

**Planning Together for Winter 2025/2026: Regional Self-Assessment Template**

This template is provided as part of the Planning Together for Winter 2025/2026 Toolkit to support regions to self-assessing their readiness against the expectations outlined. Please complete the self-assessment template and return it to *(insert email address)* by *(date)* 2025.

Winter Strategic	Key Actions	Deadline for delivery	RAG Rating	Implementation Status	Risks	Gaps	Controls In Place
1. Building community capacity to support care closer to home	Proactive management of 0.5% most at risk of urgent care (including falls / care home residents) through implementation of Proactive Care principles by Regional Partnership Boards, Pan Cluster Planning Groups and integrated health and social care community	01-Dec-25	Red	<p>Frailty registers have been implemented in GP practices. These have enabled the identification of the 2% most frail patients within their practice population using the electronic frailty index.</p> <p>High Risk patients are also identified following front door attendance or admission, and details shared with Virtual Wards. This allows the GP and Virtual Wards to proactively manage this high risk/ vulnerable patient group, optimise existing comorbidities and prevent further admission.</p> <p>West Glamorgan currently has 30 surgeries across the region that are actively participating in the Care Home (pandemic) Directed Supplementary Service.</p> <p>Piloting the Roll out of Consultant Connect Technology to Care Homes in partnership with Welsh Govt and providers.</p>	There is no share of funding for implementing this scheme at practice or cluster level. Any actions would be dependant on funding being made available.	There is no shared funding available at the practice or cluster level for implementing the scheme. This could significantly impact the feasibility and sustainability of the proposed actions.	<p>1. Frailty Registers in GP Practices - These are already implemented and allow identification of the most vulnerable patients using the electronic frailty index. This is a low cost, data-driven approach that supports proactive care without requiring new funding.</p> <p>2. Virtual Ward Integration - High-risk patients are flagged during hospital attendance and shared with Virtual Wards. This leverages existing systems and staff to manage risk without additional financial burden.</p> <p>3. Care Home Directed Supplementary Service Participation - 30 surgeries are actively involved, utilising existing</p>
	Health boards provide robust community nursing services to support the multiprofessional team around the person across a 7 day period - Weekend capacity should be at circa 80% of that of weekday. Self Assessment and subsequent planning should consider and advise improvement trajectories against target expectation	01-Dec-25	Amber	<p>Swansea Bay University Health Board currently delivers a range of services that support multiprofessional teams across a 7-day working week, though coverage levels vary depending on available resources and contractual arrangements. Services such as ACT, district nursing, domiciliary care, and community reablement teams operate over 7 days where possible, with further enhancements requiring additional funding.</p> <p>While social workers are not contractually required to work weekends, senior decision-makers and operational staff are available on-call to support discharge planning. Community therapies maintain 7-day working with a specific focus on weekend flow, and secondary care therapists also support weekend and on-call rotas. The community equipment store provides 7-day access via satellite equipment pods across the region.</p> <p>Transport and pharmacy services are available throughout the week. Pharmacy is scaled back on weekends, but out-of-hours access is supported through WP10 availability in admission areas and pre-pack options for post-surgical patients. A pharmacist is also on call for out-of-hours needs.</p> <p>The Integrated Discharge Hub pilot, launched in July 2024, currently operates Monday to Friday without additional resource. A business case is being developed to support sustainable 7-day delivery as part of seasonal planning. Reablement services are available 7 days a week, with senior care assistants rota'd to initiate packages. In-house domiciliary care also operates across the full week, and commissioners are engaging with external providers to maintain discharge flow during surge periods.</p> <p>Clear leadership and collaborative escalation are in place throughout the week, with robust planning for weekend discharges. This is essential given the reduced scale of weekend services compared to weekdays. These arrangements demonstrate Swansea Bay's commitment to consistent coverage and integration with multiprofessional teams.</p> <p>To meet the target expectation of weekend capacity reaching approximately 80% of weekday levels, self-assessment and planning should continue to identify improvement trajectories and investment needs.</p>	<p>Variability in weekend staffing and service availability could lead to delays in discharge, reduced patient flow, and increased hospital bed occupancy.</p> <p>Depending on on-call support rather than contracted weekend staffing may result in limited decision-making capacity and slower response times.</p> <p>Reduced pharmacy services on weekends could lead to medication delays, especially for post-surgical or urgent discharge patients.</p> <p>Further enhancements are dependent on additional funding, which introduces uncertainty and potential delays in achieving full 7-day coverage.</p>	<p>Coverage levels vary depending on resources and contractual arrangements, which may lead to inconsistent service delivery.</p> <p>Pharmacy services are scaled back on weekends, relying on workaround solutions like WP10 and pre-packs.</p> <p>Social workers are not contractually required to work weekends, potentially impacting multidisciplinary discharge planning.</p> <p>The integrated Discharge Hub currently operates only Monday to Friday, limiting its impact during weekend surges.</p>	<p>Services such as ACT, district nursing, domiciliary care, community reablement, and community therapists are already operating across 7 days where possible.</p> <p>Transport and pharmacy services are available throughout the week, with out-of-hours pharmacy access supported via WP10 and pre-pack options.</p> <p>Senior social work decision-makers and operational staff are available on-call to support discharge planning, even though social workers are not contractually required to work weekends.</p> <p>The community equipment store provides 7-day access via satellite pods.</p> <p>Community and secondary care therapists support weekend and on-call rotas.</p> <p>IDH currently operating Monday to Friday, a business case is being developed to support 7-day delivery.</p> <p>Reablement and in house Dom care services are available 7 days a week, with senior care assistants empowered to initiate packages.</p>
	Health Boards and Local Authorities to collaborate to continue to increase referrals to Enhanced Community Care and Multi Professional Wrap Around Care (including Reablement). Self Assessment and subsequent planning should consider and advise improvement trajectories.	01-Dec-25	Green	<p>Community Review Commissioned: As of July 2025, a new CRT demand modelling tool has been launched for Neath Port Talbot CRT, with Swansea implementation expected by autumn.</p> <p>D2RA Pathways Embedded: Across West Glamorgan, Discharge to Recover then Assess (D2RA) pathways are fully embedded into practice. All service users are assigned a pathway within 24 hours of admission, following a "what matters to me" conversation with the patient, their relatives, or carer.</p> <p>Integrated Discharge Hub: Referrals are reviewed and agreed once the patient is clinically optimised for community care. Daily board rounds ensure pathways are reviewed, actions are taken, and accountability is maintained.</p> <p>Home First Approach: The default discharge position is to return patients to their home, using proportionate assessments to support this goal.</p> <p>Rehabilitation and Reablement Services: These services ensure continuity of care during the transition from hospital to home. Full assessments are conducted at home post-recovery to better understand ongoing needs.</p> <p>Pathway-Specific Discharge Targets:</p> <p>Pathway 0: Same-day discharge with pre-arranged support.</p> <p>Pathways 1-3: Targeted discharge within 48 hours of clinical optimisation, though delays may occur due to legal and safeguarding processes.</p> <p>Pathway of Care Delays Workstream: This initiative is analysing granular data and individual cases to expedite discharge where possible.</p> <p>Integrated Team Support: Joint health and social care arrangements are in place to support discharge planning, including early identification of high-risk patients and proactive communication with community professionals and families.</p> <p>Operational Improvements:</p>	<p>Delay in rolling out the CRT tool in Swansea could lead to inconsistent service planning and resource allocation.</p> <p>While daily huddles and board rounds are effective, they may be resource-intensive and vulnerable to staffing pressures or operational disruptions.</p> <p>Discharge targets for Pathways 1-3 may be missed due to external legal or safeguarding processes, which are often outside the control of health and care teams.</p> <p>The success of integrated discharge planning depends on ongoing collaboration between health and social care, which may be at risk if priorities or funding diverge.</p>	<p>The CRT demand modelling tool is only live in Neath Port Talbot; Swansea's implementation is pending, which may create regional variation in planning quality.</p>	<p>A new CRT demand modelling tool has been launched in Neath Port Talbot, with Swansea implementation expected by autumn, supporting data-driven planning and resource allocation.</p> <p>Discharge to Recover then Assess (D2RA) pathways are fully embedded, with all patients assigned a pathway within 24 hours of admission, ensuring timely and person-centred discharge planning.</p> <p>Referrals are reviewed once patients are clinically optimised in the IDH. Daily board rounds ensure accountability and timely action.</p> <p>The default discharge goal is to return patients home, supported by proportionate assessments, promoting independence and reducing unnecessary care home placements.</p> <p>Joint health and social care arrangements support early identification of high-risk patients and proactive communication with families and professionals.</p> <p>Clear targets are in place:</p> <p>Pathway 0: Same-day discharge with pre-arranged support.</p> <p>Pathways 1-3: Discharge within 48 hours of clinical optimisation (with exceptions for legal/safeguarding delays)</p>

Implement Single Point of Access to Urgent Care (LHBs) as a component of enhanced regional system navigation	Oct-25	Amber	<p>Partial approval of funding bid submitted (E49k) - Awaiting confirmation of final award to progress SPOA (UEC Nav. Hub). Work underway building on SDEC services already in place (and providing 5 day model) - further work required. For acute hospital care navigation we have recently stood up a 'UEC Care Co-ordination Hub Task &amp; Finish Group'. This Task &amp; Finish Group has been established to develop a service model for pre-hospital triage and clinical management of patients. The multi-agency group have been established to develop and implement a service model aimed at appropriate streaming of patients into the various UEC pathways within Swansea Bay and to improve admission avoidance and to reduce ambulance conveyance to hospital where clinically appropriate.</p> <p>The aim of the 'UEC Care Co-ordination Hub' is to be a central point that focuses on avoiding conveyance and admission avoidance ensuring people have timely and safe alternatives to attendance at emergency departments (the previously mentioned IDH providing discharge coordination and support). Implementation to be over the winter period with a desire to provide 7-day provision (subject to funding). Where funding is a challenge, it is anticipated that existing services such as GPOOH will be utilised. The UEC Care Co-ordination Hub will provide:</p> <ul style="list-style-type: none"> <li>•Multi professional assessment of need and oversight of subsequent care plans that meets the holistic and complex needs of the population it serves.</li> <li>•Ensure that high risk cohorts are flagged and a shared record (proportionate) available to all professionals involved in the persons care.</li> <li>•Accept referrals from local health and social care professionals for assessment and consideration of escalated needs (includes discharge from hospital, care homes, WAST) to mitigate risk of crisis and provide a safe alternative to hospital (e.g. Enhanced Community Care and / or reablement) where it is safe and appropriate to do so.</li> <li>•Accept referrals from '999' / '111' and other health care professionals</li> <li>•Direct access to pathways that facilitate diagnostic assessment e.g. direct referral to SDEC/ Older Persons Assessment Unit etc.</li> </ul> <p>Initial focus for September 25 is on the 'call before convey' initiative whereby paramedics who attend a call in a Care Home contact the UEC SPOA to have a clinical discussion regarding the case and to explore clinically safe alternatives to conveyance which may include referral to community based services/teams.</p> <p>The SPOA will have access to ED, internal specialties, Older Persons Assessment services, Same Day Emergency Care services and community services. Social Care can be accessed via the Common Access Point in Swansea and the Single Point of Access in NPT.</p>	Unsustainable funding could limit implementation and scalability of the UEC SPOA.	Limited service model - not able to realise the full potential of the UEC SPOA	<p>5 day limited model in place.</p> <p>SPOA (SBUHB UEC Navigation Hub) workgroup stood up (to include membership from WAST and LA)</p> <p>WG Six Goals bid submitted to enhance the 5 day model - this partially approved (initial funding allocated) with remainder under review</p> <p>Some of the service functionality will shift to GPOOH outside of the operating hours of the UEC SPOA.</p>
Within an integrated IAA model of care, implement the six goals programme community-based falls response framework	Nov-25	Amber	<p>Level 1 Response – Four Approaches:</p> <ul style="list-style-type: none"> <li>- Domiciliary Care – Now active, with 8 providers delivering Level 1 falls response.</li> <li>- Care Homes – Project live with one care home and one nursing home; wider roll-out planned for September 2025.</li> <li>- St John Ambulance – Pilot underway; data collection in progress to assess impact.</li> <li>- Telecare – Local authority developing a business case to explore an in-house falls response model.</li> </ul> <p>Monies have been accessed from a competitive bidding process via 6 Goals until end of 25/26 F/Y – plans include:</p> <ul style="list-style-type: none"> <li>- Further roll-out of iStumble application and procurement of lifting cushions for care homes and domiciliary care providers</li> <li>- Associated training for care homes re; use of iStumble application/ assessment tool and how safely lift form the floor</li> <li>- Level 1+ service to be procured from St Johns Ambulance (First Aider in a car) to provide 'eyes on' and level 1+ treatment at scene of faller(s)</li> <li>- Enhanced senior therapies support to facilitate Therapy Technicians in the community and provide a L2 falls service (avoid unnecessary conveyance and/ or lengthy waits on the floor after a fall)</li> </ul>	<p>Uncertainty in local authority funding and timelines for telecare model.</p> <p>National pilot for SJA response - funding unknown for future development</p>	<p>Level 2 response - currently no level 2 falls response available.</p> <p>Discussions with UEC to develop proposal underway.</p>	<p>real time data available for dom care and care home projects Ongoing engagement with providers and local authority partners.</p> <p>Scheduled evaluation points built into pilot projects.</p> <p>September 2025 roll-out plan in place for care home expansion.</p> <p>Business case development to ensure</p>
Implement community breathlessness hubs (*three pilot sites only)	31-Oct-25		<p>Awaiting formal notification of allocation of funding, which will pay for additional resources and equipment. Clusters are well placed to take on the pilot with 2 Spirometry Hubs (Neath and Gowerton), 11 practices in pilot for acute respiratory illness and an echocardiogram hub.</p>			
Health boards to commission Supplementary Services from General Medical Services to support identification of 0.5% population at greatest risk of urgent care needs	01-Dec-25	Red	<p>Frailty registers have been implemented in GP practices. These have enabled the identification of the 2% most frail patients within their practice population using the electronic frailty index.</p> <p>High Risk patients are also identified following front door attendance or admission, and details shared with Virtual Wards. This allows the GP and Virtual Wards to proactively manage this high risk/ vulnerable patient group, optimise existing comorbidities and prevent further admission.</p> <p>West Glamorgan currently has 30 surgeries across the region that are actively participating in the Care Home (pandemic) Directed Supplementary Service.</p> <p>Piloting the Roll out of Consultant Connect Technology to Care Homes in partnership with Welsh Govt and providers.</p>	<p>There is no share of funding for implementing this scheme at practice or cluster level. Any actions would be dependant on funding being made available.</p>		<p>Service improvement work as described will continue to support.</p>
Implement 'neighbourhood level' timely, accessible, coordinated and TEC enabled Information, Advice and Assistance (IAA)	01-Dec-25	Green	<p>Local authority's 'front doors' to Adult Social care fully embedded.</p> <p>Adult Services Common Access Point (CAP) within Swansea council includes IAA offer enhanced with additional Early Help roles including Wellbeing officers via third sector commissioned support for short term case management and co-ordinated support to prevent / delay escalation of need. Also Sensory Support Team and Carers Support worker working alongside information and advice assistants. within CAP fully operational integrated MDT in situ with therapy and social work input. Rapid response function also operational within CAP. NPT Single Point of Contact (SPOC) offers IAA. NPT has an established prevention service and staff dedicated to supporting individuals with TEC.</p>	<p>Workforce capacity pressures may impact timely response and continuity.</p>		
Health Boards to promote community pharmacy services (Sore Throat Test and Treat / UTI services)	01-Oct-25	Green	<p>Community pharmacy provision to support demand and capacity –including common ailments scheme, out of hours provision, UTI services, Sore Throat , Test and Treat, Flu programme (89 practices)</p>			
Increasing uptake among staff groups through LHB review of winter 24/25; vaccination champions; peer vaccinators; MECC; and routine monitoring	31-Dec-25	Amber	<p>Our HB plan to vaccinate staff groups has been revised. To date we have recruited over 100 peer vaccinators in order to support staff flu vaccination across the Health Board; ensuring high risk areas are covered. MECC will be part of the training offered this year. Well-being champions will be provided with information to support positive conversations regarding flu to colleagues. Staff flu vaccination dashboard will be updated in advance of the season, which will be accessible to each SDG flu lead.</p> <p>Immunisation team to support SDG with lowest uptake in the 2024/25 season during the first few weeks of the campaign</p>	<p>Current vacancies within the immunisation team will reduce ability to support effectively and efficiently during the Winter months.</p> <p>Understanding the importance of vaccination/myths around influenza and it's risks continues to be a risk to improved vaccination uptake.</p>	<p>Not all wards/departments will have peer vaccinators</p>	<p>Flu leads in each SDG. Vaccination bases at hospital sites in addition to mobile vaccination sessions will support vaccination in areas where there are no peer vaccinators in place.</p> <p>Revised communication plan will be in place to address myths.</p> <p>Increased number of peer vaccinators and support from well-being champions will also mitigate risk.</p>

	To increase uptake of vaccines to protect against winter respiratory illnesses, consider targeting populations in areas of socio-economic deprivation	01-Oct-25	Amber	GP's and community pharmacists are main providers of the flu and COVID-19 vaccination in primary care, with additional support from the immunisation team. All links to the National resources available have been shared in addition to the Health Equity and inclusion toolkit (PHW) to complete. We are also forwarding resources to all partners; primary, secondary and third sector organisation. The immunisation team are scoping community based venues in order to support improved uptake from December 2025, as outlined in the WHC and will target the lower performing areas in the first instance. The Imbalance will also be utilised in order to provide an equitable offer of vaccination. HB comms are developing a communication plan to support uptake throughout the Winter months. Contact has been made to all specialist nursing teams, including those who are immunosuppressed to promote uptake of the vaccine. Care home staff will be sign posted to community pharmacy, or GP if staff are in at risk groups. A pilot vaccination programme is planned to support improved uptake of the 2 and 3 year old flu vaccination programme in two clusters from September. RSV vaccination programme will continue following support from the immunisation team during the Summer months to improve vaccination uptake in this cohort.	Potential risks that partners may not utilise information links that have been shared.	Timescales for PHW to produce resources in alternative languages to Welsh and english may take up to two weeks to produce.	Immunisation team will order some resources in alternative languages in advance, for primary care to receive, if required.
	Health boards to ensure clinical teams in primary and community settings dealing with chronic and acute respiratory disease are encouraged to apply, where appropriate, the nationally agreed management guidelines for COPD, asthma, RSV Bronchiolitis, and Community Acquired Pneumonia.	01-Dec-25	Green	Clinical teams in primary and community will be issued communications highlighting the guidelines to encourage compliance. This will include all GP practices/ OOH and UPCC. Cluster CRP project will be continued with evaluation undertaken..	Risk if outbreak or system becomes overwhelmed that patients will not be able to be seen face to face.		
<b>2. Maximise available acute hospital capacity</b>	Review of emergency department delivery plans informed by GIRFT recommendations, ambulance patient handover guidance (WHC) and the quality statement for care in ED	Nov-25	Green	Self assessment in progress against the GIRFT and MAG recommendations to ensure continuous improvement programme addresses the key findings of these reviews. Recent changes to the operating model in Morriston and the wider Health Board have resulted in significant improvement in the ambulance patient handover position however further work is required to reduce the handover times as part of the UEC continuous improvement programme. Follow-up GIRFT visit scheduled 4th Sept 25.	ED workforce risks associated with closing the ED assessment delays.	Potential workforce gaps in relation to medical cover to address the work in progress position that results in the assessment delays during the overnight period.	Currently testing different models of medical workforce deployment in the department as part of the continuous improvement programme with the aim of reducing assessment delays.
	Develop regional operational resilience plans for the period 22 December 2025 – 13 January 2026 (*separate guidance to be issued by WG July 2025)	15-Oct-25	Amber	Yet to receive the guidance and templates. However, work has already been progressed in preparation for the completion of the template by all service groups			
	Implement an Acute Front Door Frailty Service at all acute hospitals (building on implementation of SDEC services)	Ongoing develop	Amber	5 day acute frailty service in place.	Risk associated with recruitment to provide seven day service model.	Workforce gaps, including nursing, therapies and in particular Consultant cover as they are rostered into the Acute Medical on call rota currently.	Limited service provision
	Deliver a pilot 'Urgent Care Centre' service at up to three sites across Wales (co-located and standalone) (*pilot sites only)	01-Dec-25		Awaiting confirmation of pilot site			
	Development and delivery of a plan capable of effectively managing periods of increased demand in paediatric care across acute services on an all-Wales basis (*health boards to connect to nationally led NHS PI work)	01-Dec-25	Green	Winter plan for acute paediatric services fully imbedded within the service	Planned care would be cancelled due to capacity issues.	IPC constraints due to minimal cubicle capacity on ward template	Risk assessments, robust winter plan including seeking mutual aid from neighbouring HB
	Health boards must follow Infection Prevention and Control guidance to reduce Acute Respiratory Infections transmission	Throughout	Amber	<ul style="list-style-type: none"> <li>Implemented throughout the year as cases present.</li> <li>Testing of symptomatic patients is in line with national policy. Access hot-lab testing where timing of results is critical.</li> <li>Isolation and cohorting in line with national IPC Measures for ARI (2024 v3.0a)</li> <li>Local and national surveillance informs universal masking when circulating community incidence increases and informs public visiting (also enacted during outbreaks).</li> </ul>	<ul style="list-style-type: none"> <li>Unscheduled care and emergency patients present with one condition, but may be asymptomatic with ARI and infectious.</li> <li>Insufficient numbers of single rooms in ED, Acute Medical Units and Surgical Assessment Unit and in Morriston wards.</li> <li>Lack of mechanical ventilation on acute hospital wards and departments, including ED. Limited impact of natural ventilation as windows generally on one wall only and there is no cross-flow.</li> <li>Poor update of vaccination.</li> </ul>	<ul style="list-style-type: none"> <li>Limited access to hot lab rapid testing based on laboratory capacity.</li> <li>Potential delays in test results with samples being sent from other hospital sites to the laboratory in Singleton.</li> <li>No lateral flow testing availability.</li> </ul>	<ul style="list-style-type: none"> <li>Where there is no mechanical ventilation, windows are opened to improve natural ventilation, although with limitations due to lack of cross-flow.</li> <li>Potential delays in test results with samples being sent from other hospital sites to the laboratory in Singleton.</li> <li>Transmission-based precautions and isolation or cohorting.</li> </ul>
	Healthcare Associated Infections (HCAI): Health boards and NHS Trusts must deliver against the improvement goals set out in the Welsh Health Circular issued in September 2024	Throughout	Amber	<ul style="list-style-type: none"> <li>Internal improvement plans in place with trajectories set and monitored in line with WHC2024(038).</li> </ul>	<ul style="list-style-type: none"> <li>Off trajectory for</li> <li>Insufficient numbers of single rooms in ED, Acute Medical Units and Surgical Assessment Unit and in Morriston wards.</li> <li>Lack of mechanical ventilation on acute hospital wards and departments, including ED. Limited impact of natural ventilation as windows generally on one wall only and there is no cross-flow.</li> <li>High- or over-occupancy on wards and departments.</li> <li>Lack of mechanical ventilation on acute hospital wards and departments, including ED. Limited impact of natural ventilation as windows generally on one wall only and there is no cross-flow.</li> </ul>		<ul style="list-style-type: none"> <li>Policies, procedures, protocols and guidelines supplement the National Infection Control Manual.</li> <li>IPC related-training provided programmes.</li> <li>IPC-related audit management and tracking system.</li> <li>Surveillance of infections, with early identification of increased incidence, and instigation of controls.</li> <li>Antimicrobial stewardship programmes and systems of monitoring and feedback.</li> <li>Provision of cleaning service to meet National Standards of Cleanliness.</li> <li>Infection Improvement Plans.</li> </ul>

3. Optimal hospital patient flow and a home first approach	Consistent delivery of the six goals programme 'optimal hospital flow framework'	01-Dec-25	Amber	<p>Ward J, test bed for Optimal Hospital Flow framework with a view to roll out Health Board wide. Two Band 6 posts out to advert.</p> <p>Working with Deloitte colleagues to explore the financial opportunity associated with improved flow and improved operating processes at ward level.</p>	Two Band 6 appointments - fixed term to end Mar 26. Likely to have six months only in post due to delayed recruitment.	Training and education resource that the Band 6 roles would have offered to work with ward based MDT's to deliver the optimal flow model.	
	Applying a proportionate approach to 7-day health and social care working to enable discharge of people during the weekend and prevent admission.	01-Dec-25	Amber	<p>A proportionate 7-day working model is already in place across several health and social care services to support discharge and prevent admission over weekends. Key services such as ACT, District Nursing, Domiciliary Care, Community Reablement Teams, and Community Therapies operate across 7 days where resources and contracts allow. Senior decision-makers and operational staff are available on-call to support weekend discharges, and transport and pharmacy services are also accessible, albeit scaled back.</p> <p>The Integrated Discharge Hub pilot, launched in July 2024, currently operates Monday to Friday without additional resource, with a business case underway to extend this to 7 days. Reablement services, including senior care assistants, and in-house domiciliary care are available 7 days a week. Equipment access is supported through regional satellite pods.</p> <p>However, full 7-day coverage across all services would require additional funding and contractual changes—particularly for Social Workers, who are not currently contracted for weekend work. Continued collaboration and robust weekend planning are essential to maintain flow, especially during surge periods.</p>	Some reduction in flow over the weekend	Limited coverage, especially for social care	Senior pharmacy services are accessible on a contact basis over weekends.
	Undertaking Decision Support Tools (DST)/CHC process in the community	01-Dec-25	Amber	<p>West Glamorgan prioritises timely and community-based assessments through the Decision Support Tool (DST) and Continuing Healthcare (CHC) processes. A 50/50 funding agreement, established during the COVID-19 pandemic, remains in place to support older individuals undergoing DST assessments at home within a two-week timeframe—ensuring no delays in care.</p> <p>Integrated teams, in place since 2012, consist of trained nurses and social workers who receive joint CHC training from the Long-Term Care Team. These professionals are skilled in conducting assessments and maintaining high standards of care. Individuals and their representatives are actively involved in discussions, with translators available to support language preferences.</p> <p>Currently, no commissioned step-down beds are available in care homes due to past challenges. However, West Glamorgan is exploring alternative discharge options. Key challenges identified include:</p> <p>Availability of Beds: Ensuring timely access to suitable facilities.  Quality of Care: Maintaining high standards in step-down settings.  Coordination: Strengthening collaboration across hospitals, care homes, and community services.  Funding and Resources: Securing sustainable support for the model.</p>	<p>Lack of step-down beds may lead to delayed discharges, increased hospital stays, and pressure on acute care capacity.</p> <p>Exploring new discharge options without established standards may risk inconsistent quality of care.</p> <p>Effective collaboration across hospitals, care homes, and community services is essential.</p> <p>Weak coordination could result in fragmented care and missed opportunities for timely discharge.</p> <p>While the 50/50 funding model is in place, long-term sustainability is uncertain, especially if demand increases or if additional services (e.g., step-down beds) are introduced.</p> <p>Maintaining a skilled and available workforce for DST/CHC assessments is critical. Any staffing shortages or training gaps could impact assessment quality and timeliness.</p>	<p>Currently, there are no care home beds commissioned for step-down use, limiting options for patients who cannot return home immediately.</p>	<p>A joint funding model between health and social care, established during COVID-19, remains in place to support timely DST assessments at home.</p> <p>Since 2012, West Glamorgan has maintained integrated teams of trained nurses and social workers, jointly trained by the Long-Term Care Team to conduct DST/CHC assessments. DST assessments are conducted within a two-week timeframe, helping avoid delays in care provision.</p> <p>Individuals and their representatives are actively involved in the assessment process, with translator support available to meet language needs.</p> <p>In response to the lack of commissioned step-down beds, West Glamorgan is actively exploring alternative discharge pathways.</p>
Implementing an integrated method for System Navigation	01-Dec-25	Amber	<p>Expansion of services is dependent on additional funding and contractual changes, particularly for social care roles.</p> <p><b>PLEASE REFER TO UEC SPOA/ NAVIGATION HUB (ROW 10)</b></p> <p>The SPOA will have access to ED, internal specialties, Older Persons Assessment services, Same Day Emergency Care services and community services. Social Care can be accessed via the Common Access Point in Swansea and the Single Point of Access in NPT.</p>		Expansion of services is dependent on additional funding and contractual changes, particularly for social care roles.	Active focus on improving flow Monday - Friday, limited demand for D2RA discharges for Saturday and Sunday	

Consistent delivery of the Trusted Assessor model	01-Dec-25	Amber	<p>D2RA Programme established and TA model agreed along with referral form. Programme of implementation/Training to commence from Sept</p> <p>We have a strong Trusted Assessor model that assess for: Community Reablement; Bedded Reablement; EMI Resettlement Assessment Beds. Action for the next period is to develop stronger trusted assessor role with external care home providers and long-term Dom care.</p> <p>West Glamorgan promotes "Home First" where possible and uses the discharge to recover then assess model extensively</p> <p>Our current trusted Assessor model promotes a proportionate assessment and discharge to domiciliary care reablement and short-term bedded reablement, to promote recovery pending full assessment for those with ongoing care and support needs. Changes to the structure of the assessment and care management functions have been designed to increase the review function to support the undertaking of timely and agile reviews.</p> <p>Discussions have recently started to explore the opportunities for Hospital based physio or OT use proportionate assessment to step down to a care home or commission Reablement or bridging community services.</p> <p>Trusted Assessors / Community Discharge Liaison Nurses are working closely with Care Homes to develop relationships and support the acceptance of their trusted assessment to facilitate discharges for individuals returning to a care home.</p> <p>There is a long-standing Trusted Assessment approach to support nonregistered therapy staff to prescribe equipment.</p> <p>Trusted Assessors / Community Discharge Liaison Nurses work to support step down to our inhouse reablement service.</p> <p>Some of our Community services (community DLN team) have been aligned to deliver the integrated discharge hub to pull patients from the wards.</p> <p>As part of IDH roll out a specific work strand on developing TA model at P3 will be taken forward.</p>	All partners to sign up to changing current processes and changing to current model	All partners to sign up to changing current processes and changing to current model	T&F group established to ensure adequate trusted assessor model for West Glamorgan is developed due September/October
Embed D2RA Pathways into practice (optimising the Home First approach)	01-Dec-25	Amber	<p>Home first will be default position and all patients will auto-register as Pathway 0. D2RA hub with multi-disciplinary team including LA in place. Trusted assessment model with proportionate assessment in use in front door service areas. Capacity and demand in progress as part of the community services review. Reliant on the P1 capacity to implement the D2RA model Health Board wide.</p>	<p>Insufficient capacity in the community to discharge patients to Pathway 1 within 48 hours.</p> <p>Ongoing delivery of the D2RA Hub as a temporary operating model - need to move to OCP with LA commitment to equally commit the appropriate level of resource.</p>	Unquantified at present pending the demand and capacity review.	Training and implementation will take place from October onwards subject to available resources