qualitative review has recently been completed to assess the current pilots and support the next phases of development.

Through 2018/19 PTHB and Powys County Council will work to implement the recommendations of that review and further develop the integration model in the community with Partners, to continually improve the quality of care to patients and carers. The improvements will involve the following:

- Establishment of robust professional and operational matrix systems.
- Further development of joint Standard Operating Procedures, Joint Governance systems and Policies, recording and reporting processes.
- Full roll-out across Powys of the WCCIS system to support care coordination.
- Further embedding of the role of Community Connectors within the Integrated Teams.

Virtual Ward

Reducing more avoidable emergency admissions and re-admissions of people with chronic disease, plus the frail elderly, is a priority to improve patient outcomes and to reduce the costs of unscheduled care. Working together with Adult Social Care colleagues, the Virtual Ward aims to reduce hospital admissions by identifying patients who are at high risk of admission and managing them more effectively in the community, as well as supporting a more timely discharge back home if admitted.

The virtual ward model of care has been in operation across Powys for a number of years. Over the coming year we will review how it operates and how it can be further improved to ensure that the patients admitted to a virtual ward are truly those who will benefit the most, i.e. those most at risk of unplanned hospital admission and ensure effectiveness in terms of patient experience and cost.

By reviewing and further developing the multi-disciplinary approach we will address individual patient needs across health and social care to prevent crises from occurring; reducing duplication, improve continuity and the quality of care across providers and ensure that resources in the community are used efficiently by targeting additional services to those most at risk.

Health and Care Coordination Hub

When requiring secondary care, Powys patients are admitted to any one of the six other health boards in Wales or the two main NHS Trusts in England. This makes the prioritisation and coordination of repatriation complex. The Coordination Hub will ensure a more efficient way of managing the timely repatriation of Powys patients from other health board's DGH / acute hospital beds in Wales and England and manage flow in and out of Community Hospitals in collaboration with Powys County Council. It will increase our ability to ensure the length of stay in a DGH / acute care bed for Powys patients is minimised, as patients who are admitted will be transferred to the most appropriate setting in a timely way as soon as they no longer need acute hospital care. This will support a 'home first' ethos and a 'discharge to assess' model of care.

The Coordination Hub will hold and manage bed and service capacity data from across the health and social care system in Powys. It will act as the central point for referral and allocation of community hospital beds, assessments of need, packages of care, residential and nursing home beds, for those who are currently in a DGH /acute care bed in Wales and England. By providing one single source of real time admission, transfer and discharge data that can be accessed and acted upon, a more effective method of prioritisation and allocation will be implemented. The Health and Care Coordination Hub will be established in 2018.

Reducing Length of Stay

Improving discharge planning processes provides opportunities to release inpatient capacity and reduce Length of Stay. Early identification of simple or complex discharge pathways to enable better facilitation of the discharge process with a named care coordinator to manage complex discharges are important. The improvements will involve the following:

- Introduction of pan Powys Joint Care Coordination Hub to provide a consistent. managed approach to flow and communication through the community hospitals.
- Embrace LEAN approaches with a piece of work to assess demand and capacity.
- Consistently embed Estimated Discharge Date (EDD) identification and planning process throughout the community hospitals, providing EDD to DGH's to secure timely transfers.
- Continued focus on DToC, zero health DToC and early escalation at DToC trigger points.
- Work closely with key stakeholders to revisit the implementation of the good practice guidelines set out in 'Passing the Baton' to improve patient flow and consequently outcomes for patients across the whole system including length of stay.
- Create a dashboard as a ward performance tool fed from IFOR to highlight Length of Stay (LoS), use of EDDs, DToC and compare sites. Identify target LoS and discharge profiles for each ward area.
- Develop and test a Discharge to Assess (DTA) Model in collaboration with Powys County Council.
- Review District Nursing specification, caseload activity, acuity and skills with national programme to provide enhanced care in the community, in line with the Chief Nursing Officer District Nursing Principles and a test of Buurtzorg in Powys.
- Evaluate in-reach schemes that support facilitated hospital discharge and invest in appropriate models.

Improving the Discharge process

The key findings of the Delivery Unit discharge audit identified that PTHB demonstrated the intention to improve discharge planning in collaboration with key stakeholders. The six recommendations of the Audit will be taken forward to ensure effective and efficient discharge processes are in place to improve the patient journey and patient experience are:

- Pathway Development - Earlier identification of simple or complex discharge Pathways, with flow charts to support staff. Pathways to be set out in revised discharge policy and discharge training programmes.
- Policy Review – to work jointly with key partners to review discharge policy to guide staff in discharging patients safely, to include Care Home Choice Policy implementation.
- Training on discharge planning – to provide discharge planning on induction and refresher training for all relevant staff.
- Discharge policy compliance – introduce an audit cycle to ensure compliance with the discharge policy against good practice checklist.
- Discharge reporting - develop an agreed set of discharge reporting performance measures to feed Flow dashboard via Intelligence Focused Online Reporting (IFOR).
- Communication with patients and families - Review and update patient and family information packs across Powys with Adult Social Care partners, ensuring the multiagency patient discharge leaflet is used consistently across the health board.

Joint Reablement Service

The current reablement service is provided jointly between Powys County Council and PTHB through a Section 33 agreement and offers intensive support to help people who are recovering from an illness or injury to regain their maximum level of independence.

The service was established to provide reablement to regain and increase an individual's ability to manage their personal care, daily living activities and other practical tasks, usually for up to six weeks. Reablement encourages service users to develop the confidence and skills to carry out these activities themselves and continue to live at home. The pressures faced by this service during the winter months has identified that there is a need to undertake a review of the service specification for the reablement service, to consider the current model, the appropriate methods of delivery, and to analyse capacity and demand. The review of the joint reablement services will:

- Develop a set of key performance indicators for health to be introduced.
- Provide a summary of the current financial contributions to the Section 33 and what the elements are used for.
- Review the schedules and service specification to ensure they meet the needs of both organisations.
- Propose an improved model for the reablement service in Powys.

Children's Services

Consultant Community Paediatricians already deliver services to children with disabilities, chronic conditions or where there are safeguarding concerns. It is possible to further review and divert, from secondary care to the Consultant Community Paediatricians, those referrals from GPs where children appear to be presenting with developmental, minor or long term health problems. Community children's nursing will review methods of working and undertake analysis of workload and staff requirements to create more nurse led services that will complement the work of the Consultant Community Paediatrician

releasing capacity for them to undertake new developments e.g. allergy testing, further reducing the number of children being treated out of Powys. However, a fundamental component of this service redesign will be the development of a more robust community children's nursing team with opportunity for repatriation.

Working in partnership with Social Services and Education, further integrated working includes delivery, management and where possible physical integration in fit for purpose facilities that enable the seamless delivery of services to children and their families. This will be taken forward as a change programme, taking advantage of opportunities such as '21st Century Schools' and the Integrated Care Fund to provide the appropriate integrated facilities for children that are required.

Learning Disabilities

The delivery of the Joint Commissioning Strategy for adults with learning disabilities in Powys aims to 'enable People with learning disabilities to lead meaningful and valued lives within their own community'. Powys is committed to improving opportunities for people with a learning disability through planning and commissioning services that work with people to meet their needs and fulfil their choices.

The future direction for learning disabilities services is governed by the implementation of the joint commissioning strategy (2015-2020) with Powys County Council and a joint service delivery model. The ten key priorities of the joint commissioning strategy are:

- Information
- Staying Healthy
- Choice, control and relationships
- Right Time, Right Place (Flexible Support)
- Somewhere to live (Accommodation/Housing)
- Consultation and co-production
- Staying Safe
- Moving on and transition
- Good Support
- Opportunities for work, leisure and learning

Non Emergency Patient Transport (NEPT)

There are a number of challenges currently facing the provision of non-emergency patient transport from a service, governance and financial viewpoint. In Powys, matching transport provision to patient need is a very complex task given the geographic expanse, the number of journeys and the multitude of variables which affect each journey. The demand for non-emergency patient transport continues to grow across Wales and is influenced by the services provided and commissioned. The health board commissions, and therefore coordinates, journeys to and from a significant number of geographically dispersed sites. In addition, with many patients journeying to English hospitals, their needs are met by alternative transport arrangements commissioned through Clinical Commissioning Groups.

The Emergency Ambulance Services Committee (EASC) will continue, in the coming months, to take over the commissioning responsibilities for NEPTS in Wales but the future commissioning of NEPTs for Powys patients travelling to English hospitals will be evaluated during 2018/19.

In 2018/19, the health bard will:

- Continue to work closely with WAST to provide an accurate account of NEPTs activity in support of the commissioning responsibility transition.
- Further explore the cope that WAST has to pick up additional Extra Contractual Referrals (ECR) journeys to offset underactivity of PTHB's contract
- Continue to drive for absolute assurance that the additional resources agreements are providing the desired impact to reduce ECR costs
- The PTHB commissioning team/team partners to receive from English CCGs the routine receipt of commissioned NEPTs performance indicators to provide assurance that the service represents good value for money.
- Consider the future management arrangements of the NEPTs service to enable its management accountability to provide a patient focussed service.

5.2.3 URGENT CARE

Out of Hours' Care

Practitioners working in primary and community care have a crucial role as the first contact point for many episodes of unscheduled care, and in helping people maintain independence in their own homes. Hospitals, both acute and community, remain an important part of our care networks, but to ensure their appropriate use there must be:

- Anticipatory care planning for people with long term conditions.
- Effective and easy to use alternatives for appropriate conditions.
- Well managed flow through the whole care system.
- An effective balance between demand and capacity.

Within Powys, where acute care is largely commissioned from external NHS providers, including NHS England, there is a real opportunity to integrate health and social care provision in primary and community settings in a way that will have a major impact on the demand for more specialist acute care. Getting this right will mean that more people remain active and independent within the community and that care is delivered at the right level for people's needs. The intended impact of the work on unscheduled work is to reduce avoidable acute care demand from Powys residents; to improve flow across the system through reduced lengths of hospital stay and delayed transfers of care; and to improve WAST eight minute performance.

Shropdoc, the current provider of GP out of hours' services in Powys is facing a number of challenges. Firstly they have ongoing financial problems. We along with commissioners in England have been supporting Shropdoc to ensure that services are being maintained. Secondly there are risks to the ongoing sustainability of GP out of hours' services. Commissioners in England have confirmed that they plan to undertake a procurement process for out of hours'

services during 2018, as has been their intention since 2016. Given Shropdoc's financial challenges there is a risk that they would not be successful in a procurement process. If they were not successful then there is a significant concern that the organisation would no longer exist in a form that enabled them to sustain a viable out of hours service just for Powys.

We are developing and implementing a plan for a sustainable and continuous services for the people of Powys.' Robust project management arrangements have been established to oversee GP out of hours' services led by the Chief Executive, and contingency plans have been established to ensure continuity of services.

Alongside these challenges we have opportunities. For example, Wales is well on the way to developing a country-wide NHS 111 service priovidng a one stop shop for health information and advice including access to GP out of hours services. This is already in place in ABMU, in Carmarthenshire, and most recently in Ystradgynlais. It helps to remove the confusion of "should I ring NHS Direct or GP out of hours" as there is a single free number to call.

Given these challenges and opportunities we have put in place a programme to agree and implement the future delivery of integrated 111 and out of hours' services for Powys.

This will include:

- A single free number for patients to call 24 hours a day for health information and advice—111.
- Out of hours call handling and initial triage through NHS 111 Wales, provided by WAST.
- A Powys-specific secondary triage and face-to-face service.

Community Paramedics

Managing the unscheduled care flow into our two main neighbouring NHS Trusts on the English Border is challenging, not only in terms of increased cost and activity, but in relation to the potential delays faced by WAST transporting patients across the border.

This collaborative working between the two unscheduled care services in that geographical area aims to improve communications to avoid untimely responses and unnecessary patient admissions to hospital and create care / support packages for frequent service users. Additionally, with the creation of anticipatory care plans for those with Long Term Conditions, paramedics will work alongside District Nursing, Occupational Therapists, Physiotherapists and other colleagues to support more patients to be appropriately managed within the community. This will potentially avoid unnecessary conveyance of these patient groups to hospital, & enable paramedics to effectively become members of the existing community teams.

This year we will develop and test the concept of a new model and pathway linking the local rapid response vehicle directly to a Minor Injuries Unit in North Powys.

Joint Initiatives with Wales Ambulance Services Trust (WAST)

The health board have agreed the following joint initiatives with WAST for 2018/19:

- Development of a single directory of services connecting with Infoengine and Dewis.
- Explore and scope with the PTHB the following additional Care Pathways: Trial an End of Life Pathway (aligned to the ongoing review of EOL care across PTHB).
- Explore and scope a Respiratory Pathway (aligned to the ongoing review of Respiratory care across PTHB).
- Trial an enhanced Falls Pathway for patients in Montgomeryshire in collaboration with the PURSH team (Patient Urgent Response Service at Home).
- Continue Multi Disciplinary Team arrangements to identify, review and support Frequent Service Users across Powys and jointly put into place individual actions plans to meet patient need.
- Put into place clear arrangements to identify, engage and support the reduction of 999 calls generated from high volume activity Nursing / Residential Homes.
- Roll out of 111 Pathfinder across Powys THB.
- Explore options to co-locate services across Powys. There are currently two initiatives underway:
    - Exploring opportunities for a tri-partite agreement with Fire & Police to relocate staff from Llandrindod Wells ambulance station,
    - Re-location of Llanidloes ambulance station to Llanidloes Fire station.
- Support and understand the implications for WAST with regards to service re-configuration.

Performance Improvement of Ambulance Services

The health board will continue to support WAST to improve the local operational performance with particular focus on:

- Reducing the response times to Amber rated calls.
- Delivering improved operational efficiencies (e.g. reducing post production lost hours / reduce handover delays to improve availability of resources to respond).
- Enhance Community First Responder/Uniformed First Responder provision across Powys (exploring additional schemes with Young Farmers Clubs and also looking at opportunities with the Police).
- Demand Management – Reducing Frequent Service Users & Nursing homes will help to reduce 999 activity including Ambers thus creating increased capacity to respond. The Community Paramedic model may also support performance improvement across Green & Amber by potentially reducing what could have become 999 activity.

Emergency Ambulance Service Commissioning (EASC)

The Commissioning Intentions for 2018/19 will build upon the:

- Strong foundation of the Framework Agreement.
- Revised EASC support structure given Chief Executives request for EASC to have a strategic focus following the WAO Commissioning Review and to

be a conduit for what works ('once for Wales' offers) and what does not work.

- Close relationship with the National Programme for Unscheduled Care (NPUC) on its intention to focus in the immediate term upon:
    - Health board commissioned initiatives for urgent and emergency care from home to hospital.
    - Understanding the 'Big five' unscheduled care demands of Healthcare Professional Calls, Falls, Respiratory, Chest pain, Mental Health.
    - Examining solutions to better manage demand and capacity in the services and activities in pre-hospital pathways including Emergency Departments.
    - Sharing good practice about urgent care in the community.

The full Integrated Medium Term Plan is available from the health board's website at http://www.powysthb.wales.nhs.uk/sitesplus/documents/1145/02%5FPowys%20THB%20IMTP%2018%2D19%5FMarch%20Submission%5FFINAL.pdf

Appendix 2: Extract from Powys Teaching Health Board Annual Plan 2018/19

The key priority areas for Powys Teaching Health Board in 2018/19 relation to Care Co-ordination and Urgent & Unscheduled Care are set out in the health board's Annual Plan:

14.	**Care Coordination and Unscheduled Care**	Director of Community Care and Mental Health	a	Further develop the Virtual Ward and Integrated Teams for frailty and older people.
			b	Implement a new joint health and care coordination hub to reduce length of stay, reduce Delayed Transfers of Care (DTOC), improve patient repatriation time, level discharges and assess social care demand and capacity utilising Lean methodology.
			c	Jointly review the Reablement Model, to ensure effectiveness, efficiency and accessibility.
			d	Develop and implement unscheduled care improvements including a Powys Wide Discharge to Assess model and community paramedic development.
			e	Implement the Learning Disabilities Strategy Action Plan, incorporating feedback and recommendations from the Delivery Unit & Healthcare Inspectorate Wales review.
			f	Progress an integrated, co-ordinated and appropriate service for children with a disability and additional learning needs.

The full Annual Plan is available from the health board's website at:
http://www.powysthb.wales.nhs.uk/sitesplus/documents/1145/board%5FItem%5F2.1c%5FAppendix%201%5FAnnual%20Plan%20Framework%20DRAFT%20v81.pdf