Appendix 2

RPB Winter Plan

Interim Review & Risk Assessment

9 March 2023

This document is provided by the Gwent Regional Partnership Board and may not be fully accessible, please contact the Partnership and Integration Portfolio Management Office for advice.

Bwrdd Partneriaeth Rhanbarthol Gwent
Gwent Regional Partnership Board

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Partnership & Integration Portfolio Management Office

Introduction

- A workshop interim review of winter plan delivery was undertaken within the Gwent Adult Strategic Partnership on 9 March 2023
- The interim review focussed on current status of project delivery along with any considerations as to successful capacity that should be considered to be sustained into the new financial year.
- The recommendations from Gwent Adult Strategic Partnership are reflected against each scheme within the updated risk assessment.

Resilient Community Capacity

ACTIVITY	STATUS	DEPENDENCY/ RISKS	MITIGATION	PROPOSED IMPACT	VIABILITY RAG RATING	IMPACT RAG RATING	GASP Recommendation
New Directions Caerphilly Continue to provide domiciliary care commissioning via complex care (inc. within current SC2H pathway)	Ongoing informal arrangement – 6 people currently being supported	Continued availability of provision; no risks identified through consideration	Nil required	Maintained or improved DTOC position Good person centred outcomes	High	Low additional impact as Stabilising existing capacity	As part of the Step Closer to Home pathway, this capacity is reported to be impactful to individuals that have been supported, with packages of care right-sized. The capacity has been fully utilised throughout 2022-23. GASP recommend this initiative continues into the new financial year to sustain the capacity.

Resilient Community Capacity

ACTIVITY	Progress	DEPENDENCY/ RISKS	MITIGATION	PROPOSED IMPACT	VIABILITY RAG RATING	IMPACT RAG RATING	GASP recommendation
Additional winter capacity within community teams Supporting the ability to offer additional hours of work to mitigate further staff shortages due to sickness/leave over the winter period (provided via overtime/ additional hours of existing staff)	**Blaenau Gwent** Approx 495 additional hrs provided of 7 day social work capacity, as well as agency social worker and Health and wellbeing worker.	Reliant on willingness of staff	Nil available	Stabilised workforce Capacity to provide 7 day working (e.g. brokerage over the weekend)	Medium	High	The nature of the temporary capacity is useful for periods of additional system resilience activity. Recommendation to have system resilience capacity ringfenced within the RIF programme, not specific to winter seasonality.
	Caerphilly Partial success – increase capacity for hospital discharge, but less success with increasing care capacity						
	Monmouthshire Additional 314 hours of care brokered through 2 domiciliary care agencies						
	Newport Update awaited – due to leave						
	Torfaen Update awaited – due to leave						

Resilient Community Capacity

ACTIVITY	STATUS	DEPENDENCY/ RISKS	MITIGATION	PROPOSED IMPACT	VIABILITY RAG RATING	IMPACT RAG RATING	GASP recommendation
Equitable fuel reimbursement for care staff *(providers only – excl. Health and Social Care care staff)* Responding to the cost of living crisis and increasing number of carers leaving the profession, methodology developed to identify methods of providing equitable fuel reimbursement for care staff across the region.	Payments made to providers and delivered in full, with positive feedback from staff supported. Feedback overall suggests monitoring the continued pressure into 2023-24 to assess whether further support may be needed.	Mitigate ongoing staff retention issues due to the cost of living crisis within the provider sector	Not required	Stabilised workforce	High	Low-Med - stabilising existing capacity	Suggest maintaining an overview of the impact cost of living has on care works. Also need to ensure the communication that has been issued from commissioners to providers reflects the 31 March 2023 conclusion.

Admission Avoidance

ACTIVITY	STATUS	DEPENDENCY/ RISKS	MITIGATION	PROPOSED IMPACT	VIABILITY RAG RATING	IMPACT RAG RATING	GASP recommendation
COTE/Frailty Redesign - 8-8 CRT Model extend the operational hours for CRT rapid medical up to 8pm Monday to Friday, by Jan/Feb 23. It is proposed that by recruiting additional support now, it would be possible to make the existing CRT medical team more robust across all areas and develop a weekend response in the same timescale.	Due to the short-term nature of the funding, recruitment has been challenging. A key recommendation when the bid was submitted was that all posts are substantively employed because temporary posts are unlikely to be attractive. However permanent at risk recruitment could not be completed in the current financial climate	Recruitment Initiative cannot be viewed in isolation of the wider activities within the CRT	Comms and engagement across all CRTs re. the Pilot development Clear dependency map	As a 7 day model, the service could support a further 32 patients to remain at home each week, avoiding a hospital admission	Unable to deliver during winter plan term	None	Following completion of first phase Redesigning Services for Older People programme, if needed, a fuller business case will be developed to demonstrate any needs.
COTE/Frailty Redesign - Proactive Frailty Transformation Project developing a robust method of identification and collaborative planning, admissions and GP interactions reduce. Project resource needed: • 1 WTE Band 8a programme manager • 4 medical sessions each week spilt across CRT consultant and GP • 1 WTE Band 5 Project support officer	Programme manager recruited on a temporary basis to support the redesign work	Recruitment	Nil	Indications have previously suggested that approximately 60% (LFS) of actual beds are utilised to support these individuals. The Redesign programme is working to avoid admission and thus move care into individuals own homes.	High Programme Manager in place up to 31 March 2023	Low	Following completion of first phase Redesigning Services for Older People programme, if needed, a fuller business case will be developed to demonstrate any needs.

Admission Avoidance (cont…)

ACTIVITY	STATUS	DEPENDENCY/ RISKS	MITIGATION	PROPOSED IMPACT	VIABILITY RAG RATING	IMPACT RAG RATING	GASP recommendation
COTE/Frailty Redesign: Night Time Support Develop two teams of HCSW working initially in the out of hours period 8 pm to 8am, seven days per week. Each team would consist of two Health Care Support Workers who are trained to undertake observations and provide personal care and support to people to enable them to stay safely in their own home.	Recruitment completed. Service not yet operational, planned commencement for April 2023. Programme board and steering group established via RSfOP programme.	Recruitment activity having a detrimental effect on other services Incremental gains in the early stages of the programme not realising full impact within winter period	Recruitment will be for a night contract only, which will minimise the staff pool interested, and therefore less likely to impact domiciliary care market	Keeping frail and/or elderly people at home reduces dependency on longer term social care services, increasing independence and quality of life.	Low Soft launch planned for April following part successful recruitment	None	Following completion of first phase Redesigning Services for Older People programme, if needed, a fuller business case will be developed to demonstrate any needs.
Same Day Emergency Care @ YYF The development of the SDEC treatment space alongside other improvements in AMU will ensure that YYF is in a position to meet the demand and requirements for the Caerphilly population, supporting whole system flow and optimising patient outcomes.	The pilot project has been successfully implemented and has treated 440 patients between 31 October '22 and 24 February '23. Data has demonstrated a reduction in waiting times, a high assessed out rate, excellent patient satisfaction rates and good staff experience which has reduced congestion and unnecessary admission in a very busy Acute Medical Unit (AMU).	Recruitment of staff for a 6-month pilot	Confirmation of interest in the posts from existing staff, opportunity to work in a new initiative service, delivering patient centre care	Avoids unnecessary admissions to hospital often being cared for in the AMU corridor or boarded. Prevents avoidable disruptions to packages of care / support at home because patients are not waiting overnight for assessment, treatment and investigations	Delivering as intended	High	Recommend further detailed consideration of impact across YYF as part of formal winter evaluation, and understanding of WG SDEC funding already provided.

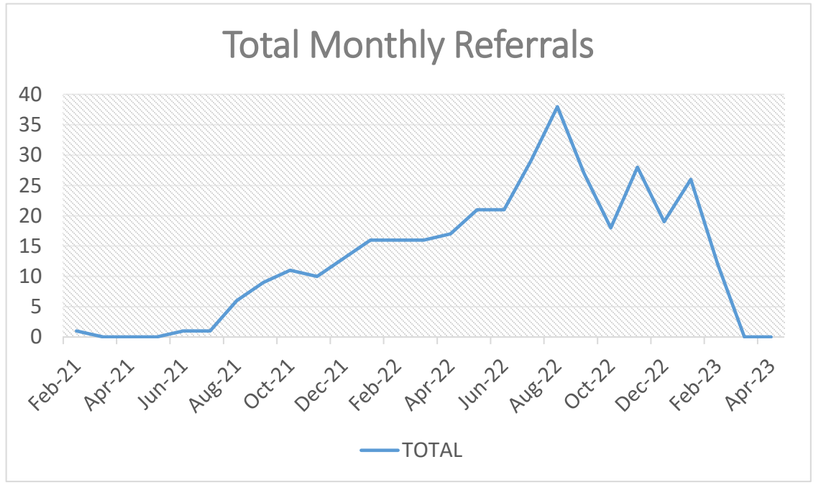
Discharge Enablers

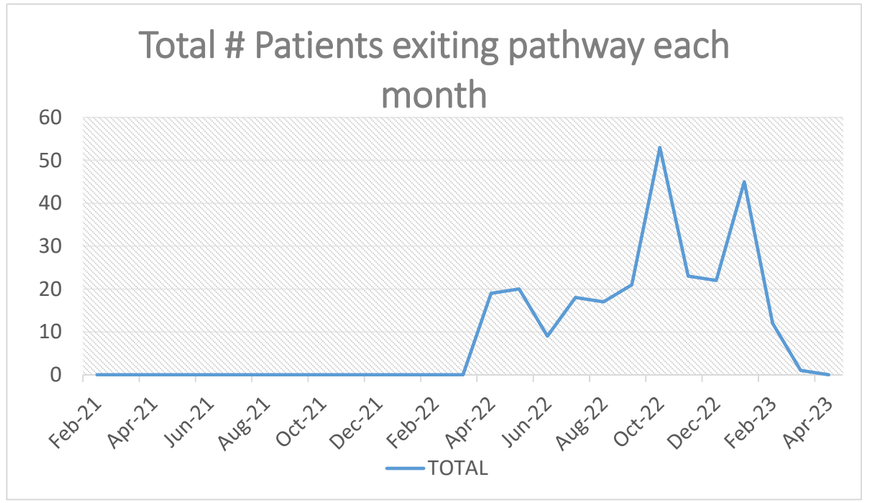
ACTIVITY	STATUS	DEPENDENCY/ RISKS	MITIGATION	PROPOSED IMPACT	VIABILITY RAG RATING	IMPACT RAG RATING	GASP recommendation
Additional equipment for GWICES to facilitate hospital discharge Phase 1: Manual Handling (seating, hoists & standaids) - £300,000 Phase 2: Bettercare (showering, bathing including bariatric) - £100,000 Phase 3 - Single handed care)Elks, slings, returns including bariatric) - £100,000	Phase 1 - Manual Handling 605 items (Seating, Hoists & Standaids) Phase 2 - Bettercare 1,413 items (Showering, Bathing including Bariatric) Phase 3 - Single Handed Care items 1,208 (Elks, Slings, Returns including Bariatric) TOTAL 3,226 items provided	Procurement of stock, potential supply chain issues	Phased procurement takes account of lead in timeframes	Avoidance of delays due to equipment availability	High	Medium	To include early within winter system resilience activities, to enable proactive planning and procurement for increased demand in September. Recommend, ringfence funding to support system resilience.
Strengthened resource for Home First Service Existing home first resource from RGH & NHH spread to GUH. Proposal is to strengthen the capacity to reflect the 3 hospital model.	Agency staff secured to enable strengthened capacity over the winter period. Additional resources were utilised to improve the capacity within the dom care provision.	Ability to appoint staff, due to funding decision timeframes		# Turnaround at front door Reduction in admissions	High	Low (unable to exceed average baseline discharge rate during term of plan – external factors contributing)	Further more detailed consideration is needed, year end reporting and evaluation will be undertaken for HF. Noted wider initiatives have impacted on HF performance data.

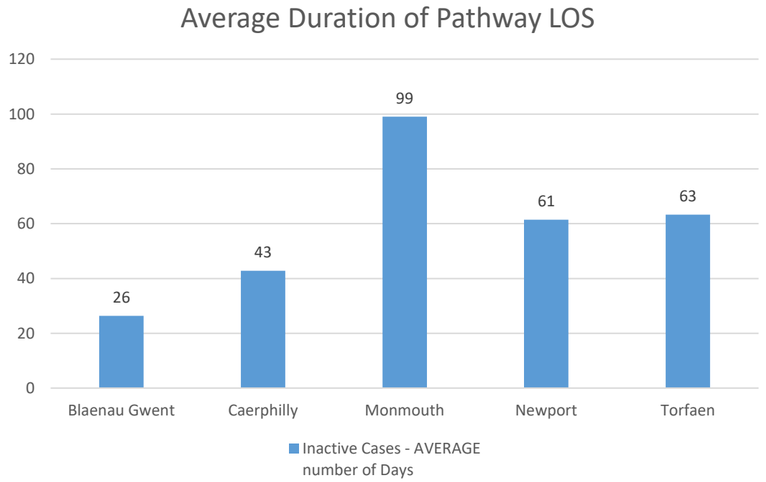
Alternative Bedded Capacity

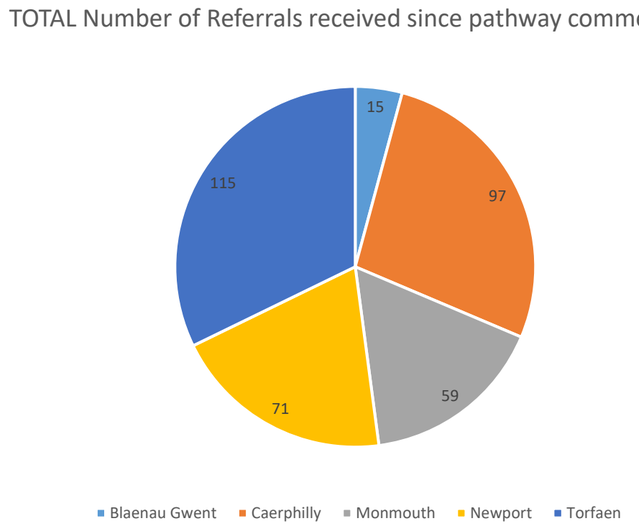
ACTIVITY	STATUS	DEPENDENCY/ RISKS	MITIGATION	PROPOSED IMPACT	VIABILITY RAG RATING	IMPACT RAG RATING	GASP recommendation
Create additional beds as part of a graduated care pathway (costings and modelling taking place on 80 beds). Supporting convalescence for individuals awaiting community support.	A hybrid model of SC2H with block booked and spot purchase arrangements has been in place. The criteria for this initiative was to support individuals waiting for 3-4 dom care calls per day to enable discharge from hospital. Utilisation of the pathway has been significantly lower than projected. Referrals rates have reduced, whilst POCD data still demonstrates significant amount of patients 'stuck' within the hospital system, demonstrating the lack of impact of this initiative. Providers mobilised ready to support the model in anticipation of the projected demand, however as the demand has not materialised it has resulted in provider disappointment and frustration.	Staff shortages noted in the care home sector, may impact the ability for homes to respond to the tender invitation. Ability to source Therapy capacity (OT/Physio/Assts) Throughput of the pathway to maintain flow Capacity of GP surgery(ies) to support additional care home capacity	Refined patient cohort included within service specification for these beds. Patients moved on maintenance plans waiting for PoC, reduced reliance on therapy capacity To be considered following care home responses as to suitable geographical area – engage with NCN leads	Up to 693 patients could be supported within a 26 weeks timeframe Reduction in DTOC	High Capacity sourced within care homes via SC2H Hybrid Model	Very low	Acknowledge additional capacity where able to be utilised has proved beneficial, with good service user experience. Block booked beds could only be sourced in the north of the region, patients not resident within the catchment were therefore not referred despite being a regional offer. High level data shown overleaf for SC2H alternative bed pathway Pending detailed evaluation at year end, GASP shared early recommendation to continue some capacity as referrals still being received and patients currently within pathway.

SC2H Data









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What would we do differently?

- Short termism associated with typical winter planning periods is a constraint to having significant impact.
- Additional areas of focus were considered, such as Assistive Technology and Technology Enabled Care which we were unable to address due to the short timeframe.
- Support was received to focus on a Prevention and Wellbeing Strategy, also to ensure connectivity and alignment between existing preventative offers.
- The important distinction was highlighted between early preventative activity (keeping well and independent in the community), and response services considered to be preventative (e.g. Falls preventing hospital admission)
- GASP recognise radical changes need to be considered, this will form part of a follow up discussion with the formal evaluation of the winter plan, in addition to the early work of the Redesigning Services for Older People programme.