Meeting Date	**30 January 2020**	**Agenda Item**	**2.4**
Report Title	**Implementation of Winter Plan (Update)**		
Report Author	Craige Wilson, Deputy Chief Operating Officer		
Report Sponsor	Chris White, Chief Operating Officer		
Presented by	Chris White, Chief Operating Officer		
Freedom of Information	Open		
Purpose of the Report	In response to the unprecedented pressure being experiencing in unscheduled care 2019/20 a detailed Winter Plan has been produced to manage demand, increase capacity and manage risk. This reports provide and update on the agreed actions which have been funded.		
Key Issues	This report provide details of the implementation of the Winter Plan as part of the overall plan for the deliver off unscheduled care. An unscheduled care action plan is in place to make improvements across the whole unscheduled care system, improve access and enhance patient experience. In particular actions which appropriately avoid admission, increase flow through hospital and facilitate timely and appropriate discharge are key.		
Specific Action Required ***(please choose one only)***	**Information**	**Discussion**	**Assurance**	**Approval**
	☐	☒	☐	☐
Recommendations	Members are asked to: - • **NOTE** the progress in relation to the Winter Plan from both a Health Board and Regional Partnership Board perspective.		

IMPLEMENTATION OF THE WINTER PLAN (UPDATE)

1. INTRODUCTION

In response to the unprecedented pressure being experiencing in unscheduled care 2019/20 a detailed Winter Plan has been produced to manage demand, increase capacity and manage risk. This reports provide and update on the agreed actions which have been funded.

2. BACKGROUND

Health and social care services experience pressures all year round, but the winter months can be a particularly challenging period. Colder and more hazardous weather conditions; increases or changes in activity in some parts of the system; and spreading of infectious diseases such as influenza and norovirus can all result in additional pressure for front line services, and negatively impact on timeliness of patient access and patient and staff experience.

Recognising that unscheduled care pressures are evident all year round, the Seasonal Pressures Plan for the Swansea Bay Health Board area reflects the Health Board's programme for delivering system wide improvement in unscheduled care, incorporating the work of the West Glamorgan Hospital to Home transformation programme.

Unlike previous years, the health and social care system in Swansea Bay has not seen a de-escalation of unscheduled care pressures during the summer months. This has been evident through the increased demand at our Emergency department and minor injuries units, workforce capacity gaps in key clinical areas, and an increasingly fragile domiciliary care sector, all of which have contributed to patient flow and capacity constraints and subsequent performance deterioration.

In addition, the unforeseen loss of 31 inpatient beds at Singleton hospital this financial year, following a fire in March 2019, along with subsequent environmental issues, has also had a major impact on flow and capacity within the Health Board.

The winter plan has also taken account of lessons learnt from previous winters, and outlines the further measures that the health and social care system is planning to support in Swansea Bay, through additional winter pressures funding of circa £3.5 million, which was confirmed by Welsh Government at the end of September. This additional funding has been allocated to Health Boards and Regional Partnership boards with a specific focus on allocating this funding to support 7 nationally agreed themes as follows:

- Optimised cross sector working – to keep more people at home
- Urgent primary care/ out of hours service
- Preventing un-necessary conveyance and admission to hospital
- Discharge to recover and assess – to enable more timely discharge
- Community step down capacity – to enable more timely discharge.
- An enhanced focus on the respiratory pathway to keep more people at home.
- Enhanced focus on frailty services/ pathway.

3. GOVERNANCE AND RISK ISSUES

The Health Board's unscheduled care programme and the West Glamorgan's Hospital to Home transformation programme are closely aligned with the seven nationally agreed themes, and reflect the primary aim to enhance capacity in our primary and community services, thereby supporting more people to keep well at, or closer to, home.

The additional funding (£1.25m) announced by WG at the end of September to assist with the management of winter pressures and is being used to enhance, and, where possible, accelerate the plans that are already progressed through this multi-agency programme of work. The details of the schemes funded by the Health Boards allocation for winter can be seen at **Appendix 1**.

The table below summarises the key actions to improve capacity from within the current financial envelope, through efficiency and service improvements, or through additional investment following the approval of business cases, and identifies the expected impact on system resilience or performance

Action	Expected impact	Timescale
Ensuring **SAFER flow** principles are increasingly used in the day- to- day management of patient flow	Eliminate un-necessary delays in a patient stay in hospital.	In place and being embedded as a consistent part of daily operational processes through senior clinical leadership.
Expansion of ESD service to cover the whole of Swansea Bay area	An additional 60 patient caseload will be supported in the community when the ESD team is fully staffed, in addition to the current NPT ESD patient cohort which is currently staffed to manage up to 35 patients.	In place since December 2019
Fully embed the **COPD early discharge team** in Swansea which was funded in 2018/19, but which only became fully staffed and rolled out across the HB from the end of May 2019.	Support earlier discharge of patients with exacerbations of respiratory illness, which is one the key emergency care pathways targeted for improvement.	In place
Our **frailty services** have been remodelled on all hospital sites namely ICOP service at Singleton, Older Person's Assessment service (OPAS) at Morriston, and the enabling and early supported discharge service at NPT. This has been achieved through a combination of	Reducing length of stay through admission avoidance , rapid access to diagnostic tests, earlier discharge. Reduction in the number of stranded patients > 7 days length of stay.	Full ICOP team in place in Singleton **>80%** patients assessed are discharged to place of residence rather than admitted. OPAS at Morriston -in place – supporting **90.6%** of patients assessed in ED to return home

service redesign within existing resources and through changes to workforce models. Further work is now taking place to realign services into one frailty model for Swansea Bay UHB.	Reduced risk of hospital acquired infection and deconditioning.	Enabling ward at NPT – in place
Further maximise the use of and access to **day care and ambulatory care facilities**	Increased throughput through resourced capacity and revised ambulatory care pathways.	In place and ongoing
Flexible use of **CEPOD(emergency)** theatre capacity	Reduce waiting times for inpatients awaiting emergency surgery	As required to respond to inpatient demand
Strengthened medical staffing cover.	Improved access to senior clinical decision makers to enable more timely decisions and management plans to be initiated – releasing system capacity.	In place through junior medical staff cover at Singleton (to manage outlying patients) Additional medical staff in Morriston medical services to ensure timely patient reviews - in place.
Agreement to support **2 additional ED consultants at Morriston** initially	Increased senior medical decision making support and capacity at the front door.	Unable to recruit to post at present No suitable candidates, to be re-advertised.
Eight 4x4 vehicles secured from within existing resources to assist with essential transport arrangements during adverse weather	Safe staffing levels/ staffing capacity to deliver essential patient care	Available from November 2019– March 2020
Strengthening **non-emergency ambulance transport** capacity through • Non emergency patient transport to maximise existing capacity. • Commissioning additional HB wide vehicle to support patient flow over the winter	Earlier and more timely patient discharge.	In place and ongoing Commissioned in December 2019 from Winter monies allocation
Mental Health services: **Psychiatric Liaison Team (PLT)**	The PLT has now extended its hours of operation and works from 7am to 10pm 7days a week.	In place with extended hours

Crisis Resolution Home Team: (CRHT) **Older Persons Mental Health services (OPMHS)**	The CRHT teams for SBUHB now provide a 24 hour assessment service for all individuals suffering from a mental health problem and in a degree of crisis. The service has an assessment & treatment component that focuses on early diagnosis and intervention. This primary care service is supported by an established secondary care service built on a CMHT model.	
Increase the number of patients who receive end of life care by the palliative care team from current baseline	Relaunched end of life work programme - increasing the number of patients who can be supported to receive end of life care in their own homes. Reduction in up to 1560 bed-days.	In place since October 19 and ongoing
Improved models of care for higher dependency patients (see section 3.5 below on critical care)	Improved utilisation of existing critical care resources, and enhanced respiratory services through the provision of NIV facilities at Morriston hospital.	In place
3rd sector services – British Red Cross and Care and Repair	Facilitates and supports more timely patient discharges	In place with non-recurrent WG funding support from April 2019 to 31st March 2020.

In partnership with Swansea City Council and Neath Port Talbot County Borough ,the Health Board is implementing a transformational project to strengthen the Western Bay optimum model to become a Hospital 2 Home service. This is an outcome of the Right Place Right Care review findings in October 2018, which highlighted there is a great deal of opportunity to make changes, both within Health Board services, and in partnership with the Local Authorities to improve flow through the whole system, to use our joint capacity effectively and to improve outcomes for older people

The development of an agile Hospital2Home service that has the ability to assess, care and re-able patients at home is based on research undertaken by Professor John Bolton of Oxford Brookes University. This service will maximise the independence of older people and ensure care packages are right sized before being put in place. The model is being built around a trusted assessor model where assessment does not take place in a hospital bed, and where strengths-based assessments take place when the patient is not in crisis. It is considered that this service model will help to maximise the

use of the existing social care capacity to best effect, ensuring that there is improved patient flow across the system.

This additional WG funding allocated through the Regional Partnership Board provides additional opportunities to enhance capacity over the winter period through the following mechanisms:

- Enhanced support for care homes
- Supporting hospital discharge for people in care homes
- Enhanced third sector support to assist with the discharge of patients from hospital
- Enhanced domiciliary care capacity in NPT Local authority area
- Enhanced capacity to review and right size existing packages of care in Swansea Local Authority.
- Acceleration of capacity in the hospital to home service.
- Additional community equipment and weekend opening to facilitate timely discharge
- Assistive technology
- IT equipment
- Pooled fund to enable rapid response to support patient discharge/admission avoidance

The December progress report submitted to Welsh Government can be seen at **Appendix 2.**

An evaluation of all of the various winter plan schemes will be undertaken to determine their impact on improving the flow through the unscheduled care system. This will determine whether or not to make a case to seek funding to maintain them or built in to the plans for next winter.

4. FINANCIAL IMPLICATIONS

The Health Board has received an allocation of £1.2m winter pressure monies which is being utilised to support the schemes identified in **Appendix 1.** In addition the Regional Partnership Board was allocated £2.2m for scheme that traverse both health and social care seen in **Appendix 2.** Expenditure against the plan is being closely monitored.

The £60k of winter pressure monies has been utilised to commission additional agency social worker support to Morriston Hospital to support early discharge of medically fit patients. In addition, the money has been used to support short term employment of agency medical staff as and when basis.

5. RECOMMENDATION

Members are asked to:

- **NOTE** the progress in relation to the Winter Plan

Governance and Assurance		
Link to Enabling Objectives ***(please choose)***	**Supporting better health and wellbeing by actively promoting and empowering people to live well in resilient communities**	
	Partnerships for Improving Health and Wellbeing	☒
	Co-Production and Health Literacy	☒
	Digitally Enabled Health and Wellbeing	☐
	Deliver better care through excellent health and care services achieving the outcomes that matter most to people	
	Best Value Outcomes and High Quality Care	☒
	Partnerships for Care	☒
	Excellent Staff	☒
	Digitally Enabled Care	☐
	Outstanding Research, Innovation, Education and Learning	☐
Health and Care Standards		
(please choose)	Staying Healthy	☒
	Safe Care	☒
	Effective Care	☒
	Dignified Care	☒
	Timely Care	☒
	Individual Care	☒
	Staff and Resources	☒

Quality, Safety and Patient Experience

Delivery of improved unscheduled care performance through the Winter Plan will decrease access times for patients, improve patient experience and promote increased flow through the unscheduled care system.

Financial Implications

There are no immediate financial implications, as they are covered by the allocations from Welsh Government, of this report but consideration will be made through the IMTP process of the schemes which have delivered benefits in 2019/20 for continuation in 2020/21. As assessment of the financial implications will be made once these areas are agreed.

Legal Implications (including equality and diversity assessment)

There are no known legal or equality and diversity impacts. Patients are treated based on clinical need.

Staffing Implications

As with finance, there are no immediate staffing implications but longer term continuation of schemes currently in place may require a recruitment programme to make services sustainable.

Long Term Implications (including the impact of the Well-being of Future Generations (Wales) Act 2015)

The '5 Ways of Working' are demonstrated in the report as follows:

Long term – Actions within this report are for 2019/20 but will have a long term impact in terms of improved access and patient experience.

Prevention – some of the service modernisation within these services will help to prevent patient health deterioration and keep patients as independent as possible at home. Integration – clinical pathways are delivered across primary and secondary care. Collaboration – come clinical pathways within unscheduled care (stroke, vascular for example) cross Health Board boundaries and require collaboration within the NHS system. Involvement – Partner organisations, Corporate and Delivery Unit Leads are key in identifying performance issues and identifying opportunities to improve flow and develop services which are fit for purpose to meet the needs of our citizens.	
Report History	No previous reports
Appendices	Appendix 1 Appendix 2

Appendix 1 **WINTER PLANNING MONIES ALLOCATED BY WG 2019/20**

SCHEME	INVESTMENT REQUIRED	FORECASTED BENEFITS	EXPECTED IMPACT/UPDATE
Acute GP triage of patients on the ambulance stack (Singleton/Primary care)	£40k HB contribution to provide 5 day service from November – March.	Redirection of appropriate patients to alternative care pathways and services who have requested an emergency ambulance response	44% reduction in ambulance conveyance – day time hours and a reduction in ambulance handover delays. In place since December 2019.
Phase 2 of the COPD service which will further reduce the un-necessary admission of patients with an exacerbation of this chronic condition (HB wide)	£72.8k for 5 months	Will be dependent upon success of the recruitment of nursing and therapy staff but full year impact expected to be a reduction of 2645 bed days.	Admin support will release clinical time to manage increased demand over the winter. In place from February 2020.
Improve proportion of medical patients treated using ambulatory care pathways (Morriston)	£61k	Reduced overcrowding in ED Reduced length of stay More timely patient access and improved patient experience for medical patients	In place
Increased pharmacist support in Morriston ED Extended pharmacy hours in Singleton SAU 5- 8pm and on a Sunday (overtime)	£79.2K (5 months) £20k	The Welsh Government's winter themes plan includes a specific recommendation that Health Boards should develop plans for pharmacists in ED services and other relevant areas to support flow and medication safety.	Reduction in ED waiting times Improved patient safety in respect of medicines management. In place since November 2019
Microbiology will run a seven day a week service to provide rapid flu testing (based at Singleton Hospital).	£80k	Service will accommodate rapid testing of 655 patients over the 2019/20 winter period.	Early identification of patients with confirmed influenza to ensure appropriate treatment, management

SCHEME	INVESTMENT REQUIRED	FORECASTED BENEFITS	EXPECTED IMPACT/UPDATE
Point of care Testing in ED at Morriston	£12k		and flow of patients attending hospital. In place since Dec 2019.
Increase temporary Mortuary capacity (HB wide)	£17k	Ensuring sufficient body store capacity through the provision of 12 additional spaces.	In place
Health Board Ambulance Liaison role – 10am -10pm 7 days a week.	£76.6k	Improved communication between emergency department and WAST at times of heightened escalation. Assisting with the management of patients who may have a prolonged handover wait. Reduction in delays through maximising fit to sit protocols and shared management of patients in hospital ED's to release ambulance crews.	Reduction in ambulance handover delays as consequence of improved communication. In place since December 2019.
Enhanced diagnostic capacity for 3 months: Biochemistry Singleton. Extended radiology cover for SAU Singleton MRI capacity Morriston ECHO Morriston	 £38.6k £3.2k £51k £4k	Improved and more timely access to diagnostic investigations which will support patient flow through a reduction in waits for diagnostic tests and investigations	Difficult to quantify but expected to contribute towards a reduction in length of stay. In place.

SCHEME	INVESTMENT REQUIRED	FORECASTED BENEFITS	EXPECTED IMPACT/UPDATE
Expand the OPAS service at Morriston to 6:00pm weekdays and also Saturday working for 4 months to increase the scope of admission avoidance already delivered by the baseline service Expand ICOP service to Sunday morning at Singleton for 4 months	£17k £5.9k	Reduction in admissions for over 65 fallers	In place since December 2019
Enhanced medical and nurse staffing Morriston x 3months Singleton x 3 months	£100k £100k	Increased staffing capacity ad service resilience. Improved patient care.	Difficult to quantify – but will improve quality and patient safety through increased capacity to manage front door patient demand and patient acuity. Utilised as and when required since November 2019.
Speech and Language Therapist role in ED (agency)	£18k	• Prevention of recurrence of readmission and failed discharge • Prevention of aspiration of pneumonia • Reduction in malnutrition/dehydration/ un-necessary naso-gastric tubes.	Admission avoidance Improved patient experience and clinical outcome Reduction in consumable costs. In place since December 2019.
Enhanced asthma service	£47k	The focus will be on identifying high-risk patients at increased risk of severe exacerbations and death, requiring referral to the specialist asthma service, through Morriston Emergency Department (ED), Singleton Assessment Unit (SAU) and inpatients across the two hospital sites with asthma. There will be an important focus on identifying	Reduced emergency admissions/ 999 presentations following severe exacerbation of asthma. In place.

SCHEME	INVESTMENT REQUIRED	FORECASTED BENEFITS	EXPECTED IMPACT/UPDATE
		so-called ED 'revolving door' patients, and improving self-management to reduce reliance on unscheduled care in ED. Providing specialist input to support discharge and prevent readmissions. Health Care Professional access to refer to hot clinics to support admission avoidance	
Primary care doctor role in ED - day time hours.	£47K	To support patient triage and, where appropriate, the redirection of patients presenting at ED with a primary care condition.	Release of capacity in ED to manage emergency patients Improved 4 hour performance and education of triage staff. In place since December (Monday – Friday)
Pilot of HB wide patient flow co-ordinator role. (5 months)	£37k	More streamlined patient flow arrangements across the HB through improved communication and alignment of patient flow resources.	Appointed in December, delay in commencing due to sickness. Commencing 27 January.
Additional non emergency ambulance transport to facilitate hospital discharges/ patient transfers	£91k	Additional transport capacity to facilitate hospital discharges and non-emergency patient transfers.	Improved patient flow and patient experience as discharge and transfer waits are reduced. In place since December 2019.
19 surge beds – Singleton Hospital (Q4)	161k	Appropriate ward environment for the management of additional emergency inpatients.	Improved patient care and patient experience. Reduction in ambulance delays through increased bed capacity. 12 beds currently re-commissioned – remaining depending on ability to identify staff.

SCHEME	INVESTMENT REQUIRED	FORECASTED BENEFITS	EXPECTED IMPACT/UPDATE
Upper valleys cluster initiative	15k	To provide targeted support for frail elderly patients within Upper Valleys Cluster Network by undertaking proactive home visits by an experienced Registered Nurse leading to: • Better winter preparedness of those patients identified as frail and at higher risk for admission. • Patients will have ACP and DNA CPR in place where appropriate • Better informed patients through completion of My Winter Health Plan • Earlier contact with healthcare services in case of deterioration/ill health which will allow early intervention and treatment. • Proactive and tailored patient centred care within patient's own home	Reduction in avoidable admissions and 999 call out. In place.
WAST falls vehicle	40k	To increase capacity to provide a level 1 falls response service through a second falls response vehicle in Swansea Bay UHB	To avoid un-necessary conveyance to hospital for appropriate non injury falls patients. In place since Nov 2019
Total	1,234,300		

This will leave a contingency sum of £60,700 which will be managed by the Chief Operating Officer to respond to any unforeseen additional demands over the winter period.

Appendix 2 **Monthly status report - winter key priority actions**

Key priority area	Project Lead/Lead Organisation	Progress ▪ Have all actions been funded? ▪ Barriers? ▪ Successes/ benefits realised? ▪ L ▪ Partners involved in delivery?	Budget	Spend to date against budget	Projected Year End Spend	Comments
1. Optimising cross organisational and sector working						
2. Urgent primary care out-of-hours resilience						
3. Preventing unnecessary conveyance and admission to hospital	Karen Gronert, Swansea Bay University Health Board	**1. Enhanced Support for Care Home:** No GP cover secured as yet. The generic out of hours service currently has gaps in terms of GP's in Out of Hours and 111. Recruiting additional GP is proving problematic, however have one GP that is potentially interested and also recirculating advert again to all practice managers shortly and further update will be provided in the January report. Once recruited, the GP will enhance the out of hours team on a Saturday in order that the GP can respond to calls in care homes and also work on a more proactive basis. This was previously piloted on a cluster basis and evaluation demonstrated reduction in hospital admissions and there was good feedback from care homes as they were able to pre-empt some of the problems.	£30,000	£0	£30,000	
	Karen Gronert, Swansea Bay University Health Board	**2. Supporting Hospital Discharge for People in Care Homes:** No referrals for discharge to assess received at end of December. 2 Part time Nurse assessors have been appointed, nurses salary will be invoiced in Qtr. 4. No Locum Social Worker secured as yet. At present a barrier to this project is recruitment, to mitigate this we have 2 nurses recruited and commenced in the project and we continue to seek to recruit a social worker and OT. These additional staff will undertake assessments in the home in order to support discharging people from hospital back to their care homes.	£113,200	£0	£113,200	Invoice for costs in December will be included in the return in January
	Amanda Aldridge/Michelle Worth, Swansea Council on behalf of NPT CBC and SBUHB	**8. Community Equipment:** All anticipated expenditure has been incurred and the service has so far exceeded expected delivery volumes. Volumes delivered in November were: Solite Pro & Bradshaw beds 42 Overlay Mattress 53 Sara Steddy 33 Repose Cushions & Mattress 187 GSM Units for Life Line - £15,132	£64,605	£64,935	£0	

		This additional community equipment enables the support of discharge of patients from hospital and more people able to remain independent in their own homes.				
	Annette Davies, Swansea Bay University Health Board	**9. Assistive technology:** All equipment in the process of being ordered. Staff training for Point Of Care machines usage being mapped out. Due to an error with original calculations there will be an overspend of £9,212.50; this will be considered in the next return. The introduction of Point of Care testing for the Acute Clinical Teams will enable the blood tests to be performed in the patient's home. This will enable rapid test results to be available to the Nurse Practitioners which will expedite clinical decision-making and initiation of appropriate treatment. This will improve patients outcomes and satisfaction by providing more value based prudent health care	£76,371	£85,583.35	£76,371	Consider if overspend can be picked up by alternative scheme reporting underspend in next return OR organisation will need to pick up costs
	Karen Gronert, Swansea Bay University Health Board	**10 IT Equipment:** Awaiting NWIS advice and procurement of iPad's, which should progress shortly. This pilot is to provide IPads for Care Home staff to skype into Acute Clinical Teams and speak to Nurse Practitioner for advice and support and discuss concerns.	£5000	£0	£5000	
	Ian Austin, Pooled Fund Manager, West Glamorgan	**11. Pool Fund for Community Surge** A pooled fund has been agreed by all West Glamorgan partners. The purpose of the Pooled Fund is to provide surge capacity in the community at point of crisis. Partners include Swansea Council, NPT CBC and the Health Board. Given tight timescales a MOU was drafted and signed by all partners. The decision making process for allocation of the Pooled Fund will be made by the relevant Joint Chairs of the Joint Partnership Boards. The pooled fund manager in West Glamorgan manages the process. The monitoring of the Pooled Fund will be via the Joint Partnership Boards (JPBs) for Swansea Council and NPTCBC, with strategic oversight and escalation of any key issues to the Adults Transformation Board. MOU has been agreed by Swansea and NPT JPBs in December. 3 proposals submitted in January, details to be included in January's return.	£302,787	£0	£302,787	
4. Discharge to assess/recover (D2AR)		**4.THIRD SECTOR GRANT POT for Supporting Hospital Discharge:** Overview: Schemes 4a, 4b and 4c involves a collaborative approach where all 4 organisations, Care and Repair, Age Cwmru, YMCA, Swansea Carers and NPT carers are all working together to support patients discharged from hospitals. This includes transport from hospital, low level support, support with financial assessments, aids and				

		adaptations and preventative approaches such as yoga and mindfulness. Feedback from these organisations have confirmed that working together in this collaborative way has highlighted further future opportunities of how these organisations can work together in other areas. This is an area we intend to explore further in order to facilitate further collaborative working with third sector organisations. A barrier to recruiting more third sector organisations to support hospital discharge and support in the community is the short term funding, given there was insufficient time for organisations to go out and recruit more staff.				
	Emma Tweed, WB Care and Repair and Age Cwmru, Swansea	**4a. Transport and handover from hospital discharge team** <u>Start of projects 4a & 4b - December 2019</u> Number of patients accessing Care and Repair via our Hospital to Healthy Home Caseworker = 24 Number of patients assisted with hospital discharge works from Handyperson service = 15 Cost of Handyperson works completed = £6,746 Number of Healthy Home Assessments completed post discharge = 7 (+ 9 planned) Number of welfare benefit applications completed = 3 Number of bed days saved = 48 (24 patients x average of 2 days per patient) with an associated cost avoidance of £19,200 (average cost of bed day at £400) 4 referrals to Age Cymru for welfare benefit advice and form filling in December 2019	£42,500	£10,971	£42,500 £42,500	£10,971
	Anne-Marie Rogan, Swansea YMCA And Swansea Carers Centre	**4b. Swansea Outreach Hospital Support Project:** Members of Team appointed and in place. Processes developed including referral mechanisms, reporting and evaluation. Marketing Campaign developed. Inductions completed. Launch and face to face work ready to begin. Joint meeting between 3rd sector providers has taken place to dovetail provision and refer to projects with Age Cymru, Care & Repair, and Neath Port Talbot Carers Centre to maximise impact. Joint working and robust processes in place will ensure successful delivery. In order to maximise impact we are working collaboratively with other third sector organisations in receipt of the grant and will deliver dual marketing campaigns & cross referral to support patients and carers discharged across all services to ensure access to all appropriate services available. Making links with Hospitals and key staff will be key and is a key focus for January as part of the roll-out of the project.	£35,880	£5445	£35,880	

	Mariann Peresden, NPT Carers	**4c. To be able to provide greater access to a sitting service:** No data as project will start 01.01.2020. No feedback as yet. Project in its infancy. Member of staff has started his 1.5 days per week and we are currently procuring coaches and venues for the activities to be undertaken. Meeting with other providers have taken place (06-01-20) and another meeting on the 13.01.2020.	£18,833	£0	£18,833	
	Lucy Friday, Swansea	**5. Existing Domiciliary Care Packages:** Swansea Council: Additional hours provided - 2,348 hrs internally, increasing the domiciliary capacity for Swansea Further costs for Q3 not available in time for return, all costs will be captured in Q4	£144,000	£32,895	£144,000	
	Sarah Waite, NPT	**5. Existing Domiciliary Care Packages:** NPT Council: Overtime offered to support workers, resulting in additional 1180 hours in November and 1261 hours in December, increasing the domiciliary capacity for NPT	£100,000	£39,874.56	£100,000	
	Helen St John, Integrated Community Services Manager – Swansea	**6. Utilise locum resource to review current packages of care for brokerage:** Swansea unable to secure agency support to date, so in qtr 3 existing staff working additional hours above contracted hours to review the packages of care. This additional support will continue alongside secured locum OT support once recruited. There are numbers of clients waiting for long term maintenance packages of care on the brokerage list in Swansea. This additional support will provide significant benefit as additional time can be devoted to cleansing the brokerage list and ensuring that all data is up to date and accurate. This will in turn improve the flow through into long term care providers.	£41,600	£28,303	£41,600	
	Annette Davies Integrated Community Services Manager – NPT	**6. Utilise locum resource to review current packages of care for brokerage:** Qtr 3 costs to be reported in qtr 4.	41,600	£0	£41,600	
	Hilary Dover, SBUHB Sarah Waite, Interim Programme	**7. Hospital to Home –** • Developed and refined standard operating procedures for each element of the H2H model	£852,284	£123,023	£729,260.77	Awaiting figures from HB

	Manager, NPT CBC	• Staff engagement sessions held to ensure all operational staff understand the rationale for change, providing opportunity to ask questions • Recruitment of therapist to support the model completed • First phase, soft launch implemented in December • Performance measures agreed and baseline data captured • Data collection systems currently under development, including electronic SIGNAL system • H2H navigator competency training completed • Communications material produced • Service launched on 10th December • Outward Flow for Reablement Services was considered and option agreed • Service operating procedures brought together as one regional document and reflects local delivery				
5. Community step-down capacity	Lucy Friday, Swansea	**13. Packages of Care: Unblock Brokerage:** Swansea: Additional Hours and expansion of carer resource in development with external sector. Work in progress and full spend including associated with registration and training costs to be recovered in Qtr. 4	£198,000	£0	£198,000	
	Sarah Waite, NPT	**13. Packages of Care: Unblock Brokerage:** NPT: Domiciliary care hours from extra care schemes transferred to external market to free up in-house capacity. Circa 3600 hours paid for in November and December	£118,970	£62,023.30	£118,970	
6. An enhanced focus on the respiratory pathway	Dr Anjula Mehta, Swansea Bay University Health Board	**12. Point of care (POC) CRP testing in UPC service:** Awaiting procurement of POC testing machines, POC testing team involved, nil cost at end of Dec 2019 as we are awaiting procurement Once purchased this will allow the introduction of CRP POCT at all three UPC delivery sites - POW, NPTH and Morriston Hospital. This will allow instant confirmation of a diagnosis of bacterial pneumonia and accurate antibiotic prescribing.	£15,370	£0	£15,370	
Totals			**£2,201,000**	**£453,053**	**£2,002,401**	

RPB area: West Glamorgan

Date: 10.01.2020
Completed by: Emma Jones, Finance and Performance Officer.

RPB Internal Arrangement