



Llywodraeth Cymru
Welsh Government



Gwella Gofal Brys
Unscheduled Care Improvement



GIG
CYMRU
NHS
WALES

Winter 2017-18

An Evaluation of the Resilience of Health and Care Services



Summary report

BACKGROUND

Health and social care services experience varying degrees of pressure on a year round basis, although winter is always a particularly challenging period. This can be due to a range of factors not limited to increases in activity; a change in the nature of demand on services; prevalence of infectious diseases such as influenza; and extreme or inclement weather conditions that can result in exacerbations of viral and chronic conditions.

These added pressures can inevitably result in delays for access to care, poor patient experience and clinical outcome as well as impacting on the ability of clinicians and practitioners across the system to always provide the high quality standard of care for which they strive to achieve.

In summer 2017, the National Programme for Unscheduled Care (NPUC) Board endorsed an *'Evaluation of the resilience of the health and care system for winter 2016/17'* and a report was published with nine recommendations for NHS Wales and partners to consider in preparation for winter 2017/18.

The Cabinet Secretary for Health and Social Services made a commitment to evaluate the winter 2017/18 period and Simon Dean, Deputy Chief Executive NHS Wales and chair of the NPUC Board, subsequently sponsored a review. An interim report covering activity, performance and context for December 2017 and January 2018 was submitted to the NPUC Board on 23 February 2018 to provide an overview of the winter at that moment in time.

PURPOSE OF SUMMARY REPORT

This report explores how health and care services managed over winter 2017/18, the challenges the system experienced and opportunities to prioritise actions to deliver improvements over winter 2018/19.

It seeks to interpret evidence from a range of sources for the period commencing 1 December 2017 and ending 31 March 2018, and identify key risks and areas of learning for Local Health Boards, Local Authorities and the Welsh Ambulance Services NHS Trust.

Methodology

Evidence was sought from the following groups and organisations:

- Local Health Boards (LHBs) and NHS Trusts;
- Local Authorities (LAs);
- Third Sector organisations supporting health and social care;
- Independent sector care home providers;
- Patients and their families;
- Professional bodies (Royal College of Emergency Medicine, Royal College of Nursing, Royal College of Physicians, Royal College of Occupational Therapists, Royal College of Psychiatrists, General Practitioners Council for Wales); and
- Welsh Government.

Evidence was captured through the following mechanisms:

- *Integrated health and social care organisation self-assessments:* LHBs, LAs and WAST completed a self assessment tool to determine the strength of their original winter plans following the winter period. This tool was focused on learning from what went well, but equally from what did not, to inform future planning.

- *Engagement with Professional Bodies:* A questionnaire was distributed to professional bodies inviting feedback on whole system resilience over the winter period.
- *Engagement with the Third Sector:* A questionnaire was distributed to third sector organisations, such as Age Cymru and United Kingdom Homecare Association (UKHCA) and the Expert Reference Group Domiciliary Care Wales (ERGDCW) inviting their feedback on their involvement and whole system resilience over the winter period.
- *Engagement with patients and their families:* A questionnaire was developed for patients and their families to provide feedback on their experience of health and care during the winter period.

Evidence was also gathered through discussions with clinical and managerial representatives of Local Health Boards through site visits, a national winter resilience engagement event (attended by key health and social care representatives) and through a national summit meeting of leaders of clinical professional bodies.

This summary report should be read in conjunction with the '*Evidence and supporting information document*' which also reflects the evidence submitted by professional bodies, NHS Wales organisations and other stakeholders. It also contains an assessment of available data to understand how health and social care services managed over winter 2017/18.

SUMMARY

1. *Summary of winter2017/18*

- 1.1 Despite substantial effort by health and care communities to plan for winter 2017/18, front line staff experienced an extremely challenging period characterised by a difficult influenza season, blizzard conditions and sub zero temperatures and changes in demand that may have been difficult to predict.
- 1.2 A small proportion of citizens who accessed the health and social care system during the winter period unfortunately experienced long delays for assessment, care or treatment and this may have impinged on their experience and outcome. There was also an increase in postponed elective operations this winter. However, using a mixture of patient satisfaction surveys and quality and delivery indicators suggests the majority of citizens received a good standard of care and timely access despite the added pressures presented by the winter period, alongside ongoing challenges on the system.

2. *Challenges over winter2017/18*

- 2.1 There was clear feedback from staff in parts of the system of a winter spent under significant and unrelenting pressure, and of the associated impact it had on their workload and morale. It is testament to the dedication and commitment of the health and social care workforce, and key partners, that the vast majority of citizens continued to receive the care they needed in a professional and timely manner, and particularly noteworthy given the extreme weather at times over the winter months.
- 2.2 There are lessons to be learned from the response from health and social care service staff and volunteers to enable services to continue to run during blizzards in March 2018. This period had a tangible impact on timeliness of access to services in

the community for citizens as well as their opportunities to leave hospital beds for home given disruption to transport links.

- 2.3 In terms of the changes in patterns of activity, the ambulance service reported the highest number of 'immediately life threatening' incidents (December 2017) since a change to its model of delivery in October 2015. December 2017 was the busiest December on record in terms of presentations at A&E departments and this was also the case for January, February and March 2018. There were further increases in the volumes of patients aged 85 and over who were admitted as an emergency.
- 2.4 There were anecdotal reports of increases in activity in other parts of the system such as primary care services although this was difficult to substantiate through hard evidence. Feedback from a professional body suggested GPs found it increasingly difficult to make as many home visits as they would have liked over the winter period.
- 2.5 Feedback from some citizens also suggested there were difficulties in booking appointments with their GP and a recent report by the Health Foundation focusing on avoiding emergency admissions in England ¹suggests that has led to an increase in presentations at A&E departments.
- 2.6 In addition, some stakeholders felt that, at times, fragile primary care out-of-hours services had an impact on other parts of the health and social care system causing additional pressure although there is no available evidence at present to substantiate that hypothesis.
- 2.7 An expert view from the *Health Service Journal* ²suggests that activity levels are often over used as an indicator of the pressure on health and social care systems and that 'small vital groups' - often older people and others with multiple long term conditions – account for a disproportionate amount of emergency attendances and admissions, and of NHS Wales' resources.
- 2.8 To this end, Welsh Ambulance Services NHS Trust (WAST) data show there was an increase in reported incidents relating to 'breathing problems' over the most recent winter period, with 'fallers' and 'chest pains' also among the highest sources of demand on the Trust.
- 2.9 Further exploration of changes in the patterns of demand on services and of hospital emergency bed days used over the winter period suggest there was a small increase (around 0.5%) in overall bed days* in February and March 2018 when compared to the previous two winters. There was a more marked increase in *cardiology* emergency bed days over the most recent winter when compared to the previous two. In contrast, fewer emergency bed days were used in the *trauma and orthopaedic specialties* when compared to the past two winters.

* The total number of days for patients who were admitted for an episode of care

- 2.10 An assessment of the length of stay for patients in 'care of the elderly' beds over the winter period suggests around 20% of patients aged over 85 spent at least 28 days

¹ Emergency hospital admissions in England: which may be avoidable; the Health Foundation (2018)

² Expert Briefings; Performance Watch: Does the NHS have an unhealthy obsession with activity? (May 2018)

in a hospital bed. There are clear opportunities for health and social care services to work collaboratively to target improvements to discharge practices to ensure this group of people are able to leave hospital for their local communities when they are ready and without delay. This should also be seen in the context of acute and community hospital bed capacity which was at its lowest point (in the current time series). Local Health Boards will wish to consider whether the shift in capacity to the community has been sufficient to support management of these 'small vital groups'.

- 2.11 The 2018 influenza season saw the highest number of GP consultations and confirmed flu cases in hospitals since the 2009 pandemic, increasing pressures on GPs and the ability of hospital staff to optimise patient flow through the system. For example, there were reports from several Local Health Boards of the need to cohort patients with suspected influenza in assessment units to restrict spread of infection. This had a tangible impact on the ability to pull patients through the hospital system, creating blockages and delays in A&E and for ambulance response.

3. Engagement with front line staff and partners for winter

- 3.1 In terms of planning and engagement, there were reported improvements on previous years from the majority of stakeholders although feedback from some professional bodies suggests clinicians were not always engaged in the winter resilience planning process. Although engaging with all clinicians is challenging, some felt more can be done by health communities to ensure voices of clinical leaders and relevant partners are heard in the winter planning process. Joint sign-off by clinical leaders, Regional Partnership Boards and others from key parts of the system should be considered to support development of resilient plans.

4. Operational delivery

- 4.1 In terms of delivery, many stakeholders felt more needs to be done to understand the role of primary and community care in managing demand over the winter period, and their role – and resilience - in managing risk during peaks in pressure. Specific examples where demand could be better managed included better scheduling of Health Care Professional referrals of people by ambulance to hospital and ensuring this group of patients bypass A&E. Greater use of acute/enhanced care at home to enable appropriate people to access specialist care in their own home from a team of medical and nursing staff. As previously referenced, concerns about primary care out of hours services were expressed repeatedly over the winter period and into spring and summer. These three areas are being prioritised by the National Programmes for Unscheduled and Primary Care.
- 4.2 Enhancement of the WAST Clinical Support Desk (CSD) following Welsh Government investment enabled more clinicians to provide secondary clinical triage to patients. This enabled a greater proportion (up to 10%) of patients to be discharged over the telephone or signposted to other services using their own transport or a taxi. This initiative helped to reduce inappropriate despatch of ambulance resources and significantly reduced the number of emergency ambulance arrivals at A&E departments over the winter period. Without the enhancement to the CSD it is possible the numbers of ambulance hours lost and level of delay ambulance handover delay experienced by patients would have been far greater.

- 4.3 Turning to services delivered in acute and community hospitals, performance against many of the key access indicators declined over winter and remained at lower levels into spring. It is clear front line staff continued to make every effort to ensure patients received the care they need but some patients experienced unacceptable waits, inevitably leading to poor patient experience. This was difficult to quantify but the volume of patients waiting over twelve hours in A&E before being admitted or discharged over the winter was at its highest on record, and this is a useful indicator for experience.
- 4.4 The reported deterioration in access performance is a reflection of the significant pressures services faced this winter but also suggests there are opportunities for local systems to plan and deliver differently in future to support increased resilience. There appeared to be variability in adherence to escalation policies across Wales and the capability to respond to some of the peaks in pressure, which was above that which could have been anticipated, to enable action to be taken to mitigate challenges quickly.
- 4.5 Some stakeholders referred to the phenomenon of ‘escalitis’ – where, on occasion, systems / front line staff felt they needed to pass issues to executive level management immediately - as a barrier to dealing with challenges as close to the patient as possible. However, the vast majority of stakeholders felt that operational and management staff worked tirelessly at peaks of pressure to identify solutions and reduce delays for citizens. Some Local Health Boards and their partners introduced local time-based interventions or ‘breaking the cycle’ initiatives immediately following the Christmas holiday period in particular, which involved focusing on integrated actions which make the most impact. There is a clear opportunity to use this learning to enhance operational grip and enable clinically focused hospital management to mitigate peaks in pressure and manage risk effectively without defaulting to ‘escalitis’. Systems should work to empower staff to make decisions based on a clearly defined escalation policy.
- 4.6 Temporary capacity was put in place across the system and was likely to be insufficient to deal with:
- increases in activity and changes in pattern of demand;
 - a rising age in population and patients suffering from multiple conditions and complex needs;
 - rising emergency admissions; and
 - workforce challenges.
- 4.7 There was a high level of medical bed occupancy in our 13 district general hospitals which, according to the Royal College of Emergency Medicine, is closely associated with longer waiting times in A&E departments. Hospitals are routinely operating with bed-occupancy rates above 85 per cent – above which it is broadly accepted that hospitals will struggle to deal optimally with emergency admissions. Occupancy levels are highest in the winter months, and this is when A&E performance is most challenged.
- 4.8 The Chief Executive, NHS Wales has commissioned a review of the adequacy of the current bed stock to deal with demand. An analysis of the current NHS Wales data indicated that there has been a 20% reduction in NHS beds in Wales over the past ten years. A similar pattern has also been seen in other UK countries (England 22%, Scotland 21% and Northern Ireland 26%). In Wales, there are 3.49 beds per 1,000

population (England 2.36, Scotland 4.05 and Northern Ireland 3.17). Data also indicates that nearly 1,000 elderly care home places have been lost across Wales since March 2011.

- 4.9 This combined with increases in occupancy levels, emergency medical demand with the elderly accounting for the majority of this increase, and increasing long stay patients is putting a significant strain on the hospital system and its ability to maintain patient flow. This in turn has resulted in delays, increased medical outliers and was a contributory factor in added pressures on elective activity. There are opportunities for local systems to focus on these areas ahead of next winter to strengthen delivery. There is also an opportunity to focus on the cohort of patients who are admitted for short periods via A&E (for one day or less) and Local Health Boards should consider whether more can be done to better manage these patients and prevent unnecessary admission.
- 4.10 There were reports of variability in social care availability and access over the Christmas and New Year period in particular, resulting in some delays in social assessment and transfers of care. However, there were also examples where support from social services was invaluable with assessments and interventions provided at short notice during peaks in pressure. This included targeting social care and third sector resources at enabling people to return home or to a care home following admission to a hospital bed.

5. Lessons and opportunities for change

- 5.1 Regional Partnership Boards (RPBs) should consider how a more seamless health and social care response can maintain flow through the hospital system. This should include reflection on whether there is sufficient nursing home / residential bed capacity and how domiciliary (home) care packages can be maximised with staff retained ahead of winter 18/19, including over the Christmas and New Year period.
- 5.2 Workforce challenges in some parts of the system have been longstanding, and inevitably impact on services' ability to deliver care to people in the right place and at the right time.. For example, A&E departments face longstanding challenges in recruiting and retaining sufficient staff to cope with rising demand. Similar challenges exist in other key areas too, with the availability of locum staff or agency nurses becoming increasingly difficult. There are recruitment and retention challenges in the primary and social care sector, for example in relation to domiciliary care workers and nurses in care homes, which can similarly impact on patient flow and in particular delayed transfers of care. Out of hours primary care capacity was flagged as a particular issue for attention ahead of winter 18/19.
- 5.3 There was broad agreement among stakeholders that a shift is needed in regard to the alignment of workforce capacity to demand with changing patterns of demand into evenings and weekends. This should include much more focus on interrogation of patient activity data across the system to understand how demand has changed and ensure alignment of the right capacity from across the workforce spectrum to meet that demand. Examples include the flow of Health Care Professional call referrals by ambulance to A&E departments, the use of Allied Health Professions (AHPs) to support patient flow and the requirement to better manage capacity across the system over the weekend periods.

- 5.4 Most Local Health Boards identified the need to deliver fast tracked or streamlined pathways of care for older people to help reduce unnecessary emergency admissions, including frailty teams at the front door of acute hospitals.
- 5.5 Almost all Local Health Boards identified opportunities to deliver 'discharge-to-assess' models of care as part of learning from winter 2017/18 to support improved patient flow, and optimise experience and outcome. Feedback from stakeholders suggests prioritising delivery of such models - where people who are clinically optimised and do not require an acute hospital bed, but may still require care – are provided with short term, funded support to be discharged to their own home (where appropriate) or another community setting – will yield significant whole system benefit, enabling the most productive use of available bed capacity in acute and community sites.
- 5.6 There are many examples of good practice and initiatives in place across the system, utilising the investment made by the Welsh Government through the Integrated Care Fund (ICF), the Primary Care Fund and additional winter pressure monies, some of which are beginning to have a positive impact. However, more needs to be done to measure the impact of different practices and evidence value for money and, if successful, implement on a 'once for Wales' basis where appropriate.
- 5.7 More intelligence is required to better understand the broader primary, community and social care capacity and, therefore, build into an improved understanding of 'whole system' capacity.

6. *Conclusion*

- 6.1 Winter 2017/18 was an extremely difficult period for front line health and social care services. A challenging influenza season, changing patterns of demand that were more complex to predict and manage and extreme weather, added to ongoing all year round pressures on systems. This combined to create a perfect storm of pressures for health and social care services.
- 6.2 There was general consensus that the majority of systems had planned for winter with more rigour and had engaged more front line staff in the process than previously, and that planning helped to prevent an already difficult situation from escalating. Enhancements to services by organisations in some parts of Wales resulted in tangible success, either through limiting ambulance journeys or emergency admissions or through greater operational grip and decision making at times of pressure.
- 6.3 The majority of people accessing health and social care services during winter 2017/18 received timely and safe care, and a high proportion of those who responded to 'patient satisfaction' surveys were satisfied with the service they received. This is testament to the thousands of committed staff working in often difficult circumstances, often going above and beyond what could reasonably be expected of them.
- 6.4 Many people waited longer than they would have expected for an ambulance response, were unable to access a GP appointment or were not admitted to a hospital bed in a timely fashion as a result of additional pressures. It should not be accepted that each winter will be worse than the one before. Learning should be

applied more rigorously than ever in preparation for the forthcoming winter to improve patient experience and improve staff well-being.

- 6.5 A high level review of local plans developed to aid resilience following investment from Welsh Government in January and February found local systems were 'spread betting' and planning generally too many initiatives. A less targeted approach appeared to limit impact and made initiatives more difficult to measure. Prioritising delivery of a small number of areas in a targeted way ahead of next winter should support better management of surges in demand and changes in patterns of demand.
- 6.6 Five 'priority areas' have been collaboratively agreed for planning and delivery for winter 2018/19 to enable a better response, improve patient care and experience, and to reduce pressure on staff (overleaf).

FIVE PRIORITIES FOR DELIVERY FOR HEALTH AND SOCIAL CARE FOR WINTER 2018/19

1

Optimise clinical and organisational engagement and partnerships to deliver timely and high quality access to services

This will focus on strengthening engagement within and between services across the health and care sector to better inform planning and to support the delivery of services over the winter period.

2

An explicit focus on better management of demand in the community

This will focus on the better management of patients with urgent care needs in the community, particularly during peaks in pressure. For example, focusing on better management of Health Care Professional referrals; enhanced GP support to care homes; extending accessible hours; and on primary care out of hours capacity.

3

Enhance operational grip and empower clinically focused hospital management to mitigate peaks in pressure and manage risk effectively

This will focus on management of peaks, and changes, in activity through the hospital system, and strengthening escalation arrangements through 'gold command' style monitoring and decision making at executive level over winter period.

4

Focus on delivering the right discharge-to-assess models for the local health community to improve patient flow

This will put more focus on implementing 'discharge-to-assess' models for the local health community to improve patient flow across Wales on a sustainable basis. Different models should a) avoid hospital admission wherever possible by assessing, treating and supporting at home; and / or b) Minimise hospital stays by supporting recovery and proportionate assessment in people's own environment.

5

Focus on the significant opportunities to enable people to return home when ready to be discharged from a hospital bed

This will focus on exploring opportunities to help people return home, or as close to home as possible, expediting discharge to free up in-hospital capacity, when it is appropriate to do so. Working with local authorities and the third sector will be a key part of this priority.

Evidence and supporting information

1 PREPARATIONS FOR WINTER 2017/18

The Welsh Government worked closely with health and social care services across Wales 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. NHS Wales and Local Authorities developed integrated local winter plans with an emphasis on collaboration and taking a whole-system approach.

As identified through the *'Winter 2016-17 – An Evaluation of the Resilience of Health and Care Services'*, the general consensus was that the approach taken was reasonably embedded and has contributed to greater resilience. The position is unchanged in this regard, although the increased pressures, such as 'flu and adverse weather made it more difficult for local services.

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. This was developed specifically to focus on some of the key areas highlighted in the evaluation. These were:

- I. Governance;
- II. Engagement with staff and patients, including Public Health Wales;
- III. Preventative Measures;
- IV. Aligning right capacity with demand across the system;
- V. Workforce;
- VI. Escalation;
- VII. Key Collaborative Arrangements;
- VIII. Winter Resources Envelope;
- IX. Monitoring of Resilience and Quality of Delivery of services during the winter period.

Organisations were invited to provide feedback on the 'Checklist' and many found it useful. There was a general agreement that it focussed on the key areas and supported consistency.

One LHB indicated that the 'evaluation report' and the 'checklist' helped them shape planning for 2017/18, and this included the implementation of a 'Breaking-the-Cycle' initiative which had not previously been tested during the winter. The LHB indicated the impact and learning from this approach was invaluable and would be used to inform their planning for 2018/19. Another LHB found it useful but indicated that issuing such a checklist earlier in the year would be beneficial. Quarterly national events to support planning were held by the Welsh Government, in addition to a number of mechanisms to share learning throughout the year.

Organisations felt it would be useful if the key areas contained within the checklist was integrated with the national supportive guidance to inform the development of winter resilience plans. There was also general consensus that *key areas and learning from winter 2017/18 should also become part of this guidance for 2018/19.*

In addition to the checklist, the Deputy Chief Executive of NHS Wales held 'winter planning summit' meetings focussing on the local winter resilience plans with all seven LHBs and their partners. This helped ensure the key challenges and mitigations were understood and

being managed, and also enabled additional and proactive support from National Programme for Unscheduled Care and NHS Wales Delivery Unit teams to enhance plans.

Governance and Leadership

- All integrated winter plans developed by Local Health Boards, Local Authorities and the Welsh Ambulance Services NHS Trust and approved at Board level.
- Organisations identified Executive level officers responsible for winter planning and nominated winter resilience leads.

The Welsh Government monitored delivery and pressures via weekly Chief Executive and Executive level calls; daily executive level emergency pressures conference calls; and through the NHS Wales Unscheduled Care dashboard which provides live data and information on a range of indicators, including bed capacity, handover delays and escalation levels.

A review of the daily NHS Executive Level Emergency Pressures Conference Call is currently underway to identify how the calls can be further strengthened.

2 NATIONAL SUPPORT – INVESTMENT

The Welsh Government supported health and social care services to deliver safe and timely services over the winter and beyond through the following investment:-

- nearly £43m for 2017/18 via the Primary Care Fund to support primary care services deliver more local health services at or close to home, intervening early to avoid problems that may lead to unplanned admission to hospital.
- £60m through the Integrated Care Fund (ICF) for 2017/18 to help provide care and support closer to home and prevent unnecessary hospital admissions, as well as tackle delayed transfers of care (DToC) – supporting patient flow across the system.
- an additional £50m for NHS Wales (August 2017) to mitigate winter pressures; help balance the delivery of elective and emergency work; and improve elective waiting times. This investment enabled LHBs to increase internal resource capacity (including bringing in external independent providers), and outsourcing patients to alternative providers in Wales and in NHS England to reduce the backlog and patient waits for surgery.
- nearly £700,000 was provided to the Welsh Ambulance Service to increase the number of clinicians in their contact centres from 18 to 30. This has increased their capacity to safely treat patients over the telephone or to divert them to other services, resulting in a substantial reduction (around 10%) of unnecessary ambulance journeys to hospital.
- in recognition of some significant increases in demand, in early January, the Cabinet Secretary for Health and Social Services allocated an additional £10m to support frontline services to support them in taking immediate action to improve patient care. Each LHB area was required to develop a short outline plan with details of where their allocations were to be targeted and the NPUC team produced a high level review of how the money was spent

- LHBs and WAST invested in 159 separate initiatives, focusing mainly on secondary care and resources that enhanced existing services across the pathway. Examples of how this funding was used included:
 - Cwm Taf extended GP Practice opening hours on weekends to support primary care Out of Hours Service;
 - Hywel Dda increased therapy, social worker and consultant resources to support primary care weekend discharges; and
 - Cardiff & Vale commissioned additional rehabilitation beds to support patients with their ongoing care needs.

Learning from this evaluation will be used to inform future planning processes and practices in terms of both winter resilience and overarching Integrated Medium Term Plans (IMTPs).

- On 13 February, the Cabinet Secretary for Health and Social Services announced an additional £10m for Local Authorities to address their most immediate priorities which had been identified following discussions with the WLGA and ADSS. The additional resource was targeted towards the provision of domiciliary care packages; care and repair services to enable quicker discharge from hospital and maintain independence at home; and for short-term and step down residential care.

3 ENGAGEMENT

The ‘*Winter 2016-17 – Evaluation*’ broadly found that key health and social care staff, including executive teams, were fully engaged in the winter planning process. However, the Royal College of Emergency Medicine (RCEM) and the Royal College of Physicians (RCP) suggested there were opportunities to engage speciality doctors and A&E staff at an earlier stage locally. Primary Care clusters also felt that they needed to be engaged at an earlier stage. Earlier engagement with these staffing groups was identified as a recommendation for winter 2017/18 and the ‘checklist’ issued to organisations clearly articulated the need to focus on strengthening engagement in these areas. Submissions made by LHBs provided assurance on engagement.

The RCEM recognised improvements had been made this year in this regard, acknowledging the Welsh Government and the NPUC Board had engaged with them and clinicians on winter resilience planning “*earlier and better than previous years*”.

Despite this progress, feedback from some RCEM members and General Practitioners (GPs) indicated they were not engaged. In response to this the review team sought further assurance from health and social care organisations, where they clearly evidenced that a wide range of staffing groups were engaged and informed their planning, including the clusters and emergency medicine.

Whilst there was variation in the methods of engagement between organisations, the evidence provided demonstrated this was done via a range of channels. For example:

- **ABMUHB** advised that their 6 service delivery units, clinical leads/clinical director were engaged, cluster level discussions were also held with primary and community service staff, clinical leaders and the western bay community services operational

group. The 5 primary care clinical directors, including OOH also contributed to the development of the plan. Their plan was also approved via a range of mechanisms including the unit management boards (with clinical and managerial presentation), and ultimately at Board level.

In regard to communicating the plan to staff, it was circulated widely via practices and community groups, included in team briefing arrangements across the LHB, discussed at consultant meetings and with ward managers/heads of department.

- **Betsi Cadwaladr UHB** confirmed clusters were involved via the Medical Directors in each area as members of their Unscheduled Care Transformation Group. A&E consultants were also involved.
- **Cardiff & Vale UHB** confirmed a Local Medical Committee (LMC) representative had been engaged. The LMC were involved in the early planning of winter and contributed to proposals. EU consultants and other senior medical staff were engaged, and continue to be, through their respective Clinical Boards and Directorate Management Teams.
- **Cwm Taf UHB** confirmed there is an Unscheduled Care Delivery Group, which meets on a monthly basis, in addition to a Winter Pressures Group, which meets weekly when required. These groups have responsibility for planning services during the winter period, and are multi-disciplinary with representation from primary, community and secondary care (including lead clinicians, assistant directors, and directorate managers). The Welsh Ambulance Services NHS Trust; Merthyr Tydfil and Rhondda Cynon Taf local authorities and the third sector are also represented. The Assistant Director Primary Care and Localities; the Head of Primary Care and Directorate Manager for acute medicine and A&E are also members with responsibility for ensuring the views of key staffing groups are considered.
- **Hywel Dda UHB** confirmed a winter resilience group was established with management and clinical representation. Winter resilience was also a standing agenda item on their Unscheduled Care Programme Board, which has primary care, secondary care, GP OoH, mental health, local authority and CHC representation. Each acute site also engaged their own staff in slightly different ways. For example,
 - **Pembrokeshire** involved A&E and Acute Medicine Consultants led by the General Manager at Withybush;
 - **Carmarthenshire** did the same led by the hospital director at Glangwili. The winter planning process was shared within Directorate Team meetings and weekly reviews in place for updates. Primary care staff were engaged via County Director and Community Leads, and is an agenda item in all 3 Carmarthenshire cluster meetings with interactive discussion facilitated by County Director. Winter Delivery is also discussed at Carmarthenshire County Management Team and Carmarthenshire Integrated Service Board;
 - In **Ceredigion** there was full engagement involving a collaboration of key stakeholders in June 2017, and involved subsequent bi-weekly meetings.
- **Powys tHB** confirmed there was close working with both Welsh and English partners in developing the local plan and included a range of stakeholders.

Based on the information provided, the review team found that considerable effort appears to have been made to engage with primary care and A&E staffing groups, alongside other key services. Despite progress being made, the concerns raised by GPs and RCEM, and similar concerns subsequently raised by members of the RCN, suggests gaps in engagement remain. This may, in part, be due to an organisation's need to strengthen the way its winter planning arrangements are signed off and communicated to all staff, those in the frontline in particular, recognising it can be difficult to involve every individual directly in the planning process. However, it is clear that organisations need to better understand the specific concerns around engagement.

What improvements can be achieved for future winters?

- **Building on progress made and reflecting on winter 2017/18, LHBs need to work closely with all staffing groups in delivery local winter delivery plans. This should include 'sign-off' of plans by clinical leaders and Regional Partnership Boards.**

4 WINTER WEATHER

Information from the Met Office states mean temperatures were marginally above the long term average for December 2017 and January 2018 but there were some significant cold periods during these months. February was 1.2°C below the long term average.

March began with an exceptionally cold easterly flow and widespread snow, and daytime temperatures remained below freezing in many parts of the country. It turned milder from the south during the first week of March and until mid-month the weather was generally wet and cloudy for most with low pressure dominant, but north-western areas remained drier. A second cold easterly outbreak brought widespread snow on 17 18 March, though this was not as severe as at the beginning of the month.

Evidence suggests there can be an increase in mortality at up to 2% for every one degree fall in temperature from 18 ° C.³ The most vulnerable group are the elderly. Even at 2°C, there is a significant impact on overall morbidity with a significant increase in hospital admissions in the very young, the elderly and vulnerable. The impact of low temperatures on health can occur over a few weeks and there is a time lag between exposure and the outcome of around 2 weeks with respiratory disease and a few days with cardiovascular disease.

5 IMMUNISATION

More people in eligible groups in Wales received influenza vaccine last season than ever before, with the estimated total number of individuals immunised against influenza at 820,183, compared to 761,838 during the previous season. Uptake rates in those aged 65 years were higher than ever before. Increases in uptake were also seen in healthcare staff

³ Alderson MR. Season and mortality. Health trends (1985)

and the childhood influenza programme. Uptake in other at risk groups varied between groups but overall was higher than last season.

Table 1: Uptake of Flu vaccination rates as at 31 March 2018 compared with March 2017 in key groups

Key Group	At 31 March 2017	At 31 March 2018
Over 65 years	66.1%	68.8%
Under 65 years at risk	46.2%	48.5%
Pregnant women (number)	12,098	13,922
NHS staff (direct contact)	51.2%	56.9%
Children 2 & 3 years	44.9%	50.2%
Children in primary school (up to year 3 in 2017 and year 4 in 2018)	66.8%	68.3%

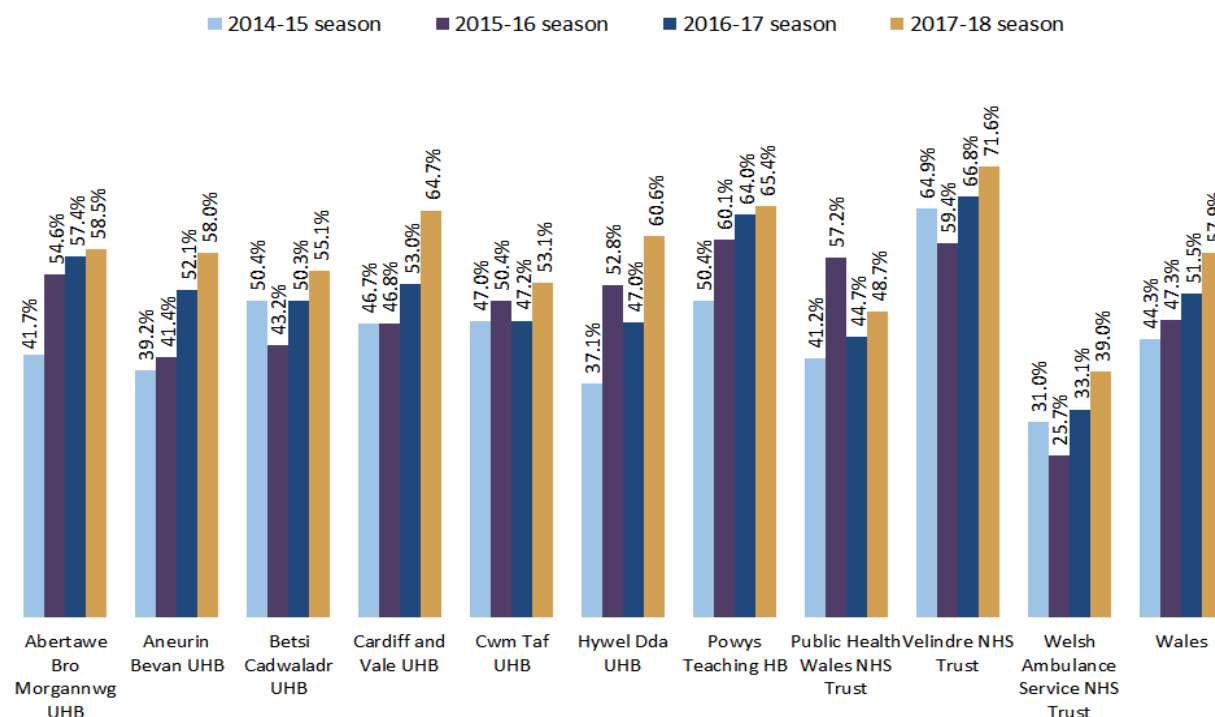
The target for flu vaccine uptake in 2017-18 was 75% for those over the age of 65 and 55% for those under 65 years in clinical at risk groups. *Table 1* shows that uptake in at-risk groups has improved on last year, but is below the current national target.

A considerable number of flu vaccines were delivered in January and February during this flu season, resulting in an increase in the uptake rate above expected levels. This late demand for the vaccine will, in part, be attributable to the misconception on the expected impact of the “Aussie flu” and frequent media reports of deaths in children and young adults.

Children’s vaccination

The benefit of vaccinating children against flu is understood both in terms of personal protection and in reduction of circulating virus in the community. In 2017/18, the childhood programme was extended by one school year to include school year 4. The programme was offered to all 2 and 3 year olds (though primary care) and to all children in reception class and years 1, 2, 3 and 4 in primary school (through the school nursing service). In 2018/19, the school programme will be extended to include school years 5 and 6 as well, so that all children in primary schools will be offered the flu vaccine next season.

Chart 1: Uptake of influenza immunisation in NHS staff with direct patient contact in Wales, 2014/15 - 2017/18



The target for flu vaccine uptake rate for healthcare workers who have direct patient contact is 60% (an increase from 50% last year), and this additional emphasis and effort directed towards staff vaccination continues to have an impact. Four organisations, Cardiff & Vale, Hywel Dda, Powys Health LHBs and the Velindre NHS Trust exceeded the Welsh Government target. Whilst some LHBs were below 60%, every organisation showed an increase in uptake compared to the previous season and reflects the year on year improvement we have seen in Wales. Uptake with the Welsh Ambulance Service has risen by 5.9% but remains significantly lower than their counterparts.

What improvements can be achieved for future winters?

- Offer the improved quadrivalent vaccine for those aged 6 months to 64 years in clinical risk groups.
- Offer the improved adjuvanted trivalent vaccine for those aged 65 to 74 years and in particular for those aged 75 and over.
- Offer the quadrivalent vaccine to children aged from 2 years up to and including the last year of primary school (school year 6).
- The current annual awareness raising campaign to be reviewed and its impact on behaviour change considered.
- To improve uptake of flu vaccine in those with asthma who are eligible for the flu vaccine.
- The good practice of those who achieved the target should be shared with other health boards so that, as a minimum, the 60% target will be achieved by all in the 2018/19 flu season.

Chronic Respiratory Disease

In Wales there are approximately 200,000 individuals aged between six months and 64 years with chronic respiratory disease who are at increased risk of influenza each season. Those with chronic respiratory disease account for 38% of all those with underlying medical conditions aged between six months and 64 years for whom seasonal influenza vaccine is recommended.

Flu vaccination of individuals with chronic respiratory disease is one of the work streams of the refreshed Respiratory Disease Delivery Plan.

What improvements can be achieved for future winters?

- The planned work for 2018/19 flu season is to improve uptake of flu vaccine in those with asthma who are eligible for the flu vaccine e.g. individuals who have a diagnosis of asthma recorded, prescription of oral or inhaled steroid recorded since 01 Sep of flu season, or an emergency admission due to asthma at any time.

6 INFLUENZA AND INFECTION CONTROL

There are two types of influenza virus that commonly affect humans, known as influenza A and influenza B, although there are many different sub-types within these groups as influenza virus undergoes continual genetic change. Characteristic symptoms of 'flu include fever, chills, headache, cough, body aches, fatigue and sore throat, which normally come on suddenly.

The flu virus can be spread easily from person to person and most often circulates during the months of October to April, with numbers of cases usually peaking between December and March. Flu viruses frequently undergo genetic changes (known as genetic drift); this means that people who encountered flu viruses in previous years may not have been fully immune to viruses circulating in the current season.

What happened this winter?

Flu

This flu season has seen the highest number of GP consultations and confirmed flu cases in hospitals since the 2009 pandemic and this placed extraordinary demands on the NHS. Whilst not quantified this will have inevitably impacted on the availability of beds in wards and affects specialist critical care beds. It is also likely to affect the speed with which beds can be accessed from A&Es, in addition to pressures in care homes and the community as well on the well-being of as NHS Wales and Local Authority staff.

Chart 2 - Clinical consultation rate per 100,000 practice population in Welsh sentinel practices (week 47 1996 - week 13 2018)

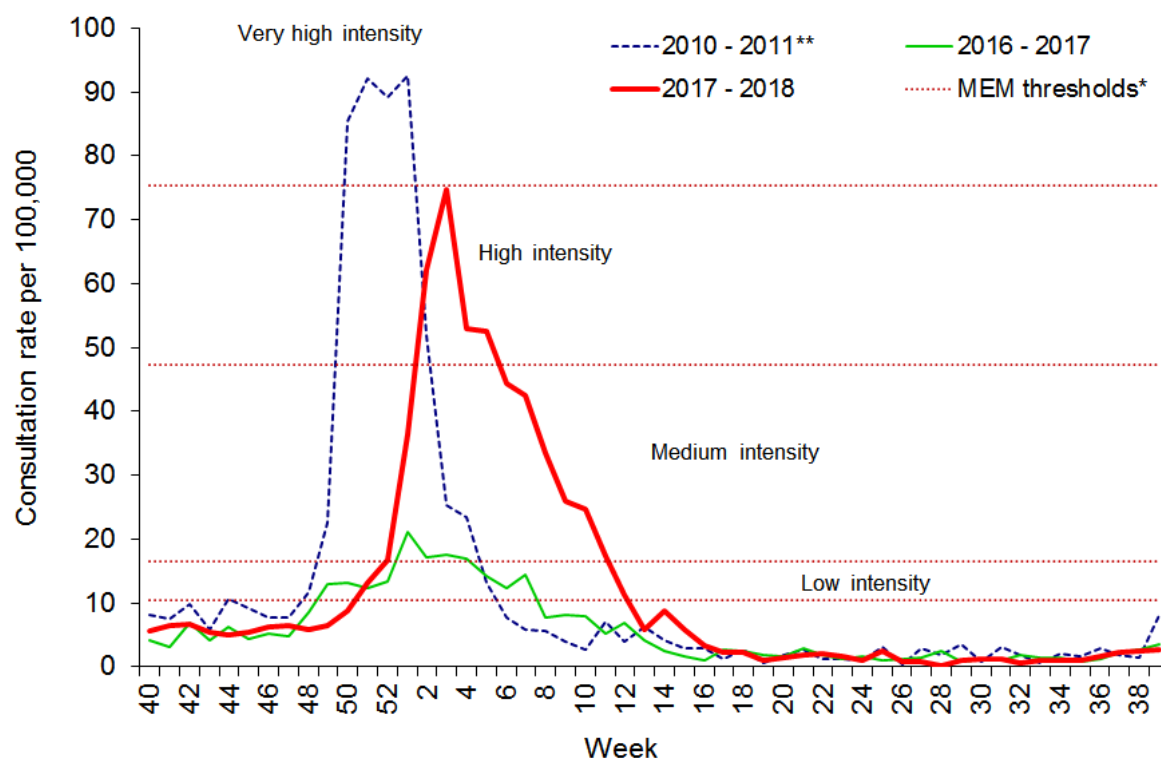
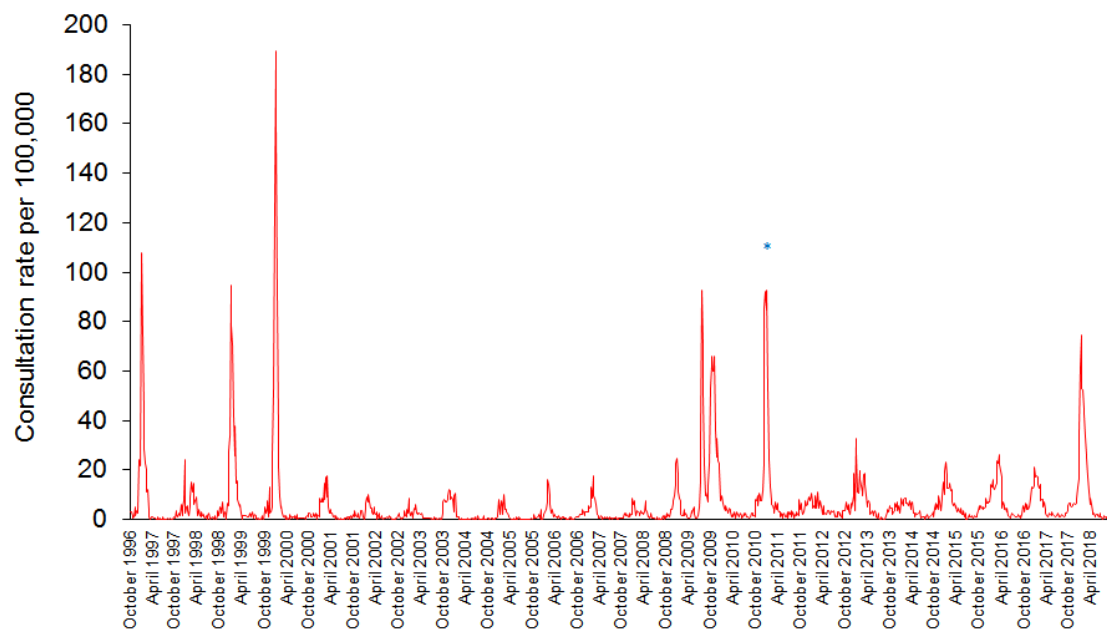
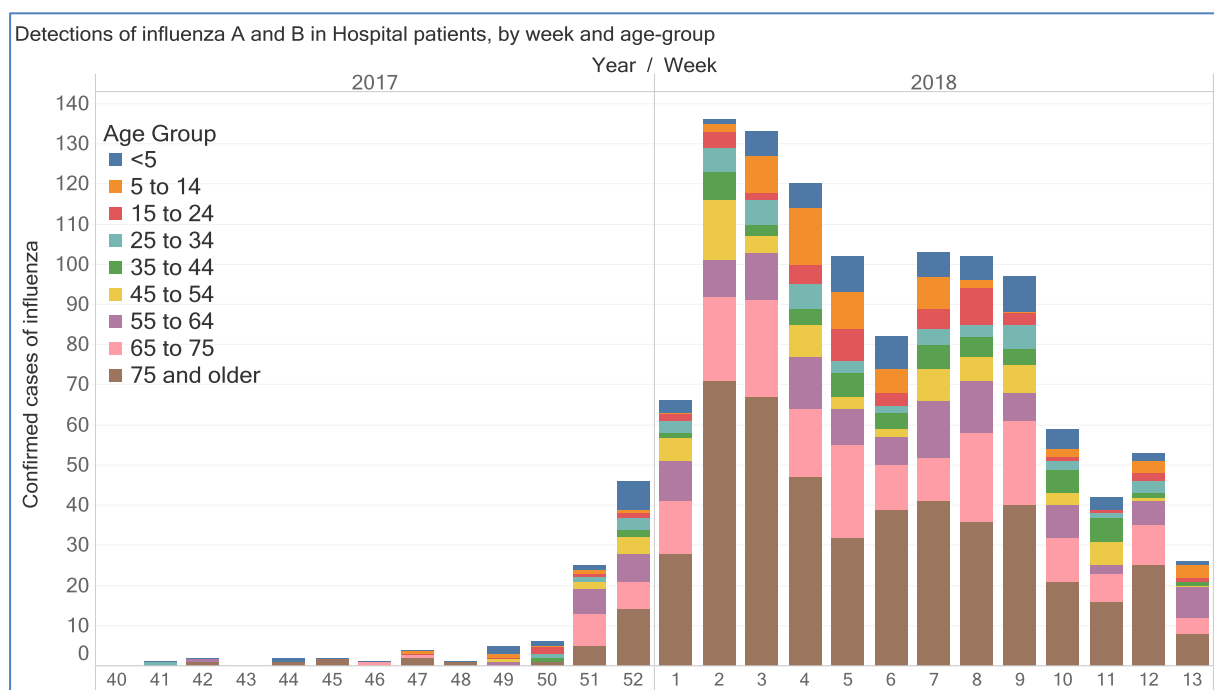


Chart 3 - Clinical consultation rate per 100,000 practice population in Welsh sentinel practices (week 47 1996 – week 13 2018)



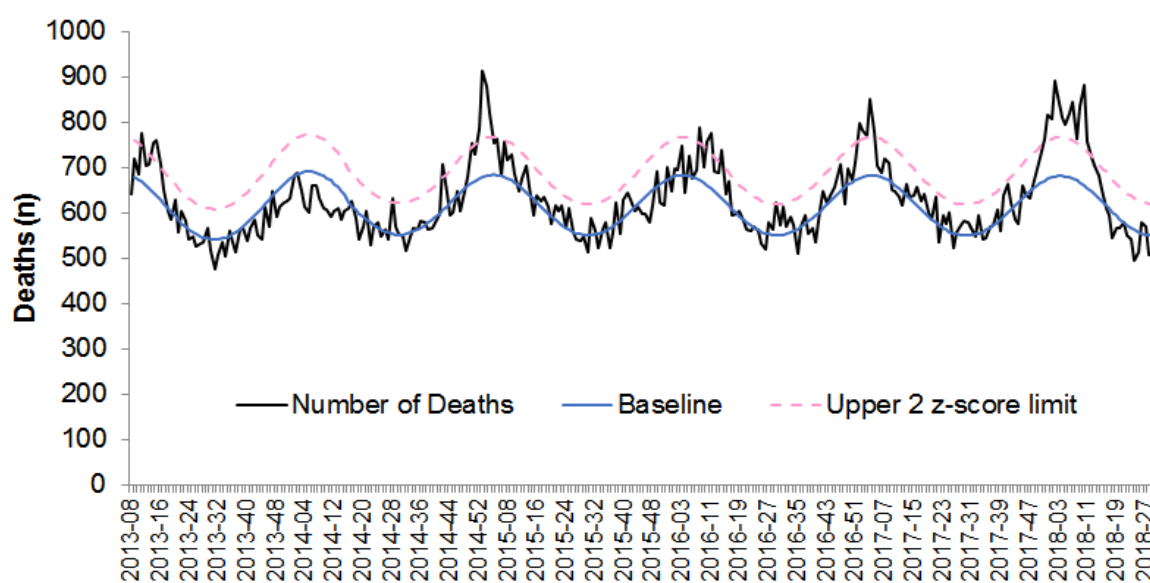
Influenza B, influenza A(H3) and influenza A(H1) have all been detected in Wales this season. Unlike in recent influenza seasons, influenza B was predominant early on however this changed with influenza A becoming the predominant strain later in the season. Influenza B infections are not less severe than influenza A.

Chart 4 - Weekly confirmed cases of influenza (any type) in hospital patients, by age-group



The influenza vaccine advised for the 2017/18 flu season offered protection against the same strains as the vaccine recommended for the 2016/17 flu season. We know from the analysis of the vaccine effectiveness during the 2017/18 season no vaccine offered protection against influenza A (H3N2) for any age group. There was only limited protection against influenza B due to a mismatch between the virus in the vaccine and the circulating strain.

Chart 5 - Weekly surveillance for significant excess in seasonal all-cause mortality (all ages) in Wales, dominant circulating types of influenza for seasons 2014/15 to 1017/18 are included.



In response to an increase in flu demand this winter, the Chief Medical Officer issued guidance to GPs and hospital clinicians on 12 January 2018 to support the management of patients with suspected flu and when to test for influenza.

Direct Enhanced Service (DES) for antiviral prophylaxis

The DES for antiviral prophylaxis has been well received. Since its implementation in mid-January almost all residential care homes where Influenza-Like Illness (ILI) has been circulating had a confirmed diagnosis and residents received antiviral prophylaxis where appropriate. For example, there were 583 community prescriptions for Oseltamivir in January 2018 compared to 223 in January 2017.

Respiratory and Gastrointestinal outbreaks

Table 2 - GI and ARI outbreaks in Hospitals and Care Homes only from Week 49 of 2017 to Week 13 of 2018 and Week 49 of 2016 to Week 13 of 2017

	GI Outbreak		ARI Outbreak	
	Hospital	Care Home	Hospital	Care Home
2017-18 TOTAL	28	67	21	49
2016-17 TOTAL	35	60	26	23

Acute Respiratory Infections (ARIs)

From the beginning of December 2017 to the end of March 2018 there were 70 acute respiratory outbreaks reported to the Public Health Wales Health Protection Team, with more than two thirds of these outbreaks from care homes. This compares to a total of 49 acute respiratory outbreaks reported during the same period in 2016-17 with less than half of these from care homes. Information on the causative organism is not available for all reported outbreaks and not all outbreaks described as acute respiratory infection or influenza-like illness will be due to influenza.

Norovirus/Gastrointestinal Infections (GI)

Winter stomach bugs such as Norovirus place additional strain on the NHS and this winter has been no different. Over the same period there were 95 gastrointestinal outbreaks in hospitals and care homes in Wales with more than two thirds of these outbreaks from care homes. There was also a total of 95 reported outbreaks during the same period in 2016-17 with just under two thirds of these from care homes.

What improvements can be achieved for future winters?

- For the 2018/19 season, flu vaccine will be offered to staff in nursing and residential care homes in Wales (both health and social care personnel) through the community pharmacy scheme - funded by the NHS.
- Following a successful pilot in Cardiff, the Vale and Bridgend, training sessions on outbreak prevention and management will be provided to staff in care homes in all local authority areas.
- An e-learning package will be produced for clinicians to increase knowledge and awareness on the testing for and the treatment of influenza.
- Continuation of the Direct Enhanced Service (DES) for antiviral prophylaxis.

7 PRIMARY AND COMMUNITY CARE

There remains limited data available at a national level on activity in primary care services in-hours. Despite this, anecdotal evidence indicates GPs and community services came under increasing pressure. The period following Christmas and the New Year was particularly challenging with an estimated 100,000 patients accessing these services on some days.

Recruitment and retention in primary care is a significant challenge which inevitably impacts on the ability to provide the required level of capacity to meet demand during peaks in pressure, both in the 'in' and 'out of hours' period.

Investment in Primary Care

Nearly £43m for 2017/18 was made available by the Welsh Government via the Primary Care Fund to support primary care services deliver more local health services at or close to home, intervening early to avoid problems that may lead to unplanned admission to hospital. Additional winter pressures monies were also made available, some of which is being used to provide additional support to primary care services.

GP Services

In recognition of the increasing pressures on GP services, the Welsh Government relaxed the 'Quality and Outcomes Framework' element of the GP contract until the end of March 2018. This was intended to free up more capacity for GPs and their teams to manage their most vulnerable and chronically sick patients and enable them to prioritise patient treatment.

Primary Care Information

The NHS Wales Informatics Service (NWIS) is working with the Directors of Primary Care and Mental Health and the Welsh Government to enable the capture of key Primary Care information. This will include the number of consultations; the manner of these consultations (in the surgery, or at home, etc); by whom (GP, nurse, etc); and the number of patients that don't attend. This information will support the primary care community and the wider system from a demand and capacity perspective.

GP Feedback

Comments received from GPs are included below:

"Cancellation of planned care increased GP workload"

"...no physical help. GP surgeries were left to fend for themselves."

"We blocked all routine appointments on days that we were short of clinicians and saw urgent on-the-day cases only..."

"GPs should avoid taking holidays during winter"

Monitored our appointments daily and opened and closed depending on demand. We employed locums/ANP and a Pharmacist..."

"Extra funding so general practice can temporarily increase clinical front line staff..."

"Consideration should be given to increasing home visiting services to reduce admissions to hospitals, including ANPs."

"... we are firefighting on a daily basis and there is little time for strategic planning within primary care due to lack of clinicians and extreme workloads."

NHS Direct Wales

Key results during the quarter ended 31 December 2017:-

Caveat: The operation of 111 Wales in pilot areas (ABMUHB and Carmarthen) will have affected the number of calls to NHS Direct Wales.

- 76,200 calls were made to NHS Direct Wales, of which 66,774 (88%) were to the main 0845 number.
- 943,303 visits were made to the NHS Direct Wales website.
- During the quarter ended 31 December 2017, around 1,000 calls were made each day over the weekends, compared with a daily average of 600 on weekdays.

Key results during the quarter ended 31 March 2018:-

Caveat: The operation of 111 Wales in pilot areas (ABMUHB and Carmarthen) will have affected the number of calls to NHS Direct Wales.

- 83,292 calls were made to NHS Direct Wales, of which 73,918 (89%) were to the main 0845 number.
- 1,187,884 visits were made to the NHS Direct Wales website.
- During the quarter ended 31 March 2018, almost 1,200 calls were made each day over the weekends, compared with a daily average of nearly 700 on weekdays.

Primary Care Out of Hours

Out of hours (OOH) covers the period from 6.30pm to 8am Monday to Thursday, and from 6.30pm Friday to 8am on Monday and bank holidays, during which time GPs are not required to provide cover as part of their GMS contract.

During these periods LHBs are responsible for the management and delivery of out of hours services.

This winter saw a reduction in the number of GPs willing to work in the OOHs service. The reasons are multi-factorial and the shortage of GPs is not unique to Wales.

Activity levels over the Christmas and New Year have usually followed the same trend in recent years, although increased activity presented earlier, well before the Christmas 2017 period, which caused backlog problems. This combined with high levels of flu-related sickness amongst staff, led to a difficult festive period for out of hours services. The daily

NHS Wales conference calls seek updates on the OOHs position across LHBs and the 'intelligence' shared on these calls relating to OOHs was generally better this winter. However, there remains room for improvement, the call and escalation position needs to reflect OOHs crucial position within the 'whole system'.

Key results for OOH services for December to March:

From December 2017 to March 2018 *(ABMU and Carmarthen are excluded from this data as they are using 111)*

- **% of urgent calls are returned within 20 minutes:** across six of the seven LHBs in Wales and across the four months the lowest percentage achieved was 53.7% - the highest 100%.
- **% of routine calls are returned within 60 minutes:** across six of the seven LHBs in Wales and across the four months the lowest percentage achieved was 51.3% - the highest 100%.
- **% of appointments provided to meet urgent need P1 very urgent – 60 minutes:** across six of the seven LHBs in Wales and across the four months the lowest percentage achieved was 33.3% - the highest 100%.

- **% of appointments are provided to meet patient need – P2 urgent – 120 minutes:** across six of the seven LHBs in Wales and across the four months the lowest percentage achieved was 59.2% - the highest 100%.

What improvements can be made for future winters?

- **Welsh Government officials and Directors of Primary Care and Mental Health are considering both short and longer term actions to sustain and develop services in the out of hours period. This will form part of the transformational model of 24/7 primary care. There are currently a number of options under consideration for delivering services out of hours, it is clear that this work needs to progress at pace, considered alongside the Wales Audit Office report on primary care OOH services. Judith Paget, Chief Executive of Aneurin Bevan UHB will provide national leadership for the developing model of OOHs within the context of 24/7 Primary Care going forward.**
- **Moving forward the intention is to roll out the 111 service across Wales which will see improvements and more consistency in the way in which Primary Care OOH is managed and will see patients benefiting from being able to contact one single, easy to remember, free to call number.**

Patient Experience

There was a limited response to the engagement exercise with patients and their families so it is difficult to form an accurate assessment in regard to experience of patients in their local community. However, the feedback from those who did respond is below.

"I would just like to take the opportunity to thank (staff name removed), who is extremely kind, caring and full of empathy, and Dr from GP OOH. As a nurse myself, I find it horrendous having to be a patient, but given an appointment very swiftly, as I needed it. The waiting time was minutes only, despite it being very busy. I think their booking-in system and management of patients is amazing. Then I saw Dr, who was also very kind and very professional"

"When trying to get an out of ours GP appointment for my son or myself I have waited up to 10 hours for a call back let alone an appointment. The tradition of GPs working 9-5 is archaic & not fit for purpose. The rest of the NHS meets need where it is. They are the only service to have not adapted to what the patients' needs are. This compounds the delay in A&E as people go there when they cannot contact a primary care worker, inappropriately"

"generally good"

"even when there are long waits they kept in contact with the patients checking the status of the condition"

"Thank you so much GP OOH - the team is indeed a credit to the NHS. In this climate, people complain a lot about the NHS, so I feel credit is needed where it's due, and this definitely is the case for my experience today"

"Went to chemists and got advice - good service that I would use again"

111 Pathfinder

The 111 Service brings together the existing NHS Direct Wales and the GP OOH call handling and triage into a single service, currently in the Abertawe Bro Morgannwg UHB region and Carmarthenshire only. It provides opportunities to: better manage the demand of unscheduled care for NHS Wales, support Primary Care; and deliver strategic change by improving and co-ordinating access to out of hospital services.

In terms of winter activity:

- For the month of December 2017 there was an increase of around 10,000 calls to the 111 Service, part of this is due to Carmarthenshire coming 'online' in May 2017, however this is still a significant increase from November 2017 to December 2017, with a difference of roughly 7,000 more calls in December 2017.
- For the month of January 2018 there were 19,003 calls offered to the 111 service, of which 17,784 were answered. The abandonment rate was 4.49% which is within the 5% target.

A strategic plan has been agreed by the NHS and the roll out of 111 will continue in 2018/19.

What improvements can be achieved for management of patients with urgent care needs in the community for future winters?

- **LHBs should complete a self assessment on the extent to which action set out in *urgent care in the community guidance* is delivered locally as part of winter delivery planning for 18/19.**
- **The *Transforming Primary Care Model* – whilst primary care teams respond to the day-to-day challenges of sustainability, there is also a focus on implementing the transforming primary care model in order to address this for the future. This model seeks to provide a wider health and wellbeing model that both promote self-care and use of the wider community assets. When a health service response is required, then a wider multi-disciplinary team should be in place to ensure that the 'GP only does what a GP needs to do'. The benefits of such a model are building resilience of the patient/citizen, the wider community assets and the general practice provision. This in turn should reduce the reliance on emergency and hospital services in the absence of alternative services. LHBs should accelerate delivery of key elements of the transformational model to support winter delivery over 2018/19.**

8 AMBULANCE SERVICES

The Welsh Ambulance Services NHS Trust (WAST) endured a difficult winter as a result of a number of factors. Lengthy ambulance patient handover delays at the majority of A&E departments contributed to limiting available ambulance capacity during January –March in particular and this appeared to have an impact, alongside other factors like sickness absence, on capacity to respond to patients in the ‘amber’ category of call.

WAST were broadly able to respond very quickly to the patients in most need of an emergency response (Red: life threatening calls) with a typical response of 5 minutes 32 seconds over the winter period. The Trust also delivered important interventions that delivered system wide benefits helping to limit more pressure on Accident & Emergency Departments by limiting unnecessary ambulance journeys.

Pressures on the service resulted in an increase in the average response time to ‘amber’ patients of 15 minutes 58 seconds when compared to winter 2016/17 and appeared to cause a small rise in serious adverse incidents related to delay in response. A clinically led ‘Accelerated Programme for Amber Review’ (APAR) has begun following the winter period and will report findings in September 2018.

Feedback from the Trust suggested pressures felt over winter also directly affected WAST staff morale and may have contributed to fewer staff deciding to take up overtime opportunities as well as increasing sickness absence, further depleting ambulance capacity.

Other issues to affect ambulance services over the winter period included the ‘batching’ of ambulance vehicles at A&E departments at very specific times of day, largely caused by an increase in referrals of patients to hospital by ambulance by GPs and other Health Care Professionals in the community. This often manifested in a ‘second wave’ of pressure for A&Es during the early evening following GP surgery closure and further limited ambulance capacity as crews waited for often lengthy periods to transfer patients to the care of A&E staff. There are clear opportunities to better manage the flow of patients referred by ambulance to hospital by Health Care Professionals.

There is anecdotal evidence to suggest ambulance resources were also affected by gaps in primary care out-of-hours capacity in parts of Wales causing patients to dial 999 in lieu of an urgent response from that service. However, there is no available evidence that this caused a tangible impact on WAST capacity.

However, WAST were generally able to respond very quickly to patients in most need of an emergency response. The clinical response model change in October 2015 has enabled those in most clinical need of a fast response and this was unaffected despite ambulance patient handover delays, heavy snowfall and exceptionally cold weather over the winter period.

WAST were also able to make a significant contribution to the wider system by limiting further pressure on A&E departments through enhancements to its Clinical Support Desk. Additional clinicians were recruited to provide secondary clinical triage over the telephone to patients in the ‘amber’ category or to review Health Care Professional requests for transport following Welsh Government investment. This additional intervention resulted in up to 10% of patients being discharged over the telephone, signposted to an alternative service or making their own way to the A&E department and contributed to a reduction in

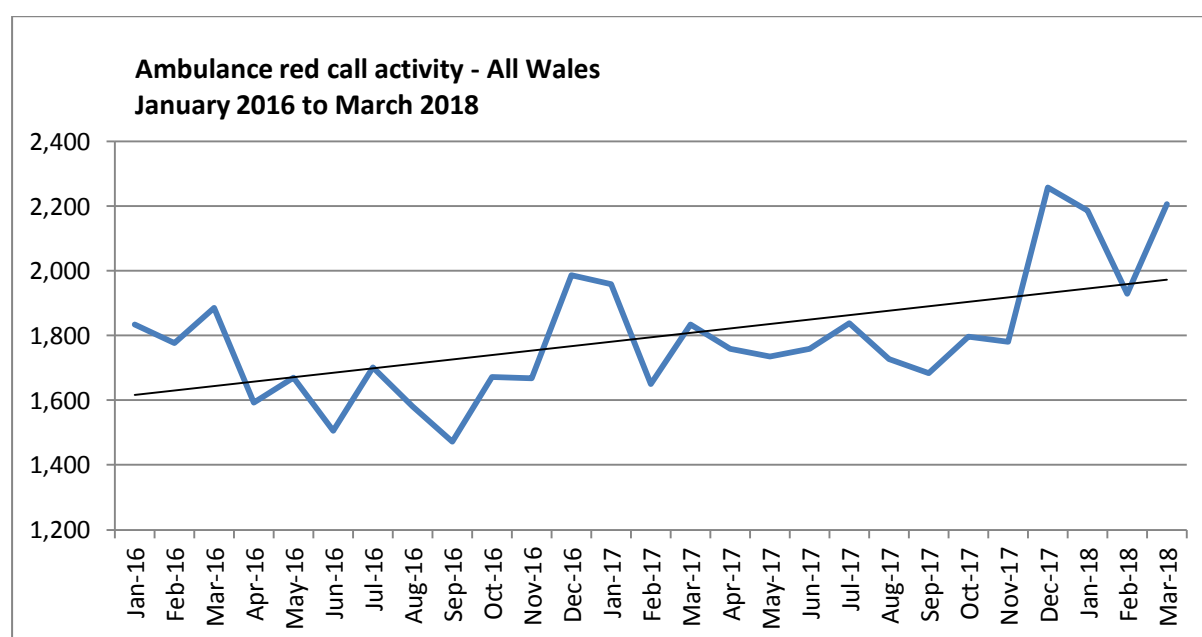
ambulance arrivals of up to 20% over the winter 2017/18 period when compared to previous winters.

The Trust also delivered a number of other interventions with mixed results. A new Advanced Paramedic Practitioner (APP) model was tested in north Wales over the winter enabling over 1000 patients to avoid admission, although the introduction of Hospital Ambulance Liaison Officers (HALO) to support streaming of patients and to limit handover delays was less successful. The Trust's Regional Escalation Action Plan (REAP) was particularly successful in enabling greater resilience at times of pressure.

What improvements can be achieved for future winters?

- **There are significant opportunities to better manage the flow of patients referred by ambulance to hospital by Health Care Professionals (HCPs) and this should be considered a priority by the National Programme for Unscheduled Care and the Emergency Ambulance Services Committee ahead of next winter.**
- **The review of amber (APAR) and aligned work to link data between ambulance services and the hospital system should enable greater understanding about how groups of patients can be better dealt with in the community without being transported to hospital. Lessons from the review should be considered by NHS Wales to support delivery over winter 2018/19 where possible.**
- **Consideration should be given to scaling up the APP model and further enhancement of the Clinical Support Desk. This should enable more patients to be discharged over the telephone or signposted to another service thus avoiding unnecessary use of ambulance resources.**

Chart 6: Ambulance Red Call Activity – January 2016 to March 2018



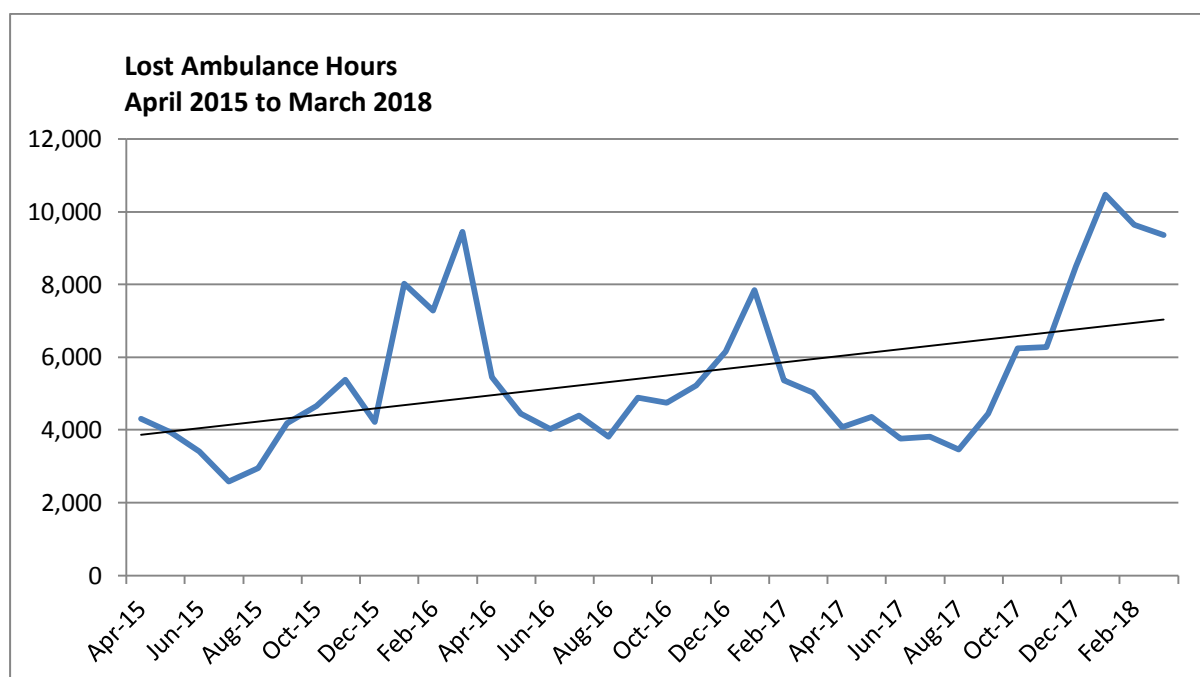
December was the highest month for red demand since the new model was introduced in October 2015. January 2018 was the third highest month for demand, with March 2018 the second highest. There were 425 (24%) more red calls in March 2018 than in March 2017.

Ambulance response performance

The national target is for 65% of Red calls (the most immediately life threatening) to receive a response within 8 minutes. The target was exceeded in each month. The target was also met in each LHB area, with the exception of Aneurin Bevan in February (61.4%) and Hywel Dda in March (58.9%).

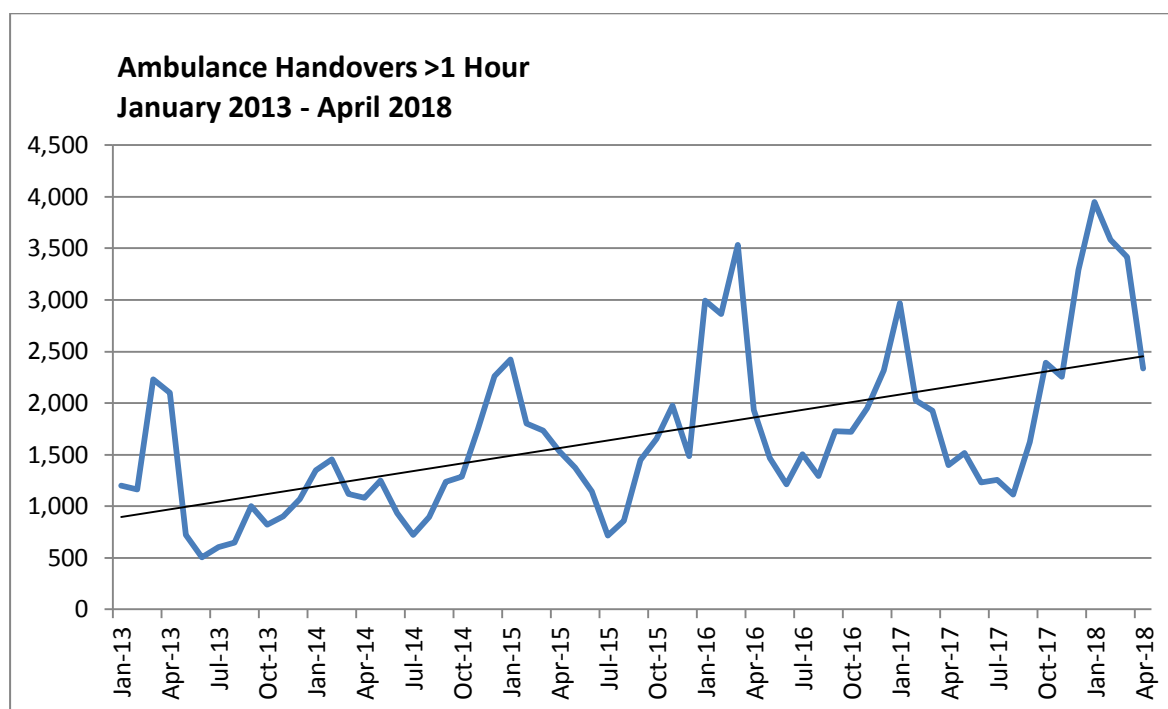
Ambulance Patient Handover

Chart 7: Lost Ambulance Hours – April 2015 to March 2018



There were more lost ambulance hours due to handover delays in January 2018 (9970) than any other month going back to April 2015. There were 2819 (39%) more lost hours in January 2018 than in the same month last year. Lost hours reduced in February and March 2018 but were both significantly above those for the same period last year.

Chart 8: >1-Hour Ambulance Handover delays – January 2013 to March 2018



January 2018 saw the highest recorded monthly number of ambulance handover delays in excess of 1 hour. There were 979 (33%) more delays of 1 hour than in January 2018 when compared to January 2017. February 2018 improved on the previous month but still recorded the second highest on record (1,561 more than in February 2017). March 2018 improved on the previous month but remained high with the fourth highest month on record (1,493 more than in March 2017).

9 ACCIDENT & EMERGENCY DEPARTMENTS

Accident and Emergency (A&E) Departments experienced a very difficult winter, having seen the busiest winter months on record due to increased demand in terms of A&E attendances, including the highest number of patients over the age of 85 requiring admission to hospital via A&E in particular. 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.

Many patients presented with respiratory infections and bad chests in particular this year and the 'flu season saw the highest number of GP consultations and confirmed flu cases in hospitals since the 2009 pandemic. This added pressure to busy A&E departments, which impacted on patient flow through A&E due to the need to restrict infections.

Activity and case mix:

- There was a 5.5% increase in presentations of patients older than 75 when compared to last year, an increase of 12.2% when compared with the average over the past five winters (majors only). These patients are more likely to have co-morbidities, require more diagnostic tests in A&E and to need admission to hospital;

- There was a 3.7% increase in patients over the age of 75 admitted to hospital via A&E when compared to last year, a 7.6% rise on the average over the previous five winters;
- Increasing bed capacity across the health and social care community, was insufficient to manage the increased admissions from A&E. In addition, the extra bed capacity was occupied quickly and remained full for longer periods than intended, this in itself caused some staffing pressures.

Learning :

- Whilst there are examples of good service models being implemented or tested with the aim of preventing admission or expediting discharge from hospital, the pressures experienced resulted in 'bottlenecks' and delays across the system, with patients waiting longer in A&E until a bed was available. This also limited the A&E departments' ability to transfer patients from an ambulance, resulting in increased handover delays and poor patient experience;
- Bed occupancy levels and the staffing challenges across the system is a challenge and this has been a longstanding flow problem and a cause of 'exit block' which is related to available beds, rates of bed occupancy and the number of admissions, which also reflects the feedback received from RCEM;
- Several stakeholders indicated that an insufficient number of social care packages over the post-Christmas and New Year period (due to a reduction in provision over the holiday period) further impounded on the hospitals ability to discharge and impacted on flow, resulting in having to manage a backlog patients in early January.

The significant pressures experienced this winter is reflected in the increased escalation levels being reported and is evidence that services endured an 'extended winter'. Unfortunately, this has also been reflected in deterioration in levels of performance and longer waits will have inevitably impacted on patient experience.

In response to the significant sustained pressure, recognition must be given to the hard work and dedication of all A&E staff who worked tirelessly to ensure the vast majority of patients were assessed, treated, admitted or discharged with four hours.

Organisations will want to consider the impact of working under such pressure has on the staff, not those just in A&E. RCEM and senior ED clinicians have publically raised concerns about the pressures on front line staff and patient safety. The feedback received through the engagement process also reflected this.

Patient Experience

There was a limited response to the public engagement exercise but of those who responded demonstrated a variation in patient experience but very complimentary in regard to the service received by staff, but some negative feedback on the length of time waiting in A&E. Some comments on experiences in A&E included:

"They (staff) are very good – don't know what we would do without them"

"Really good service – no complaints. Staff are on the go all the time."

"Much better than it used to be."

"Too long waiting in A&E"

"Really busy, had to sit in chair for hours"

"Chaotic – didn't seem to be much organisation"

"There was a lot of waiting without being told 'the plan'."

"Although there was a delay in A&E, the announcement (on delays) helped so that I understood the reason for the delay..."

Waiting in a busy department is not good for someone to remain in for many hours when they are so unwell..."

Staff Experience

The response to the engagement exercise with staff working within or in association with A&E departments was again limited, but this highlights the pressure staff are under and the impact this can have on both staff and, consequently, potential increased risks to patient safety. Some of the comments received in response to a number of questions included:

How did the health and social care system perform?

"Considering the huge pressures the system performed as expected"

"Just about managed to get by, but major issues over patient safety, and the system felt close to collapse at times"

"More fragile than previous years with increased acuity of patients for a system that doesn't have sufficient front end capacity as a result of the inefficient back door systems and processes"

"The pressures on the emergency services were relentless...There were patients in hospital beds who do not need to be there – due to lack of capacity in social services and care home placements"

"Staff work on past their shift time, are stressed and this has an impact on sickness and well-being"

"Patients sat inappropriately in A&E waiting room or corridor"

"The extra 22 hours per week advanced practitioner hours funded by winter pressures monies really helped us..."

"There was really good team working to support patient flow..."

"We struggled with demand...Demand for a pharmacy service during this time increased beyond our normal scope."

"Patients kept in corridors for hours and some stayed in A&E for up to a day or more"

"Difficulty maintaining professional and personal development due to lack of time"

"Safety Huddle has helped."

What improvements can be achieved for future winters?

- **Whilst much of the feedback refers to A&E, it is important that organisations ensure they fully consider the impact significant pressure has had on all staffing groups in the wider setting, given that delays in A&E can be a symptom of significant challenges elsewhere in the system.**
- **The development of a Quality and Delivery Framework for Emergency Departments represents an opportunity to identify actions for LHBs to take in preparation for next winter.**

10 SOCIAL CARE PROVISION

What was very clear in the early winter periods (December and January) was that the problems for local authorities in meeting demand for home care packages in several LHB areas had worsened despite the improvement that followed from remedial action taken when the issue first became apparent in late summer.

The problem was most noticeable in the Hywel Dda, Powys, Aneurin Bevan and Betsi Cadwaladr health board areas. However, the indications were that the local authorities concerned were not failing to meet previous levels of demand but were experiencing difficulties with the pace of increased demand, coupled with some instability in the domiciliary care market. In the January and February periods, delayed transfers of care due to a lack of domiciliary care capacity reduced considerably in the Aneurin Bevan health board area but difficulties remained in some other areas despite Social Services' efforts in working with the care sector to develop increased service capacity and to temporarily expand their in-house home care services with the use of £10m (non-recurrent) funding provided by the Welsh Government.

We know that winter demand for social care, particularly home care services was very high with social services supporting people through interim arrangements – either reablement services or step down beds, wherever this was feasible, and right for the individual. An example of increased demand on services was seen in the level of referrals to Community Services through IAA service in the Carmarthenshire local authority area, which increased sharply from around 150 referrals per week in December to 250 referrals per week in January, up by 67%.

Over the last year, the Welsh Government has been supporting the provision of good quality care with an additional £19m of recurrent funding to help manage the impact of the increase to the National Living Wage (NLW). This was intended to improve workforce conditions and so build increased stability and resilience into the home care sector, which should reduce the incidence of patients who are delayed in hospital, whilst waiting for home care services. We have been legislating to that effect as part of the Regulation and Inspection of Social Care (Wales) Act.

The £10m (non-recurrent funding) made available to local authorities in Wales to support them in managing winter pressures was used to provide additional domiciliary care services, aids and adaptations to enable people to remain in their own homes. It also provided for step-up/down placements, which move people out of a hospital environment

and into supportive community facilities with reablement services to restore their ability to perform day-to-day activities and improve their well-being, thus reducing dependency on long-term services.

11 DELAYED TRANSFERS OF CARE (DToC)

December 2018

The **December census** of Delayed Transfers of Care covered the period from 16th November to 20th December and recorded an all Wales total of 425 delays. This was a significant reduction in comparison with the November total – i.e. down by 32 (-7%). It was also 1% lower than the same period in the previous year (which was the lowest monthly total in that year). From a full year perspective, the total number of delayed transfers 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.

Whilst the overall effect of sizeable reductions in some LHBs was offset by sharp increases in other regions, in Wales as a whole, all main categories of reasons for delay (*Social Care* and *Healthcare Assessments and Arrangements* and *'Choice'*) were down. However, *'Choice'* related delays continued to account for almost a third of all delays with 60% of them attributable to patients selecting or waiting for nursing care placements.

Delays due to patients awaiting social care arrangements, which had increased by more than a quarter in the previous period, showed a small reduction but accounted for 28% of all delays. The indications were that the local authorities most affected by the loss of domiciliary care provision in the previous month had made determined efforts to limit the impact by applying the measures outlined in their Resilience Plans, such as the work on a 'single handed care' project, reviewing existing packages of care to ensure they were still proportionate to need and the increased use of third sector 'care at home' services. However, the positive effect of improvement in the level of social care related delays in some localities was negated by the sudden loss of domiciliary care capacity in other local authority areas.

January 2018

The **January census** period was the true test of Winter Resilience planning since it extended from 21st December to 17th January, encompassed the high pressure Christmas and New Year period and pre-dated the distribution of the additional £10m, intended to alleviate winter pressures. The census recorded a total of 442 delayed transfers of care, which represented an increase of 17 delays (+4%) compared to the previous month. Whilst this position was 12.8% up on the equivalent period in 2017, it was the third lowest January total in the last 13 years. This may suggest that improvements made over recent years were not sustainable in a winter when service demand was exceptionally high.

Again, the all Wales total reflected the effect of significant reductions in some LHBs having been overshadowed by the extent of the increases in others. This was also apparent within LHBs where problems confined to just some of the local authorities distorted the overall position. Feedback from LHBs and LAs make clear that their resilience plans were applied, but the volume of demand overwhelmed the contingency measures in place so that additional capacity was exhausted much sooner than anticipated.

The all Wales data also revealed that whilst the level of 'Choice' related delays were unchanged and accounted for 31% of the total, the increase in delays was due to patients waiting for social care arrangements and healthcare arrangements, which rose by 11% and 23% respectively, despite the increased resources put in place. One local authority noted that *'the level of referrals to Community Services through its Integrated Assessment service increased from around 150 referrals per week in December to 250 referrals per week in January, up by 67%. In part this is related to the annual discharge of patients over Christmas and the predictable increase in activity their re-admissions create in the system'*.

There is no doubt that difficulties in brokering packages of care are the biggest challenge facing many local authorities. Their various interventions to support the domiciliary care market with re-tendering at enhanced rates, contracts ensuring better terms and conditions for care workers and assistance with recruitment campaigns are not having the early impact they anticipated. On the health side, the greatest obstacle to a sustained improvement in the level of delayed transfers of care is the shortage of nursing care capacity, which is accountable for the greatest proportion of 'Choice' related delays. It does seem that LHBs and LAs will need to create in-house nursing and domiciliary care services if they are to be able to plan with more certainty for future winter periods.

February 2018

The **February 2018 census** covered the period from 18th January to 21st February. The additional £10m made available to assist LHBs and LAs in managing winter pressures would have had an influence on performance during this period.

The All Wales total of delayed transfers of care at the February census date was **391**. This represents a significant reduction of **51** delays (**-12%**) in comparison with the January 2018 period. This total is identical to the total recorded in the same period last year and therefore both are the fourth lowest total recorded in the last 13 years.

Relatively, sizeable reductions were made at Aneurin Bevan (-25), Hywel Dda (-16 largely, reversing the sharp rise in the previous month), Betsi Cadwaladr (-13) and Powys (-8). These improvements were offset by increases at Cardiff and Vale, ABMU and Cwm Taf.

Delays for reasons of social care assessments and arrangements collectively were down by 19%. Within this category, delays due to patients waiting for home care services to be put in place reduced by 30%. This reduction was particularly evident in some parts of the Aneurin Bevan UHB region. However, problems with a lack of home care provision were still apparent in a number of LA areas, particularly Carmarthen, Swansea, Powys, Wrexham and Flintshire.

There were also notable reductions in the categories of healthcare assessments and arrangements with Aneurin Bevan and Betsi Cadwaladr showing the greatest improvement. Betsi Cadwaladr indicated that the reduction in delays for reasons of patients awaiting assessment stemmed from a greater focus on patient flow and the implementation of SAFER guidance.

Delays falling within the category of 'Choice' fell by 16% and whilst this group continued to represent the greatest proportion of all delays that proportion was down to 29%, as opposed to the 32% average over the last year. Of the 114 patients delayed for reasons of choice, 50% were selecting or waiting for nursing care placements. A lack of sufficient nursing care capacity is particularly acute in the ABMU and Betsi Cadwaladr LHB areas.

One area of disappointment was the rise in the number of delays in the smaller categories of reasons for delay – i.e. Legal/financial issues, Disagreements and Protection/safety issues. These rose by +2, +6 and +14 respectively.

March 2018

The total number of delayed transfers of care at the **March 2018 census** date was **399**, which represents an increase of **8 delays (+2%)** in comparison with the February 2018 period. This total is also up by 3 (0.76%) comparative to the same period last year but it is the second lowest March total recorded in the 13 years in which the data has been collected.

In terms of reasons for delays; the category of ‘Choice’ related delays showed the greatest improvement with the total down by a quarter from 114 to 86 and all LHBs reported some level of reduction – particularly Aneurin Bevan (-9) and Cwm Taf which eliminated all delays for this reason. Following on from a 16% fall in the previous month this category was no longer the leading cause of delays and did not account for a third of all delays (as has been the average in each census period in recent years).

Delays in the category of healthcare assessments increased by 12 (+25%) and continued to be largely CHC related whilst social care arrangements were up by 5 (+5%) with problems due to a lack of domiciliary care capacity still very much in evidence. However, the largest increase was seen in the category of Disagreements which rose by almost 60% to *further investigation is required on this specific issue and on the rises in healthcare assessments and social care arrangements*.

In particular we aim to have an understanding of why the additional funding made available to alleviate winter pressures appears to have had less impact than anticipated in the Betsi Cadwaladr, Hywel Dda and Aneurin Bevan health board areas.

The further £10m made available to support social services in February to alleviate winter pressures seemed to have had less impact than anticipated, in the Betsi Cadwaladr, Hywel Dda and Aneurin Bevan LHB areas in particular.

What improvements can be achieved for future winters?

- **Increased focus on *Discharge to Assess*** - in respect of wider community services, a key reflection from winter 2017/18 is the need to establish ‘Discharge to Assess’ service as part of the range of available services for unscheduled care.
- **Specific focus on working together with Local Authorities to increase availability of domiciliary care packages** to enable citizens to leave hospital when ready.
- ***Integrated Pathway for Older People*** – ensuring strong links between this work and the transforming primary care work. This includes informing the GMS contract reform priorities. Learning from Camden, Hywel Dda and Cwm Taf will be fed into the Transforming Primary Care Model as it becomes available.
- ***Enhanced Services*** – the full implementation of the enhanced services for care homes and diabetes. This provides a wider range of services available in the community supporting the ‘care closer to home’ principle.

12 ELECTIVE ACTIVITY

The national target for referral to treatment (RTT) waiting times remains 95% of patients to be waiting less than 26 weeks at the end of each month with 100% waiting less than 36 weeks. By default, due to the current status of waiting lists across Wales, the focus of delivery has been around reducing the over 36 week waits.

In anticipation of increased pressures and as part of their planning LHBs will often consider reducing their elective inpatient activity, over the festive period in particular, in order to create capacity to meet the increase in urgent and emergency demand we tend to see at this time of year. These planned reductions in elective activity, in the majority of cases, will often be in relation to routine elective inpatients – and not those requiring urgent or emergency treatment – those needing cancer treatment for example, or day surgery where a bed is often not required tend to continue to be seen. However, the increased urgent and emergency pressures impacted on their ability to maintain the intended level of elective activity over the winter period, resulting in an increase in postponed operations.

Impact of additional £50m investment

The Welsh Government provided an additional £50m to NHS Wales for winter pressures to help balance the delivery of elective and emergency work and improve waiting times by the end of March 2018. Significant focus was given to reducing the number of patients waiting over 36 weeks, those waiting over 8 weeks for diagnostics and those waiting over 14 weeks for therapy services.

This funding enabled LHBs to increase both their internal and external resource capacity to support delivery and five of the six LHBs achieved a better position in March 2018 than they were by the end of March 2017. The only exception being Betsi Cadwaladr.

Postponed Operations

In terms of postponed procedures at short notice, the number for non-clinical postponements was 30% higher in the period December 2017 to March 2018 than in December 2016 to March 2017 and the total number of non-clinical postponements was 5% higher in the December 2017 to March 2018 period than in December 2016 to March 2017.

It should be noted that during the December 2017 to March 2018 period, 47% of all postponements were made by the patient and a further 10% were by the hospital for clinical reasons. The previous year, 45% of postponements were by the patient and 11% by the hospital for clinical reasons.

Although the Royal College of Surgeons felt that this winter passed more smoothly when compared to the previous two years, and understanding there will always be occasions when elective surgery has to be cancelled in the event of extreme urgent and emergency care pressures, the College felt that more planning is needed at an earlier stage to adjust elective capacity.

What improvements can be achieved for future winters?

- **Local Health Boards should engage with clinicians and consider what further action they can take to prioritise elective inpatient activity earlier in the year, and restricting the winter period to day-case surgery and some routine elective activity, as part of their planning arrangements.**

13 CAPACITY & DEMAND

The integrated winter plans are focussed on preventing unnecessary admission and improving discharges to maintain flow across the system and ensure bed capacity is maximised. This includes many innovative models across Wales that are helping to reduce avoidable admissions of patients to hospital, thus alleviating the requirement for increasing levels of bed capacity in community or acute sites.

Overall capacity needs to be viewed in the context of an overall bed stock which is at its lowest point in the current time series. The reduction in beds reflects a move of care closer to home in community settings and efficiencies in terms of reduced length of stays in high volume surgical procedures, day surgery, the greater use of assessment units etc. However, there remains a question of whether the current quantum and balance of bed and non bed capacity is appropriate to meet demand, the character of which has changed as beds have been taken out of the system.

Surge Capacity

In anticipation of increased unscheduled care activity during the winter period, the integrated winter plans identified around 400 additional beds or bed equivalents across the system. Some organisations also refined the use of their surgical and medical beds to provide flexibility in response to increases in medical or surgical activity. The number of additional surge beds identified for this winter is similar to that during winter 2016/17.

The services have however experienced significant pressure with a number of hospital sites having to respond to increases in flu activity which has run at the highest level for some years. This has inevitably impacted on available beds in wards and affects specialist critical care beds, which in turn affect the speed with which beds can be accessed from A&Es. This is in addition to the increases in activity and demand, including increases in older people attending hospital and needing admission – often having complex needs and tending to stay in hospital longer.

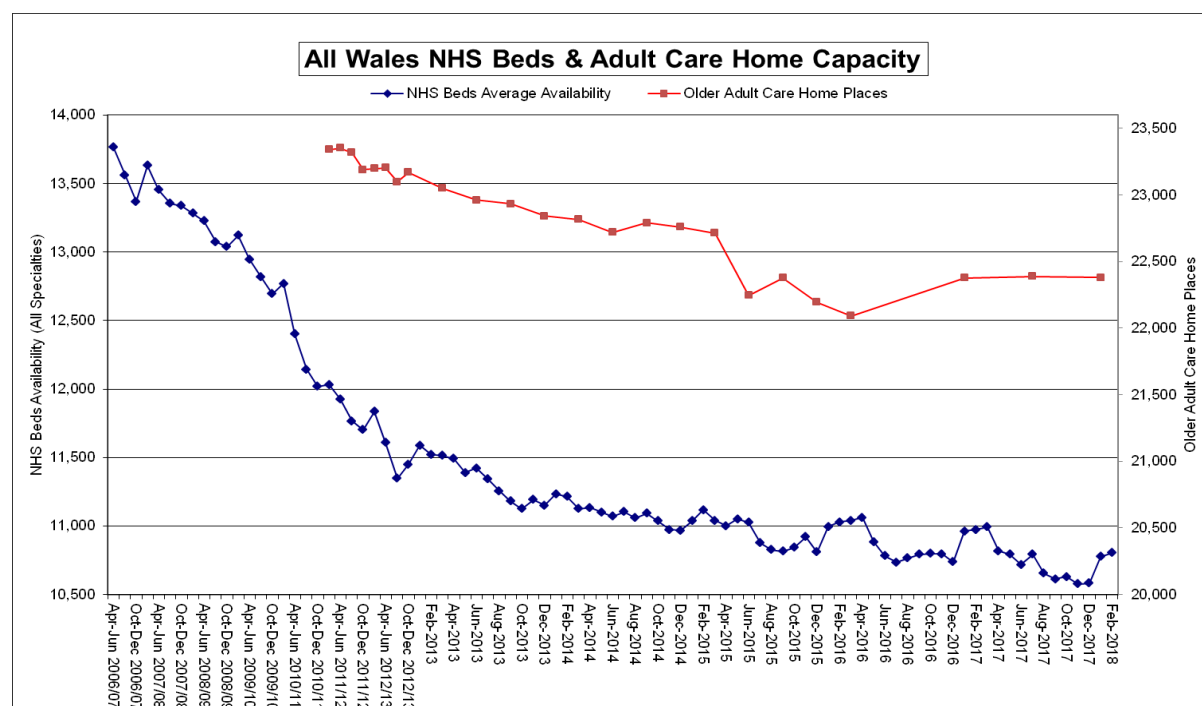
Plans were also made for the additional surge capacity to fluctuate in response to the demands placed on the service at a particular time. However, anecdotal information indicates that some organisations opened their surge capacity earlier than intended and also, when opened, found those beds were often being utilised. This restricted their ability to flex their beds leading to blockages and delays.

In addition to the identified surge capacity, demand outstripped capacity and some LHBs have to put in additional measures.

Bed Capacity

An analysis of the current NHS Wales data indicated that there has been a 20% reduction in NHS beds in Wales over the past ten years. A similar pattern has also been seen in other UK countries (England 22%, Scotland 21% and Northern Ireland 26%). In Wales, there are 3.49 beds per 1,000 population (England 2.36, Scotland 4.05 and Northern Ireland 3.17).

Chart 9: All Wales NHS Beds & Adult Care Home Capacity



The above chart shows that over 2,700 NHS beds have been removed in 10 years between 2006/07 and 2016/17 (20% reduction). The reduction over 10 years at LHB level ranges from 10% (Hywel Dda) to 23% (BCU).

Data also indicates that nearly 1,000 elderly care home places have been lost across Wales since March 2011. Approximately 48% of elderly care home places are in homes registered for nursing care. Not all such places will be allocated for nursing care.

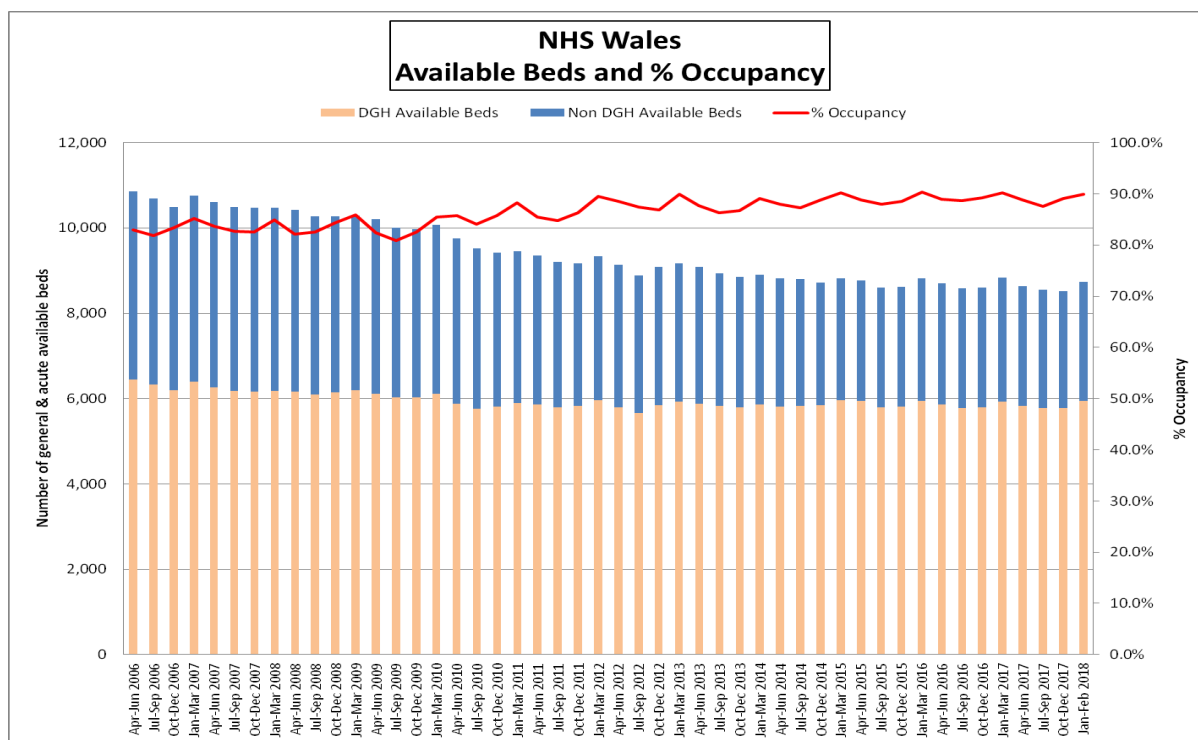
In addition:

- there has been a 6% increase in occupancy levels;
- there has been a 6% increase in emergency medical demand over the past 6 years against a 6% increase in medical beds;
- the elderly accounting for the majority of this increase and nearly 70% of emergency bed usage;
- there is increasing pressures on District General Hospitals (DGHs) from long stay patients, with approximately one third of DGH beds being occupied by long stay patients (UHW highest at 42%); and

LHBs should also consider whether more can be done to better manage the cohort of patients who are admitted for short periods. For example, whilst data quality is compromised by inconsistency in assessment unit reporting, NHS data indicates there has been a real growth in 'short stay' admissions (those who are admitted for less than one day), with the

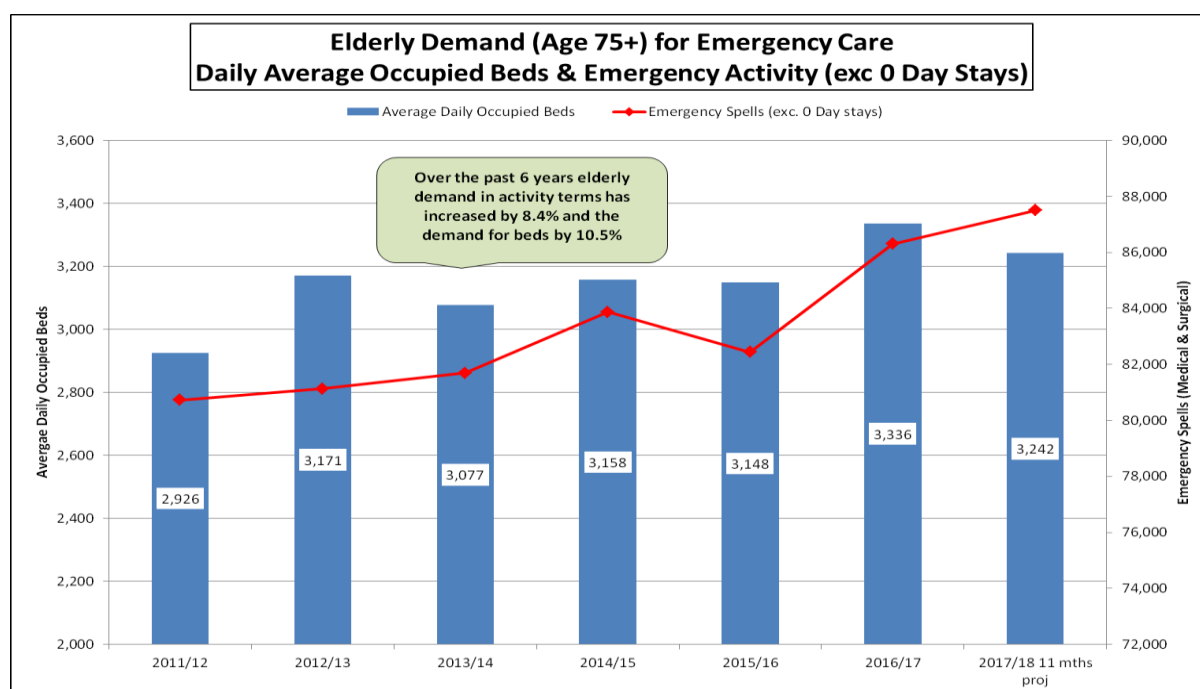
proportion of around 32% of beds taken up by these patients in 2017. This is a growth of 16.6% compared to the previous 4 year average.

Chart 10: NHS Wales Available Beds and % Occupancy



The above chart shows the vast majority of reduction in beds has occurred outside in the community, placing extra burden on DGHs. In 10 years between 2006/07 and 2016/17 DGH beds fell by 8% (over 500 beds) while beds in other sites fell by 35% (over 1,500 beds). Over the same period occupancy rates rose by nearly 6% towards 90%

Chart 11: Elderly Emergency demand – Medical and Surgical



- The above chart includes emergency discharges and average daily occupied beds (derived from bed days) for medical and surgical specialties aged 75 and over. Elderly emergency spells (excluding 0 day) represent 40% of total activity, elderly emergency bed usage 58% of emergency bed usage.
- The population of those over the age of 85 is expected to increase by 62% by 2029 (an extra 50,000)

It is clear that the reduction in the number of beds, combined with these added pressures, is putting a significant strain on the hospital system and their ability to maintain patient flow. This in turn has resulted in delays, increased medical outliers and a contributory factor in added pressures to elective activity. More intelligence is required to better understand the broader social care capacity and therefore the 'whole system' capacity and, whilst there is clear evidence of NHS Wales and social care services across Wales working together towards a care closer to home model, the pace of change in the way services are delivered across the system does not match the pace of change in population needs in recent years.

A detailed analysis has been shared with LHBs for consideration with a requirement to inform their planning and a mechanism for monitoring progress on capacity and demand modelling has been put in place via the Welsh Government's Quality and Delivery meetings with NHS organisations.

What improvements can be achieved for future winters?

- **There needs to be more pace in using intelligence to inform capacity and demand planning across primary/community, acute and social services.**
- **LHBs should review the cohort of patients who are admitted to hospital via A&E for short periods (less than 24 hours). This should include undertaking an analysis and clinical review of the types of patients and their condition(s) to consider whether there are further opportunities to better manage these patients and avoid unnecessary admission.**
- **Health and social care organisations should prioritise discharge-to-access modules to enable people who do not require hospital treatment to be managed at home.**

14 TIME-FOCUSED INTERVENTIONS OR INITIATIVES

The ‘*Winter 2016-17 – Evaluation*’ identified the need to focus on planning for December and immediately after the festive period through local time-focused interventions or initiatives similar to ‘breaking the cycle’. Therefore some LHBs introduced initiatives this winter that focused on collaborative working and being proactive through escalation to address pressures quickly, and improve patient flow. This approach has shown evidence of success in other parts of the UK. This included focus on making A&E and patient flow “everyone’s business”.

15 PATIENT EXPERIENCE

Capturing information on patient experience, including over the winter and, eventually, on patient outcomes in a systematic way is an area in need of development.

Health and social care services will routinely obtain feedback from patients and their relatives through a range of mechanisms such as patient surveys, complaints, feedback boards, drop-in clinics, throughout the year, including occasional inspections from bodies such as the Community Health Councils or Health Inspectorate Wales.

In general, the feedback received indicated that patients were satisfied or pleased with the care they received from staff, and there were examples of good communication with patients. The public engagement exercise asked the public a number of questions and some of the comments included:

How well has the health and social care system performed during the winter and your experiences?

"Coped well under great pressure"

"It has struggled more than in previous years"

"They struggled with sheer volume of people, some of which perhaps didn't need to be there, but they still managed to do a job"

"Very over worked and short staffed"

Very professional

"Just wanted to say thanks for the wonderful treatment I received in the emergency unit last Saturday night. On what was a very busy night the staff were all very kind and helpful and very professional"

"The two paramedics were very helpful and polite..."

However, despite the dedication and hard work of frontline staff, many patients experienced lengthy waits at some point in the care system. These delays will have inevitably led to poor patient experience, and there will understandably have been occasions where interactions with patients, or their relatives, were difficult, especially for those who were very ill.

ANNEX A

KEY ACTIONS/INITIATIVES AND HIGHEST RISKS/CHALLENGES – BY HEALTH BOARD AREA

Organisations were asked to provide a brief summary of the action or initiatives taken, their purpose and the benefits and any lessons learnt of implementation. The information below was provided. Further work is ongoing to evidence the benefits and will be fed into the final review.

ABM	
High Impact Actions	Biggest Challenges/Risks
1. Breaking the Cycle – further information can be found in the report under ‘Targeted Interventions’.	1 Impact of flu and other infections on capacity and flow.
2. Enhanced capacity/ changes to front door models to support admission avoidance/ early discharge (frailty models), including 10 additional mental health beds over and above that planned for clearly defined patients whilst they waited provision of permanent arrangements in the community setting.	2 Variation in capacity/ practice/processes impacted on patient flow - need to reduce this variation through a targeted approach and supported with ongoing training/ awareness sessions. The additional winter pressures funding was targeted towards increasing capacity and piloting different models of care to increase the number of patients who are discharged to assess. However, the timing of the additional winter pressures funding limited the impact and it would have been helpful receiving the funding earlier to improve planning.
3 Management of urgent/cancer elective admissions.	3. Workforce remains an ongoing challenge in key service areas – A&E at Morriston, GP Out of Hours and primary care in particular. Nursing workforce also difficult in March impacting on ability to staff additional capacity in accordance with their pre-emptive protocol.
4 Positive management/containment of flu outbreak	4. Domiciliary Care Capacity/social care provision – particularly in Neath Port Talbot and Swansea.
5 Other initiatives which had a positive impact included: <ul style="list-style-type: none"> • Bevan commission pilot between WAST and acute care team to support admission avoidance and to avoid the deployment of an ambulance response; • surgical ambulatory care pilot in 	

Princess of Wales; <ul style="list-style-type: none"> • extension of transfer of care service in NPT/ accelerated placement team; • enhanced frailty/ front door model at Singleton; • increased throughput through community hospitals; and • Green to go ward at Morriston. 	
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Aneurin Bevan	
High Impact Actions	Biggest Challenges/Risks
1. Acute hospitals – targeted Interventions <ul style="list-style-type: none"> • Breaking the Cycle – A number of events over the winter period were put in place to coincide with expected peaks in demand, including a full audit of patient pathways and unblocking barriers to discharge or pathway continuation. They also reintroduced a transfer team to improve the EFU pathway to avoid unnecessary stays within A&E for elderly frail patients. • Ongoing use of SAFER bundle aligned to discharge coordinators across all sites which resulted in a 2 day reduction in length of stay and 20% increase in discharges. 	1. The fragility of GP practices and the number of GP gaps have struggled to support the demand and needs of patients. The increased need for urgent appointments have also compromised home visits. They have reported a high numbers of patients presenting with coughs, colds/flu like symptoms and respiratory illnesses particularly given their population demographic. GP OOHs fill rates were lower than last year and particularly compromised on weekends. There are a range of factors impacting on this such as a HMRC ruling around taxation, increased demand etc, which made the position more difficult.
2. Additional Capacity <ul style="list-style-type: none"> • Discharge to Assess - commissioned service to provide up to 15 patients a week with a bridge to their Package of Care, releasing capacity at Nevill Hall Hospital and reducing length of stay. • Increased management and senior nurse weekend rotas to support business as usual approach to OOH periods providing a wider oversight. • Building on the success of last year, we introduced an 18 bedded therapy led ward for patients who have completed their acute episode of care but require reablement or are waiting a package of care or community rehabilitation bed 	2. Additional Capacity beyond anticipated The winter plan to increase bed capacity in a phased way was followed, however additional capacity was needed above this to cope with pressures on certain days. By 4 th January, 82 additional beds were open and these were full by 11 th January. There have been long and sustained periods of the highest level of escalation across the whole LHB. This impacted on patient flow and their ability to fully to de-escalate or provide staff with any ability to catch up. The major concerns related to congestion in A&E, which is solely driven by walk in majors who are staying longer than 4 hours. More needs to be done to strengthen communication at the front door and internally review their escalation processes.

<p>3. Primary care and community services</p> <ul style="list-style-type: none"> • Strengthened support to WAST through monthly meetings between primary care/MAU and WAST. A nurse practitioner and a salaried GP worked with WAST to review the ambulance stack and A&E doctors have been on the road to prevent admissions. WAST regularly link with the OOH service to avoid unnecessary hospital admissions. • They increased their nursing support in several areas e.g. palliative care and included an ACP lead to drive a rapid plan. • The overnight nursing team provided telephone support/assessments to OOHs and alleviating 500 calls per month and avoiding admissions. • They have secured ICF funding to pilot an in-reach nurse practitioner/advanced nurse practitioner to support care homes overnight and at peak times during the weekend. • Frailty/CHC work closely with in-reach to nursing homes in an attempt to provide care closer to home. Significant amounts of advanced care training and planning has taken place in nursing and residential homes. Their GP Macmillan facilitator is involved in multi-agency work around the deteriorating patient. • Pharmacy - The national enhanced service for the treatment of Common Ailments (CAS) was in place across all our pharmacies. Additional rotas were established to facilitate some premises opening late on Sundays. • They have extended their falls vehicle support to the whole of the Gwent area. 	<p>3. Workforce</p> <p>Workforce remains an ongoing challenge in key areas. This is not only vacancies, but also the aging nature of the workforce and their own health. Compared to this time last year, they have:</p> <ul style="list-style-type: none"> • 277 registered nursing vacancies which is 35 higher than this time last year. 105 of these are in unscheduled care. • 34.8 medical vacancies and whilst they had success with some medical appointments, they have now been prevented from concluding the recruitment process because the UK has reached the visa cap for tier 2 certificates of sponsorship. • They have also seen an increase in staff sickness.
<p>4. Out of Hospital and social care</p> <p>As part of their out of hospital plan they introduced a range of activities to include:- My Care my Home and local authority</p>	<p>4. RTT</p> <p>RTT risks associated with the emergency activity, reported patient acuity and adverse weather. The LHB planned less elective</p>

partners agreed to an increase in social worker capacity through the evenings and weekends to support assessment and aid capacity.	activity in the post Christmas period but went back to full elective plans for February and March. The increased pressures in February and the adverse weather resulted in significant cancellations of elective activity.
<p>5. We promoted and/or developed a 'Be winter wise' campaign, 'Choose Well' campaign, 5th Dr Olivia video and extensively used social media platforms to communicate the messages to staff and the public.</p> <p>We also offered incentives to divisions who met staff flu targets.</p>	

Betsi Cadwaladr	
High Impact Actions	Biggest Challenges/Risks
1. Frailty Services - implemented the frailty assessment and admission services across 2 of the 3 acute - leading to very good feedback on patient outcomes and positive evidence on reduced hospital admission and length of stay for this group of patients. More patients are discharged from ambulatory care facilities following assessment and therefore maintain better independence as a result of this initiative – although capacity challenges have made this difficult to sustain.	1. Admission avoidance – plans intended to reduce admissions as part of the programme to reduce pressure on bed capacity. Although each scheme can produce evidence to support the impact, there is a lack of evidence on reduced overall admission trend. It is possible that the additional initiatives have helped to reduce the trend upwards caused by population demographics and therefore the pressure would have been worse without these changes, but the evidence is inconclusive.
2. Safety Huddle has been implemented with guidance and support from the NHS Wales Delivery Unit. This process has further strengthened medical engagement and is becoming established as the mechanism for understanding system risk on a daily basis.	2. Bed occupancy- High bed occupancy was the most significant challenge over the winter period. Systems to identify patients medically fit for discharge and “grip” on discharge processes have been improved throughout the winter but with minimal impact on AVLOS or occupancy. Further system changes are required and will be taken forward within SAFER – to support Discharge to Assess, risk assessment of patients at risk of complex discharge, and system wide planning of EDD on admission. These are significant changes requiring cultural, system and behavioural changes across all hospital wards but will be the main focus of further improvement work.

3. Health Care Professional (HCP) calls/co-ordination of pre admission screening with WAST. Systems have been implemented across the LHB to ensure that HCP Call referrals are reviewed by community teams whilst on the WAST stack. This has enabled community teams to support patients at stay home to either avoid admission or provide assurance/reduce risk while waiting for ambulance.	3. Recruitment and staffing issues have been an ongoing challenge. During the holiday periods, sickness of staff added to the pressure on rotas that were already carrying vacancies.
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Cardiff & Vale	
High Impact Actions	Biggest Challenges/Risks
<p>1. Flu based molecular point of care testing</p> <p>164 patients tested - 84 confirmed flu.</p> <p>Rapid flu test benefits:</p> <ul style="list-style-type: none"> • Patients discharged from A&E who would have previously been admitted; • Able to cohort Flu A and Flu B patients separately; • Saved bed days as early decisions enabled prompt and appropriate cohorting patients together in bays; • Able to risk assess and open ward areas earlier, this enabled beds to be used that previously we would have closed as a precaution; • Saved bed days as able to make informed decisions to open beds and bays; • Enabled more effective use of single rooms due to earlier results; and • Able to reassure patients earlier and provide early confirmation of whether they had Flu. 	<p>1. General levels of flu (and D&V)</p>
<p>2. Medical outliers team</p> <p>A medical outlier team was introduced in November 2017, including two junior doctors, two nurses and a consultant (for non-buddy wards). The team was specifically put together to review medical patients outlied on surgical and specialist wards to ensure timely review and discharge.</p> <p>Benefits of the scheme included: timely reviews, better patient care, improved flow</p>	<p>2. Difficulty across all staff groups (including social care) in recruiting for short term and temporary schemes</p>

and discharge rates on outlying wards and reduced LOS for patients.	
<p>3. Increase in discharge to assess beds in Ty Llandaff</p> <p>Used additional winter pressure funding to increase the bed base in Ty Llandaff to 10 beds from 28th November 2017 to 16th April 2018.</p> <p>Benefits of the scheme included:</p> <ul style="list-style-type: none"> • Average length of stay = 12 days, improvement from 14 days target • Utilisation rate = 97% ↑ from 95% target • Bed days saved = 270 	<p>3. Late notification of additional Welsh Government funding for winter pressures within the context of very limited staffing availability, minimising and delaying the impact in alleviating the January pressures</p>

Cwm Taf	
High Impact Actions	Biggest Challenges/Risks
<p>1. Establishment of the Stay Well at Home Team - the SW@HT, including a skill mix of social workers, occupational therapists, occupational therapy technicians and physiotherapists, working 7 days a week to undertake assessments at the A&E departments and support individuals to be discharged home. The SW@HT will 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.</p>	<p>1. The availability and sustainability of staff over the winter period has been a key challenge for the LHB and workloads had to be prioritised on a daily basis to ensure that the patient flow is maintained.</p>
<p>2. A range of primary care projects and service improvements such as a pilot project for the virtual ward that aims to keep patients at home as long as possible; joint pathways agreed with WAST for chronic conditions such as diabetes, falls and respiratory patients; and cluster schemes around chronic conditions management.</p>	<p>2. Inability to increase level of surge capacity due to staff restrictions</p>
<p>3. 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.</p>	<p>3 Ability to maintain compliance with the performance targets during times of high escalation.</p>

Hywel Dda	
High Impact Actions	Biggest Challenges/Risks
<p>1. Additional resources was in place at weekends, on all acute sites, to support safe discharge and to provide additional senior review at the front-door, which in-turn helped reduce admissions.</p>	<p>1. Lengthy waits in and outside of their A&E departments – dedicated reviews which were highlighted in bed meetings.</p>
<p>2. Additional Care of the Elderly Consultant with an interest in frailty commenced on 6th November at Glangwili Hospital. This Consultant works closely with the Transfer of Care Advice and Liaison Service (TOCALS) at the 'front door' supporting the identification of patients who could, with appropriate care and treatment plan, be discharged home. This Consultant along with the TOCALS team focus on one ward dedicated to frail patients whose length of stay could be reduced by embedding a frailty approach to their care.</p> <p>A similar model is also in place at Withybush Hospital, the Frailty Consultants, again work closely with the MAST team in both the A&E department and CDU, either providing advice and treatment plans for those who can be discharged home or pulling patients through in a timely manner to the ward reducing the length of stay where possible.</p>	<p>2. Nurse Staffing across the acute hospitals – insufficient to sustain all surge areas for a long period.</p>
<p>3. A perfect-week methodology brought wider community, social services and joint discharge team resource in to the bed meetings to enable timely decisions and management of patients to ensure those able to mobilise could safely proceed. It has been acknowledged that these weeks need to be undertaken in the run up to and from bank holidays to gain the most benefit. In addition all meetings were cancelled during the first 3 weeks of January so that the management team could establish control rooms and an additional tier of on-call management was put in place as support.</p>	<p>3. Medically Fit numbers run at 20% of the bed base available for urgent care and this put considerable pressure on the Withybush site/Front Door. Spikes in activity in Carmarthenshire increased the numbers on the complex patient working list, requiring an increase in community care support and compromising length of stay.</p>

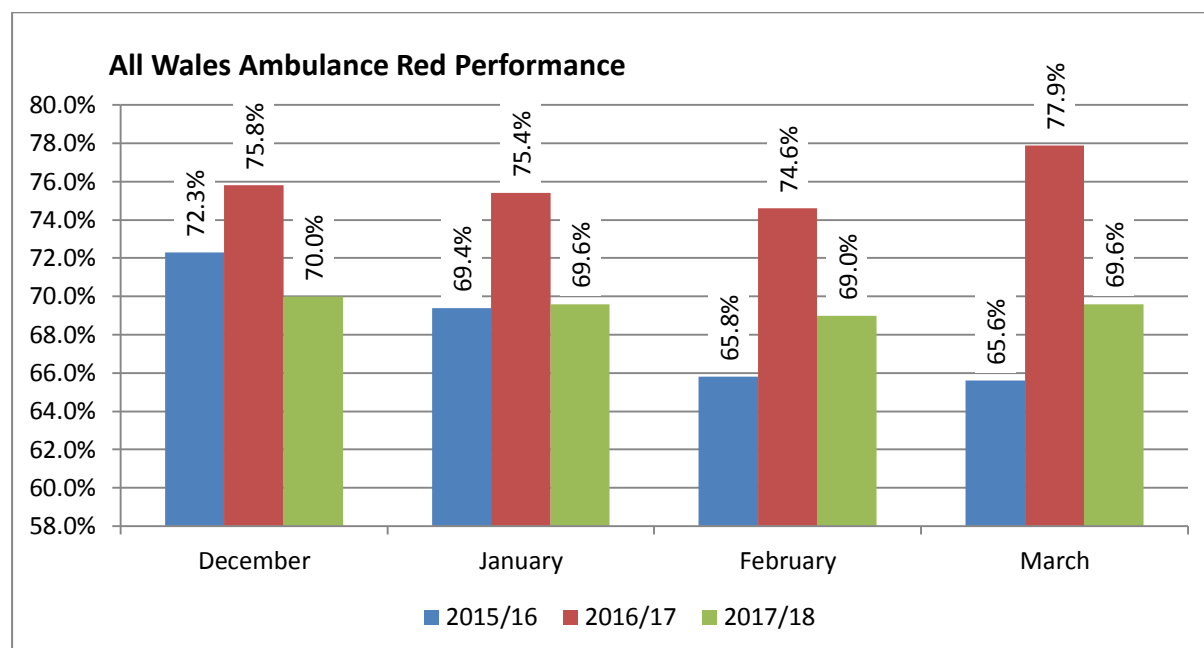
	<p>4. Cardiac patients waiting ABMU was very challenging, no doubt due to pressures in ABMU. This has raised clinical questions about the purpose of invasive angio if it is not done in a timely way.</p>
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The above learning and examples of good practice across Wales has been shared with health and social care organisations to support the enhancement of planning and delivery of services and identify areas needing further focus ahead of the next winter period.

Annex B - PERFORMANCE AGAINST KEY UNSCHEDULED CARE INDICATORS FOR THE DECEMBER 2017 – MARCH 2018 PERIOD

This report is not intended to be read as a performance report and the focus of this review is on the sharing of lessons learnt collaboratively to strengthen the planning process and deliver service improvements.

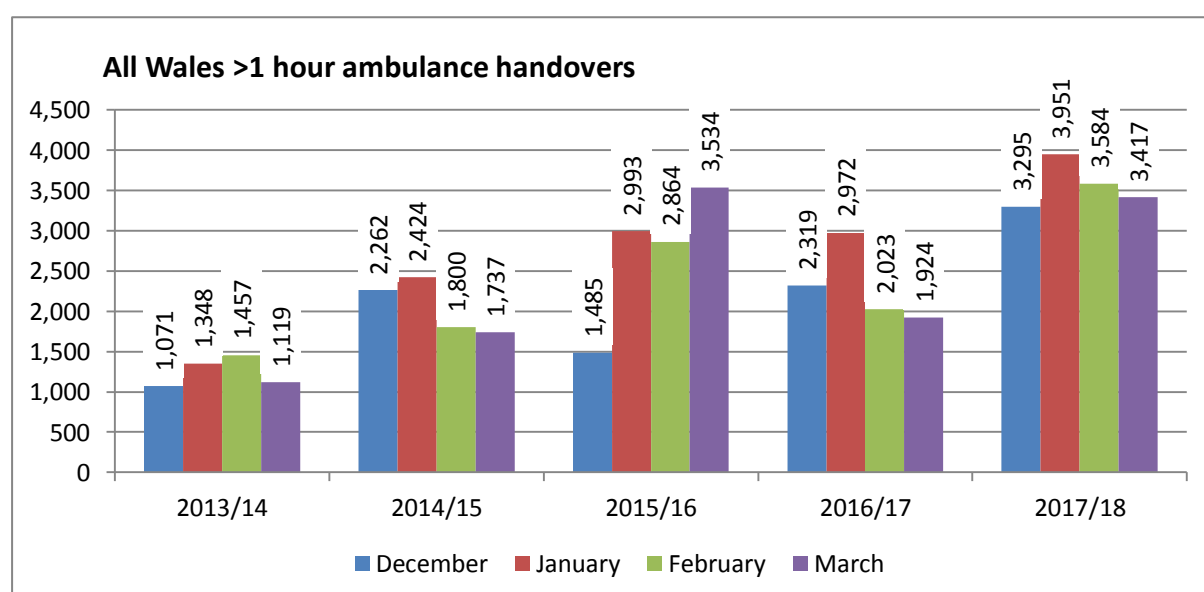
Chart 12: Ambulance Red Performance – Monthly Comparisons (December to March)



*The above chart includes ambulance Red performance since 2015/16 as the clinical response model commenced from October 2015. The figures are not comparable with those prior to this date.

Ambulance Handover

Chart 13: > 1-Hour Ambulance Handover Delays – December to March

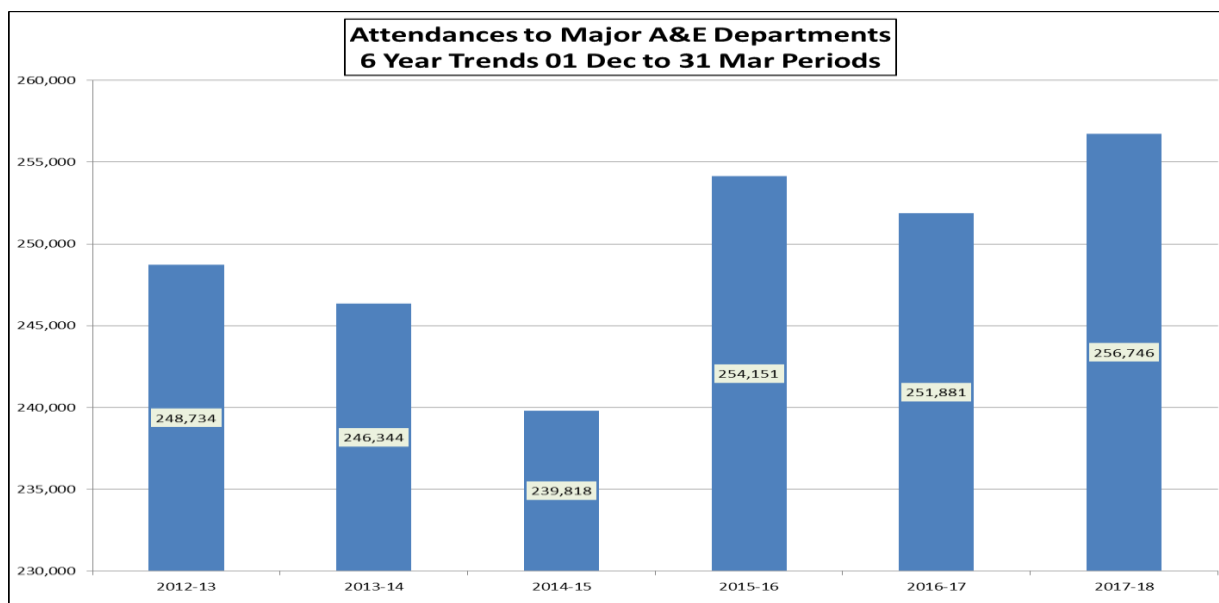


Handover delays inevitably impact on the ambulance services' ability to respond to calls in the community and was identified as a risk in the ambulance services' winter plan.

Accident & Emergency

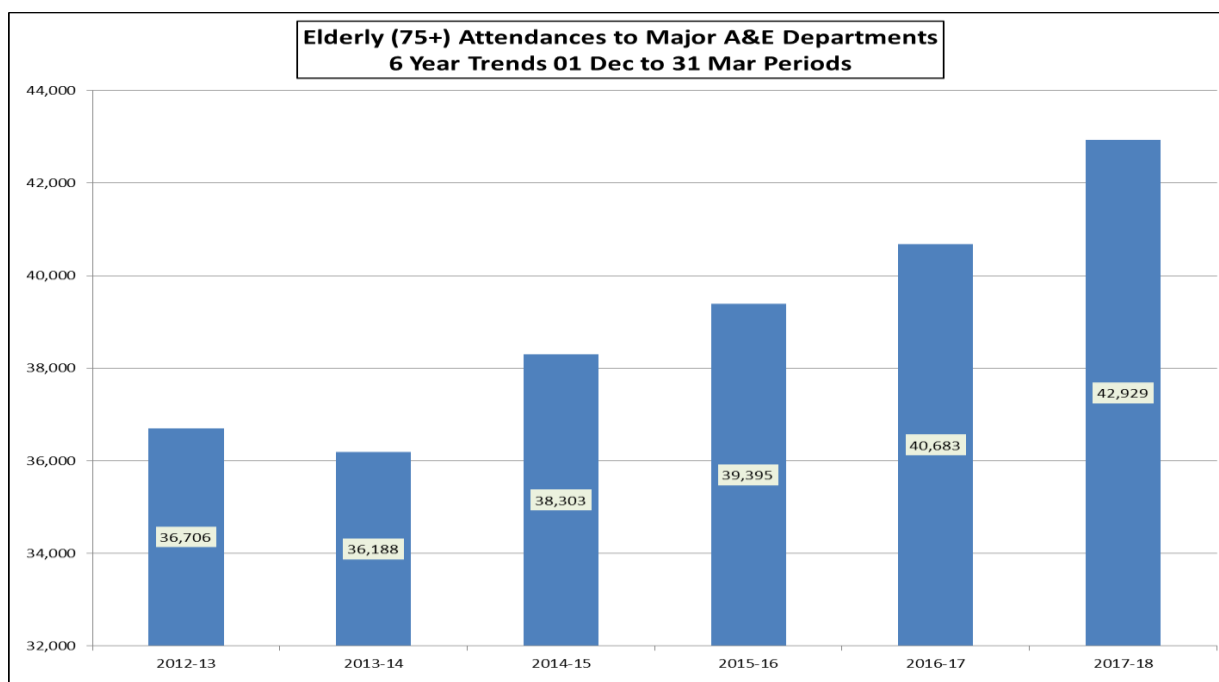
TRENDS

Chart 14: A&E Attendance Trends – 1 December to 31 March



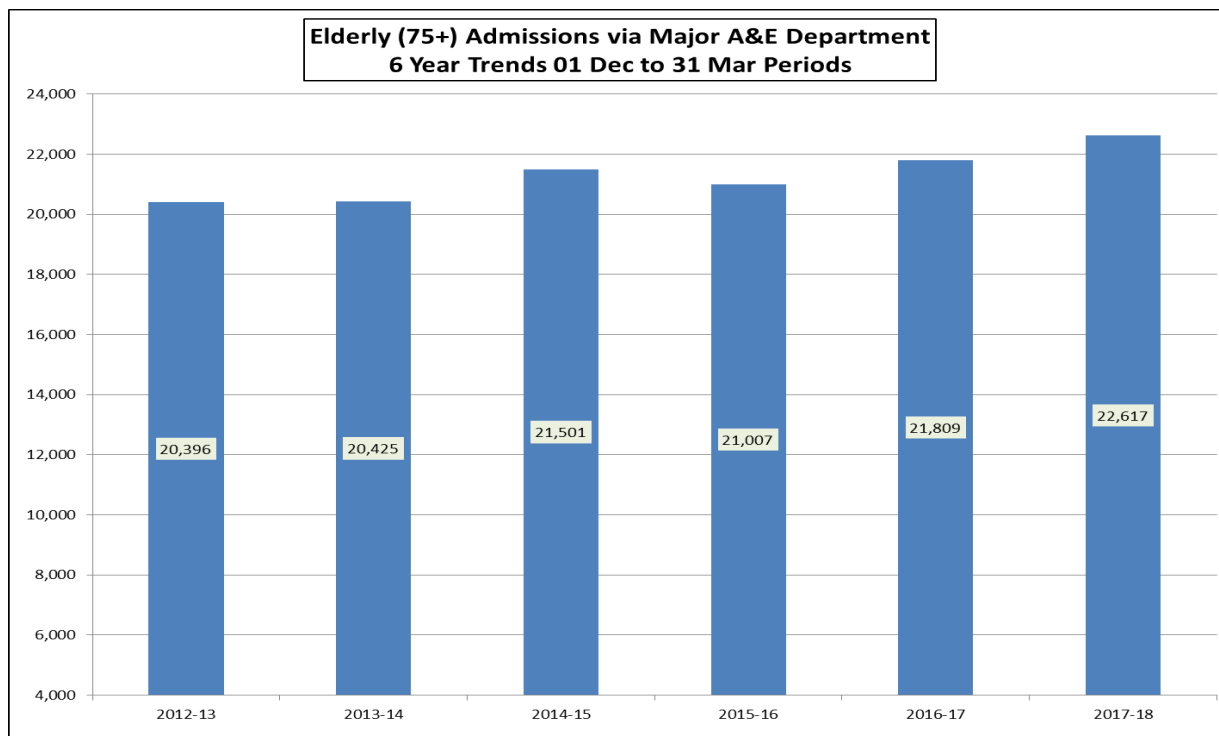
Data indicates 2017/18 attendances 1.9% up on previous year and 3.4% up on previous 5 year average.

Chart 15: >75 Elderly attendances to Major A&E Departments – Trends 1 December to 31 March



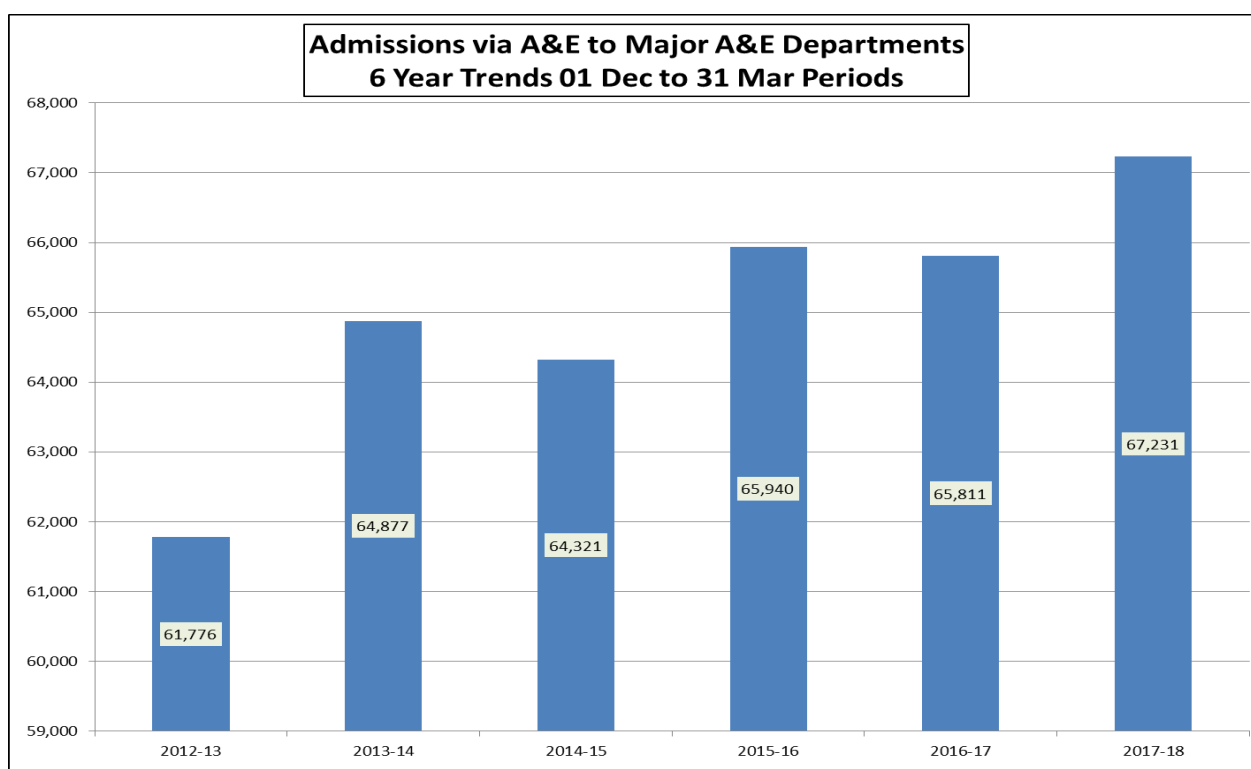
Data indicates that 2017/18 attendances were 5.5% up on previous year and 12.2% up on previous 5 year average.

Chart 16: >75 Admissions via A&E – Trends between 1 December to 31 March



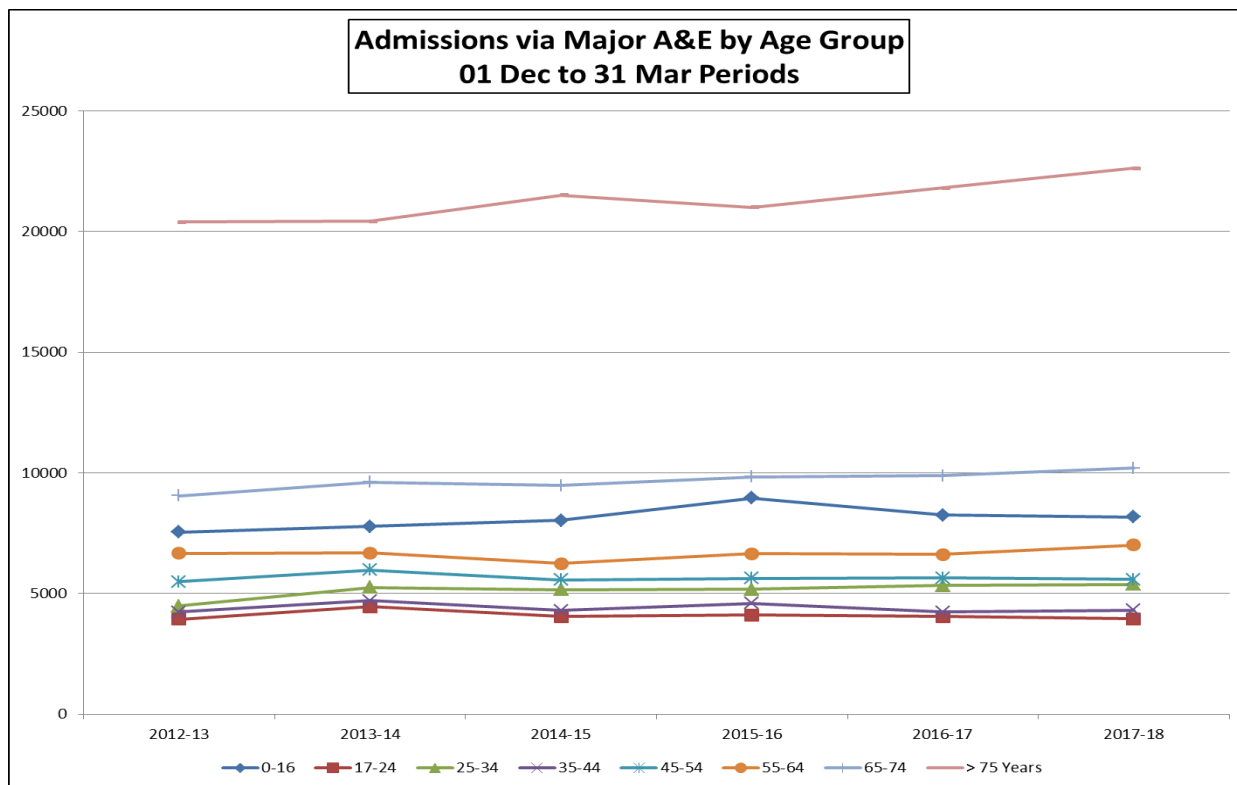
- 2017/18 admissions 3.7% up on previous year and 7.6% up on previous 5 year average.
- Over 53% of elderly attendances have been admitted so far this winter.

Chart 17: Admissions via A&E – Trends from 1 December to 31 March



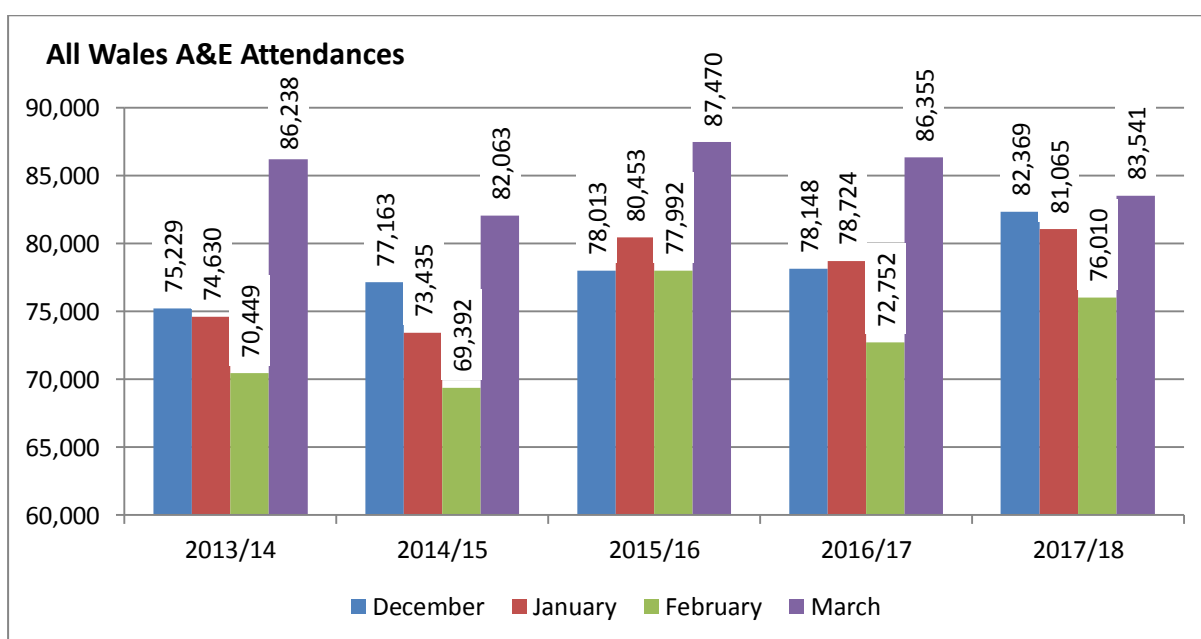
- 2017/18 admissions 2.2% up on previous year and 4.2% up on previous 5 year average.
- 2017/18 conversion rate is currently running at 26.2% compared to 24.8% in 2012/13.

Chart 18: Admissions via Major A&E by Age Group - 1 December to 31 March



A&E Attendances

Chart 19: A&E Attendances



December 2017

December 2017 was the busiest December on record (since we began reporting differently in 2011) for A&E attendances with 82,369 patients attending A&E Departments across Wales (a 5.4% increase on December 2016). This is on average around 136 more attendances per day compared to last year.

December also saw the highest number of patients aged 85 and over admitted to hospital via A&E. 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.

Similar to the ambulance service, A&E departments across Wales experienced some significant spikes. For example, the level of 999 demand resulted in a surge in number of patients arriving at A&E via ambulance, many of which requiring admission and causing added bed pressures across the system. To put this into context, 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.

January 2018

January 2018 data indicates that 81,065 patients attended A&E departments across Wales (a 3% increase on January 2017). Also, the highest January on record since records began. The attendance rate for those aged 85 or over and those over 85 admitted via A&E was the second highest on record after December 2017.

February 2018

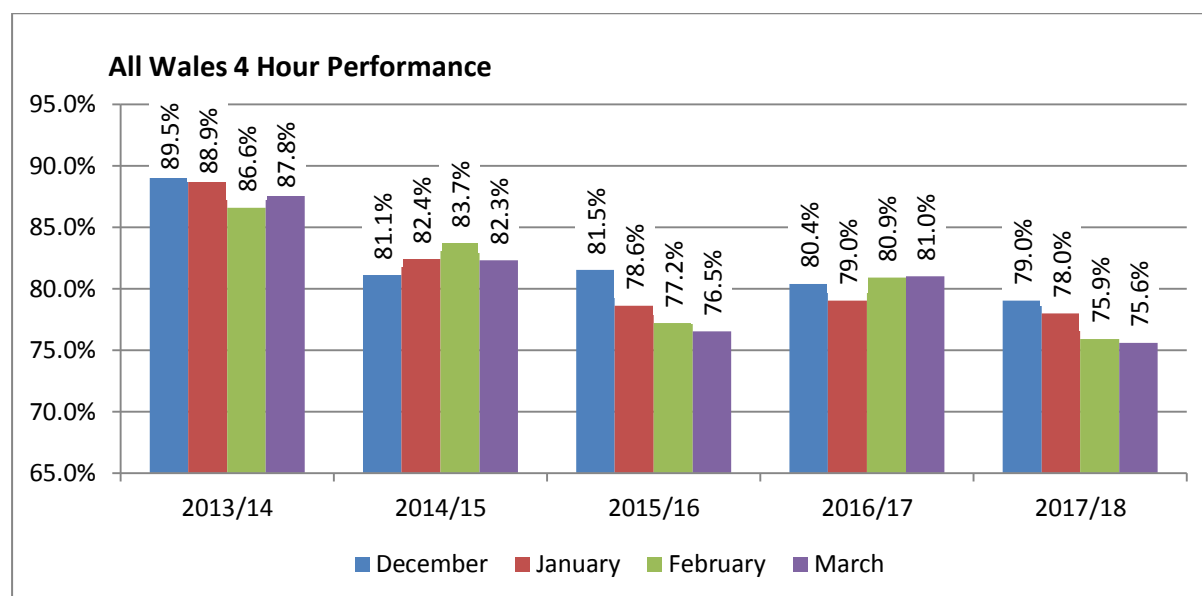
February 2018 data indicates that 76,010 patients attended A&E departments across Wales (a 4.5% increase on February 2017). This was the highest 28-day February on record (February 2016 was higher but it should be noted there were 29 days in the month). The attendance rate for those aged 85 or over and those over 85 admitted via A&E was also the highest February on record.

March 2018

March 2018 data indicates that 83,541 patients attended A&E departments across Wales (a 3.3% reduction on March 2017). However, March 2018 was also the highest March on record in regard to the attendance rate of those aged 85 or over and those over 85 admitted via A&E.

A&E Performance

Chart 20: All Wales 4-Hour A&E Performance



December 2017

Performance against the 4-hour A&E target to be treated, admitted or discharged within 4 hours of arriving at A&E for December 2017 was 79.0%, which is a 1.4% deterioration on the December 2016. It should be noted that despite the increased activity and reportedly increasing acuity, and fall in performance, more patients were admitted or discharged within 4 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 4 hours compared to the December before.

January 2018

Performance against the 4-hour A&E target to be treated, admitted or discharged within 4 hours of arriving at A&E for January 2018 was 78.0%, which is a 1.0% deterioration on the January 2017.

February 2018

Performance against the 4-hour A&E target to be treated, admitted or discharged within 4 hours of arriving at A&E for February 2018 was 75.9%, which is a 5.0% deterioration on the February 2017.

March 2018

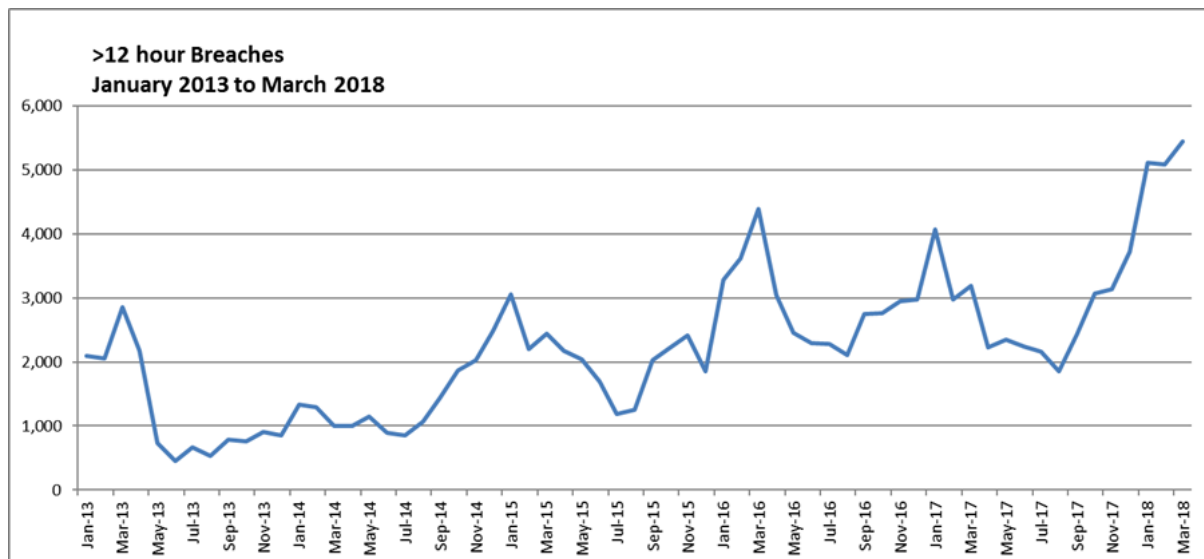
Performance against the 4-hour A&E target to be treated, admitted or discharged within 4 hours of arriving at A&E for March 2018 was 75.6%, which is a 5.4% deterioration on the March 2017.

Whilst performance deteriorated, 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 4 hours. The typical time spent in A&E before admission or discharge was just over 2 hours.

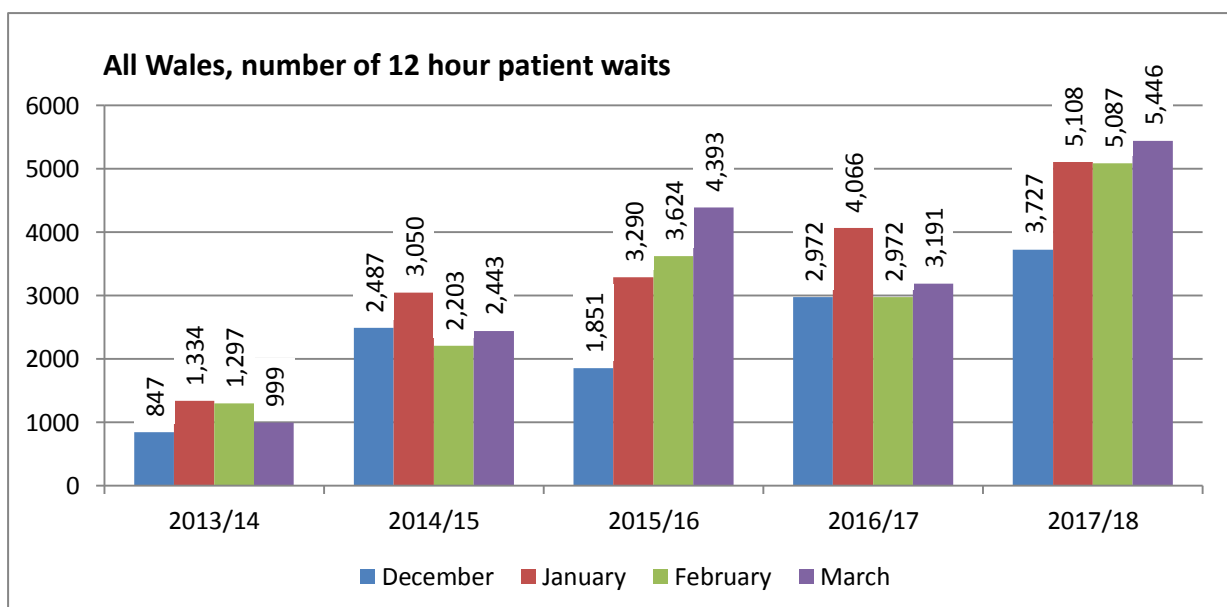
12 Hour Waits in A&E

Chart 21: Number of patient waits over 12 hours in A&E – January 2013 to March 2018



Winter 2017/18 saw the highest number of patients waiting over 12 hours in A&E on record.

Chart 22: A&E >12-Hour Waits



December 2017

3,727 patients spent 12 hours or more in an emergency care facility, from arrival until admission, transfer or discharge. This is an increase of 585 patients compared to November 2017 and an increase of 755 patients compared to December 2016.

January 2018

5,108 patients spent 12 hours or more in an emergency care facility, from arrival until admission, transfer or discharge. This is an increase of 1,381 patients compared to December 2017 and an increase of 1,042 patients compared to January 2017. This is the second highest on record.

February 2018

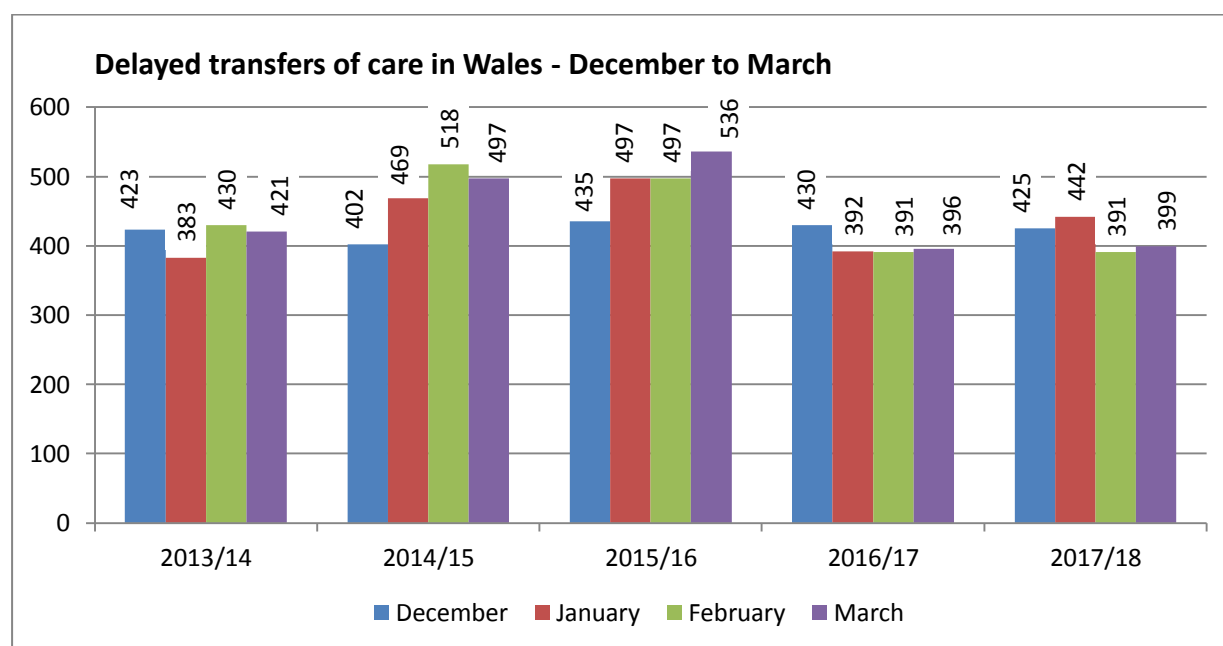
5,087 patients spent 12 hours or more in an emergency care facility, from arrival until admission, transfer or discharge. This is a marginal decrease of 21 patients compared to January 2018 but an increase of 2,115 patients compared to February 2017. This is the third highest on record.

March 2018

5,446 patients spent 12 hours or more in an emergency care facility, from arrival until admission, transfer or discharge. This is an increase of 359 patients compared to February 2018 and an increase of 2,255 patients compared to March 2017. This is the highest on record.

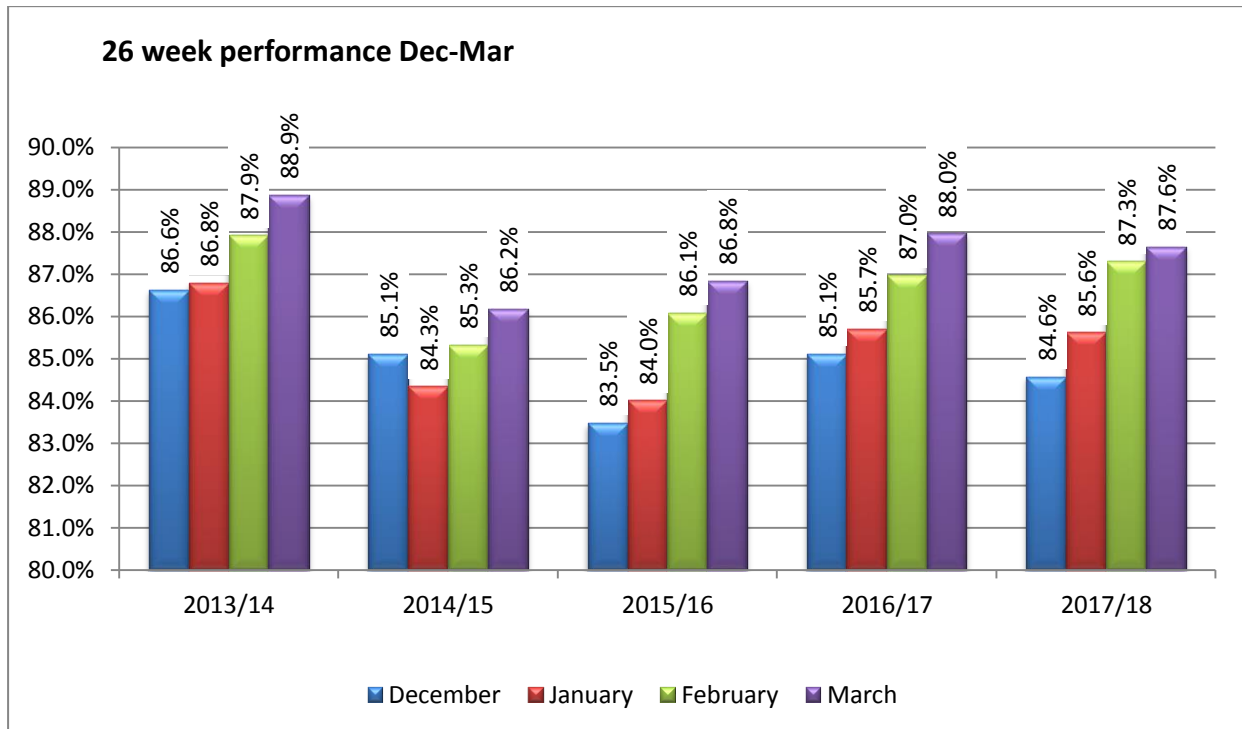
Delayed Transfers of Care

Chart 23: Delayed Transfers of Care – December to March



Planned Care

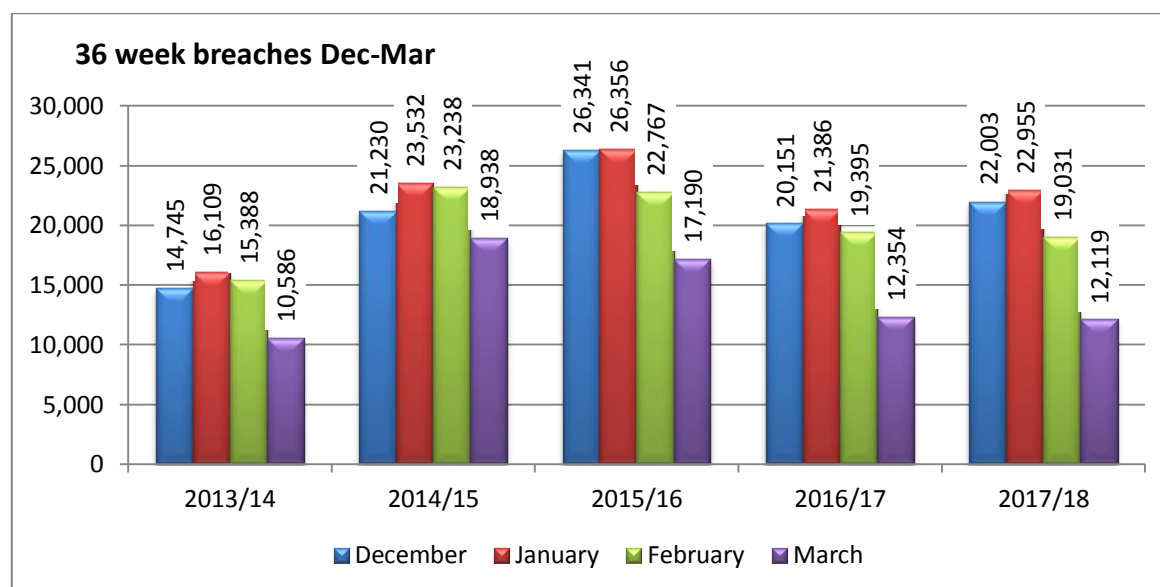
Chart 24: Referral to Treatment 26 Week Performance – December to March



When looking at RTT over the winter period, performance against the 26-week RTT target for December 2017 was 84.6%. This was a reduction when compared to December 2016. However, since the end of December, performance improved, with the March 2018 performance at 87.6%, a slight reduction on the March 2017 position.

Referral to Treatment 36 Week Performance – December to March

Chart 25: Referral to Treatment – 36 week breaches – December to March



At the end of December 2017, there were 22,003 people waiting over 36 weeks, an increase of 1,852 (9%) when compared to December 2016. As with 26 week performance, the number of people waiting over 36 weeks has improved since the end of December, with the March position showing 12,119, a 2% improvement on the March 2017 position. Betsi Cadwaladr UHB remains an outlier and accounts for 47% of the all Wales over 36 week figure at the end of March 2018.

Six of the seven LHBs are in the same or a better position in March 2018 as they were at the end of March 2017. The only exception being Betsi Cadwaladr.

Escalation

National Escalation and De-Escalation Action Plan

NHS organisations are actively and consistently using the National Emergency Pressures Escalation and De-Escalation Action Plan, which was developed using an operational multi-agency approach to the effective management of capacity and escalation processes across Wales.

The plan ensures a formal structure to the approach taken with the management and co-ordination of responding to emergency pressures experienced throughout the year, designed to enhance the effectiveness of patient flow and maintain patient safety through the implementation of procedures that support best practice through proactive management.

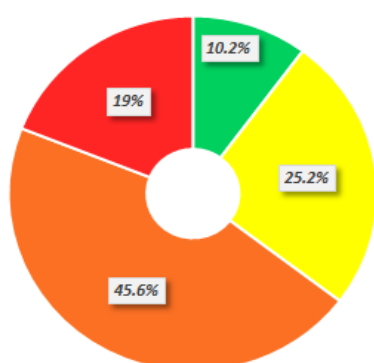
The plan was developed in 2012 and the Welsh Government has since been working closely with NHS organisations who have been further developing their approach to escalation following review and improving their local escalation arrangements, which have a stronger focus on risk management.

Escalation levels - Key

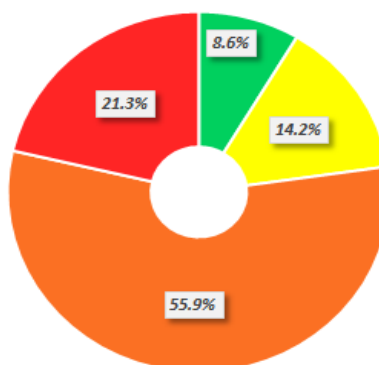
Green	Steady State	Ensure all standard operating processes are functioning as efficiently as possible in order to maintain flow.
Yellow	Moderate Pressure	Respond quickly to manage and resolve emerging pressures that have the potential to inhibit flow. Initiate contingencies. De-escalate when applicable.
Amber	Severe Pressure	Prioritise available capacity in order to meet immediate pressures. Put contingencies into action to bring pressures back within organisational control. De-escalate when applicable.
Red	Extreme Pressure	Ensure all contingencies are fully operational to recover the situation. Executive command and control of the situation. De-escalate when applicable.

Hospital Escalation Levels and Comparisons with last winter

December 2016

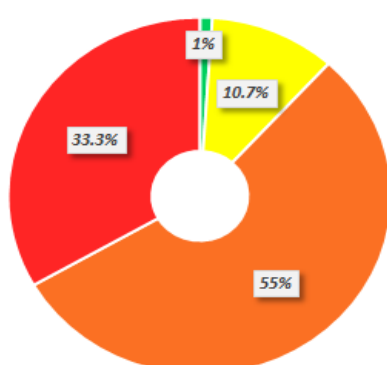


December 2017

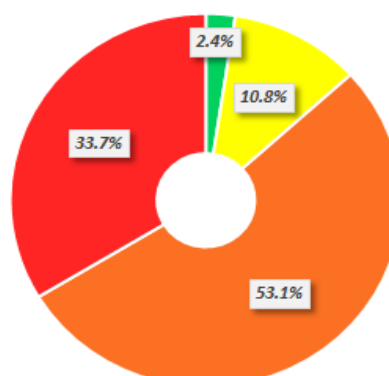


The above charts indicate that hospitals reported escalation level 4 for 21.3% of December 2017, an increase of just over 2% when compared to December 2016. To put this into context, escalation levels for Decembers 2016 and 2017 were significantly above the level reported in December 2015. There was also an increase in escalation level 3's being reported. This high escalation reflects the additional pressures experienced this year.

January 2017



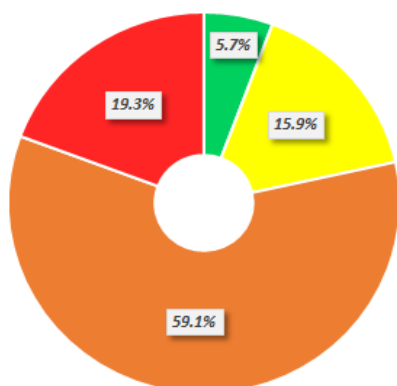
January 2018



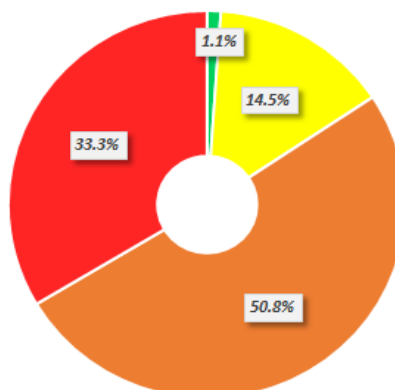
The above charts indicate that hospitals reported escalation level 4 for 33.7% of January 2018, which is very similar to January 2017. The beginning of January is always particularly challenging and experienced some exceptionally busy days for services across the system

and this is reflected in the increased high escalation. Escalation level 3 reduced and escalation level 1 (the lowest escalation level) increased by 1.4%.

February 2017

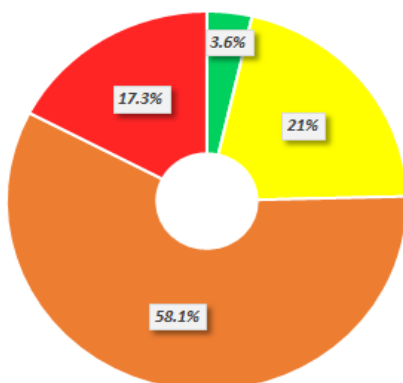


February 2018

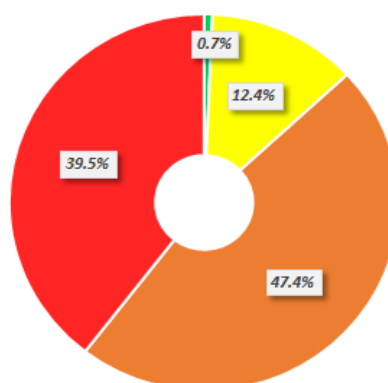


The above charts indicate that hospitals reported escalation level 4 for 33.3% of February 2018, which is a significant increase when compared to February 2017, indicating hospitals across Wales continued to experience spells of significant pressure throughout February this year.

March 2017



March 2018



Similar to February 2018, the above charts indicate a significant increase in hospitals reporting escalation level 4 in March 2018 when compared to March 2017. The escalation levels are similar to that reported in 2016, although the heavy snowfall during March will have had an inevitable impact of the services this year.

What happened over winter?

The escalation levels reported provide a clear indication that hospitals were under a great deal of pressure, and significantly more so than last year. It is important to recognise there will always be occasions when demand placed on our health and care services will put a strain on services, requiring local escalation.

In line with local escalation protocols, there continues to be clear evidence of good communication between LHBs, WAST and LAs through a range of mechanisms such as daily

multi-agency conference calls and executive level calls, including on call executive arrangements. There were also specific communication arrangements within multi-disciplinary teams in response to daily pressures requiring action, which can vary throughout the day across Wales.

In addition, pressures have been monitored via weekly Chief Executive and Executive level calls; daily Executive level emergency pressures conference calls; and through the NHS Wales Unscheduled Care dashboard which provides live data and information on a range of indicators, including bed capacity, handover delays and escalation levels.

Services have indicated that escalation protocols and winter resilience actions have supported them in their response to escalating and de-escalating pressures, enabling them to recover and manage the immediate pressures through increased resilience. However, the escalation levels reported clearly show that the services have experienced an 'extended winter' this year. Operating under high pressure on a consistent basis can inevitably be seen as a contributing factor in deteriorating levels of performance when compared to last winter, and potentially patient experience. However, the huge efforts made by staff to ensure patients received a safe and professional response during such difficult circumstances must not go unrecognised.