Cwm Taf Morgannwg
Bwrdd Partneriaeth Rhanbarthol | Regional Partnership Board

WINTER PROTECTION PLAN 2021/22

Version 0.4

Contents

1. Introduction

The Cwm Taf Morgannwg Regional Winter Plan sets out the Region's response to the Welsh Government Health and Social Care Winter Plan 2021 to 2022.

The Plan has been developed with input from the regional statutory and voluntary sector partners and builds to demonstrate an integrated approach that is deliverable and addresses the challenges associated with both the COVID pandemic and usual winter pressures across the region.

Through the winter, there will be a continued focus on maintaining the resilience of the health and social care sector to support people's wellbeing in keeping with the principles of integration, prevention, collaboration and co-production.

The Plan builds on existing plans that focus on preventing the five harms related to COVID-19 (Table 1 below) by:

- **Protecting communities and health and social care staff against COVID**. The Region has achieved great success with its Test, Trace, Protect and COVID-19 Vaccination programmes and continues to delivery including against the Welsh Government COVID-19 Vaccination Strategy for Autumn/Winter 2021.

- **Keeping people well**. In addition to concerns around covid 19, there is a significant risk that the levels of respiratory disease will increase this year including the impact of seasonal influenza and RSV. To that end, the Health Board and partners will maintain a focus on flu vaccination and will also work with community colleagues to help people with respiratory conditions.

- **Maintaining safe health and social care services.** Including those which support:

    - Vulnerable groups;
    - Mental health and wellbeing;
    - Primary and community care;
    - Long Covid;
    - Children and young people;

- Essential services – ensuring that the provision of services is maintained services that are urgent and life threatening or life impacting as well as services that without timely intervention could result in harm over the longer term;
- Planned Care – ensuring patients who have been waiting extended times as a result of the pandemic are treated as soon as possible, in a prioritised manner with appropriate infection prevention controls and within the context of managing variation in the needs of COVID cases;
- Urgent and Emergency Care – the six goals set out by the Welsh Government which outline longer term plans for this area as well as some short term measures including NHS 111.

- **Protecting the rights of people who need care and support** and carers who need support, including through developing a National Plan for Carers

- **Supporting Our Health and Social Care Workforce** recognising the unrelenting challenges and pressures strive to look after their physical and mental health and wellbeing.

- **Keeping everyone informed**. Choosing the right type of care will be vital for services to continue to work well over the winter and the Region will contribute to making this a reality via consistent messaging to our population.

- **Support and retain new ways of working** adopted through the pandemic COVID which support integrated working between health, social care and third sector.

Table 1: Harm Related to COVID-19

1. Harm directly arising from SARS-CoV2 infections;
2. Indirect COVID-19 harms due to surge pressures on the health and social care system and changes to healthcare activity, such as cancellation or postponement of elective surgeries and other non-urgent treatments (e.g. harm from cessation of screening services) and delayed management of long-term conditions.
3. Harms arising from population based health protection measures (e.g. lockdown) such as, educational harm, psychological harm and isolation from shielding and other measures.
4. Economic harms such as unemployment and reduced business income arising both from COVID-19 directly and population control measures, like lockdown.
5. Harms arising from the way COVID-19 has exacerbated existing, or introduced new, inequalities in our society.

2. Aims of the 2021 Winter Plan

The aim of the Plan is to:

- Respond to the Welsh Government's 6 goals of urgent and emergency care;
- Coordination, planning and support for people at greater risk of needing urgent or emergency care;
- Signposting to the right place, first time;
- Access to clinically safe alternatives to hospital admission;
- Rapid response in a physical or mental health crisis;
- Optimal hospital care following admission; and
- Home-first approach and reduce risk of readmission.

A range of performance measures will be used to measure the impact of the Plan including:

- Preventing hospital admission for specific conditions / complaints.
- Timeliness, quality and frequency of assessment in ED.
- Improving flow of patients through hospital to reduce risk of harm and delays in onward care.
- Focusing on timely transfer home to reduce risk of harm and improve outcomes.
- Discharge data.
- Delayed transfers of care.
- Flu and COVID-19 rates.

3. Context

Our Plan has been developed on a partnership basis with the Local Authorities, Third Sector and Health Board. The Plan is in line with A Healthier Wales commitments.

It follows those clear design principles of:

- A whole system approach where seamless support, care or treatment is provided as close to home as possible;

- Services designed around the individual, based on their unique needs and what matters to them;
- People will only go to a general hospital when it is essential, with hospital services designed to reduce the time spent in hospital;
- A shift in resources to the community that enable hospital-based care (when needed) to be accessed more quickly; and
- Using technology to support high quality services.
- Develop more meaningful measures and use feedback from patients and staff to measure what matters most to people.

Winter Viruses

Welsh Government modelling suggests that we can anticipate significantly higher numbers of people to become unwell with winter viruses. This increased demand will place a significant burden on our already-stretched health services. The Technical Advisory Group (TAG) *Winter modelling update - Modelling other viruses* notes that modelling shared with the Joint Committee for Vaccination and Immunisation has suggested that the 2021-22 flu season could be between 50%-100% higher than a typical season and could peak at a different time1 than ordinarily expected. The report also highlights that modelling by The University of Warwick indicates that case numbers, hospital cases and deaths are "almost certain to be higher in a flu season following a suppressed flu season (e.g. winter 2020/21), with counts up to two times a normal flu season plausible." The uncertainty about the likely timing of the flu season makes planning more complex and the implication is that it is highly likely that we will see major increases in need for urgent care across primary, community and acute services for people with flu. However, it is still possible that we may see another quiet flu season.

Respiratory syncytial virus (RSV) is a concern this autumn and winter. Following a season with reduced incidence in 2020, due to social distancing and lockdown measures, the concern is that there will be a surge in cases this year in particular among young children who were not exposed to the illness last year.

(Welsh Government, Health and Social Care Winter Plan 2021 to 2022)

4. Prevention & Response

4.1 Test, Trace, Protect Strategy

Welsh Government released their "Test, Trace, Protect" strategy on 13th May 2020. This was based on Public Health Wales advice. It worked by:

- Identifying those who have COVID-19 symptoms, enabling them to be tested while self-isolating.
- Tracing people who have been in close contact with the symptomatic person, requiring them to self-isolate for 14 days.
- Providing advice and guidance, particularly where the symptomatic individual or their contacts are vulnerable or at greater risk.
- Ensuring that individuals and their contacts can get back to their normal routines as soon as possible.

The CTM response plan, referred to as the CTM TTP Programme, is being managed on a regional (CTM) footprint under the leadership of the Director of Public Health. A multi-agency Regional Oversight Group (RSOG) comprising of members of the Health Board, Local Public Health Team, Public Health Wales (PHW), the three Local Authorities and Regional Partnership Board Chair has been set up to operationalise the response plan within the CTM area.

The CTM plan is based on the three pillars of the PHW plan (sampling and testing, contact tracing and case management and population surveillance) underpinned by a risk communication and community engagement plan.

A further area, comprising of the 'protect' element of work was agreed by the UHB and LA Chief Executives, the role of the RPB is as outlined below. Chaired by Rachel Rowlands Member and former chair of the Board, and the work is overseen and driven through the RPB.

4.2 Protect

The strategic aim of the Protect work stream is to identify the support which may be required by some people to enable them to successfully self-isolate and ensure this support is provided openly and equitably across CTM.

Ensuring high levels of adherence to the need to self-isolate in response to symptoms, a positive test for COVID-19 or having been contact traced is fundamental to the success of the overall Test Trace Protect programme. It is recognised that people will face different challenges in successfully self-isolating, potentially on more than one occasion.

A range of support has been provided to individuals who have faced challenges during lockdown. Local Authorities, in partnership with the Third Sector and Volunteers, have helped people with shopping, collecting medicine, loneliness and isolation, emergency food and support and a very wide range of other support needs.

This current 'offer' provides a guide to the kind of support likely to continue to be relevant to support self-isolation as part of the CTM Test Trace Protect Programme, as well as the identification of additional developments, depending on how events with Covid-19 unfold.

A Monthly 'Protect' task group, Chaired by Rachel Rowlands is set up. The group provide local intelligence and dissemination of key local messages and coordinate any gaps in service.

4.3 COVID-19 Vaccination

The COVID-19 Vaccination programme continues to delivery including against the Welsh Government COVID-19 Vaccination Strategy for Autumn/Winter 2021. The Winter Booster campaign was extended on the 15 November 2021 to over 40's, with the campaign therefore planned to extend into March 2022.

5. Building on Existing Plans

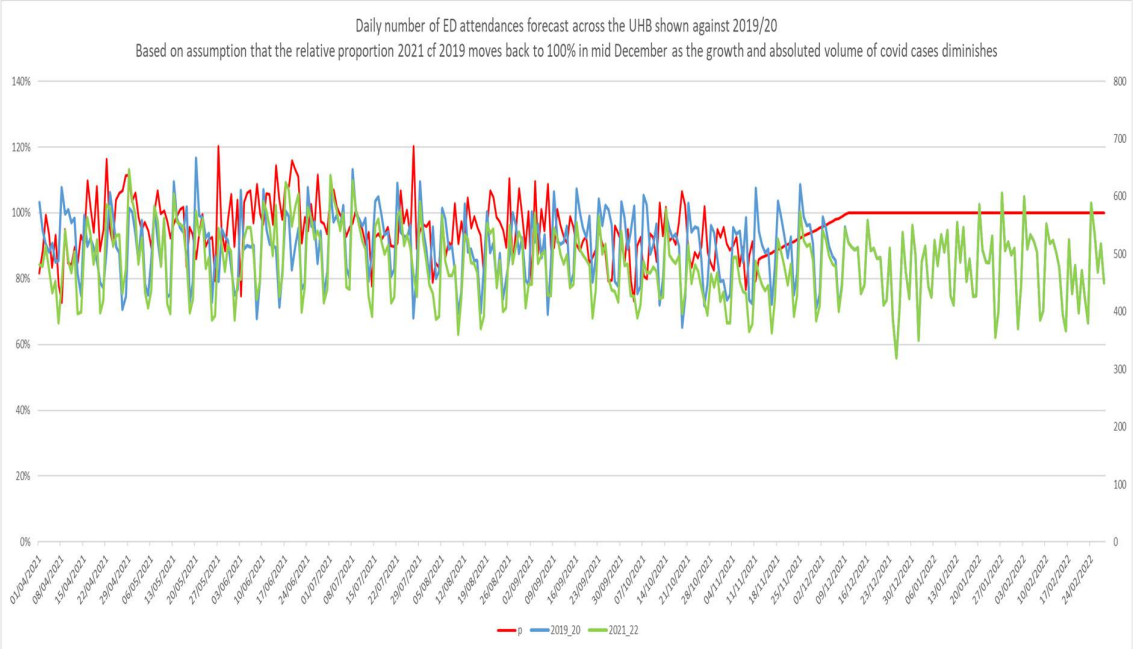
The past 18 months have been unprecedented for all other public services – and staff are managing ever increasing demands in all areas.

The challenge on Emergency Departments (set out below) and the provision of Planned and Urgent and Emergency Care remains sustained and demanding and the region is working across the health and care system to find as many ways as possible to meet and manage this demand. Existing plans include:

- Daily operation escalation and management – with a gold / silver / bronze structure implemented to monitor day to day operational responses to demand;
- Facilitating Hospital Discharges – truly integrated working on a range of issues including safe and effective discharges, with daily collaboration and joint appointments;
- NHS 111 and Flow Centres – investment into the Flow Centre has been made and is an important part of the urgent care management centre;
- PCH Improvement Programme – working to address concerns raised by HIW and also to improve flow and maintain a high standard of patient care;
- Unscheduled Care Improvement Programme, including:
    - Urgent Primary Care Centres – following the success of the UPCC, the UHB aims to roll the model out across other parts of the UHB, forming an important part of community and primary care;
    - Same Day Emergency Care: Ambulatory Emergency Surgical Units at Royal Glamorgan Hospital (RGH) and Princess of Wales Hospital (POWH), Integrated Frailty Model for Merthyr Cynon and an Acute Frailty Service and extension to the Ambulatory Emergency Care Unit in Rhondda Taf Ely;

- WAST Pathways and Support - the UHB will pilot and evaluate PTAS or a similar scheme to enable senior community clinicians to monitor the WAST dispatch queue;
- Lifestyle Improvement – patients of specific specialties including cardiology, gastroenterology and pain will be encouraged to attend a structured wellness programme;

- A therapies led focus on:
  - Facilitating front door discharge of frailer people and reducing length of stay;
  - Delivering acute stroke interventions and maintaining flow of the critical stroke pathway
  - Maintaining core services to include community services, LT condition services and paediatric services with a consideration of statutory duties e.g. ALN but also an awareness that some RTT targets may unavoidably breach.



6. Priorities for Winter 2021 – 22

There are a range of specific funded schemes which are divided in the main into two distinct areas and are Acute Flow Schemes and Same Day Emergency Care (SDEC) (with associated) SDEC Capital Schemes.

The range of investment including the Winter Pressures funding routed through the RPB is detailed. (note schemes funded through the RPB allocation are provided in appendix 1).

6.1 Acute Flow

6.1.A Bridgend Locality

- **Appointment of a Head of Patient Flow** with a remit to lead and manage patient movements across the sites, as well as discharge liaison, ambulance liaison, voluntary sector liaison and also to provide flow data and lead on flow improvement initiatives;

- **Appointment of Discharge Navigators** to work between ward and discharge teams to facilitate discharge by providing support and momentum to chase follow up actions;

- **P&I Analysts who are funded by the NHS but jointly appointed with LA partners**, these members of staff work between the HB and LA on joint data processes;

- **Hospital Social Workers** have been appointed to be on site at least four days a week to assist with discharges;

- A scheme to include **Pharmacists in the ED** has developed, providing near patient dispensing by a dedicated ED pharmacy team and other medicine management services which can expand to cover other areas including AMU and ED Minors area to aid flow;

- The **appointment of Therapists (OT, Dietetics and Physiotherapy) for ED and AMU** will also make a significant contribution to flow and patient care;

- It is likely that **e-whiteboards** will be in place across the POWH site this winter acting as a helpful communication tool;

- The ILG will appoint an **intermediate "hospital@home" Team** which will provide follow up for patients in their own homes following discharge;

- There will be spot **purchase of additional care home places** – the number will be determined as the winter demand increases.

These schemes reflect an investment of **£656,674** full year effect.

In addition the following are funded through RPB Winter monies:

- **Better@Home+** The team will focus on facilitating earlier hospital discharge, liaising with the Registered Managers and overseeing the use of temporary community flexible beds, ensuring people have exit strategies and progress chasing those to ensure flow.

- **Community Equipment:** Increased demand for community equipment services, including minor aids and adaptations and Telecare Installation.

- **Therapy Tech:** Therapy Technicians, to implement therapy programmes with people in their own homes following clinical assessment.

- **Care Home Placement:** Additional care home placement and support costs, including interim placements, additional 1-1 support and top up fees over the winter period.

- **Emergency Pathway**: Creation of a bed pool in care homes to facilitate discharge from hospital whilst an individual waits to access care at home (reablement limited based to needs only basis).

- **Marie Curie:** The provision of planned palliative nursing care covering multiple patients per shift in their usual place of residence who are in the end of life stage of their illness whose needs can be met through short episodes of care delivered through an agreed combination of days and/or evenings and/or nights as appropriate to support the needs of patients and carers.

6.1.B Merthyr / Cynon

- **Robust and appropriate community response to reduce conveyance** with a two hour response – this is a Falls Pathway and response service which is being explored with WAST and St John's Ambulance and will involve specialist lifting equipment;

- Improvement of **turnaround at the front door** – this will involve Emergency Department Clinical Specialist Physiotherapist for MSK attendances and a Pharmacists in the ED at PCH providing seven day cover;

- **Improvement of flow** across the Hospital site – this is a scheme that will improve flow after appointing **Radiology, Pharmacy and additional medical staffing**. In addition, a **Data Performance post** will be appointed to for four months, **Physiotherapy and Radiology** staff will be appointed specifically to assist in the ED, work with **Occupational Therapy** staff training is ongoing successfully;

- Implementation of **dynamic discharge principles** supported by discharge to recover and assess pathways – a multi faceted approach which will involve the appointment of Care Navigators / Hospital Discharge roles, improvement of access to intermediate care and D2RA pathway, an increase in Community care capacity via training the trainer for reviewing double handed calls to release domiciliary care capacity, purchase of specialist equipment to support avoidance of double handed care and CHC, appointment of a Discharge Liaison Nurse Co-ordinator at YCC to further enhance the discharge efficiency and capacity and some Convener / Data support for Flow and discharge.

These schemes reflect an investment by the UHB of **£509,519**.

In addition the following are funded through RPB Winter monies;

- Additional capacity for support @home service (intermediate care and reablement) facilitate hospital discharge or prevent admission

- Additional capacity for community based care services over winter period to facilitate hospital discharge or prevent admission includes DP.

- Additional care home placements & support which will include 1-1 support in care homes, interim arrangements & top up where first choice is not available

- Additional capacity to support carers including crisis support

- Independent sector domiciliary care incentive payment for Christmas and continue as in previous years

- Enhanced social work capacity across Adult Services to meet the demands of winter pressures and the limitation on services because of global pandemic

- Additional OT & OTA to support reablement, provide aids and assess for adaptations

- Additional capacity for adult duty (SPA) service to meet increased demand over winter period

- Increased demand for community equipment services, including delivery drivers and equipment provision.

- Emergency Pathway: Creation of a bed pool in care homes to facilitate discharge from hospital whilst an individual waits to access care at home (reablement limited based to needs only basis).

- **Marie Curie:** The provision of planned palliative nursing care covering multiple patients per shift in their usual place of residence who are in the end of life stage of their illness whose needs can be met through short episodes of care delivered through an agreed combination of days and/or evenings and/or nights as appropriate to support the needs of patients and carers.

6.1.C Rhondda Taf Ely

- Establishment of the **Discharge Lounge** – freeing spaces on wards and adding to efficiency

- **Pharmacy in the ED** – the presence of a Pharmacist in the ED releases medical and nursing time, aids the quality of prescribing and improves the patient experience;

- **Expediting Complex Discharges and Transfer of Care Safely and Efficiently** – the management and referral of patients who have complex needs such as medicine compliance issues, monitored dosage trays (MDS), patients at risk of re-admission or social care support due to inability to manage and take medicines;

- **Community Medicines Optimisation for Care Homes Service** – this service will achieve medicines optimisation for care home residents thereby reducing medication errors, risk of harm, wastage and hospital admissions and is UHB wide;

- **Pharmacist led clinics for chronic conditions** – this will improve patient outcomes particularly for those with interstitial lung disease and heart failure;

- **RTE Flow Team** – the Team will lead and manage patient flow and movements across the site, discharge liaison, ambulance liaison, voluntary sector liaison and provide flow data and has proved valuable model in other areas.

These schemes represent an investment by the ILG of **£579,024**.

In addition the following are funded through RPB Winter monies;

- Enhanced social work capacity across Adult Services to meet increased demands to support discharges and avoid admissions along with the further demands of winter pressures.

- Additional capacity for hospital discharge coordinators across hospital sites to meet increased demand over winter period.

- Additional capacity for support @home services (short term intervention) over winter period to facilitate hospital discharge or prevent admission.

- Enhanced occupational therapy capacity across Adult Services to meet increased demands to support discharges and avoid admissions along with the further demands of winter pressures.

- Additional home care and care home broker capacity to meet increased demand over winter period.

- Additional care home placement and support costs, including interim placements, additional 1-1 support and top up fees over the winter period

- Independent sector domiciliary care home care incentive payment for Christmas and New Year Holiday period

- Increased demand for community equipment services, including delivery drivers and equipment provision

- **Emergency Pathway:** Creation of a bed pool in care homes to facilitate discharge from hospital whilst an individual waits to access care at home (reablement limited based to needs only basis).

- **Marie Curie:** The provision of planned palliative nursing care covering multiple patients per shift in their usual place of residence who are in the end of life stage of their illness whose needs can be met through short episodes of care delivered through an agreed combination of days and/or evenings and/or nights as appropriate to support the needs of patients and carers.

6.1.D Primary Care

- **COPD annual reviews** – home visiting service to optimise management ready for winter;

- **Production and distribution of 'old fashioned' patient leaflet** describing services available over winter to (primary and community services) to every household in CTM. This will educate patients in choosing the right service for their particular healthcare needs and provide an easy reference tool recognising that not all patients can access information online or through social media. This will be supported by visits to patient forums;

- **GP OOH to continue PTAS** – for a three month, the service will work over the weekend (eight hours each Saturday and Sunday), with the GP to assess and pull off the WAST stack for treatment and care in primary care;

- GP Clusters have put forward – **delivering flu vaccine for the patients on the district nurse case loads**. Normally housebound patients on DN caseloads have theirs delivered by district nursing teams but in recognition that the teams are depleted due to Covid and non Covid absence and vacancies, the practices will pick this up.

6.1.E Discharge to Recover and Assess

The Discharge to Recover then Assess model is predicated on optimising recovery and reablement/rehabilitation. The 'home first: discharge to recover and assess' pathway means patients are discharged home once they are medically fit and no longer need a hospital bed. Patients' immediate support needs will have been assessed prior to discharge and the necessary arrangements put in place. Ongoing assessment of patients' support needs can be safely continued at home by members of the appropriate community health and social care team. The approach means patients are not kept in a hospital bed longer than is necessary.

D2RA development has enabled further discussion and enhancement of models of care that prevent unnecessary admission to hospital and enable people to leave hospital when they are ready is essential in order to provide care closer to home and limit time in hospital unless essential, in line with key commitments of *a Healthier Wales*.

Proposals include;

- Additional capacity for support @home services (short term intervention) over winter period to facilitate hospital discharge or prevent admission.
- Additional capacity to support carers including crisis support to facilitate hospital discharge or prevent admission.
- Increased capacity for community equipment services, including delivery drivers and equipment provision.
- Increased support to ED and frailty teams and improved partnership working, Improved patient safety and experience.

- The provision of additional capacity across community services will support people to return home through the provision of packages of care and further assessment to be undertaken.

The breakdown of funding across the region is based on Social Services funding formula and is approximately;

- Rhondda Cynon Taf £997,687
- Bridgend £563,170
- Merthyr Tydfil £251,143

6.2 Same Day Emergency Care & SDEC Capital

Welsh Government has made some financial assistance available for Same Day Emergency Care (SDEC) and also for the capital consequences of the SDEC schemes – and the UHB made a bid against that funding. The following areas were successful:

Ambulatory Emergency Surgical Unit, Bridgend ILG

Opened in January 2020, this Unit provides rapid assessment and discharge for many suspected surgical patients presenting at the Princess of Wales Emergency Department. It is expected to:

- Reduce surgical admissions;
- Improve patient experience by moving more work into the working day;
- Improve patient experience with assessments and treatment delivered more rapidly (reduced WIP);
- Math admissions with resources (reduction in LOS);
- Improvement in patient flow to improve performance against the ED four hour standard;
- Promote appointments for emergencies

Ambulatory Care Unit, Rhondda Taf Ely ILG (Extension of hours)

The AECU enables GP referred patients to receive same day emergency care that provides assessment, diagnosis and treatment promptly and effectively with the aim of getting patients home safely on the same day, without the need for an admission whilst easing the pressure on the ED.

It also provides support to primary care when escalation is needed and a credible care model for acutely unwell patients while decongesting the ED, reducing the pressure on limited inpatient beds, and therefore facilitating more treatment of acute illness from a community setting. The AECU sees patients with a wide range of problems but common examples include new chest pain or breathlessness, pneumonia and other infections, blackouts, severe headaches and suspected deep vein thrombosis.

Following a successful pilot, the triage hours were extended into the evening to 10pm, to enable assessment and care of the second peak of patients referred late in the afternoon. SDEC funding enabled the continuation of this service through the winter.

Ambulatory Emergency Surgical Unit, Rhondda Taf Ely ILG

A consultant led Surgical Hub or 'hot clinic' operates at the RGH Outpatients Department, which sees the majority of GP referred surgical patients (mainly general surgery and urology) as well as ED referred patients on an ambulatory care basis. There is also an orthopaedic hub. However there was no provision for the care of patients outside hub hours (i.e. after 5pm) or who require a period of observation / fluid resuscitation / IV antibiotics, but not an inpatient stay.

The plan is to set up an extended hours Surgical Assessment Unit in RGH, incorporating the Surgical Hub, as**:**

- A place for ED patients to be assessed, freeing space in ED;
- A place to see those GP patients who can be turned around within 24 hours with some treatment / investigations;
- A place for GP patients to be seen after the current cut off for hot clinic referrals;
- An appropriate place for those more unwell GP referrals to be treated initially.

The extension will need additional nursing, health care support workers and admin staff and it is hoped it can be accommodated at close as possible to AECU.

Acute Frailty Service, Rhondda Taf Ely ILG

A whole system frailty model is being worked up with partners across primary, community and social care, but meanwhile the ILG plans to develop an acute assessment service for patients attending ED who would currently be admitted to one of our medical wards for observation, assessment and treatment.

This will involve the taking of a Comprehensive Geriatric Assessment to identify the person's holistic needs and inform an appropriate discharge plan, ensuring patients are only admitted to a ward when absolutely necessary and with a clear outcome focus. The service would work in close liaison with the Stay Well @Home service and @Home services, to enable safe discharge and appropriate follow up services in the community.

This Acute Frailty Service will enable:

- Prompt, specialist and holistic assessment of patients' needs, and subsequent care planning
- Avoidance of inpatient admission unless necessary
- Facilitation of timely discharge
- Relief of pressure from ED
- Promotion of independence and patient experience.

The ILG has recently appointed a new Care of the Elderly Consultant who will provide the clinical lead for the Acute Frailty Service, but additional therapy staff will also be required. To help develop the Frailty model across whole system, a fixed term Project Manager will be required.

It is anticipated that these developments will make the achievement of the UHB's priorities for winter increasingly achievable.

Acute Frailty Service, Merthyr Cynon ILG

The ILG has identified the need for an Acute Frailty Service in the Merthyr Cynon ILG and this has been successful in attracting funding.

It is anticipated that the benefits will closely mirror those in Rhondda Taf Ely and will be expanded to include a specific look at the issues that the lack of geriatrician consultants pose to the service in this area.

Note a separate capital proposal for minor work at RGH to enable one scheme, and a range of equipment including scanners, beds and other items across all three ILGs, which will come to a sum in the region of £900k has also been made.

7. Third Sector Provision

Third Sector organisations across CTM operate at all levels of in our communities and are best placed and often far more responsive to the daily and ongoing needs within and across our local communities.

They are able to make a significant – and rapidly increasing – contribution to the health and well-being of local communities across CTM and indeed Wales. It has been made every clear that charities and Third sector voluntary organisations would be expected to perform an increasing amount of the social and cultural functions which previously the public sector struggled to provide. Our attempt's and efforts to fully and truly engage with our Third sector colleagues has enabled us to refocus more of our health and social care services to the more clinical aspects across our communities releasing much resource within the Third sector across our communities, therefore maximising the excellent work undertaken and looking at how they influence and build on this work further.

The Third sector are currently playing a vital role in developing high-quality services the public rightly expects and helping direct existing and future pathways as they are developed and reviewed. They have particular strengths, such as reaching the most disaffected people, finding innovative solutions and offering a personal touch as well as really understanding the needs at a local level.

Increasing the community resources and support mechanisms within a consistent community wide system of care and support including;

- **Befriending services** which have been vital in helping to address loneliness and social isolation;

- Accessible information on the range and level of support available for people of all ages who need **mental health support**;
- Expansion of **digital skills programmes and loaning of digital equipment** to enable more people to get online and maintain contact with relatives and friends as well as undertake a host of other activities that are reliant on being digitally included;
- Support for **volunteer training** to ensure that volunteers have the confidence and skills to provide appropriate support as the need arises.
- **Marie Curie:** The provision of planned palliative nursing care covering multiple patients per shift in their usual place of residence who are in the end of life stage of their illness whose needs can be met through short episodes of care delivered through an agreed combination of days and/or evenings and/or nights as appropriate to support the needs of patients and carers.

Awaiting outcome of WCVA funding application to determine gaps in resource that require funding. Links with Prevention funding linked to Building a healthier Wales.

8. Workforce

Our workforce challenges are likely to be significant this winter applicable to all Partner agencies.

In addition to regular seasonal illness, we are expected to experience additional staff absence due to:

- COVID illness
- Winter pressures and normal recruitment risks
- Childcare
- Bereavement
- Self-isolation
- Stress and anxiety

- Careful management of low level symptoms where staff would usually continue to work through (e.g. Coughs, colds etc) which will result in staff being off work due to being symptomatic.

9. Overall Investment

A range of resources contribute to this RPB Winter Plan.

With reference to the two sums of RPB funding detailed below these have been looked at together and detailed breakdown of proposed use of the £1.812m is shown in appendix 1.

- Minister for Health and Social Services confirmed funding of £1.505M to support Regional Partnership Boards to deliver the winter plan.
- Funding of £307k to support the social model of care component of the Primary Care Model for Wales aligned Social model of care component of the Primary Care Model for Wales.

10. Conclusions

The last two years have been extraordinary times for all public services and the Region is proud of the way that its staff have rallied and worked together to maintain a high standard of care. The plans set out in this document will, with support from our partners, place the Region in a good position to support the population through what is likely to be a challenging winter.

Appendix 1

Project Description	Cost / Resource
Increased demand for community equipment services, including delivery drivers, equipment provision, minor aids & adaptations and telecare installation	£ 383,000.00
Independent sector domiciliary care home care incentive payment for Christmas and New Year Holiday period	£ 78,000.00
Additional capacity for support @home service (intermediate care and reablement) facilitate hospital discharge or prevent admission	£ 257,000.00
Additional care home placement and support costs, including interim placements, additional 1-1 support and top up fees over the winter period	£ 351,000.00
Enhanced social work capacity across Adult Services to meet increased demands to support discharges and avoid admissions along with the further demands of winter pressures	£ 293,000.00
Additional capacity for community based care services over winter period to facilitate hospital discharge or prevent admission includes DP.	£ 30,000.00
Additional capacity to support carers including crisis support	£ 30,000.00

Additional OT & OTA to support reablement, provide aids and assess for adaptations	£	60,000.00
Additional capacity for adult duty (SPA) service to meet increased demand over winter period	£	16,000.00
Additional capacity for hospital discharge coordinators across hospital sites to meet increased demand over winter period	£	31,000.00
Enhanced occupational therapy capacity across Adult Services to meet increased demands to support discharges and avoid admissions along with the further demands of winter pressures	£	53,000.00
Additional home care and care home broker capacity to meet increased demand over winter period	£	36,000.00
Better@Home +	£	60,000.00
Therapy Techs	£	60,000.00
Community Equipment / District Nursing	£	14,000.00
Marie Curie	£	100,433
	£	**1,852,433**
	***40k over allocation.**	
Health Board Proposals		
Additional bed capacity on hospital sites through improved patient flow	Budget TBC	
Voluntary Sector	Budget TBC	