Bwrdd Partneriaeth Rhanbarthol Gwent
Gwent Regional Partnership Board

The Gwent Integrated Winter Protection Plan 2020/21

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Gwent Regional Partnership Board

GIG CYMRU NHS WALES
Bwrdd Iechyd Aneurin Bevan Health Board

GAVO
Gwent Association of Voluntary Organisations
Cymdeithas Mudiadau Gwirfoddol Gwent

CAERPHILLY COUNTY BOROUGH COUNCIL
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INTEGRATED
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Home First
cartref Yn gyntaf

tva

Foreword

It is a pleasure to submit the first Integrated Winter Protection Plan on behalf of the Gwent Regional Partnership Board.

The plan has been developed through a genuinely collaborative approach, building on the existing mature partnership arrangements in place in Gwent and which have been further enhanced to help us manage COVID-19 across our large region.

This year we face the unprecedented challenge of planning for winter pressures amidst a global pandemic, that has meant we have had to plan, structure and deliver services differently. The plan demonstrates the challenges we face together as a health and social care sector going forward, with protection and support for our frontline staff a priority.

The early opening of the Grange University Hospital in November of this year, demonstrates the ongoing herculean efforts of our staff and partner agencies to provide the best available care and support across our region and this plan demonstrates the ongoing transformation across the region to provide care 'close to home' reducing pressure on the secondary care sector during the pandemic.

The collaborative and co productive relationship emerging between Welsh Government and Regional Partnership Boards is reassuring to see as we head into a period of great uncertainty for our services. We will need to continue to work collaboratively with Government to continue to provide protection and support for our citizens during the winter period, in extremely challenging circumstances. At the heart of this plan is the dedication from our staff to work together collaboratively, to provide our service users and their families with resilient, safe and accessible seamless care across Gwent.

As I hand over the Chair from November to my Local Government Colleagues, I have great confidence that this Integrated Plan will forms the basis of a solid approach, to what may be the most challenging winter period the Health and Social Care Sectors will have faced in many years.

***Phil Robson** Chair of Regional Partnership Board*

Contents

Executive Summary

Each winter health and social care services come under increased pressure as demand for services grows, due to increased vulnerability and need, particularly amongst the frail elderly. Protecting our citizen's wellbeing during the winter period remains an absolute priority for the Gwent Regional Partnership Board (RPB), but this year COVID-19 represents a significant and additional challenge on an already fragile system. The plan evidences the fragility of health and social care system, particularly the care sector over the winter period, likely to be dangerously exacerbated this year due to COVID-19. These are of real concern to the RPB and mitigating actions are underway to support improved access to services, workforce resilience and market resilience.

Across Gwent we expect that there will be a far higher demand on our services for treatment and support, resulting directly from the increasing prevalence of COVID-19 and its related impacts. We have undertaken a collaborative process to identify the required additional capacity needed to safely manage demand, however there remains a shortfall in available funding to meet the total requirement. The RPB remain concerned about this and appended to this plan is a detailed budget breakdown which highlights the current unfunded gap in capacity.

The plan is not limited to the additional capacity required, but for the first time sets out the totality of activity across the Regional Partnership Board to deliver safe and seamless care this winter. It is derived from the refreshed Population Needs Assessment (PNA), ABUHB Q3/Q4 plan and the Gwent Care Home's Action/Failure Plan.

The additional capacity required, across each of the five local authorities and health board, is set out within this plan and based on previous evidenced need. To fund this the RPB have directed that slippage from partnership funding is to be utilised, alongside additional funding received from welsh government for D2RA and Discharge flow. This is to mitigate the absence this year of a directly allocated additional sum from Welsh Government. An element of required capacity, remains unfunded and this has been included in the plan. Whilst we will continue to work closely together regionally to mitigate this, we would welcome discussions around further available funding from welsh government.

This funding will provide additional hours and people to provide domiciliary care, social work (brokerage), emergency care at home, anticipatory care planning and discharge to assess and recover in the community, alongside additional housing solutions, equipment and winter vehicles.

The plan, It sets out the totality of activity including:

- Agreed core activity to provide services during the winter and aligned to ABUHB Q3/Q4 plan.
- Additional capacity required and which is funded through redirecting partnership slippage monies.
- Additional Capacity required to support Discharge Flow and D2RA and which is funded from additional WG funding to the region.
- Unfunded additional capacity required, to due lack of available resources and which WG are asked to consider funding.

1 Introduction

The winter period remains the greatest challenge for health and social care services, and this year's integrated plan is a clear statement of the maturing 'whole system approach' guided by the Regional Partnership Board. This plan provides a statement of all activity, undertaken during the winter period. It includes the Social Care activity and additional need, alongside arrangements to be implemented by the Health Board (Q3/Q4) to provide Primary and Community Care, Mental Health and Wellbeing services and access to (urgent) hospital care where required.

Development of the plan has been through a multi-agency task group, drawn from RPB partners which has met virtually. It has been developed at pace in line with Welsh Government deadlines, and it complements the committed activity in existing plans including ABUHB Q3/Q4 operating plan, Gwent Care Homes Action Plan and Transformation/ICF programmes. Throughout this plan, there is a strong emphasis on supporting mental wellbeing and resilience, recognising the enduring and detrimental impact lockdown is having on mental health.

The addition of a potential surge in COVID-19 infection during the winter, is a new dynamic for the health and social care system. Lessons learned from the first wave of the pandemic have informed the seasonal planning process and core operating models included in this plan. The plan sets out the challenges and fragility across the sector likely this winter and our detailed response to meet need and mitigate risk. Not all additional activity required can be funded from the resources available and the plan includes an 'unfunded' budget for Welsh Government consideration.

The plan is structured on WG's **'six goals to support integrated winter planning'** and **'four harms'** to safely mitigate and manage the ongoing impact of the COVID-19 pandemic. The activity set out, demonstrates the ongoing need to build system resilience through a multi-disciplinary approach and ensure safe, high quality services, at a time of unprecedented circumstances for all partners. The plan is written in the context of the early opening of the Grange University Hospital in November 2020. Whilst this is dealt with in detail in the Health Boards detailed Q3/4 plan, it is referenced within this plan as a key local impact. The Regional Partnership Board will develop an effective systems wide performance and assurance framework to monitor delivery and system impact.

The plan:

- Emphasises our commitment to protecting Public Health, through Test and Trace, our programme of Mass Vaccination and the scaling up of community mental wellbeing services.
- Details the capacity secured to widen access to (urgent) primary care, social care and community services to maintain wellbeing and prevent crisis escalation and hospital admission.
- Provides an overview of the additional hospital capacity available due to the early opening of the Grange University Hospital (GUH).

- Sets out the implementation of our D2RA Pathways and the scaling up of HomeFirst as part of the opening of the Grange University Hospital (GUH).
- Demonstrates the extensive activity underway to build capacity and resilience through effective partnership working with our Care Homes and Providers.

The action set out in this plan provides assurance of the 'whole systems approach' in place in Gwent to support both the health and social care sector in Gwent through the winter period.

The local priorities that have informed this plan are:

- The opening of the Grange University Hospital in November 2020.
- The need to maintain access to core services across primary and community care and advance the Gwent place based care model.
- Preventing unnecessary hospital admission amidst increased demand using Home First and D2RA pathways and increased social care assessment capacity.
- Securing timely discharge from hospital into the community to free up bed capacity using D2RA pathway guidance & funding and expansion of community care & therapeutic services.
- Maintaining resilience and stability within the care sector within ongoing COVID-19 restrictions in line with the Gwent Care Home Action Plan.
- Promoting Mental Wellbeing across primary, community and inpatient services.

Figure 1. Six Goals to support Winter Protection Planning.

GOAL	OBJECTIVE
Goal 1: **Co-ordination, planning and support for high risk groups.**	Planning and support to help high risk or vulnerable people and their carers to remain independent at home, preventing the need for urgent care.
Goal 2: **Signposting, information and assistance for all.**	Information, advice or assistance to signpost people who want - or need - urgent support or treatment to the right place, first time.
Goal 3: **Preventing admission of high risk groups.**	Community alternatives to attendance at an Emergency Department and/or admission to acute hospital for people who need urgent care but would benefit from staying at, or as close as possible, to home.
Goal 4: **Rapid response in crisis.**	Optimal hospital based care for people who need short term, or ongoing, assessment/treatment, where beneficial.
Goal 5: **Great hospital care.**	Capacity to ensure effective and timely discharge from hospital, when individual is ready to most appropriate location.

2 Additional Capacity required in Gwent for winter 20/21

2.1 Managing risk during the winter period

COVID-19 has placed additional pressures on the health and social care sector in Gwent and which could likely impinge on the effectiveness of the system during winter.

However, the fragility and pressures within the system must not be under estimated. Regionally there are concerns about the resilience of the health and social care sector locally, to cope with the rising demand and the ongoing impact of COVID on services.

The below section outlines the key concerns from Gwent and provides detail on the mitigating actions implemented. The following section provides detail of the additional capacity required to achieve the actions in practice.

2.1.1 Workforce Resilience

Challenge

The recruitment and retention of domiciliary care workers, with the right skill set, remains the sector's biggest challenge. This is a particular challenge as the C-19 pandemic continues. Gwent Directors agree that the recruitment and retention of domiciliary care workers requires urgent further Gwent-wide co-ordination and action. The current pandemic threatens to further destabilise this sector as carers and services users are vulnerable to C19 infection. This is likely to lead to increased levels of absence amongst staff, sometimes whole runs may be affected.

Mitigation: Creation of real time assessment of capacity across the region. Discussions with commissioners are on-going to establish a weekly Situation Report approach.

Mitigation: Development of a regional approach to recruitment/ training for Gwent whole sector. Scoping agreed as a priority and the rapid development of an MOU to follow.

Mitigation: The development of a Gwent-wide communication and marketing campaign build on the foundations laid with the national 'WeCare Wales' campaign as well local initiatives such as the 'Magic Moments' events. Engage all communication leads to be practice and on message and support the shaping and deliver of a regional communication plan.

2.1.2 Resilience of the Care Home Sector

Challenge

Care Homes have been at the sharp end of the pandemic with some very real and concerning issues that will need to be safely and effectively managed over the winter period. These include maintaining the viability of the sector as bed vacancy rates rise and supporting care homes to safely mitigate and manage infection control and safety.

In line with the recommendations from Prof John Bolton's work in Gwent, to consider the nature of their relationship with their Care Home providers and ensure that future work is carried out in a spirit of true partnership, we have implemented the following activity.

Mitigation: Development in Gwent of Care Homes Action Plan and Care Homes Failure Contingency Plan.

Care Homes Acton Plan sets out our collective action towards managing:

- Infection Prevention and Control
- PPE
- General & Clinical Support
- Residents/Social worker Wellbeing
- Financial and Sector Stability

Care Home Failure contingency plan sets out collective action across 4 escalating tiers:

- Surveillance and risk assessment
- Protective measures
- Critical incident management
- Closure of a home

2.1.3 Access to services

Challenge

Ensuring that during the winter period local residents can access the right service at the right time.

Mitigation: Provision of Information, Advice and Assistance digitally and in our health and care settings.

Mitigation: Funding a range of additional care staff to provide enhanced access to social care services, including: out of hours cover, emergency cover in care homes, community outreach, hospital liaison, brokerage, therapeutic capacity.

Mitigation: The establishment of Urgent Primary Care Centres as an extension of the GP OOH/111 service, providing access to a range of professionals who could meet a wide range of presenting conditions, and secondly be an extension of the capacity for same day appointments in local GP practices. The full provision of care through an Urgent Primary Care Centre requires a wide multidisciplinary team consisting of a GP, Nurse Practitioner, Mental Health practitioner, Physiotherapist and a non-clinical Receptionist. Phase one of the development of UPCC's will be based at the Royal Gwent ELGH to support the area of highest demand. Phase two will see the service expanded to Nevill Hall Hospital.

Mitigation: The use of additional funding to support the implementation of D2RA pathways, enabling enhanced community support for reablement/rehabilitation. This includes step up/down beds, therapeutic capacity, rapid home adaptation and alternative housing options.

2.2 Identifying Gwent Winter Additional Capacity

All partners were asked to undertake a review exercise of the additional capacity required during the winter period and with direct emphasis on managing the challenges outlined above. This was based on data from previous years and was undertaken collaboratively by Heads of Adults Services and Directorate Manager of the Primary and Community Care Division. Third sector and Housing partners were also involved and sighted on the exercise.

The results of this exercise are appended in the attached spreadsheet which:

- Sets out the existing and additional capacity by Goal.
- Sets out the cost of the additional capacity and the funding source.
- Identifies the remaining unfunded amount for consideration by WG.

This exercise identified that additional capacity was required under the three primary headings as detailed below.

Providing additional capacity during winter in Gwent to achieve:

1. Preventing unnecessary admission (Goals 1, 2, 3 & 4)

- Providing additional out of hours capacity
- Extending night service provision across the region
- Paying for additional nursing capacity to support admissions avoidance
- Provide additional support workers to work with CRT to prevent admissions avoidance
- Enhanced capacity to provide community support
- Increased provision for emergency care at home
- Increased capacity for ACP/TEP

2. Supporting timely Discharge (D2RA) (Goals 5 & 6)

- Providing additional hospital liaison support
- Additional step up/step down beds
- Additional support for brokerage to facilitate discharge
- OOH Domiciliary care
- Additional capacity for domiciliary intake team
- Additional MDT capacity including Occupational therapists, Community Pharmacists, therapeutic support
- Care and Repair in Hospitals

3. Care Home Support (Goals 1,2, 3 & 4)

- Liaison nurses
- 121 capacity for Care Homes
- Greater in reach support
- Additional capacity for ACP/TEP

4. Additional Equipment (Goals 1 & 3)

- Emergency vehicles for adverse weather conditions
- Increased capacity for Housing Adaptations
- Increased capacity for GWICES
- Additional Telecare
- Purchasing of emergency housing solutions
- Rapid provision of stair lifts to support discharge

3 Delivering Services in Gwent –The Current Picture

3.1 Social Care

The social care sector across Gwent has worked well to provide regional support to those in need of care and support in the community or in residential settings. There is recognition of the value of regional collaborative working – the Home First approach being an important focus for this, and other initiatives – such as collaboration on attracting and recruiting direct care staff – are being actively developed.

The COVID pandemic has placed new demands on a sector still recovering from the impact of significant and ongoing budget cuts over recent years. There is a need for specific and ring-fenced funding for social care, to provide additional and sustainable capacity going forward. The plan highlights prevailing concerns around the resilience of the workforce, capacity assessment, ongoing management of complex needs and admission avoidance. The additional capacity outlined in this plan is a vital contribution to the Gwent whole systems approach and will enable social care to provide valuable enhancement to community services, to reduce hospital admission and support timely discharge.

Across all five local authorities, there remains a strong emphasis on promoting wellbeing and independence, adopting the 'what matters to you approach' and co-producing with carers and service users the right package of care for them. Providing support to stay safely at home, which promotes wellbeing and independence and avoids the need for hospital admission remains the priority. A range of innovative measures are in place and have been scaled up or refocused to support the response to COVID, these include transformation and ICF funded initiatives such as Home First and IAA services.

In Gwent we have benefited from the expertise and input of Prof. John Bolton and have developed a Gwent Care Homes Action Plan and Failure support plan, which provides a framework for the ongoing management, improvement and support for this vital sector. However, increasing demands on community services are escalating, not least due to suspension and reduction of some service availability due to resource allocation to addressing the Covid-19 pandemic. This has 'build up' some demand, which always rises in the winter period, with services seeing a steady increase in the need for care and support and requiring a more rapid and integrated response to escalation of need and avoid hospital admission both in relation to community referrals and those being discharged from hospital.

As such there remain concerns about the capacity and resilience of the social care workforce and additional funding is sought to ensure capacity to provide care, undertake assessment and delivery therapeutic services in the community to prevent the need for hospital admission.

3.2 Aneurin Bevan University Health Board

The Health Board's continued focus and approach is to ensure robust measures are in place to optimise patient flow across the Health and Social Care System by managing the whole system flow; optimising capacity within community health and social care teams, reduce demand into secondary care, reduce unnecessary delays within the primary community and acute system and facilitating discharges effectively.

Ensuring that essential services are maintained and that routine care is undertaken where safe and practical remains the priority and relevant activity from ABUHB Q3/Q4 submission to Welsh Government is included in the appended activity tables. Ministerial approval for the early opening of the Grange University Hospital in November has provided a major new element to operational planning assumptions and processes, with implementation and commissioning now forming one of the key work streams during the third quarter of 2020/21.

The Health Board has adopted a three phase approach to its planning through the year.

Figure 2. ABUBH COVID-19 phased response plan.

Phase 1: Immediate Response the Health Board	Phase 2: Adapt and Sustain the Health Board	Phase 3: COVID 19 & Winter
Redirected staff and capacity to meet the demands of COVID 19. Created pathways and streaming for the management of COVID patients. Implemented the All Wales Framework to release workforce and physical capacity. Maintained essential services across the spectrum of primary, community and hospital services. Carefully reviewed its responses to ensure it was effective, timely and proportional	Refined existing pathways and streaming for the management of COVID patients, based on additional data and operational experience. Continued to maintain essential services across primary, community and hospital services. Re-established a range of routine activity, consistent with clinical triage and comprehensive risk assessment. Carefully reviewed its responses to ensure it was effective, timely and proportional. Undertook a series of 'lessons learned' exercises to support and inform advance plans in anticipation of a second wave of COVID infection, most notably in respect of a comprehensive Health Board bed capacity / surge plan.	Ensuring that it has the capacity to respond to COVID, consistent with the modelling scenarios set out by Welsh Government. Ensuring that it has the capacity to maintain essential non-COVID services and meet the demands of winter pressures. Commissioning and opening the new 470 bed Grange University Hospital, together with the reconfiguration of services in the remaining local general hospitals.

3.3 Gwent Third sector

Gwent Association of Voluntary Organisations (GAVO) and Torfaen Voluntary Alliance (TVA) provide third sector representation to the RPB. Both organisations have been consulted on the development of the plan and have made contributions. Whilst recognising that it third sector partners see value in a specific third sector winter grant funding award, within the current parameters they are a valued partner in the development and provision of community services.

The COVID pandemic has reinforced the critical role played by the third sector in delivering services in partnership with and on behalf of statutory partners. A range of Information, Advice and Assistance services are provided by the third sector in Gwent, alongside advocacy programmes and an emerging emphasis on promoting mental health and wellbeing and the joint pan third sector engagement work funded through the transformation programme.

Both GAVO and TVA provide an important community lifeline, which will be critical over the winter period supporting vulnerable families and services users to stay connected. They provide daily updates via networks and social media to third sector, community and statutory partners – Updates locally, regionally and nationally are shared on emerging COVID-19 health and related issues. Services offered, include information on volunteering, funding streams and grants.

Officers attend local and Gwent wide partnership/operational groups to input on behalf of the wider third sector in Gwent and take messages back to the third sector. Close links are maintained with Health, Local Authority and other government bodies such as the DWP for information sharing and problem solving.

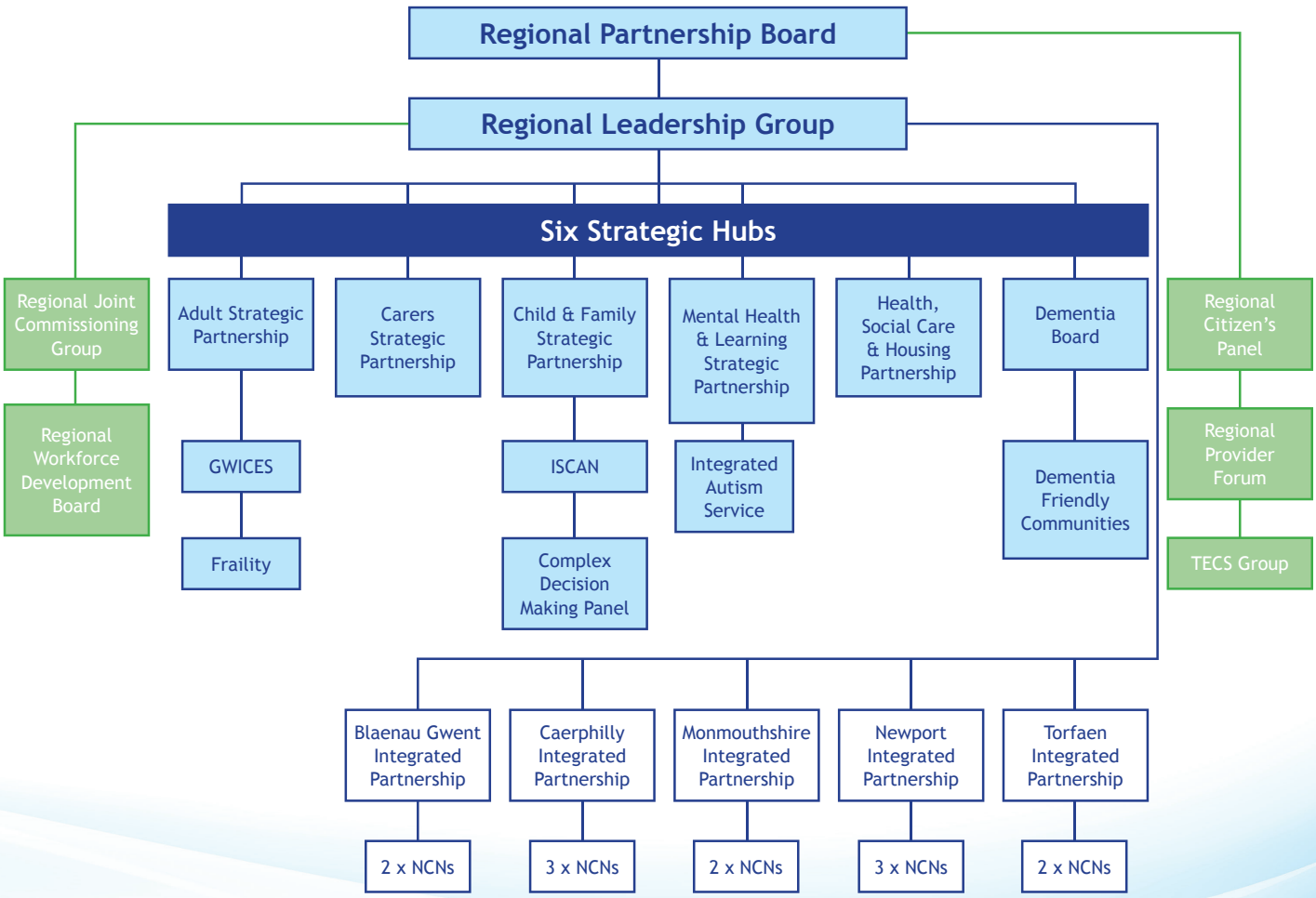
4 Governance & Assurance

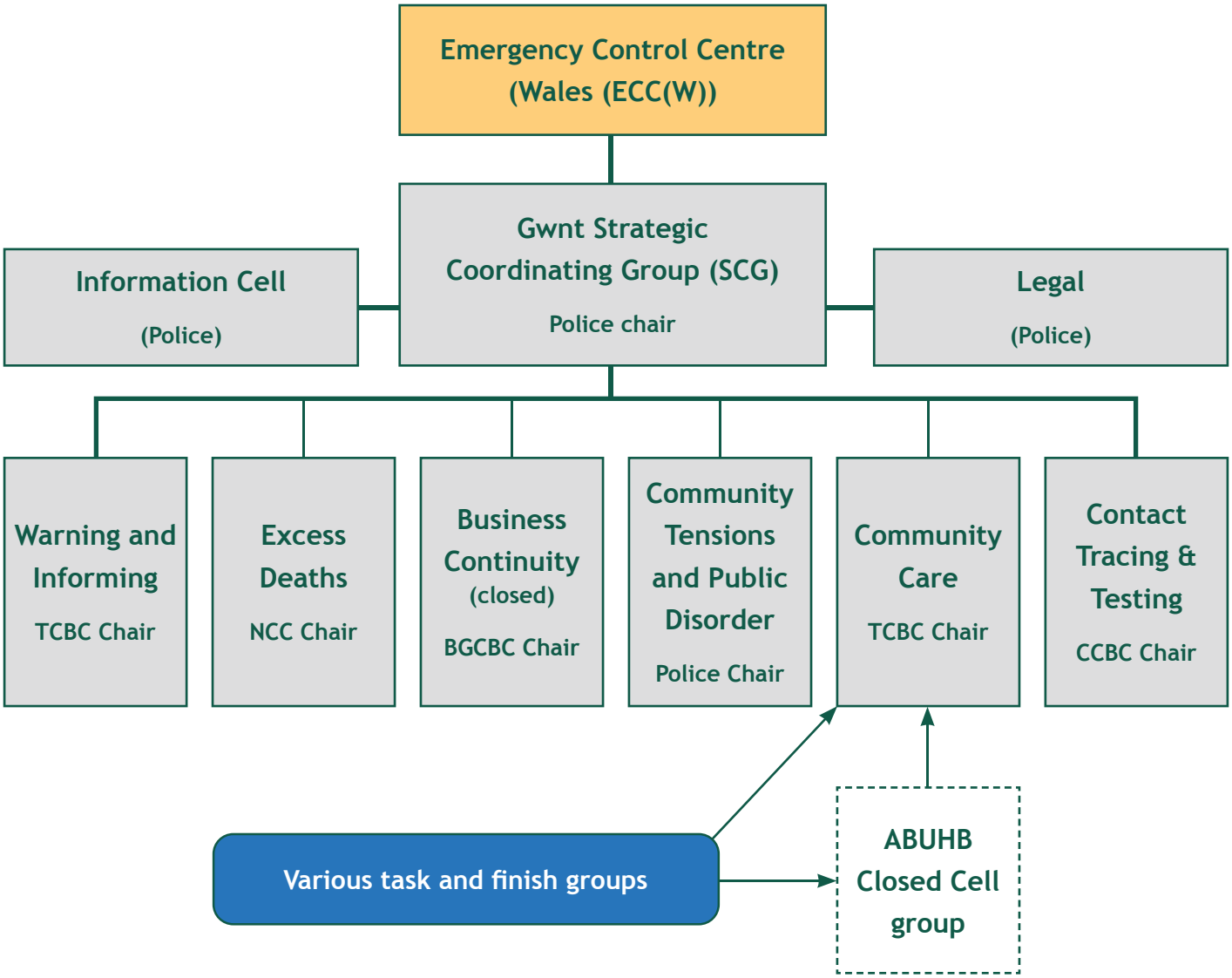
The Regional Partnership Board have oversight of the plan in its entirety and will receive strategic updates at each RPB meeting throughout the winter period. This plan is an integral contribution to the wider strategic agenda of the RPB, to advance a model of place based care through the development of new integrated service models.

Governance will be provided through the Leadership Group of the RPB, which is comprised of Health Board Executives and Directors of Social Services alongside other statutory partners. The group meets on a six weekly basis and the plan will be reviewed and monitored. Any risk mitigation or operational matters will be reviewed in the Gwent Adults Strategic Partnership Board (GASP) which meets on a monthly basis.

Subject to the agreement of the RPB and available capacity, a 'systems impact' approach will be developed to establish performance and impact.

Figure 3. Gwent RPB Governance structure/Emergency Planning Structure.




Emergency Control Centre (Wales (ECC(W))
Gwnt Strategic Coordinating Group (SCG)
Police chair
Information Cell
(Police)
Legal
(Police)
Warning and Informing
TCBC Chair
Excess Deaths
NCC Chair
Business Continuity
(closed)
BGCBC Chair
Community Tensions and Public Disorder
Police Chair
Community Care
TCBC Chair
Contact Tracing & Testing
CCBC Chair
Various task and finish groups
ABUHB Closed Cell group

5 Gwent 'whole system' Winter Protection Activity

This plan is a testament to the growing maturity of relationships across partners and the embedding role of the Regional Partnership Board as the leadership body for Health and Social Care. The activity has not been developed in isolation, but equates to much innovative work, funded through transformation and ICF, and embodies our commitment in Gwent to achieving a model of 'Place Based Care'

This section of the plan provides the detail of the totality of activity that will be delivered during the winter period, by all partners to meet demand and provide safe quality and accessible services.

A statement of activity is provided under each of the goals, and attached as a spreadsheet at Annexe A, with required financial detail.

In addition to the required winter capacity, this year the safe and effective roll out of mass vaccinations will be absolutely fundamental in supporting people to stay well at home. The detail of the Gwent Vaccination programme is provided below o underline the importance of a partnership approach this year.

5.1 Protecting our citizens -Gwent Vaccination programme

5.1.1 Primary Care Flu Vaccination Delivery Plan

- Primary Care will lead the delivery of the ABUHB influenza vaccination programme through their usual delivery routes for 2 and 3 year olds, people under 65years old in a clinical risk group and those who are 65 years and over. GP practices have been instructed to prioritise the vaccinations of housebound (through District Nursing Teams) and shielded patients, and care home residents when vaccine is delivered.
- Additional cohorts (household contacts of shielded patients and those in the 50—65 year old cohort not otherwise eligible) have become eligible for a vaccine this flu season but all practices are required to offer vaccinations to those who are usually eligible first, before additional cohorts are invited. This is to ensure that the most vulnerable patients are protected first. As well as ensuring eligible patient cohort groups are vaccinated, targeted work to ensure maximum uptake of the flu vaccine amongst frontline health and social care staff is underway.
- NCN leads and practices will work together, to undertake robust joint planning for mass vaccination clinics as required; to address any anticipated surplus demand that they cannot meet alone.
- The Public Health Wales annual Beat Flu campaign will take place again this year, and the ABUHB communications plan will be aligned with the national campaign. The ABUHB team will ensure that all key messages are cascaded using well established communication channels, such as social media (ABUHB and partner organisation and community group channels) and internal and external websites and through community networks via ABUHB integrated Wellbeing Network.

Community Pharmacy

Community pharmacies will also support the immunisation of those adults eligible to receive the vaccine although the delivery may be more constrained this year because of the impact of social distancing requirements.

So far, the Health Board has commissioned the service with 78 community pharmacies, for delivery to eligible groups including care home and domiciliary staff.

Prison Health

As identified in this year's CMO National Influenza Immunisation Programme statement we will be offering the influenza vaccine to all prisoners at HMP Usk and HMP Prescoed as availability allows.

We will commence with those over 65 and those eligible under 65 in clinical risk groups. It will then be offered to those over 50, and finally men in the under 50 age group across both prison sites.

Staff

- The Welsh Government flu vaccine uptake targets for front line health care workers in 2020/21 has been set at 75%. ABUHB has set this target organisationally and divisionally for all staff.

- A work plan and project plan have been developed, based on the multi-component approach recommended by NICE (2018).

  The Health Board will be adopting a full participation vaccination strategy, in which the organisational expectation is that all staff irrespective of patient contact should be vaccinated.

- Staff working in areas with high risk patients will be offered the vaccination as a priority when the vaccine arrives in the Health Board.

School Nursing

- Planning for the Health Board schools immunisation programme is well underway and a local working group has been meeting to ensure collaboration and co-ordination of work between the immunisation team, pharmacy, transport (including stores and waste management) and the child health department.

- This programme will be delivered 28th September and 14th December for school immunisation sessions.

5.1.2 Social Care

- Regional Partnership teams and Complex care colleagues are regularly sharing regular communications with social care providers. These include sharing of resources (e.g. letters for staff to take to pharmacies as proof of their eligibility for a free vaccine), encouraging the uptake of the Flu One online learning module and sharing of key messages about the importance of getting vaccinated.
- Pharmacies have been encouraged to proactively work with providers they have established relationships with to encourage staff to get vaccinated.
- Enhanced communications have been issued to pharmacies across Gwent from our ABUHB pharmacy team to remind of the eligibility of social care staff and letters that provide proof of this will be used.
- A guide for care homes during the 'flu campaign will be issued from the national VPDP 'flu team to all care homes- this is currently being updated nationally.
- Work is ongoing locally to ensure that proactive/reactive targeted communications can be issued in response to any feedback via the ABUHB community flu group or from other sources such as social media channels.

5.1.3 COVID-19 Mass Vaccination

A Mass Vaccination Programme has been established to provide leadership and senior decision making to drive, design and delivery of vaccination programme from August-Spring 2021. When a safe and effective vaccine against COVID-19 is available it is essential that it is delivered quickly to those that need it. Vaccinating people against the SARS-CoV-2 virus is key to reducing the severe morbidity and mortality is causes and providing a long term solution to controlling the current COVID-19 pandemic.

A plan is being developed and leads identified to progress key components of the plan. This includes identification of venues; recruitment of immunisers; end-to-end process for booking, administration, recording and reporting of results; supply of vaccines; resolving any contractual issues in primary care; and implementing a communication plan.

Vaccinations will initially be provided on a health need basis in line with vaccination available. To maximise employee well-being and reduce the adverse impact of COVID-19 to Gwent Health and Social Care colleagues by providing vaccination to the community in the quickest time that is possible, safely.

5.2 Activity to support the Six Goals

Goal 1: Co-ordination, planning and support for high risk groups

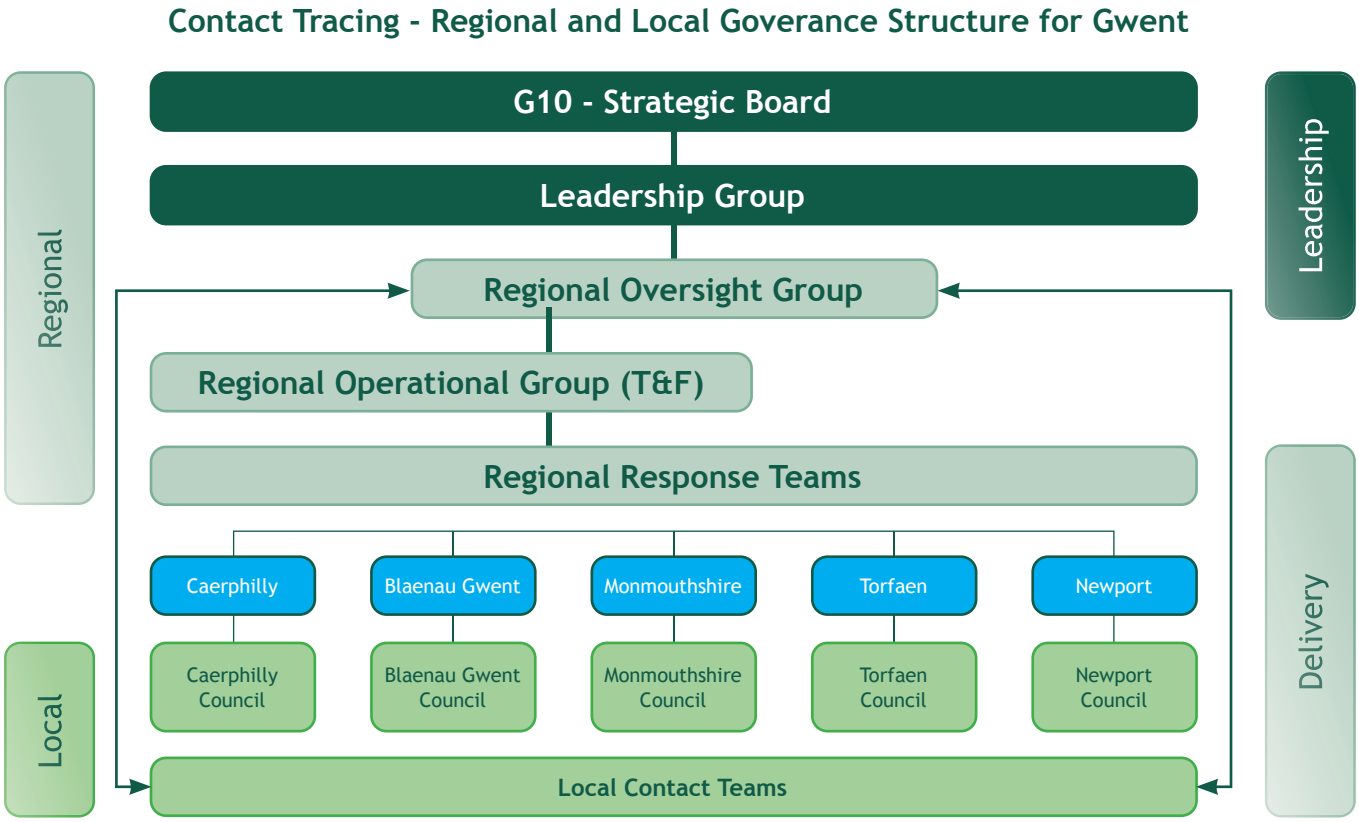
A range of coordinated activity has been planned to ensure that there remains over the winter period, responsive and accessible support for high risk groups in our communities. Core to this is the Gwent Prevention and Response Plan, Its' aim to prevent, detect and manage outbreaks of COVID-19 and to implement effective health protection and control measures across Gwent to reduce the risk of transmission of COVID-19 in our communities.

It is based on the following principles:

- The primary responsibility is to make the public safe.
- Build on public health expertise and use a systems approach.
- Be open with data and insight so everyone can protect themselves and others.
- Build consensus between decision-makers to secure trust, confidence and consent.
- Follow well-established communicable disease control and emergency management principles.
- Consider equality, economic, social and health-related impacts of decisions.

Of primary significance over winter will be the delivery of the Gwent Vaccination programme as set out above and The Test, Trace Protect (TTP) service which was an additional priority for the Health Board in response to the pandemic and a further governance structure was developed and implemented to enable concise reporting across all 5 boroughs in Gwent. An update on TTP is provided at each Tactical Group meeting where risks are escalated and updates provided. Information from Tactical is shared as appropriate with the Strategic Group and the Local Resilience Forum (LRF) Group.

Figure 4. The Gwent TTP structure.



Wider services includes the 'Care Closer to Home' agenda, and in alignment with the agreement in Gwent to create 'place based care', where services work collaboratively to provide a range of multi-agency/multi-disciplinary services in the home and community. These services are primarily aimed at people with an identified care and support need, those with ongoing chronic conditions and support to improve and maintain mental wellbeing in the community and at home.

Planning and support to help high risk or vulnerable people and their carers to remain independent at home, preventing the need for urgent care.

In Gwent we will:

- Provide improved access to Primary Care Services including through increased Out of Hours capacity, new Out of Hours Pathways and Urgent Primary Care Centres.
- Create specific support for those in the community most at risk by developing support clusters and the safety netting of those at risk (shielding and vulnerable). Arrangements will be delivered on an NCN footprint.
- Develop and implement an action plan for the delivery of COVID-19/Influenza vaccinations.
- Identify of pathways to support patients to stay well in the community including Dental, Respiratory and Palliative.
- Use available funding to provide additional social work and therapeutic staff in the community in our Right sizing teams.
- Enhancing access to therapeutic activity across the community to improve mental wellbeing including the roll out of the Mental Health Foundation Phase in partnership with our Integrated Wellbeing Networks.
- Implementation of Combined Clinical Community Teams (CCCT) in each area.
- Enhanced support to Care Homes through additional staff capacity, roll out of enhanced services, infection control, business planning (Please see Care Homes Action Plan).

Goal 2: Signposting, Information and Assistance

Providing easily accessible information to all citizens, will be absolutely critical during this winter period. Service users, carers and family members involved in managing care and support want to know what is available and how they can get access. They want it in a quick, simple and non-stigmatising manner. This is why in Gwent we have invested heavily in the roll out of DEWIS as the primary platform for accessing IAA. In Blaenau Gwent Transformation funding has paid for the piloting of a 'Single Point of Access' for IAA, with impressive results and testimonies.

This winter effective IAA will be more important than ever before. A range of approaches will be operational, with a strong emphasis on support for those with concerns about their mental wellbeing.

Information, advice or assistance to signpost people who want - or need - urgent support or treatment to the right place first time

We will:

- Continue roll out of Gwent Integrated Wellbeing Networks, with enhanced emphasis on the Community Champions
- Implement an Enhanced Foundation Tier for Mental Wellbeing in Gwent which increases accessibility to, availability and awareness of, appropriate, consistent up to date and evidence based self-help resources and messages
- Enhance access to digital technology for service users with MH/LD needs
- Provide a range of services in partnership with third sector, including Advocacy schemes and networks like the Community Halls Forum.
- Provide IAA in Care Homes to residents and families to improve wellbeing
- Continued roll out of DEWIS & Phone First

Goal 3: Preventing Admission of High Risk Groups

Preventing hospital admission, is one of the primary objectives of this plan and the activity outlined builds on the considerable activity underway as part of our Care Closer to Home Agenda. The transformation programme has provided additional capacity and trialled new approaches with Integrated Wellbeing Networks and Place Based Care, focused on early intervention and prevention of hospital admission.

Protection and support for residents in care homes to avoid hospital admission over the winter is of course an absolute priority. Activity for this cohort is set out separately to delineate the extent of work underway to support both the sector and residents over the winter period.

Community alternatives to attendance at an Emergency Department and/ or admission to acute hospital for people who need urgent care, but would benefit from staying at, or as close to home as possible.

Building on these approaches and principles we will use funding to create additional capacity to:

- Support practices to ensure that triage processes and mechanisms are in place consistently within primary care, in line with access standards
- Increase capacity to provide Emergency Care at Home
- Increase outreach capacity as part of Right sizing community teams
- Increase therapeutic staff capacity to support step up- step down services
- Increase community based social work provision and weekend capacity
- Expansion of CRT emergency home care team to support Domiciliary care over winter period

- Open urgent primary care Centre's in Newport and Nevill Hall
- Provide additional Capacity for Housing adaptation to facilitate discharge
- Extension of Primary Care ACP pilot to help increase coverage of ACPs / RBIDs for patients in care homes and with 3 or more chronic conditions as a priority
- Introduce a Frailty Advice Line
- Implement defined OOH Pathways (see also Goal 1)
- Continued implementation of dental and optometry recovery plans to provide greater access

5.2.1 Supporting Care Homes in Gwent

In order to prepare to provide support to Care Homes during the COVID-19 period the Health Board and Regional Partnership Board partners, along with Care Home operators have developed an action plan for supporting Care Homes and this has been agreed by the Regional Partnership Board and the Community Care Sub Group (CCSG). The RPB are in the latter stages of finalising a Memorandum of Understanding (MoU) that sets the direction for the future partnership working with the sector. Joint actions are identified to protect care homes from further infection outbreaks and to effectively manage and minimize further infection where this does occur and a plan has been develop to support Care Homes likely to face failure.

The Health and Care partnership is supporting each Care Home to have their own individually tailored business continuity plan. Regular situation reporting is underway and care Home matrix logs are being maintained. There is a monitoring tool in place to track and identify capacity in care homes for step down beds. During the first wave planned contingency measures that were not required, such as bring back a mothballed care home into use, are scoped and available for a second wave if required.

Digital solutions have also been used to maintain communication whilst minimising face to face contacts. This includes the use of video conferencing, telephone support and the introduction of attend anywhere for virtual GP consultations. Two Practices are also participating in the Care Home Connect pilot to improve communication between practices and care home providers.

In order to support the sector the Gwent Community Service sub group has established a multi-agency closed setting sub group which includes relevant professionals from the Health Board, Local Authority Social Services, Public Health Wales, and Local EHO staff.

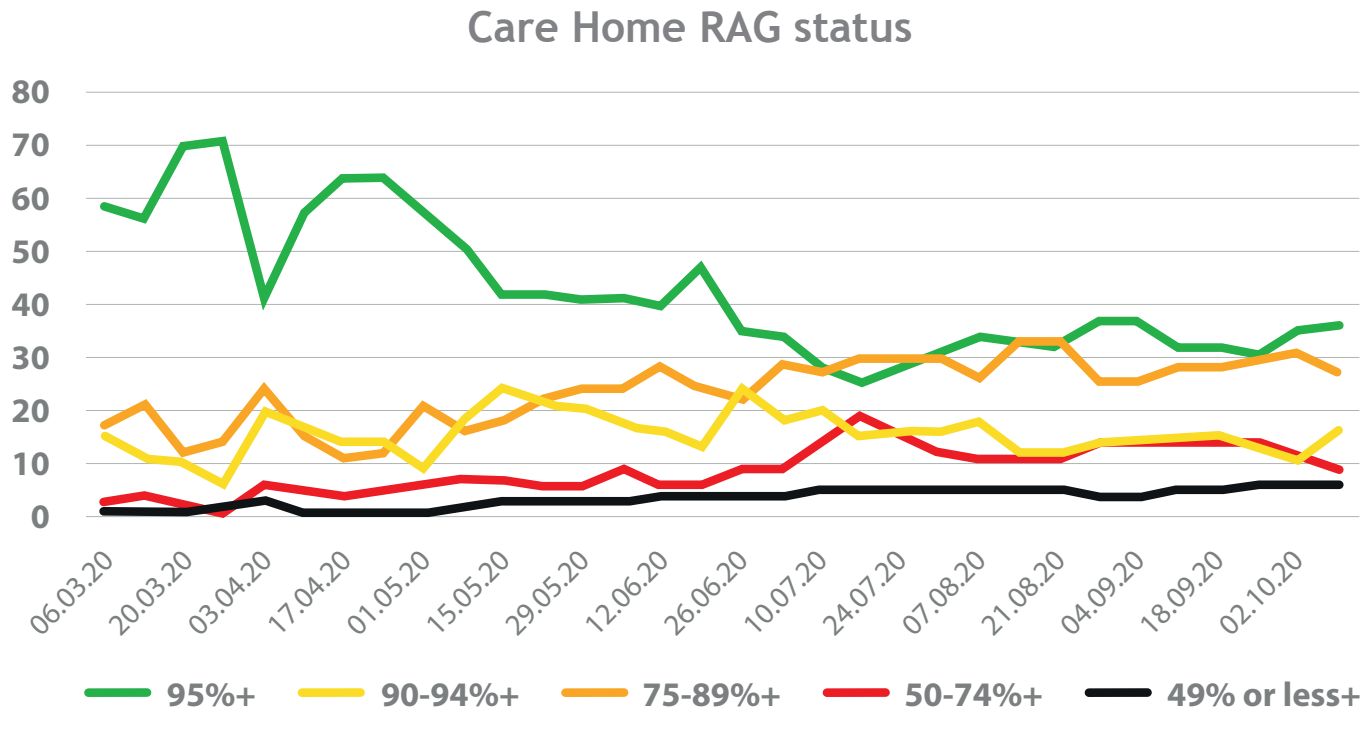
During the winter period we will ensure:

- Improved responsiveness and consistency of the routine testing programme and the management of results.
- Provision of educational resources and Infection Prevention and Control advice, to include a webinar and further planned training and visits to homes
- Ongoing support for enhanced Care Home testing from partners, including strengthening the flow from Care Homes into the Rodney parade testing centre for incident management.

- Establishing a Nurse led model to provide the Care Home DES in Caerphilly
- Development of a Community Hospital Care Home Pathway
- Delivery of the Flu and COVID-19 immunisation programmes
- Supporting Care home visiting to minimise infection spread whilst acknowledging the needs of end of life and dementia patients
- Working closely with providers around operational issues by establishing Care Home co-ordination groups at borough level
- Ensuring full engagement with incident response groups with PHW for transmissions within any closed setting

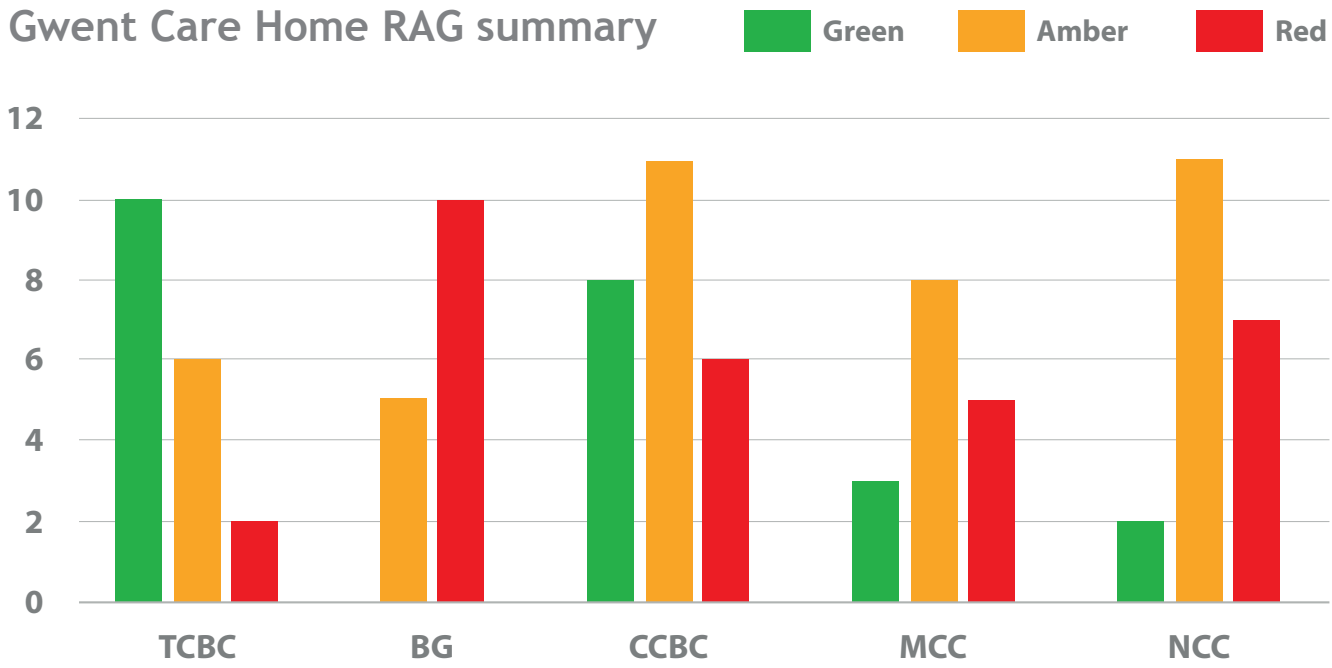
Vacancy tracker and financial risk assessment: A weekly regional care home vacancy tracker has been in place since March 2020. This tracker has shown a steady increase in care home vacancies across the region. The current vacancy level has seemed to have levelled off and stands at almost double the level of vacancies present in care homes prior to the pandemic. The concomitant of high vacancy levels is the increased risk of financial collapse. The summary graph at below to illustrate homes potentially in danger of financial difficulties without Government hardship funding.

Figure 5. Care home vacancy ratings from 6th March 2020 until 9th October 2020.



RAG rating of all Homes: The care homes in the region have been further stratified to create RAG rating for all care homes across the region. This takes into consideration vacancies levels, associated financial risk profiles, incidences of escalating concerns in the preceding 12 months, outbreaks of C19 and current quarantine status. This intelligence provides a snapshot of homes that may be used if additional placements are needed urgently.

Figure 6. Reflects all data across Gwent based on the number of care homes in each Locality, categorised based on their position within a RAG status.



Expression of Interest: In readiness for a potential surge of required bed capacity an Expression of Interest was undertaken in September 2020. Six homes responded and beds in these homes are now available should they be needed. In a separate exercise a 'mothballed' care home has been identified which could be brought back into service if required relatively quickly (1 week).

Goal 4: Rapid Response in Crisis

Across Gwent, activity will be prioritised to provide coordinated and rapid services for those people in crisis, including those with Mental Health Needs. We will expand access to primary care, through extension of Out of Hours provision, the creation of a model of 'urgent care centres'. We will introduce more streamlined single points of access to the system, and streamlined approaches to coordinate access.

The fastest and best response at times of crisis for people who are in imminent danger of loss of life; are seriously ill or injured; or in mental health crisis.

- Establish Urgent Primary Care Service in-hours as a pacesetter in line with the Clinical Futures Model
- Work is ongoing with the Falls Response Team
- Reconfiguration of ABUHB urgent care system: Aneurin Bevan University Health Board Clinical Review Hub (Phone First) establishing 111 as the first point of contact / entry into urgent care, other than via a 999 emergency call
- Reconfiguration of ABUHB urgent care system: Implementation of ABUHB Flow Centre which will create a single point of contact to co-ordinate all urgent same day access to secondary care services
- Improving crisis services for mental health by changing 'out of hours' crisis assessment provision, and commissioning of a Support House

5.2.2 Urgent Primary Care

We will adopt an urgent care model for primary care to simplify system navigation and enable needs to be met in a timely patient focussed way. It is intended this model will help to better meet the demand for urgent care services over the winter period and which primarily can be met by Primary Care services both in and out of hours. The model will also be multi NCN based and where possible involve the linking of local patients to local services.

The aim of the model is to provide same day/next day booked slots for urgent primary care which provides care closer to home, avoids hand offs and multiple entry points, and if it is linked to 111/ Phone First will provide the right portal for a large cohort of patients. Its intention is to replace the need to attend ED/MIU/MAU services.

The establishment of Urgent Primary Care Centres as part of the clinical futures model, will firstly be an extension of the GP OOH/111 service providing access to a range of professionals who could meet a wide range of presenting conditions, and secondly be an extension of the capacity for same day appointments in local GP practices.

Goal 5: Great Hospital Care

Essential services have been maintained throughout the pandemic delivering care to the population. During the winter activity is planned for the safe continuation and development of essential services as set out by Welsh Government.

The early opening of the Grange University Hospital is a core element of meeting the challenges of COVID 19 and Winter Response. The assumptions that underpin the Health Board's winter bed surge capacity are based on well-established patterns of activity over previous winters, however it is likely that up to 50% of patients presenting with respiratory problems will have COVID-19 symptoms and accordingly the winter bed capacity reflects this.

As such the hospital will open up an additional 470 bed capacity for Gwent's more seriously ill and injured patients. The hospital will have a purpose built critical care department with 30 individual rooms. In order to surge these rooms could be easily doubled up and further ICU surge would see it expanding across the second floor to be able to cater for over 100 patients requiring intensive levels of care. The supply of oxygen in the hospital is one of the largest in the UK and its 75% single rooms will help prevent the spread of infection, including COVID-19.

The Health Board has adopted two scenarios to support planning. A More Likely Scenario, built on experience of the first wave of the pandemic and the Swansea University Reasonable Worst Case Scenario Planning provided by Welsh Government. Secondly a Reasonable Worst Case Scenario to provide capacity as set out in the recommendation from Welsh Government in June. The Grange University Hospital provides a core element of the Health Boards response to these demands.

The Health Board will adopt the same triggers and phasing approach through-out quarter 3 and 4, however the early opening of the GUH affords a number of opportunities to secure the necessary capacity to meet the needs both of the Most Likely Scenario and Worst Case Scenario, whilst maintaining as much elective activity as possible. The new hospital provides 470 additional beds into the system, the Clinical Futures model identified a bed reduction of 95 Beds across the System. By deferring this reduction additional bed capacity can be provided across the system.

Figure 7. ABUHB Phase 3 (COVID, Winter and the Opening of the Grange).

No.	Objective
1	To balance demand and bed capacity for COVID, non-COVID winter pressures and essential services optimising the benefits of the opening of GUH on system capacity and flows. Where feasible to re-establish routine inpatient and daycase services safely during Q3 and Q4.
2	To sustain essential outpatient services optimising capacity through innovation, technology and patient directed care. To safely re-establish routine outpatients and maintain these wherever possible during Q3 and Q4.
3	To sustain essential diagnostic services optimising the benefits of the opening of the GUH on system capacity and flows. Where possible to safely re-establish routine diagnostics and maintain these wherever possible during Q3 and Q4.
4	To sustain essential surgery and urgent treatments. To prioritise these as appropriate against routine and elective capacity if this is constrained by COVID & winter pressures.

Optimal hospital based care for people who need short term, or ongoing assessment/treatment for as long as it adds benefit.

We will deliver:

- The early opening of the Grange University Hospital is part of our Covid Winter Response. The GUH provides 470 additional beds into the system
- Reconfiguration of Local General Hospitals in tandem with opening of GUH
- Provide in hospital third sector services to maintain and improve wellbeing
- Implement central point of access for the hospital palliative care team
- Enhanced Support for patients in inpatient MH services (Rainbow packs) additional equipment and technology to support therapeutic activity across all inpatient settings, increased access to art and therapeutic services

5.2.3 Service specific priority actions

Stroke: Inpatient stroke services have been maintained during COVID-19, with access to HASU and all urgent investigations. Pathway to rehabilitation has also been maintained across the period with beds available at St Wollos, Ysbyby Ystrad Fawr and Nevill Hall hospitals.

TIA services will continue to be held virtually by telephone to screen for urgent patients and patients who require a face to face appointment will be offered this. Spasticity injection clinics are currently on hold and plans are being progressed to reinstate these in Q3.

Respiratory: Rapid access clinics remain in place for urgent suspected cancer. Sub speciality clinics for ILD, Asthma and Sleep will continue into Q3&4. The home oxygen service will continue with telephone contact for all patients, and face to face home appointments with urgent patients when required. TB clinics have been reinstated and will continue into Q3&4. In Q3 COPD patients will be able to access virtual pulmonary rehab and telephone contact. A COPD phone application has been set up to collate data to identify patients with worsening symptoms.

Cancer: The delivery of cancer services continues to be affected by the necessary infection control measures which are reducing throughput in outpatient, diagnostic and treatment services by up to 50%. This is currently being managed by hosting additional clinics and waiting list initiatives however the impact of reduced capacity is showing through longer wait times for patients.

Priority actions for the winter period include:

- Maintain and increase current capacity in order to accommodate increased demand
- Reduce and maintain length of wait to first appointment within 14 days
- Maintain the utilisation and efficiency of the St Joseph's green zone.
- Maintain patient engagement with the pathway throughout any potential second wave.
- Implement health board wide electronic health needs assessments for cancer patients

Palliative Care: 'Attend Anywhere' has been introduced for Specialist Palliative Care Services and for hospital and community teams and digital dictation is being implemented by the Specialist Palliative Care Hospital Team. Advance Care Plan (ACP) and Record of Best Interest Decision (RBID) e-documentation templates have been introduced on Clinical Workstation (CWS) and processes have been developed for fast track testing for patients going to care homes or to their own homes with packages of care. COVID Palliative Care / End of life Care (EOLC) intranet pages have been launched to easy access to information regarding the management of palliative and end of life patients.

Sustainability of service provision for Hospital Palliative Care Team and hospice support in response to the increased demand for these services during lockdown has been monitored and the associated risks managed by the Health Board.

Priority actions for the winter period include:

- Developing a Business Case for funding for Advance Nurse Practitioner (ANP) roles to support an ANP 'Front Door' model, supporting GUH in line with the Specialist Palliative Care (SPC) Service Model.
- Developing a Business Case for consideration of funding for 'funded at risk' SPC consultant post via HB processes.
- Progressing with shared care model for implementation of the designated SPC beds in collaboration with respiratory.
- Work in collaboration with Cancer Services in relation to SPC and the development of the Cancer Day Hospital in NHH (diagnosis to palliative stage).
- Bereavement input/advice for the development of an care after death model to inform future service provision for the existing Bereavement Service.
- Develop pathway in collaboration with Frailty for palliative access to Therapeutic Day Services.
- Develop SOP for remote prescribing (inclusive of opioids) to support Out of hours medical cover for St David's Inpatient Hospice in collaboration with pharmacy.
- Re-launch and education and training for the Care Decision Tool.
- Progress with roles to support extension of Primary Care ACP pilot for ACPs / RBIDs for patients in care homes and with 3 or more chronic conditions as a priority.
- Roll out of amended Treatment Escalation Plans (extending use post covid-19) across ABUHB Secondary Care.

Goal 6. Home First when Ready

Significant activity is proposed to provide enhanced capacity over winter, to ensure we are able to operate an effective and integrated approach to 'home from hospital' services linked to the delivery of the four D2RA pathways.

The plan places a clear emphasis on scaling up D2RA capability across the region to protect the flow of patients able to be discharged from hospital for assessment and recovery. It build on the developing work within the WG national community of practice led by the NHS Delivery Unit and the Right Sizing in the Community approach, led by Prof. John Bolton and IPC. Additional funds were allocated to Gwent totalling £1.8 million to support the enhancements of the D2RA pathways.

The Regional Partnership Board have endorsed an approach that sees the utilisation of all available funding sources to provide a coherent and integrated Gwent wide approach to enhancing available capacity.

Funding sources include:

- D2RA
- Discharge flow funding
- Home First (Transformation)
- ICF Slippage from

A home from hospital when ready approach, with proactive support to reduce chance of readmission.

We will:

- Fund additional DLN support at the weekend at RGH/NHH to support Discharge
- Funds HCSW in Right sizing community teams
- Provide funding for the scaling up of HomeFirst to the Grange University Hospital
- Provide 1:1 support in Care Homes and purchase additional step up/step down capacity
- Fund additional equipment for GWICES
- Increase emergency care at home
- Provide additional therapeutic staff in step up/step down facilities
- Provide additional capacity for community social care

Given the significantly changed context of COVID-19 HomeFirst has proved its value, resilience and ability to create a seamless approach to patients and families to prevent unnecessary admission and facilitate appropriate care in the community. It embodies the principles of the D2RA pathways and embeds the value of IAA at the front door.

Annexe	Gwent integrated winter protection plan 2020-21 **Planned winter protection activity**

Key for 4 Harms	
A.	Harm from COVID-19 itself
B.	Harm from the overwhelmed NHS and Social Care System
C.	Harm from a reduction in non-Covid-19 delivery
D.	Harm from wider societal lockdown

Outcomes	
1.	Improved Patient Experience
2.	Accessible support to improve wellbeing in community and Reduce Admission Likelihood (RAL)
3.	Safe management of patients within the community
4.	Maintenance of flow and timely MDT intervention
5.	Improved MA intervention to support discharge

Goal 1: Co-ordination, Planning and support for high risk groups

OBJECTIVE: Planning and support to help high risk or vulnerable people and their carers to remain independent at home, preventing the need for urgent care.

Priority 2020/21	Activity	Measurement	Lead	Impact on Four Harms	A	B	C	D
Specific support for those in the community most at risk	Plans developed to support clusters in the safety netting of those at risk (shielding and vulnerable) and people who are symptomatic or have tested positive to COVID-19. Arrangements confirmed for each NCN area.	Q3 Q4	IWN NCN ISPB PCC	RAL Safe management of patients within the community	✔	✔	✔	✔
Develop and implement an action plan for the delivery of COVID-19 / Influenza vaccinations	This will be undertaken as a priority for all Primary Care & Community Services Division and include vulnerable groups not previously in scope. Primarily in GP surgeries but also with help of mass vaccination centres.	Q3 Q4	ABUHB PHT PCC	Safe management of patients within the community	✔	✔	✔	✔
Identification of pathways to support patients to stay well in the community	Implement a defined Out-of-Hours Respiratory Pathway. There is currently no defined out of hours respiratory pathway, clinicians manage respiratory cases on case by case basis, where appropriate managing the patient within the community. Meetings scheduled with Frailty and Respiratory Teams to understand feasibility. Implement a defined Out-of-Hours Palliative Care Pathway. Scope the possibility of implementing a palliative care nurse within the hub at Aneurin Bevan. Palliative care nurse to undertake remote consultations with patients in addition to appropriate home visits. Implement a defined Out-of-Hours Dental Pathway. Work commenced to determine best ways forward for a South East Wales out of hours dental service and to determine where there this is a sustainable mode.	Q3 Q4	PCC	Reduced hospital admission Safe management of patients within the community	✔	✔	✔	✔
Implement Discharge to Recover and Assess (D2RA) pathways consistently across all 5 regions within Gwent	**ABUHB:** DLN support for weekend at RGH. NHH to provide in reach service supporting discharge. HSCW for Right sizing community teams Discharge service to support the Grange University Hospital.	WG Template	PCC SS	Maintenance of discharge 'flow' MDT intervention RAL Improved patient experience	●	●	●	

Goal 1: Co-ordination, Planning and support for high risk groups

OBJECTIVE: Planning and support to help high risk or vulnerable people and their carers to remain independent at home, preventing the need for urgent care.

Priority 2020/21	Activity	Measurement	Lead	Impact on Four Harms	A	B	C	D
Implement Discharge to Recover and Assess (D2RA) pathways consistently across all 5 regions within Gwent	**PAN GWENT:** 1:1 support in Care Homes to ensure weekend registrant cover/spot purchase care home beds/step up/step down capacity. HomeFirst expansion to support GUH.							
	GWICES: Equipment to support rapid D2AR.							
	Blaenau Gwent: Additional outreach capacity. Increase EC at home (DASH) Weekend SW/0T X2 (RSC) Weekend support workers (RSC).							
	Caerphilly: Right sizing community teams capacity Emergency Care at Home.							
	Monmouth: Outreach staff RSC Community Based Pharmacist (RSC). Therapy staff to support Step Up/Step down staff. Emergency care at home. In reach - additional SW/OT support from Monmouthshire to YAB (RSC).							
	Newport: Right sizing community teams 1 X OT. Additional community based social worker and Assistant (RSC). Additional Social Work Assistant to work with discharge teams.							
	Torfaen: Emergency Care at Home. Weekend social work capacity (RSC).							
Enhancing access to therapeutic activity across the community to improve mental wellbeing	Maintaining and developing innovative ways to support individuals safely (e.g. 'walk and talk' in outside areas/welfare visits /Rainbow packs in conjunction with third sector partners) (800 packs sent out since April) Available for anyone in the community accessing secondary services struggling with occupational deprivation/ isolation/ loneliness/ low mood. Information leaflets on various support available given out in all rainbow packs e.g. food banks, CALL, charities etc.	Q3 Q4	ABUHB MH PCC	Safe management within the community RAL Improved patient experience	●	●	●	●

Goal 1: Co-ordination, Planning and support for high risk groups

OBJECTIVE: Planning and support to help high risk or vulnerable people and their carers to remain independent at home, preventing the need for urgent care.

Priority 2020/21	Activity	Measurement	Lead	Impact on Four Harms	A	B	C	D
Enhancing access to therapeutic activity across the community to improve mental wellbeing	Continued rolling out psychological well-being practitioner roles in Primary Care as part of PBC Transformation.	Transformation Programme **Q3**	**PCC**	Safe management within the community RAL Improved patient experience	✔	✔	✔	✔
Improved access to Primary Care Services	Introduce a sustainable process for daily situation reporting which includes all primary care and community services. Develop optometry and dental and a toolkit for NCNs and Practices and template for practice declarations. Support practices to ensure that triage processes and mechanisms are in place consistently within primary care, in line with access standards.	**Q3/Q4** Monitor the position of the phased recovery within each practice in order to obtain a picture of service activity through ABUHB, identifying any service delivery gaps and future planning needs	**PCC**	Safe management within the community RAL	✔		✔	
Improved access to Community Teams and Hospitals	Clear plans and operational arrangements for Combined Clinical Community Teams (CCCTs), developed in each area and tested in table top exercise on 30th June featuring co-ordination of community assets at point of high level of escalation. The boroughs and directorates are now adapting their existing plans into the new HB format and updating to reflect Covid learning. Surge plan for community hospitals during winter and a potential second wave of COVID-19 been compiled, verified by SLT and shared across HB. A central plan is currently being developed to agree what order surge could occur against differing situations. Division is represented on sub-group to support equipment which feeds into the wider work. Introduce MS Teams into Community Services to improve virtual communication of mobile staff, including reducing physical space required for clinical handovers / virtual ward rounds.	**Q3** **Q4**	**PCC**	Safe management within the community RAL Improved patient experience	✔	✔	✔	

Goal 1: Co-ordination, Planning and support for high risk groups

OBJECTIVE: Planning and support to help high risk or vulnerable people and their carers to remain independent at home, preventing the need for urgent care.

Priority 2020/21	Activity	Measurement	Lead	Impact on Four Harms	A	B	C	D
Support to Care Homes	**The Gwent Care Homes Action Plan will oversee the delivery of:** Business Continuity Plans. Framework for escalation. Directed Enhanced GP Service for Care Home Residents. New Directed Enhanced Service for Care Homes offered to all GMS providers. At present 54 practices are providing the DES. 20 are not. This is mapped at Neighbourhood Care Network level. Establish task and finish group to clearly define multi-agency response to management of outbreak / escalation in residential home settings and future service models. Division is supporting development of an accurate list that indicates homes that have issues.	**Care Home Action Plan**	**PCC** **SS**	Safe management of patients within the community Improved patient experience	✔	✔	✔	✔

Goal 2: Signposting, Information and Assistance

OBJECTIVE: Information, advice or assistance to signpost people who want - or need - urgent support or treatment to the right place first time.

Priority 2020/21	Activity	Measurement	Lead	Impact on Four Harms	A	B	C	D
Continued roll out of Gwent Integrated Wellbeing Networks	Continue delivery of IWN to support and enhance community wellbeing and act as a local signpost/navigator through Community Champions Programme.	Transformation Programme **Q3**	**PHT**	Accessible support to improve wellbeing in the community RAL	✔	✔	✔	✔
Implement Foundation Tier for Mental Wellbeing in Gwent which increases accessibility to, availability and awareness of, appropriate, consistent up to date and evidence based self-help resources and messages	Design and launch an accessible Central Point of Access. Design and implement a sustained mental wellbeing marketing campaign for Gwent. Commission an evidence based mental wellbeing workforce training programme. Undertake an Equality Impact Assessment to ensure the needs of groups at greatest risk of poor mental wellbeing are being addressed. Develop a mental wellbeing pack for Care Home staff and residents.	**Q3/4**	**MHLD**	Accessible support to improve wellbeing in the community				
Enhancing Access to digital technology for service users with MH/LD needs	Work underway with digital communities Wales, to promote accessibility to tech resources and support to engage in online activities and to use digital platforms to access mental health and peer support. Get there together project'- ABUHB MHLD alongside 10 OT students to build a catalogue of videos to support service users with dementia re-accessing the community.	**Q3/4**	**MHLD**	Accessible support to improve wellbeing in the community	✔	✔	✔	✔
Continued growth of third sector led support	GATA Advocacy support. Gwent MH Alliance. Community Halls forum. Delivery of engagement strategy for vulnerable groups through transformation programme. **HAFAL** -10 recovery workers are due to start in adult mental health in crisis teams and CMHTS in each borough starting in October/ November. This support will aim to provide a transition approach for service users to wider community services available. **Growing space** in the community (mental health check in, practical support with access to meds, shopping etc.) as needed alongside contracts for connecting with nature, taster sessions and creative arts.	**3rd sector assurance mechanisms** Transformation Programme **Q3**	**GAVO** **TVA**	Accessible support to improve wellbeing in the community RAL Improved patient experience	✔	✔	✔	✔

Goal 2: Signposting, Information and Assistance

OBJECTIVE: Information, advice or assistance to signpost people who want - or need - urgent support or treatment to the right place first time.

Priority 2020/21	Activity	Measurement	Lead	Impact on Four Harms	A	B	C	D
Continued roll out of DEWIS and Phone First initiative	Ongoing promotion of DEWIS as the primary portal for IAA across Gwent. Continued pilot of IAA SPA in BG. NCN funding support to regional admin support for DEWIS. Phone First roll out.	Internal SS assurance mechanisms Transformation **Q3** **HB Q3/Q4**	**SS**	Accessible support to improve wellbeing in the community RAL Improved patient/ citizen experience	✔	✔	✔	✔
Providing IAA in Care Homes to residents and families to improve wellbeing	Care Homes to consider how the emotional and well-being support continues to be offered to all residents (including younger adults in Care Homes) even though the current pandemic appears to be easing in Care Homes.	**CHAP**	Community Care Sub Group	Safe management of patients in the community Improved citizen/ patient experience	✔		✔	✔

Goal 3: Preventing Admission of High-Risk Groups

OBJECTIVE: Community alternatives to attendance at an Emergency Department and/or admission to acute hospital for people who need urgent care but would benefit from staying at, or as close as possible, to home.

Priority 2020/21	Activity	Measurement	Lead	Impact on Four Harms	A	B	C	D
Support practices to ensure that triage processes and mechanisms are in place consistently within primary care, in line with access standards	The Recovery Plans provide information and guidance to ensure that an online consultation system is in place to support total triage and remote consultations should be used where appropriate, making reasonable adjustments for specific groups when necessary. Practices have been provided with a Remote Consultation platform 'Attend Anywhere'. This will support practices to ensure that video consultation capability is available and that video consultations are offered to patients when appropriate. Re-introduce appropriate levels of face-to-face activity in GMS Services for key conditions for which physical examinations and contact are necessary.		**ABHUHB**		✔		✔	
Additional Social work capacity	Additional domiciliary care capacity. Additional Home Care OOH. Additional Social work and AMHP capacity within the community. Additional capacity to provide equipment.	Internal SS Assurance Mechanisms **D2RA WG** Template	**SS**	Safe management of patients within the community RAL	✔	✔	✔	✔
Additional CRT Capacity	Expansion of CRT emergency home care team to support Domiciliary care over winter period.	**Q3/Q4**	**SS/PCC** **GASP**	Safe management of patients within the community RAL	✔	✔	✔	✔
Scaling up of HomeFirst to the Grange	Development of new service model from 01/11 in the	Transformation **Q3 Q4/Q4**	**PCC/SS** **GASP/** Trans-formation	Safe management of patients within the community RAL	✔	✔	✔	
Ensuring Housing Adaptions are undertaken rapidly	Additional Capacity for Housing adaptation to facilitate discharge.	Internal HSC mechanisms	**SS**	Safe management of patients within the community RAL	✔	✔	✔	✔

Goal 3: Preventing Admission of High-Risk Groups

OBJECTIVE: Community alternatives to attendance at an Emergency Department and/or admission to acute hospital for people who need urgent care but would benefit from staying at, or as close as possible, to home.

Priority 2020/21	Activity	Measurement	Lead	Impact on Four Harms	A	B	C	D
Development and Delivery of Urgent Primary Care Centre	Open urgent primary care centre in Newport and Nevill Hall. Meet the demand for urgent care services, which primarily can be met by Primary Care services both in and out of hours. Be multi NCN based and where possible involve the linking of local patients to local services. Be pathway/presentation based.	**Q3/Q4**	**PCC**	Safe management of patients within the community RAL Improved patient experience	✔	✔	✔	✔
Additional Support to keep patients safe in Care Homes	Development of a Community Hospital Care Home Pathway. Extension of Primary Care ACP pilot to help increase coverage of ACPs / RBIDs for patients in care homes and with 3 or more chronic conditions as a priority. Funding approved from WG via delivery agreement in April 2020 for £80k for a Primary Care ACP Facilitator and an ACP Business Analysist. Further development of care home pathway to ensure effective multiagency support framework (Jan 21). Ongoing support for enhanced Care Home testing from partners, including strengthening the flow from Care Homes into the Rodney parade testing centre for incident management. Actively working with providers to plan for vaccinations. Provision of educational resources and Infection Prevention and Control advice, to include a webinar and further planned training and visits to homes. Continue to develop the escalation approach to incident management and learning from individual homes. Establishing a Nurse led model to provide the Care Home DES in Caerphilly.	Care Homes Action Plan	Community Care Sub Group	Safe management of patients within the community RAL	✔	✔	✔	✔
Introduce a Frailty Advice Line	Advice line established in April via Frailty SPA. Impact/effectiveness to be reviewed and a plan to consolidate. Comms reminder sent to all GP practices and numbers have dipped. Newport CRT to cover Monmouthshire area, review after six weeks.	**Q3/Q4**	**PCC/SS**	Safe management of patients within the community RAL	✔	✔	✔	✔

Goal 3: Preventing Admission of High-Risk Groups

OBJECTIVE: Community alternatives to attendance at an Emergency Department and/or admission to acute hospital for people who need urgent care but would benefit from staying at, or as close as possible, to home.

Priority 2020/21	Activity	Measurement	Lead	Impact on Four Harms	A	B	C	D
Implement defined OOH Pathways (see also Goal 1)	**Implement a defined Out-of-Hours Respiratory Pathway.** There is currently no defined out of hours respiratory pathway, clinicians manage respiratory cases on case by case basis, where appropriate managing the patient within the community. Meetings scheduled with Frailty and Respiratory Teams to understand feasibility. **Implement a defined Out-of-Hours Palliative Care Pathway.** Scope the possibility of implementing a palliative care nurse within the hub at Aneurin Bevan. Palliative care nurse to undertake remote consultations with patients in addition to appropriate home visits. Implement a defined Out-of-Hours Dental Pathway. Work commenced to determine best ways forward for a South East Wales out of hours dental service and to determine where there this is a sustainable model.	Q4/Q4	PCC/SS	Maintenance of FLOW and timely MDT intervention Improved patient experience	✔	✔	✔	
Implement pathway for rehabilitation of patients post-COVID-19 in the community setting	Wider ABUHB rehab programme in place for patients who were in critical care settings. Long Covid working group established with key stakeholders, agreed to develop a pathway whereby individuals can self-navigate to seek advice, HCP understand where support can be sought and variation framework developed.							
Optometry Recovery Plan	Plan in place, will continue to review in line with welsh gov guidance and update as necessary. The HB awaits further guidance from WG regarding next steps.	Q3/Q4	PCC					
Dental Recovery Plan	Plan in place, will continue to review in line with welsh gov guidance and update as necessary. The HB has developed a FAQs document which has been endorsed by WG and issued to NHS dental practices.	Q3/Q4	PCC	Safe management of patients within the community RAL	✔	✔	✔	

Goal 4: Rapid Response in Crisis

OBJECTIVE: The fastest and best response at times of crisis for people who are in imminent danger of loss of life; are seriously ill or injured; or in mental health crisis.

Priority 2020/21	Activity	Measurement	Lead	Impact on Four Harms	A	B	C	D
Expansion of Primary Care Services with Urgent Care Centre in Newport/NH	Extended GP out of hours service at RGH to 24/7. Multi-disciplinary workforce providing up to 90 appointments per day. Patients redirected to booked appointments via clinical hub. Capacity to manage walk in minor ailments independently. Phase 1 Development UPCC at Royal Gwent Hospital - £764,980 Phase 2 Development of UPCC at Nevill Hall Hospital - £599,435 **Total £:1,717,657** **Profiled funding for 2020/21 - £872,000**	**Q3/Q4**	**PCC**	Safe management of patients within the community RAL Improved patient experience	✔	✔	✔	✔
Reconfiguration of ABUHB urgent care system	Ensuring that there are available capacity and appropriate pathways to support the management of crisis in the community remains a priority. As part of its Clinical Futures transformation and innovation agenda, the Health Board is actively reconfiguring urgent care services across all of the acute sites.	**Q3/Q4**	**ABUHB**	Maintenance of FLOW and timely MDT intervention Improved patient experience	✔	✔	✔	
Support for citizens with Mental Health needs	Improving crisis services through changes in 'out of hours' crisis assessment provision, commissioning of a Support House and continuing to progress inpatient improvements.	**Q3/Q4**	**MHL SPB**	Safe management of patients within the community Improved patient experience RAL	✔	✔	✔	✔
Implementation of ABUHB Flow Centre	A single point of contact to co-ordinate all urgent same day access to secondary care services.	**Q3/Q4**	**ABUHB**	Maintenance of FLOW and timely MDT intervention	✔	✔	✔	✔
Aneurin Bevan University Health Board Clinical Review Hub (Phone First)	The principal aim to establish 111 as the first point of contact / entry into urgent care, other than via a 999 emergency call.	**Q3/Q4**	**ABUHB**	Maintenance of FLOW and timely MDT intervention Improved patient experience	✔	✔	✔	✔

Goal 5: Great Hospital Care

OBJECTIVE: Optimal hospital-based care for people who need short term, or ongoing, assessment/treatment for as long as it adds benefit.

Priority 2020/21	Activity	Measurement	Lead	Impact on Four Harms	A	B	C	D
The early opening of the Grange University Hospital is part of our Covid Winter Response. The GUH provides 470 additional beds into the system	Some of the Health Board's most fragile services will be stabilised by their centralisation onto the Grange site including Women and Children's services, such as Paediatrics as well as ED and Critical Care. Current plans show the Emergency Department becoming operational at the Grange at 2am on the morning of Tuesday 17th November.	**Q3/Q4**	**ABUHB**	Maintenance of FLOW and timely MDT intervention Improved patient experience	✔	✔	✔	
Reconfiguration of Local General Hospitals	The current enhanced Local General Hospitals being reconfigured to their future hospital site offering. The configuration of which will depend on the COVID situation and surge plans being developed and enacted. To do this a central control point will be established at the Grange site acting as a hospital Bronze group. This will include a multi-disciplinary team to be able to act quickly to resolve issues and be empowered to make decisions safely.	**Q3/Q4**	**ABUHB**	Maintenance of FLOW and timely MDT intervention Improved patient experience	✔	✔	✔	
To balance demand and bed capacity for COVID, non-COVID winter pressures and essential services	Optimising the benefits of the opening of GUH on system capacity and flows. Where feasible to re-establish routine inpatient and day case services safely during Q3 and Q4.	**Q3/Q4**	**ABUHB**	Safe and effective Management of the system and patient flows	✔	✔	✔	
Provide in hospital third sector services to maintain and improve wellbeing	Third sector scheme to deploy volunteers on Wards in partnership with CVC's.	**Third sector**	**Third sector**	Improved patient experience Improved multi agency intervention to support discharge	✔	✔	✔	✔
Implement central point of access for the hospital palliative care team	Central point of access for palliative care hospital support implemented.							

Goal 5: Great Hospital Care

OBJECTIVE: Optimal hospital-based care for people who need short term, or ongoing, assessment/treatment for as long as it adds benefit.

Priority 2020/21	Activity	Measurement	Lead	Impact on Four Harms	A	B	C	D
Support for patients in inpatient MH services	Pilot of discharge rainbow packs on Adferiad ward (30 packs) began at the start of September. £17,000 from corporate charitable funds, donated by the public to enable us to order a significant amount of additional equipment and technology to support therapeutic activity across all inpatient settings. Resources are being sent out across all inpatient settings as they arrive- So far this has included sports equipment, games consoles and games, arts and crafts equipment, kitchen equipment, board games, etc. Growing space staff have now commenced inpatient art and craft activity sessions at St Cadocs and Talygarn which have been met with a positive response so far. Plans to roll out over the coming months. They are also continuing with horticulture sessions where possible in small groups. Development of partnership work with PHW to support the introduction of five ways to wellbeing activities across all inpatient settings. Pilot to start on Pillmawr Ward for adult MH, Cedar Park Older adult MH and Ty Lafant LD. 'The 5 ways to well-being activities are ideal for our setting as they are accessible to all and achievable for staff and service-users. Activities don't take long to set up, and are quick to do, making them ideal for people with a short attention span. The activities can help people find new things to do or re-kindle old interests and can be continued on discharge.' Art based activity packs provided by Growing space are being distributed across all inpatient settings- to alleviate boredom, address need to attend therapeutic art activity sessions where not currently possible indoors. Personalised therapeutic activity packs provided by OT- over the next 10 weeks all patients on dementia assessment wards will have a personalised, individual activity pack staff can use one to one. Packs are made up following completion of an OT interest checklist and can be utilised by all staff - OT students will evaluate after 10 weeks.							

Goal 6. Home First when Ready (Please also see Goal 1 and Annexe A)

OBJECTIVE: A home from hospital when ready approach, with proactive support to reduce chance of readmission

Priority 2020/21	Activity	Measurement	Lead	Impact on Four Harms	A	B	C	D
Provide additional capacity to support safe and effective discharge	To identify the surge capacity within care home settings for winter and second surge COVID-19 through the community settings group by December 2020. Identify additional step down capacity to support opening of Grange University Hospital. Further develop the discharge to recover then assess (D2RA) pathway 4 across all Health Board areas by March 2021. Additional HSCW & District Nurse support workers for Right sizing teams.	**Q3/Q4 D2AR Template**	**PCC/SS (GASP)**	Improved multi agency intervention to support discharge Improved patient experience	✔	✔	✔	
To provide the appropriate levels of staffing and enhanced resilience of workforce needs	To support step down staffing models and plan for contingency for potential high levels on self-isolating staff during the next six months by December 2020. Alignment of Complex Care practitioners and Hospital Discharge Service.	**Q3/Q4 D2AR Template**	**PCC/SS (GASP)**	Improved multi agency intervention to support discharge Improved patient experience	✔	✔	✔	✔
Development of a Discharge Liaison Service	Development of Discharge Liaison service/In-reach for GUH. Funding of DLN support for weekend at RGH/NHH.	**Q3/Q4 D2AR Template**	**PCC/SS (GASP)**	Improved multi agency intervention to support discharge Improved patient experience	✔	✔	✔	
Appropriate multi agency workforce training	Dedicated training for Hospital Discharge Assistants, Liaison Nurses and social workers with HEIW & SCW December 2020/ January 2021.	**Q3/Q4 D2AR Template**	**PCC/SS (GASP)**	Improved multi agency intervention to support discharge Improved patient experience	✔	✔	✔	
Equipment to support discharge	Equipment to support rapid D2AR (Gwices) 20K.							
Additional social work capacity	Increase social workers in discharge teams. Additional community based social workers.							
Increase 1:1 support in Care Homes	Support to ensure weekend registrant cover and support to spot purchase bed (step up/ step down).							
Increase community outreach	Community based pharmacist Therapy staff to support step up/step down.							