West Glamorgan Winter Preparedness Plan 2026/27

West Glamorgan Winter Plan 2026/27

West Glamorgan Regional Partners continue to operate in a challenging environment, with high-demand for services across health and social care, workforce pressures, constrained capacity and ongoing patient flow challenges.

Winter 2026/27 planning has been developed jointly across health and social care partners, to ensure that there is a regionally co-ordinated response to winter pressures.

The plan focuses on maintaining flow, reducing avoidable admissions, maximising available capacity and protecting urgent, planned and cancer care throughout the winter period.

The plan builds on the transformation programmes aligned to both urgent & emergency care and planned care and seeks to align the benefits of these programmes to deliver improved capacity and service sustainability.

Purpose

The purpose of the West Glamorgan Winter Preparedness Plan is to:

- Provide an overarching framework for winter preparedness across health, social care and community services,
- Co-ordinate the actions required to deliver the nine national winter outcomes,
- Align Health Board, Local Authority, Regional Partnership and organisational winter arrangements,
- Support operational readiness for both the "*most likely*" and "*severe pressure*" winter scenarios
- Ensure robust escalation, resilience and command arrangements are in place across the system.

Aims and Objectives

Working together as a whole health and social care system, we will aim to:

- Improve patient flow across health and social care by embedding Home First, D2RA and Optimal Hospital Flow principles, reducing ambulance handover delays, Emergency Department waiting times and delays in discharging clinically optimised patients.
- Strengthen community, frailty and primary care pathways to increase admission avoidance and support people to remain independent at home.
- Maximise acute, community and social care capacity through effective demand and capacity management.
- Maintain resilience across health and social care services through robust escalation, command and business continuity arrangements.
- Protect urgent, planned and cancer care services during periods of increased demand wherever possible.

Key Priorities

Partners will focus on a number of operational priorities that will maximise system resilience, improve patient flow and protect capacity throughout the winter period.

Improve Flow and Discharge

- Accelerate implementation of the Optimal Hospital Flow Project.
- Increase the proportion of patients discharged before midday through the Home for Lunch initiative.
- Increase weekend discharge activity and reduce delays for clinically optimised patients
- Strengthen D2RA pathways across health and social care.

Protect Hospital Capacity

- Reduce ambulance handover delays and ED waiting times
- Strengthen front door frailty and admission avoidance pathways
- Maximise effective use of acute, community and social care capacity
- Maintain grip on system flow through proactive operational management

Strengthen Community Resilience

- Support people to remain well, independent and connected within their communities.
- Increase utilisation of community, primary care, social care and third-sector alternatives to hospital admission
- Deliver the regional respiratory vaccination programme and targeted prevention initiatives
- Support care homes, domiciliary care and reablement services and unpaid carers throughout the winter period
- Work with communities and third-sector partners to reduce isolation and support vulnerable people during winter.

Maximise System Resilience

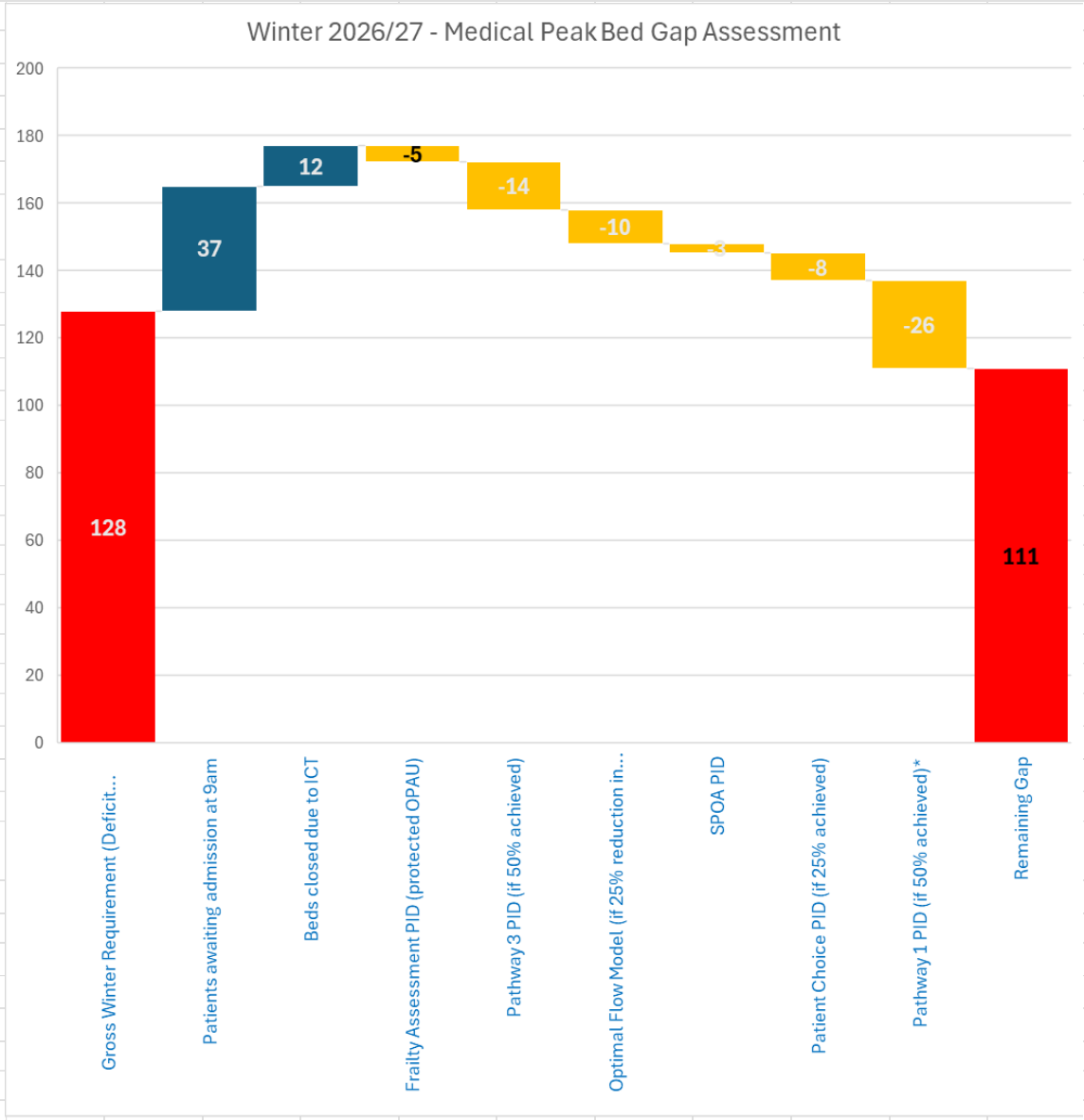
- Operate a co-ordinated health and social care response to periods of increased pressure.
- Utilise agreed escalation, operational command and business continuity arrangements
- Deliver the national Winter Sprint programme and Christmas period arrangements
- Protect urgent, planned and cancer care services wherever possible

West Glamorgan Operating Principles

To support the delivery throughout winter 2026/27, the partnership will adopt the following operating principles:

- A single whole-system approach across health, social care, community and third-sector services,
- *Home First* will remain the default approach wherever clinically appropriate,
- Decisions will be informed by system intelligence, demand and capacity modelling and operational risk;
- Escalation decisions will be taken through agreed regional operational command and governance arrangements,
- All organisations will maximise use of capacity before escalation measures are required,
- Resources will be focused on preventative and proactive models of care, reducing avoidable admissions, maintaining patient flow, protecting hospital capacity and minimising discharge delays,
- Partners will work collaboratively to resolve system pressures and minimise impact on patients and carers.

Winter Plan – closing the bed capacity gap



Transformational Requirments / Proposals	Total Acute Beds (or bed equivalent)
Gross Winter Requirement (Deficit 25/26- **80P**)	128
Patients awaiting admission at 9am	37
Beds closed due to ICT	12
Frailty Assessment PID (protected OPAU)	-5
Pathway 3 PID (if 50% achieved)	-14
Optimal Flow Model (if 25% reduction in Pathways Delays)	-10
SPOA PID	-3
Patient Choice PID (if 25% achieved)	-8
Pathway 1 PID (if 50% achieved)*	-26
Remaining Gap	**111**

*The Summary Occupancy tables demonstrate the scale of the increase in Jan, Feb and March

Additional Drivers	Impact
MORRISTON SCHEMES	
1. 30 bedded Winter Swing Ward (Singleton Base)	30
PCT SCHEMES	
1. Virtual Ward cover - weekends	3-5 additional patients per weekend day
2. Enhanced CRT cover at Weekends	2 additional patients per weekend day
3. 5% increase in GPOOH Workforce	tbc
NPT SCHEMES	
1. Discharge Lounge, or	3-4 discharges before midday - 100% compliance with "Home4Lunch"
2. Winter Discharge Acceleration Unit (DAU)	as above +2 additional discharges
REGIONAL	
1. Recommission 4 bed Bon y Maen House	4 beds
2. Transitional Bed Scheme	tbc

NET DEFICIT ASSUMING ALL PLANS SUCCESSFUL	**68**

Winter Plan - Closing the Bed Gap Through Improved Flow and Discharge

The Winter Plan aims to reduce the capacity gap by improving flow, avoiding unnecessary admissions and supporting timely discharge. It builds on agreed transformation priorities and partnership working across health and social care.

Transformation and discharge priorities

- Embed Optimal Hospital Flow and Home for Lunch to reduce delays and support earlier discharge.
- Improve Pathway 1 processes and reduce length of stay for people with complex discharge or transfer needs across Pathways 2 and 3.
- Strengthen admission avoidance through the Single Point of Access and Frailty Service.
- Strengthen the Integrated Discharge Hub, including centralised discharge co-ordination and bed booking.
- Implement revised Patient Choice, Best Interest and Reluctant Discharge arrangements, supported by clear information for patients and carers.
- Develop the Pathway 3 rehabilitation model at Neath Port Talbot Hospital.

Additional winter resilience, subject to approval and funding

- Enhance weekend Virtual Ward and Community Resource Team provision.
- Strengthen GP out-of-hours resilience.
- Extend use of Ward A through staffing of the Neath Port Talbot Day Surgical Unit.
- Consider additional capacity at Singleton, based on operational need and available resources.
- Provide dedicated discharge vehicles, patient transfer support and rapid-response domestic services.

These actions will support admission avoidance, earlier discharge and more effective use of acute and community capacity throughout winter.

Regional Operational Management

- Winter delivery will be managed through existing Health Board, Local Authority and Regional Partnership operational management arrangements; supported by agreed escalation, operational resilience and Business Continuity processes,
- Daily Health Board operational huddles and POCD meetings will focus on patient flow, discharge performance, clinical optimised patients, capacity utilisation, workforce pressures and emergency operational risks across acute, community and social care services,
- Senior operational leaders will maintain oversight of system performance and escalation frameworks and will co-ordinate actions to address barriers to discharge, flow constraints and emerging risks. Existing operational command arrangements will be utilised, including tactical bronze, silver and gold command structures, ensuring co-ordinated decision making,
- Enhanced Christmas, New Year and *Winter Sprint* arrangements will provide additional operational grip, executive oversight and system co-ordination during periods of heightened risk,
- Progress, risks and escalation issues will be monitored through weekly ROAG meetings and established Health Board and Regional Partnership Board governance arrangements.

Planned Care Through Winter 2026/27

Aim: maintain elective recovery through winter while responding safely and flexibly to seasonal pressure

Protect our recovery trajectory

- Maintain delivery against the Sustainable Planned Care Recovery Plan
- Protect progress on 104-week RTT and 8-week diagnostic waits
- Maintain focus on Stage 1 waits and overall waiting-list sustainability
- Avoid winter-driven deterioration creating a further Q4/Q1 recovery requirement

Protect elective capacity

- Maintain ring-fencing of elective capacity wherever clinically and operationally possible
- Use Singleton and Neath Port Talbot capacity to insulate elective pathways from acute pressure
- Maintain theatre productivity: 6-4-2, utilisation, HVLC and list productivity
- Protect diagnostic and cancer-supporting capacity and agreed recovery activity

Reduce avoidable demand

- Continue validation, clinical vetting and active waiting-list management
- Accelerate SOS/PIFU, referral optimisation and outpatient transformation
- Maximise day case pathways, prehabilitation and peri-operative optimisation
- Prioritise by clinical urgency, waiting time and risk of harm

Winter is not a pause in elective delivery: the default is to maintain planned care capacity, with any reduction targeted, time-limited and explicitly authorised.

Winter Elective Resilience: Maintaining Delivery Through Pressure

A graduated response to operational pressure, protecting the highest-value elective capacity wherever possible

PREPARE — Sep–Oct

- Specialty demand/capacity review
- Identify workforce vulnerabilities
- Confirm Christmas/New Year activity
- Validate high-risk/long-wait cohorts
- Agree escalation triggers

MAINTAIN — Nov–Mar

- Protect elective/day-case capacity
- Maintain diagnostics & cancer
- Maximise theatre/list productivity
- Maintain funded recovery activity
- Actively manage cancellations

FLEX — When pressure rises

- Use capacity dynamically across sites and specialties
- Prioritise day case and high-throughput activity
- Flex workforce and sessional capacity where feasible
- Maximise alternative/additional capacity
- Protect cancer, urgent and long-wait/high-harm cohorts
- Escalate emerging threats to elective delivery early

RESTORE — As pressure subsides

- Reinstate any temporarily displaced capacity promptly
- Rebook any affected patients as a priority
- Quantify any activity loss against trajectory
- Deploy targeted catch-up capacity where required
- Capture lessons to strengthen resilience through subsequent pressure

Escalation principles

GREEN

Planned delivery:
Full planned care programme maintained; productivity and recovery trajectory monitored routinely.

AMBER

Enhanced Resilience:
Additional operational actions deployed to maintain planned activity — including site, workforce, list and capacity flex — with emerging losses actively mitigated.

RED

Exceptional Pressure:
Executive oversight of material risks to planned care delivery. All reasonable alternatives exhausted before actviity is reduced; any unavoidable disruption is targeted, risk assessed and restored at the earliest opportunity,.

Core measures

RTT >104w | Stage 1 waits | Diagnostics >8w | Cancer | Elective cancellations | Theatre utilisation | Activity vs plan | Lost sessions & recovery

Vaccination Plan

The Winter Respiratory Vaccination Programme (WRVP) 2026/27 brings together the delivery of RSV, influenza and COVID-19 vaccination programmes into a single integrated approach across Swansea Bay University Health Board.

Delivery will be undertaken through a mixed model involving General Medical Services (GMS), Community Pharmacy, School Nursing, Occupational Health and the Health Board Immunisation Team.

The programme places significant emphasis on improving equity of access through targeted outreach activity, community-based delivery, use of the Immbulance, co-administration opportunities and focused interventions in underserved and deprived communities.

A targeted objective of the 2026/27 influenza programme is to increase vaccine uptake by 1% amongst eligible individuals aged 65 years and over living in the most deprived communities. This will be achieved through targeted outreach, enhanced partnership working with GP practices and community pharmacies, use of community-based vaccination venues, and data-driven interventions focused on areas with lower uptake rates

Infection Prevention & Control Winter Planning - Risks and Mitigations

Risk	Mitigation	Action Owner
Maintaining system flow and capacity		
Increased community prevalence of seasonal viruses (gastro-enteric & respiratory infections) resulting in increasing admissions to secondary care and outbreaks of infections.	Early detection of risk, prompt isolation and appropriate diagnostic testing; risk assess all O/A for symptoms and or recent exposure to an infectious person. Early diagnostics for those to be admitted. RPE/PPE provision for staff, symptomatic patients and their visitors. Reduce unnecessary staff footfall in outbreak areas. Develop a rapid discharge response team to prepare patient & effectively clean/ prepare areas for re-use. Regular Infection control huddle for the management of outbreaks. Identify a ward for cohort nursing when the number of single room is insufficient to meet demand.	Service Groups (SG's)
Exposure of individuals and outbreaks of infection in wards across the hospital sites.	Minimise the number of bed moves. Optimal utilisation of single rooms through the daily reporting by speciality Matrons at the Tactical Meeting. Testing symptomatic patients early, to prioritise single room use. Symptomatic patients to wear surgical masks as a barrier, if tolerated. Use products such as vomit bags rather than bowls to contain vomitus/infectious particles.	SG's Site flow teams
Limited number of rapid tests available per day resulting in delayed case identification. Morriston allocation: Singleton/Neath allocation:	Utilise routine molecular enteric and viral respiratory testing where possible; rapid testing allocation only to be used for those being admitted and not be utilised for *C. difficile* testing. Rapid transportation of all samples, to the laboratory for analysis. Consider the use of additional staff to facilitate an increased number of sample collection times from wards. Additional rapid tests	Site flow teams. Department leads. Pathology.
Non vaccinated inpatient population at risk of infection through exposure.	Offer, Influenza & Covid-19 vaccination to all inpatients. Check and document vaccination history on admission. Record confirmed diagnosis/recovery within SIGNAL	SG's/Immunisation team
Increased demand for 4/3D disinfection of environments (enhanced cleaning).	Develop a 24/07 rapid response team for cleaning bed spaces/bays/wards. Allow adequate time to prepare trolley/bed areas & patient equipment between discharges.	Department leads
Maintaining Workforce resilience (R1,2,3)		
Increased staff sickness due to acquisition of viral infections. Increased demand for RPE.	Vaccination against Influenza for all and Covid-19 for at risk staff. Reinforce control measures necessary to prevent transmission of infections spread via the air; staff education on the new terminology (R1, R2, R3 pathogens). Identification & relocation of vulnerable staff to alternative working roles. Reallocation of skill mix to accommodate needs of services. All front-line staff must be FFP 3 fit tested; essential to improve and maintain compliance rates. Fit test assessor in all locations Availability of RPE equal to staff needs. Ensure adequately maintained RPE/PPE stock levels at ward level.	Service Groups

Communications Plan

- **Our overarching UEC communications campaign is: Connecting Care. Improving Patient Experience. Final assets to follow.**
- This largely staff-focused campaign covers the whole UEC system; admission avoidance in the community, ambulance handovers, rapid assessments, timely decisions and referrals and ward and discharge processes including D2RA, Red to Green, Home for Lunch.
- The aim is to embed the latest improvements and progress as business as usual, improve consistency of actions and decision making and therefore improve flow.
- Key message: Putting patient and staff experience at the heart of the whole urgent and emergency care pathway.
- The overall approach and key messages of this campaign have been agreed and signed up to by Alison Gallagher, Associate Director USC, Dr Clare Dieppe, ED Consultant, Samantha Hurn and Beth Eales, WAST and Kirsty Roderick, Communications and Engagement Manager, West Glamorgan Regional Partnership.
- There is agreement that what we are seeking to achieve is for staff to take ownership and pride in the part they play within the system and to understand how what they do impacts not only the patient or patients right in front of them, but the whole UEC system.
- We are also collaborating with WGRP on patient-facing discharge communications.
- **Also key to our winter comms is the Flu Vaccination Campaign, focusing on increasing staff take up through the For me, For us, For them strand and a public-facing campaign strand to promote vaccine take up, particularly among targeted groups recognised for low uptake (i.e., 65+, 2-3 years age cohort).**
- This key work above will be supported by an IPC campaign, which is currently being developed, a Pharmacy Fortnight campaign to support admission avoidance and promote the role of pharmacy internally and the national, PHW-led winter comms focusing on providing the public with clear, consistent and behaviourally informed messaging on prevention, access to healthcare and discharge.
- The national comms will be supplied and we will utilise these messages to complement and support our messaging.

Risks and Mitigations

Risk	Mitigation
Maintaining system flow and Capacity: High demand, patient flow challenges and existing bed gap may impact capacity across health and social care services.	• Delivery of UEC and regional priorities Inc Optimal Hospital Flow, Home for Lunch, D2RA, discharge escalation arrangements, • System –wide demand and capacity arrangements, • Daily operational oversight and bed modelling.
Maintaining Community and Social Care and Third Sector Capacity: Community, care home and social care capacity pressures may impact discharge performance and admission avoidance arrangements.	• On-going planning through Older Person's Board and Integrated Health and Social Care arrangements, • Winter and Christmas planning including SPRINT plans, • Escalation processes
Maintaining Workforce Resilience: Workforce availability, vacancies and sickness absence may impact on service delivery during periods of increased pressure/ demand.	• Workforce resilience plans, • Business Continuity plans and arrangements • Operational escalation processes • Staff vaccination programmes
Protecting Planned Care and Cancer Services: Operational pressures and increased demand may impact planned care activity during winter.	• Continued focus on improving flow, reducing delays, • Protecting elective capacity where possible. • Utilising escalation arrangements to minimise impact on planned care services.
Protecting Vulnerable People and Communities: Increased demand and complexity of need amongst vulnerable groups, including for example unpaid carers, people experiencing mental ill health, homelessness and housing insecurity, may place additional pressure on health, social care and third sector services.	• Multi-agency planning through regional partnership arrangements. • Continued support for unpaid carers, mental health, homelessness and housing needs. • Continued community and third sector interventions to support prevention and early intervention. • Escalation processes and demand monitoring arrangements.

Key Messages

- The Winter Plan provides a co-ordinated response across health, social care, primary care, community and third-sector services, focused on admission avoidance, maintaining flow and supporting timely discharge.
- Delivery will be supported by Optimal Hospital Flow, Home for Lunch, D2RA, strengthened frailty and community pathways, and the Integrated Discharge Hub.
- The core acute bed base will be available. No additional surge beds are currently assumed, so delivery of the agreed flow, discharge and admission avoidance actions will be critical to managing the capacity gap.
- Planned care, diagnostics and cancer services will be protected wherever clinically and operationally possible. Any unavoidable disruption will be targeted, risk assessed, time limited and restored promptly.
- Daily operational oversight, multidisciplinary flow arrangements and agreed escalation routes will be used to identify and address emerging pressures across acute, community and social care services.
- Christmas, New Year and Winter Sprint arrangements will provide enhanced operational oversight and system co-ordination during periods of increased pressure.
- Workforce resilience, business continuity, vaccination and infection prevention arrangements will support safe service delivery, recognising that vacancies, sickness absence and seasonal infection remain significant risks.
- Progress, risks and unresolved barriers will be monitored through established Health Board, local authority and regional governance arrangements, including operational huddles, POCD meetings and ROAG.
- The plan is based primarily on effective use of existing services, capacity and agreed transformation priorities.

Note: Any additional or expanded provision will be subject to available funding, workforce capacity, partner agreement and formal approval.

Appendices

- Regional Integrated Services
- Morriston Service Group
- Neath Port Talbot / Singleton
- Primary Care, Therapies, Community and GPOOH Plan
- Mental Health and LD Plan
- Support Services

Regional Integrated Services: Planning

Area	Actions	Internal Lead	Risk / Mitigation	System Benefits
Home First Pathways	Review and further develop integrated Home First pathways and review how existing domiciliary care and reablement capacity can be aligned to support timely discharge.	Older Peoples Board	**Risk:** Community capacity may not meet demand. **Mitigation:** Review demand and available capacity regularly, realigning existing resources where possible and escalating identified gaps.	Supports timely discharge, independence at home and reduced reliance on long-term residential care.
Pathways of Care Delays	Deliver the agreed Pathways of Care improvement plan through the Older Peoples Programme, including strengthening the recording of D2RA pathways on SIGNAL and addressing recurring causes of delay.	Older Peoples Board	**Risk:** Incomplete or inconsistent information may limit understanding of delays. **Mitigation:** Strengthen data quality, validation, review and oversight arrangements.	Improves understanding of system bottlenecks and supports targeted action to reduce delays.
Data and Performance	Strengthen the integrated use of dashboards to monitor flow, capacity, delays, activity and outcomes across health and social care pathways.	Older Peoples Board	**Risk**: Data may not be accurate, timely or consistently updated. **Mitigation**: Validate data through operational, POCD and COP arrangements and address identified gaps.	Provides clearer system oversight and supports evidence-based operational and commissioning decisions.
Integrated Pathway Communications	Review and update information for staff, partners, patients and carers to explain new initiatives, discharge pathways and the integrated care approach.	Older Peoples Board	**Risk**: New pathways may not be consistently understood or applied. **Mitigation**: Provide clear, accessible and regular communications across partner organisations.	Improves awareness, consistency and engagement across the system.
Community Resource Teams	Progress the development of a more consistent regional Community Resource Team model, subject to local authority decisions, partner agreement and available funding.	Older Peoples Board	**Risk:** Different organisational models, funding constraints and local authority decisions may delay implementation. **Mitigation:** Agree the proposed model, scope, resource requirements and implementation arrangements through partnership governance.	Supports more consistent access to community services, better use of available capacity and improved referral and discharge times.
Integrated D2RA Pathways	Complete joint mapping and demand and capacity modelling for Pathways 1 and 3 and develop proposals to strengthen the co-ordination of non-acute flow. Any new or expanded arrangements will be subject to available funding and approval.	Older Peoples Board	**Risk:** Increasing demand, limited capacity and delays within Pathway 3 may increase length of stay and pressure on acute beds. **Mitigation:** Use the modelling to identify gaps, agree pathway responsibilities and develop proportionate options within available resources.	Improves flow, patient outcomes and understanding of the capacity required across D2RA pathways.
Community Capacity and Admission Avoidance	Identify high-risk population groups and complete the planned review of the Acute Clinical Team and Virtual Ward model, including demand, capacity, workforce and referral pathways. Develop proposals to strengthen community capacity and admission avoidance, subject to available funding, workforce capacity and partner approval.	Older Peoples Board / UEC	**Risk:** Increasing demand, district nursing vacancies, workforce pressures and inappropriate referrals may limit community capacity and increase the likelihood of services operating at escalation levels 3 or 4. **Mitigation:** Use the service review and transformation workshops to clarify referral criteria, identify demand and capacity gaps, improve workforce planning and develop proportionate options within available resources.	Supports timely referrals, effective use of community capacity and sustainable admission avoidance. Reduces avoidable admissions and helps people remain independent at home.

Regional Integrated Services: Tactical

Area	Actions	Internal Lead	Risk / Mitigation	System Benefits
Integrated Discharge Hub	Co-ordinate referrals, assessments and discharge decisions across health and social care through the Integrated Discharge Hub. Identify incomplete referrals and unresolved barriers promptly and escalate these through the agreed operational arrangements.	Sharon Jackson; Rebecca Jenkins	**Risk:** Incomplete or poor-quality referrals may delay assessment and discharge decisions. **Mitigation:** Apply agreed referral standards, provide prompt feedback and escalate unresolved issues through the Hub.	Supports earlier joint decisions, improved pathway co-ordination and timely discharge.
Domiciliary Care and Reablement	Regularly review available domiciliary care and reablement capacity against discharge demand. Prioritise available provision according to assessed need and escalate capacity gaps through agreed operational arrangements.	Sorelle Jones Andrea Preddy	**Risk:** Available capacity may not match discharge demand. **Mitigation:** Maintain oversight of demand and capacity, use existing provision flexibly where appropriate and escalate gaps promptly.	Supports timely discharge, effective use of community capacity and independence at home.
Admission Prevention	Identify people at risk of avoidable admission and maximise timely referral to appropriate community health, social care, reablement and preventative services. Escalate barriers where suitable alternatives are not immediately available.	Older Peoples Board / UEC	**Risk:** People may be admitted when appropriate community alternatives could meet their needs. **Mitigation:** Promote early identification, clear referral routes and timely multidisciplinary decision-making.	Reduces avoidable hospital admissions and supports people to remain independent at home.
Seven-Day Service Co-ordination	Co-ordinate available weekend provision across ACT, district nursing, domiciliary care, community reablement and other relevant services. Confirm service availability and escalation contacts and escalate gaps that may affect admission prevention or discharge.	Older Peoples Board / UEC	**Risk:** Workforce, provider and contractual limitations may restrict weekend provision. **Mitigation:** Maintain clear information on available services, prioritise capacity and escalate gaps through operational command arrangements.	Supports weekend flow and reduces delays arising from variation in service availability.
Integrated Operational Management	Use the Regional Operational Assurance Group, POCD reviews and COP meetings to maintain oversight of D2RA flow, community capacity and discharge delays. Agree named actions, owners and timescales, escalating unresolved barriers through the appropriate command arrangements.	Older Peoples Board Governance	**Risk:** Emerging flow, capacity or performance issues may not be resolved promptly. **Mitigation:** Maintain regular multi-agency oversight, assign clear actions and escalate issues requiring senior intervention.	Provides integrated oversight, clearer accountability and a timely response to operational risks.
Pathway 3 and Complex Discharge Flow	Review people experiencing extended stays or complex discharge arrangements and identify the action required from health, social care, housing, commissioning or provider services. Escalate unresolved barriers through POCD, COP and operational command arrangements.	Older Peoples Board / UEC	**Risk:** Complex arrangements and limited community capacity may increase length of stay and reduce acute bed availability. **Mitigation:** Complete regular multidisciplinary reviews, assign named actions and escalate barriers requiring senior or cross-organisational resolution.	Reduces avoidable delays, supports appropriate placement and improves acute and community flow.
Care Home Winter Capacity	Monitor care home availability, including the ability to accept appropriate placements over weekends and the Christmas and New Year period. Escalate emerging capacity gaps and apply agreed contingency arrangements where required.	Haley Short / Chris Francis / Elaine Harris	**Risk:** Staffing pressures and reduced provider availability may constrain admissions during holiday periods. **Mitigation:** Maintain regular contact with providers, confirm current availability and escalate gaps through commissioning and operational arrangements.	Supports continuity of placements and reduces avoidable discharge delays during peak periods.
Domiciliary Care Winter Capacity	Monitor the availability of new domiciliary care packages, including commencement over weekends and the Christmas and New Year period. Prioritise available capacity and escalate gaps affecting discharge or continuity of care.	Haley Short / Chris Francis / Elaine Harris	**Risk:** Workforce and provider capacity may reduce during holiday periods. **Mitigation:** Maintain regular capacity information, apply agreed prioritisation arrangements and activate contingency plans where available.	Supports continuity of care, timely discharge and reduced pressure on hospital and community services.

NB: Tactical actions will be delivered through existing services and agreed operational arrangements. Any additional capacity or service expansion will be subject to available funding, workforce capacity, partner agreement and formal approval.

Morriston– Planning

Area	Actions	Internal Lead	Risk / Mitigation	System Benefits
Discharge Lounge	Redesign of D/L services to align with new footprint to include higher number of patients, complexity and to include some IP&C patients in cubicles	ASGD - AECHO	• Staffing – Recruitment/redeployment to budgeted staffing level	• Earlier flow • Home 4 Lunch • Pull from front door areas
Post Post Take	Enlist staff for period of Winter as opposed to short term locum to ensure earliest possible discharge of patients with extended wait in ED	ASGD - Medicine	• Continuation of VP costs	• Consistency • Continuity of care • Senior decision maker availability
Key Date Resilience and Recovery Plans	Prepare detailed and bespoke plans for key holiday dates such as Christmas and New Year to include additionality to roles that support flow	SGD	• Additional cost	• Flow • Quality and Safety • Performance measures
Senior Manager of the Day Model	• Set up roster to support site in decision making and early escalation in hours • Chair Silver Cells in event of high escalation and to prevent BCI position	ASGD - AECHO	• Capacity – senior sign off	• Senior support for operational teams • Early decision making
Redesign of Site Meetings	• Complete site meeting data screen to support site meetings • Focus on clinical risks to include D2RA Red Days that require support to turn Green • Mitigate speciality risks via mitigations and action set in meetings • Reduce to 15 mins to ensure minimal time taken to release staff to fulfil actions • For 1500hrs meeting each ward to list 2 discharges for following morning to support early flow	ASGD - AECHO	N/A	• Efficiency • Focus on clinical risks • Minimise team down time • Home 4 Lunch
Expand Medical access to treatment	• Set up Neuro Hot Clinic within SDEC footprint • Respiratory Winter plan submitted	ASGD - Medicine	• Reduced capacity in SDEC • Capacity – eg nursing to bleed • Capacity – Admin – already under resourced – to be monitored	• Early access to specialist care • Potential to impact on planned care • Support for ACPs • Increased option for admission avoidance
Transfer Team	• The commissioning of a transfer team managed by site team • Focus on patient transfer and flow	ASGD - AECHO	• Financial (although pump primed by 4 Pillars funding)	• Improved efficiency in patient movements across the acute sites to support flow

Morriston–Tactical

Area	Actions	Internal Lead	Risk / Mitigation	System Benefits
Emergency Department	Additional shop floor Ops support to clinical teams via reallocation of staff responsibilities	ASGD - AECHO	• Training/coaching need – mitigated by senior managers	• Reduce burden on clinical staff • Focus on flow and escalation • Observe compliance with SBU Professional Standards
Site Management	Develop digital systems to support site team functions and reduce admin burden where site team have access to information rather than telephone conversations with wards areas	ASGD - AECHO	• Secondment of EB time limited – extended to end of Sept with view to extend further	• Focus on operational management • Support wards and specialities with barriers to flow
Emphasis on Workforce commitments	• Efficient Sickness management • Prompt recruitment into vacant posts • Support colleagues in accessing vaccines to support IP&C agenda and staff safety	All teams	• Delays in approval	• Reduction in V Pay • Roster resilience
Daily Flow Management	• Senior manager support for flow battle rhythm • Escalations mechanism to overcome delays in care • Weekend to follow same rhythm as weekday	ASGD - AECHO	• Capacity – MSG sign off	• Consistency in approach across 7 days
Closure of Capacity Gap	• Use business intelligence to inform capacity modelling • consider options to reduce the capacity gap across both community and hospital services	COO	• Finance • Workforce • Mitigation - Transformation outputs	• Bed Capacity • Improved Flow • Handover 45 • Reduced Crowding at Front Door

NPTS–Planning

Area	Actions	Internal Lead	Risk / Mitigation	System Benefits
Discharge Acceleration Unit	Establish Ward A as a hybrid bedded discharge unit and sit-out lounge, supported by a dedicated discharge team. Ring-fence agreed capacity for Breast and IP&C elective inpatients.	Hospital Operations	Risk: Funding, workforce and estate constraints. Further discussions require. Mitigation: Time-limited winter model, clear admission criteria and daily operational oversight.	• Releases acute beds earlier, reduces LOS and protects elective capacity.
Home for Lunch	Identify next-day discharges at the MDT huddle, complete TTOs, transport, equipment and community referrals in advance, and increase discharge before midday.	Hospital Operations	Risk: Inconsistent ward adoption. Mitigation: Ward-level targets, daily monitoring and escalation of missed discharges.	• Earlier bed availability, improved front-door flow and better patient experience
Rehabilitation Pull Model (NOF & Trauma)	Develop and implement a clinically-led T&O SOP and transfer criteria enabling NPT rehabilitation wards to actively "pull" post-operative #NOF and selected trauma patients from Morriston once medically optimised and rehabilitation-ready. Post Op report ready to go live – to help identify DTOC post op patients and their days post procedure.	T&O Clinical Lead, Hospital Operations	Risk: Variation in acceptance criteria, delayed transfers and bed availability. Mitigation: Agreed consultant-led SOP, standardised transfer criteria, daily trauma and rehabilitation bed meeting, and executive oversight of pathway performance.	
Pathway 3 Rehabilitation Model (Ward D)	Implement a PDSA cycle to establish Ward D as a dedicated 36-bed Pathway 3 rehabilitation unit for patients requiring ongoing assessment, therapy and discharge planning. Test revised admission criteria, therapy-led discharge pathways, expected LOS standards (<42 days), MDT operating model and community interfaces. Evaluate outcomes, bed utilisation, LOS and discharge rates with the intention of transitioning to a permanent BAU model if benefits are realised.	Hospital Operations, Therapies, Medicine, Local Authority Partners	Risk: Delays in community placements, inconsistent patient selection and failure to achieve LOS reductions. Mitigation: Agreed admission criteria, weekly performance review, executive oversight, strengthened MDT processes and formal evaluation of PDSA outcomes prior to BAU transition.	• Increases rehabilitation capacity and pathway flow. • Reduces delayed pathways and length of stay. • Improves utilisation of rehabilitation beds. • Supports acute bed availability through earlier transfer of medically optimised patients. • Creates evidence base for a sustainable BAU Pathway 3 model.

NPTS–Tactical

Area	Actions	Internal Lead	Risk / Mitigation	System Benefits
Daily Flow Management	Continue daily NPT and Singleton flow huddles covering bed capacity, predicted demand, clinically optimised patients, long-stay patients, workforce and elective pressures. Need to be part of the MSG Tactical Meetings	Hospital Operations	Risk: Delayed response to emerging pressure. Mitigation: Named actions, owners and same-day escalation	• Stronger operational grip and faster resolution of flow barriers.
Complex and Long-Stay Flow	Daily review of clinically optimised patients and LOS over 14 and 21 days, with immediate escalation of unresolved health, social care and community barriers.	Hospital Operations / MDT	Risk: Barriers remain unresolved across organisations. Mitigation: Named executive or senior owner and escalation through system meetings.	
Elective Protection	Monitor DSU, Ward A ring-fenced beds, elective admissions and cancellations daily. Escalate threats early and restore any displaced capacity promptly.	Planned Care / Site Team	Risk: Emergency pressures displace ring-fenced elective capacity, increasing cancellations and RTT backlog growth. Mitigation: Daily elective protection review, executive oversight of bed utilisation, agreed escalation process before use of ring-fenced beds, and rapid restoration of displaced capacity.	Support winter flow whilst protects Breast, IP&C, cancer and priority elective activity.

PCTS and OOH–Planning

Area	Actions	Internal Lead	Risk / Mitigation	System Benefits
Prevention: Vaccinations	Campaign and Comms developed to detail flu vaccination roll out plan District Nurses support flu immunisation for housebound patients	SM/SP	Increased GP Appointments needed Increased Hospital Admissions	Reduced demand GMS Reduced acute demand
Prevention: **Community Capacity:**	High risk population identified GMS services in place Comms Campaign to support access Community Pathways established COPD/ Breathlessness District Nursing service – Taking action to de escalate to Amber VW/ACT Transformation workshops scheduled (led by DU/PCT) Community Resource Teams- move towards regionalisation	SM/KM SP/CD	Increased GP Appointments needed Increased Hospital Admissions Vacancies in DN LA decisions to support CRT remodel	Maximise available capacity Improve referral and discharge times
Admission Avoidance:	OOH Building sustainability within the workforce in the period leading up to winter Urgent Primary Care Redesign to commence in September Acute Clinical Team,/Virtual War Review underway ACT -clinical review by GP's required Scoping pilot work WAST/DN to prevent conveyance community/yEOL/Care Home conveyance	EJ/CT	•Increased likelihood of service operating at L3/L4 •Avoid saturation of service •Reduced workforce •Inappropriate GMS referrals	Improved likelihood of service operating at L1/L2 Increased capacity/cover Improve accuracy of referrals Improve sustainability of workforce Enhanced capacity to support ED
Discharge: D2RA Flow	Centralised coordination of non-acute flow (implementation or sprint TBC) Completion of mapping and modelling P1, P3 Work with Care Homes to agree Friday/Weekend Admissions Redirect Nurse Assessor capacity to support P3 Implement escalation framework for all Pathways by October LTC to support W3/P3	EJ/SP	Increase demand Increased LOS P3 Reduced available beds Increased pressure on ED	Improve flow Improved outcomes for patients Reduced P3 LOS

PCTG and OOH–Tactical

Area	Actions	Internal Lead	Risk / Mitigation	System Benefits
Operational Management	2 X Daily PCT Huddle to provide real time data on demand and capacity and forecast and to provide assurance on system flow into D2RA pathways and support for community patients to ensure admission avoidance.	EJ	•Escalating pressures •Increased demand •Reduced staffing	•Real time understanding of demand and capacity
Operational Management	•Weekly Regional Operational Assurance Group to provide leadership and oversight of all integrated activity to support D2RA •Weekly POCD Review and site wide COP meetings	EJ	•Reduced performance •Increased delays •Capacity issues	•Effective oversight and assurance and ability for responsive mitigations to risk
Operational Management/Assurance	•Weekly Triumvirate –Provide assurance of effective PCT Escalation Frameworks for D2RA/Community services /GMS	EJ	•Service disruption due to reduced stafing, rising demand and access due to weather	•Integrated oversight at Triumvirate level anility to direct resource and activity as system requires
Operational Management/Assurance	•Review of Out of Hours Policies and Procedures to ensure all PCT Silvers are able to operate effectively during the winter and holiday periods	EJ	•Lack of knowledge •Outdated policies and procedures	•Effective Silver support in periods of enhanced crisis/challenges

Mental Health and LD–Planning

Area	Actions	Internal Lead	Risk / Mitigation	System Benefits
Mental Health Crisis Pathways	Review and strengthen Crisis Resolution Home Treatment Team (CRHTT) capacity and response times for winter demand.	Divisional Manager MH/Lead Nurses	Increased crisis presentations. Mitigation: enhanced triage and senior clinical oversight.	Reduces admissions and ED attendances.
Inpatient flow & Discharge	Weekly reviews of delayed discharges and repatriation arrangements. Strengthen discharge planning from admission	Lead nurses/ward managers /MDT	Delayed transfer reducing bed availability. Mitigation: early discharge planning and multi-agency reviews	Improved bed availability and patient flow
Community Mental Health Services	Maintain community follow-up and proactive support for high-risk individuals during winter periods.	Lead Nurses/CMHT managers	Increased deterioration and relapse. Mitigation: Risk management and targeted reviews	Prevents crisis escalation and hospital admission
Learning Disability	Review contingency arrangements for people with complex needs and those at risk of placement breakdown.	Divisional Manager LD	Placement instability over winter. Mitigation: proactive case reviews and provider engagement.	Reduces emergency admissions and out-of-area placements.
Workforce Resilience	Winter workforce plan, leave management, bank/agency arrangements and staff wellbeing support	SMT/DM's/Lead Nurses	Sickness and staffing shortages. Mitigation: escalation processes and flexible deployment.	Maintains safe service delivery.
Partnership Working	Strengthen links with Primary Care, Local Authorities, Third Sector and Police through winter planning arrangements	SMT	Increased demand across system. Mitigation: shared escalation and communication routes	Coordinated whole-system response.
Business Continuity	Review winter resilience and business continuity plans for all MH&LD services.	SMT/OPS	Service disruption due to weather or operational pressures. Mitigation: tested continuity plans	Service continuity and patient safety.

Mental Health and LD–Tactical

Area	Actions	Internal Lead	Risk / Mitigation	System Benefits
Daily Operational Oversight	Daily review of inpatient occupancy, delayed discharge, staffing and crisis demand.	Divisional managers MH/Lead Nurses	Escalating pressures identified late. Mitigation: daily operational calls.	Improved grip on capacity and flow.
Crisis Response	Prioritise same-day assessment for urgent referrals and maximise home treatment alternatives	CHTT	Increased admissions. Mitigation: senior clinical review of admission requests.	Admission avoidance and reduced pressure on beds.
Inpatient Capacity Management	Escalation process for occupancy pressures and rapid transfer/repatriation arrangements.	Ward managers/Lead nurses	Bed occupancy exceeding safe levels. Mitigation: escalation framework/bed policy.	Maintains access to inpatient care
Emergency Department Liaison	Enhanced liaison with ED and acute wards to support patients presenting in mental health crisis	Liaison Psychiatry Lead	Longer waits and inappropriate admissions. Mitigation: rapid psychiatric assessment.	Supports patient flow across UEC pathway.
Learning Disability Support	Increased specialist advice for people with LD/autism to prevent avoidable admissions.	Lead Nurses/Divisional manager LD	Crisis escalation and placement breakdown. Mitigation: urgent MDT reviews.	Improved community stability.
Workforce Escalation	Activate staffing escalation process, redeployment when required. Work with MDT to support service delivery	Nurse Lead/ AHP Leads	Staffing gaps impacting safety. Mitigation: escalation and mutual aid.	Maintains safe staffing levels
System Escalation & Command	Representation within Health Board operational command and winter escalation arrangements.	Service Director/SMT	MH&LD pressures not visible in system response. Mitigation: regular reporting and escalation.	Integrated cross-system decision making

Support Services

Area	Actions	Internal Lead	Risk / Mitigation	System Benefits
Transport DDV	Provision of DDV vehicle – per acute site	Support Services	• Support patient flow and discharge planning	• Improve flow
Domestic Services	• Provision of rapid response domestic services	Domestic Site Team Support Services	• Support patient flow • Decontamination to reduce cross contamination and infection	• Improve patient flow • Reduce spread of infection and cross contamination
Portering Services	• Provision of porters to support any patient movement task in a more timely manner	Portering Site Team	• Support patient flow	• Improve flow and reduce patient movement delays