Response to Question from Councillor Altaf Hussain by the Cabinet Member Social Services and Early Help – Meeting of Council – 1 November 2017 – **Agenda item 8 (b)**

In response to the Council question concerning Winter resilience planning across Bridgend, the Health Board's Primary Care and Community Services maintain constant efforts to maintain flow through its services to ensure maximum capacity is made available daily, a significant part of which are integrated with Bridgend CBC social care and wellbeing services. This is one element of a whole system that underpins Secondary Healthcare performance across the region. The annual Flu campaign continues and the Public Health message encouraging uptake has been important in our winter preparations, as is the "Choose Well" campaign. This reminds us that we, the public, all have a role to play in safeguarding our hospitals through the Winter and every other time during the year, to ensure hospital services are available to those that require their specific intervention.

The specific Bridgend component to support the Winter planning and resilience, which has been enhanced since last Winter, is now embedded in usual service provision and includes:

- Domiciliary care/Home care as an embedded 7 day service
- The provision of **Acute Care team (ACT)** in the community providing rapid response and intervention to support patients in their own homes, including care homes. This is a core component of the "optimal model" for the integrated Community Resource Team (CRT) implemented through Western Bay. These services are consultant led and operate 7 days a week
- ACT Bridgend are offering more services to enable to people to remain at home where it is appropriate to do so, such as Intra Venous therapies, sub cutaneous fluid therapy.
- ACT Bridgend have developed a referral pathway with the Care of the Elderly team in Princess Of Wales Hospital to facilitate earlier discharges by undertaking clinical reviews/ interventions in the community rather than keeping individuals in hospital. Requests include restarting medications, monitoring responses to treatments, reviewing blood tests to review of clinical condition in very frail patients. Before this pathway, these patients would have remained in hospital. This can facilitate improved bed availability.
- 'In Reach Coordinators' from the CRT will continue to work from the Princess of Wales site to offer and support earlier discharge from the Better@Home service until the Short Term Assessment Services can commence.
- Telecare continues to support people to remain in their own homes for longer periods with the support of 24/7 Mobile Response Team who will respond to pendant and sensor alerts. This can prevent the need to call for 999 emergency services, thereby supporting better outcomes for people who fall and ensuring ambulances are not used inappropriately.
- Implementation of the **Directed enhanced service for Care Homes** to support regular GP review to enable people to remain at their care home and prevent patient deterioration which could trigger an admission.

- An additional OT resource in Short Term Assessment and reabling service for people living with Dementia- Bridgeway; this will improve access and flow through the service.

Furthermore, from a preventative and awareness raising perspective:

- ACT Bridgend have met Welsh Ambulance Service Trust colleagues to update their knowledge on the interventions they are able to deliver and the referral pathways.
- ACT Bridgend have met GP's updating them of services available, this is resulting in an increase in GP referrals to ACT, as an alternative to people presenting at hospital.
- ACT Bridgend, linking in with Anticipatory Care within the GP clusters to assist in the development and delivery of anticipatory care plans. Again, offering alternatives to presenting at hospital, where those plans are in place.

In addition:

- Roll out the ' **I Stumble' training** programme in care homes across the Local Authority, to avoid and reduce the number of falls and conveyances to hospital.
- Maximising the benefit of the **Diarrhoea &Vomiting pathway** developed between WAST and our community services at the end of last winter, to support prevention of un-necessary admissions to hospital.
- Increased **community pharmacy capacity** at weekends and bank holidays for medication dispensing. Primary Care has commissioned 8 pharmacies to open on a Sunday to provide greater access, while 122 pharmacies are open on a Saturday across ABMU Health Board.
- Maximise the benefit of the **(IT) mobilisation programme** for community staff by releasing staff capacity for clinical/ hands on patient care.

A number of these schemes/ plans may be targeted at providing increased support and capacity for our frailty services, where we can predict that there will be an increased call on our unscheduled care services over the winter months**.**

Please find enclosed a copy of the Regional Winter Resilience Planning document that Western Bay partners have worked on under the leadership of ABMU HB.