

## Bundle Stakeholder Reference Group - Grwp Cyfeirio Rhanddeiliaid 6 October 2020

- 1 GOVERNANCE/ LLYWODRAETHU
- 1.1 Welcome and Apologies/ Cyflwyniadau a Ymddiheuriadau  
*Presenters: Steve Moore (Chief Executive) and Nicola O'Sullivan*
- 1.2 Declaration of Interests / Datganiadau o Ddiddordeb  
*All*
- 1.3 Approval of Chair of SRG/ Cymeradwyo'r Cadeirydd y GCRh  
*Presenter: Steve Moore*
- 1.4 Minutes of the Meeting held on 10th January 2020/ Cofnodion y Cyfarfod ar 10 Ionawr 2020  
*Presenter: Chair*  
[SRG Minutes 10 January 2020 Final.doc](#)
- 1.5 Matters Arising & Table of Actions from the Meeting held on 10th January 2020/ Materion sy'n Codi a Thabl o Gamau Gweithredu o'r cyfarfod ar 10 Ionawr 2020  
*Presenter: Chair*  
[SRG Table of Actions 06.10.20.docx](#)
- 1.6 SRG Terms of Reference/ Cylch Gorchwyl GCRh  
*Presenter: Chair*  
[SRG ToRs V12 Approved by Board Sept19 updated Aug 20 Final.docx](#)
- 2 STRATEGY/ STRATAGAETH
- 2.1 Discover Strategy/ Stratagaeth Darganfod  
*Presenter: Libby Ryan Davies*  
*(Papers also available to view via agenda hyperlink)*  
[Discovery Report Master Final Version - July 2020.pdf](#)
- 2.2 Transformation Programme Update/ Diweddariad ar y Rhaglen Trawsnewid  
*Presenter: Martyn Palfreman (Verbal)*
- 2.2.1 Evaluation Toolkit - Pecyn Gwerthuso  
*Presenter: Martyn Palfreman*
- 3 SERVICE IMPROVEMENT/ GWELLA GWASANAETH
- 3.1 Stakeholder Management System and Engagement Tool/ System Rheoli ac Offeryn Ymgysylltu Rhanddeiliaid  
*Presenters: Delyth Evans and Nicola O'Sullivan*  
*Presentation*
- 3.2 New Health Board Website and Accessibility Standards/ Gwefan newydd y Bwrdd Iechyd a'r Safonau Hygyrchedd  
*Item deferred to next meeting.*
- 3.3 Children in Wales Participation Standards/ Safonau Cyfranogiad Dros Blant a Phobl Ifanc  
*Presenters: Nicola O'Sullivan and Tina Taylor (verbal)*
- 4 FOR INFORMATION/ ER GWYBODAETH
- 4.1 Annual Quality Statement 2019/20/ Datganiad Ansawdd Blynyddol 2019/20  
*Presenter: Nicola O'Sullivan*  
[Annual Quality Statement 2019-2020.pdf](#)
- 4.2 SRG Update Report to January Board  
*Presenter: Chair*  
[SRG Report to the Board Jan 2020 FINAL.docx](#)
- 5 RECOMMENDATION TO THE BOARD/ ARGYMHELLIAD I'R BWRDD  
*Presenter: Chair*
- 6 ANY OTHER BUSINESS/ UNRHYW FUSNES ARALL  
*All*
- 6 DATE AND TIME OF NEXT MEETING/ DYDDIAD AC AMSER Y CYFARFOD NESAF: Tuesday 5th January 2021 – time to be confirmed





## MINUTES OF THE STAKEHOLDER REFERENCE GROUP

<b>Date and time of Meeting</b>	<b>Friday 10 January 2020 10pm to 12pm</b>	
<b>Venue</b>	<b>Caer Suite Mid and West Wales Fire and Rescue Service Headquarters Lime Grove, Carmarthen SA31 1SP</b>	
<b>Attendees</b>	<p><b>SRG Members</b>  Hilary Jones, CEO Bro Myrddin Housing Association (Chair)  Anna Bird, Head of Strategic Partnerships, Inclusion and Diversity HDUHB  Martyn Palfreman, Head of Regional Collaboration, West Wales Care Partnership  Amanda Williams, Paramedic Project Manager, Welsh Ambulance Services Trust  Alan Thomas, Patient Representative, Atacisa a Fi – Ataxia and Me  Ken Jones, Carer Representative, Carmarthenshire Carers Forum and CHC  Sam Nicholls, Carer Representative Ceredigion  Brian Elias, Patient Repetitive, Education Programme for Patients (EPP)  Alun Williams, Pembrokeshire One Voice Wales  Rosemary Whittemore, Siarad Iechyd/Talking Health Representative  Sian Davies, Siarad Iechyd/Talking Health Representative  Jackie Dorian, Health and Wellbeing Officer, CAVS  Owen Burt, Independent Board Member, HDUHB  Louise O’Conner, Assistant Director of Legal Services and Patient Experience HDUHB</p> <p><b>In attendance</b>  Helen Sullivan, Strategic Partnerships and Inclusion Manager, HDUHB  Delyth Evans, Senior Engagement Officer, HDUHB  Gaynor Megicks, Engagement Officer, HDUHB  Leanda Wynn, Public and Patient Engagement Officer, CHC</p>	
<b>Agenda Item</b>	<b>Introduction and Apologies for Absence</b>	
<b>SRG(20)31</b>	<p><b>Apologies</b>  Sarah Jennings, Director of Partnerships and Corporate Services, HDUHB  Hazel Lloyd-Lubran, CEO, CAVO  Diana Davies, Corporate Manager Partnerships and Performance, Ceredigion County Council  Gwyneth Ayres, Corporate Policy and Partnerships Manager, Carmarthenshire County Council  Paula Martyn, Care Forum Wales  Angie Darlington, Director, West Wales Action for Mental Health  Nadine Farmer, Pembrokeshire Youth Services, Pembrokeshire County Council  Nicola O’Sullivan, Head of Engagement, HDUHB</p>	

<b>SRG(20)32</b>	<p><b>Declaration of interests</b></p> <p>Sam Nicholls, Carer Representative Ceredigion and also employed by Ceredigion County Council</p> <p>Alan Thomas, Patient Representative and a member of Ataxia and Me</p>		
<b>SRG(20)33</b>	<p><b>Minutes of the meeting held on 22 October 2019</b></p> <p>Approved as an accurate record</p>		
<b>SRG(20)34</b>	<p><b>Matters arising</b></p> <p><b>Chair</b></p> <p>Hilary Jones, Chair of SRG and Chief Executive of Bro Myrddin Housing Association informed the SRG members that she has been appointed Independent Board Member at Velindre NHS Trust. In view of this, Hilary Jones advised that she will be standing down as SRG chair. The SRG thanked Hilary Jones for her dedication to the role and wished her well in her new post.</p> <table border="1" data-bbox="280 871 1445 949"> <tr> <td data-bbox="280 871 456 949"><b>ACTION</b></td> <td data-bbox="456 871 1445 949"> <ul style="list-style-type: none"> <li>• Chair nominations to be tabled at the next SRG meeting.</li> </ul> </td> </tr> </table>	<b>ACTION</b>	<ul style="list-style-type: none"> <li>• Chair nominations to be tabled at the next SRG meeting.</li> </ul>
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<b>SRG(20)35</b>	<p><b>West Wales Care Partnership</b></p> <p><b>Winter Plan</b></p> <p>Martyn Palfreman, Head of Regional Collaboration, West Wales Care Partnership provided a presentation on the winter plans that have been developed jointly by the Regional Partnership Board (RBP) and the Health Board.</p> <p>Members were advised that Welsh Government has allocated funding for winter pressures to support integrated and community based solutions. The RPB has received £2.062m and the Health Board £1.213m. Martyn Palfreman confirmed that the RPB plan has been developed in partnership at local level and Executive Directors from the Health Board meet on a weekly basis with Directors of Social Services for the three partner local authorities. The SRG acknowledged and support partnership working approach.</p> <p>SRG members were informed that the Health Board is currently under unprecedented pressures within our hospitals and services. The winter plans are being reviewed on a weekly basis with daily actions to relieve pressures on the system. It was noted that there are immediate actions the Health Board needs to take to deal with pressures and pinch points which include; how to enhance capacity, opening of beds and surgical capacity.</p> <p>The RPB plans include:</p> <ul style="list-style-type: none"> <li>• Advanced care planning to stay well</li> <li>• Improved step down facilities</li> <li>• COPD pathway to improve self-management</li> <li>• Acute response teams for palliative care patients</li> <li>• Additional community equipment</li> <li>• Working with partner agencies around capacity</li> </ul>		

There are regular reviews, monthly monitoring and final report on impact to Welsh Government.

In December 2019 the Health Board, Local Authorities and the Third Sector held a summit to discuss the pressures on the system and what could be done immediately to reduce pressures. A series of actions were identified which included:

- How to better communicate with families and patients
- Focus work with discharge teams to ensure patients were moved on as quickly as possible
- Safety and dignity of patients at the heart of everything we do

The SRG raised the following:

- SRG felt that winter plans should be set by September/October of each year and that a more proactive approach is needed by Welsh Government
- The Third Sector can play an important role in supporting winter pressures and more investment within the Third Sector should be considered, with adequate time for planning and mobilisation of staff.

SRG are mindful that our front line staff are working under difficult circumstances and would like to thank staff for their hard work and commitment.

### **Transformation Programme Update**

Martyn Palfreman also provided an update on how the three transformation programmes successful in receiving Welsh Government funding were progressing. SRG members were informed that each of the programmes has a strategic lead delivering complex programmes within the region. The following updates were provided on the three programmes:

#### **Programme 1: Proactive, technology-enabled care**

- Key staff have been recruited in Carmarthenshire and Pembrokeshire.
- Suitability assessments for the service are being conducted in January.
- Enhanced community pathways have been commissioned.

#### **Programme 3: Fast-tracked consistent integration**

- Setting up of multi-disciplinary crisis response service across the region
- Carmarthenshire Crisis response Service has been fully recruited. Pembrokeshire coming on stream shortly. Ceredigion will start later, although it was intentionally staggered to manage resources and coordination in an appropriate way.

#### **Programme 7: Creating connections for all**

- West Wales is kind being rolled out with marketing campaign and information.
- Community Action Hubs to promote volunteer opportunities.
- Appointment of Community Connector Plus posts to work with existing workers to collage best practice and optimise roles.

The strategic leads of each of the programmes to be invited to future SRG meetings to provide programme updates.

The SRG were informed that an external evaluator has been appointed. They will evaluate the impact of the programmes and produce a mid-point report required by March 2020. The report will support work being undertaken being improved as it goes along, rather than at the end. The evaluators will also produce an end of delivery report.

In addition, the RPB will be establishing a Regional Innovation Coordination Hub, to provide a resource to look at models across the world and draw on effective practice as we move forwards. Two research coordinators roles are being developed and will shortly go to advert.

### **Engagement tools**

Currently the Health Board are looking at commissioning digital engagement tools to engage with the population. The tools will be shared with the Public Service Boards (PSBs) and health and social care and prior to Christmas another £40,000 was received from Welsh Government to support this work.

### **Outcomes Framework**

Welsh Government have stipulated the need for robust ways to evaluate the transformation funds. An outcomes framework is being developed, which will include national outcomes for health and social care, regional population outcomes and programme specific indicators which include qualitative and quantitative measures.

SRG members asked that the outcomes framework to be shared at the next meeting. Martyn Palfreman noted he would be happy for colleagues to attend to speak in more detail about this.

The following comments were made by SRG members:

- The involvement of Welsh Ambulance Services NHS Trust (WAST) in the transformation workstreams was welcomed.
- Members noted that early intervention actions are critical to reach individuals before crisis.

A query was raised about how, with only 2 years of Welsh Government transformation funding, it will be possible to measure and sustain the programmes. Members acknowledged that there is a natural lead-in time before the programme goes live and can be evaluated which is at odds with the limited funding. Concern was expressed about the potential of effective projects ending because there is insufficient evaluation data to feed into budget realignment discussions.

<b>ACTION</b>	<ul style="list-style-type: none"><li>• Invitation to be extended to the programmes strategic leads to attend SRG meetings provide an update of the transformation programmes</li><li>• Update on the evaluation toolkit at the next meeting</li><li>• Outcomes Framework to be shared with SRG at next meeting</li></ul>
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<p><b>SRG(20)36</b></p>	<p><b>Update on the Patient Experience Charter</b></p> <p><b>Patient Experience Charter</b></p> <p>Louise O’Conner, Assistant Director, Complaints, Hywel Dda University Health Board provided an update and a draft copy of the Patient Experience Charter and poster to members. Members were thanked for providing their feedback on the draft Charter which had been incorporated into the current version.</p> <p>The SRG were informed the Patient Experience Charter will be taken to Board in January 2020. The Charter will be launched in April 2020 during the national patient experience week and activities are being planned at all Health Board sites.</p> <p>Comments made by the SRG included:</p> <ul style="list-style-type: none"> <li>• Some disappointment that the Charter still has nearly as many points for patients and their carers, as for staff of the Health Board. Concern was raised that patients are very vulnerable when they are unwell and find it difficult to raise issues or concerns as they fear a negative reaction which might impact on their on-going or future care.</li> <li>• The Charter needs to be made visible to staff and patients, therefore good promotion will be required. Members were provided with assurance that the information will be widely circulated including on social media and in patient letters, and will be made available and visible in all areas within the Health Board.</li> </ul> <p>Members were advised of work currently being developed within the Patient Experience team which includes:</p> <ul style="list-style-type: none"> <li>• Rollout of electronic feedback system</li> <li>• Mandatory customer care training programme to be undertaken by all staff</li> <li>• Bringing together of all Patient Experience Feedback in a new Listening and Learning Sub Committee</li> <li>• Developing of an Assurance Framework which will be shared with SRG members in due course</li> <li>• Participation in the Apprenticeship scheme to increase capacity for patient liaison</li> <li>• Development of the Patient Advice and Liaison Service (PALS)</li> <li>• Ongoing work to review appointment letters</li> </ul> <table border="1" data-bbox="280 1621 1445 1733"> <tr> <td data-bbox="280 1621 456 1733"><b>ACTION</b></td> <td data-bbox="456 1621 1445 1733"> <ul style="list-style-type: none"> <li>• Draft Assurance Framework to be share with SRG in due course</li> </ul> </td> </tr> </table>	<b>ACTION</b>	<ul style="list-style-type: none"> <li>• Draft Assurance Framework to be share with SRG in due course</li> </ul>
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<p><b>SRG(20)37</b></p>	<p><b>Supporting Vulnerable Ambulance</b></p> <p><b>Supporting Vulnerable Groups</b></p> <p>Anna Bird, Head of Strategic Partnerships, Diversity and Inclusion and Helen Sullivan, Strategic Partnerships and Inclusion Manager, Hywel Dda University Health Board provided SRG members with an overview of their work to provide assurance that the Health Board are committed in developing an accessible and inclusive organisation, culture and environment not only for patients but also for its employees. Members were informed of the breadth of work ongoing to support</p>		

vulnerable groups which include those who are homeless, asylum seekers, refugees, Gypsy and Travellers, substance misusers, armed forces veterans, EU migrants who are homeless or living in circumstance of insecurity.

A copy of the presentation will be circulated to members following the meeting as an aid memoire for members.

It was noted that Jane Watts, Regional Armed forces Covenant Liaison Officer has departed from her role in December 2019. SRG details have been provided in her handover notes to her successor which is due to take up post shortly. Gaynor Megicks to make contact with the new officer.

<b>ACTION</b>	<ul style="list-style-type: none"> <li>To make contact with the new Regional Armed Forces Covenant Liaison Officer for representation on SRG</li> <li>Copy of the presentation to be circulated to members</li> </ul>
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The SRG were pleased to hear of the excellent work being undertaken to support those who are vulnerable in our communities. Members commented that this work does make a difference to people's lives but often goes unseen.

**SRG(20)38**

**Welsh Ambulance Services NHS Trust**

**Welsh Ambulance Service**

Amanda Williams, Paramedic Project Manager, Welsh Ambulance Services NHS Trust (WAST) informed the SRG that there has been significant pressure on WAST. This is due to hospitals throughout the area and beyond experiencing extraordinary pressure.

The SRG were provided with an update on WAST performance which included:

- 66.7% performance rate against 65% target.
- On a monthly basis working against a performance target of 52%. This is lower due to increased pressures.
- Ambulance sickness absence is the highest within the NHS. SRG were advised the service continually supports staff in the workplace and at home providing a holistic wellbeing approach.

Members were informed of the significant amount of work which undertaken on discharges and getting patients home safely, as well as preventing admission to hospital. Work includes:

- Improving performance times especially for elderly fallers and the vulnerable.
- In recognition of the high number of calls related to elderly fallers, WAST have provided Falls Training to over 1,000 people including many Nursing and Care homes. This has given staff confidence to get people off the floor more quickly.
- Advanced Paramedic Practitioners in post to provide support and respond to out of hours calls. After the patient has undergone GP triage, the Advanced Paramedic Practitioner is able to undertake home visits on behalf of the GP, enabling the GP to focus on more complex issues.

SRG members were informed of two useful resources. They are;

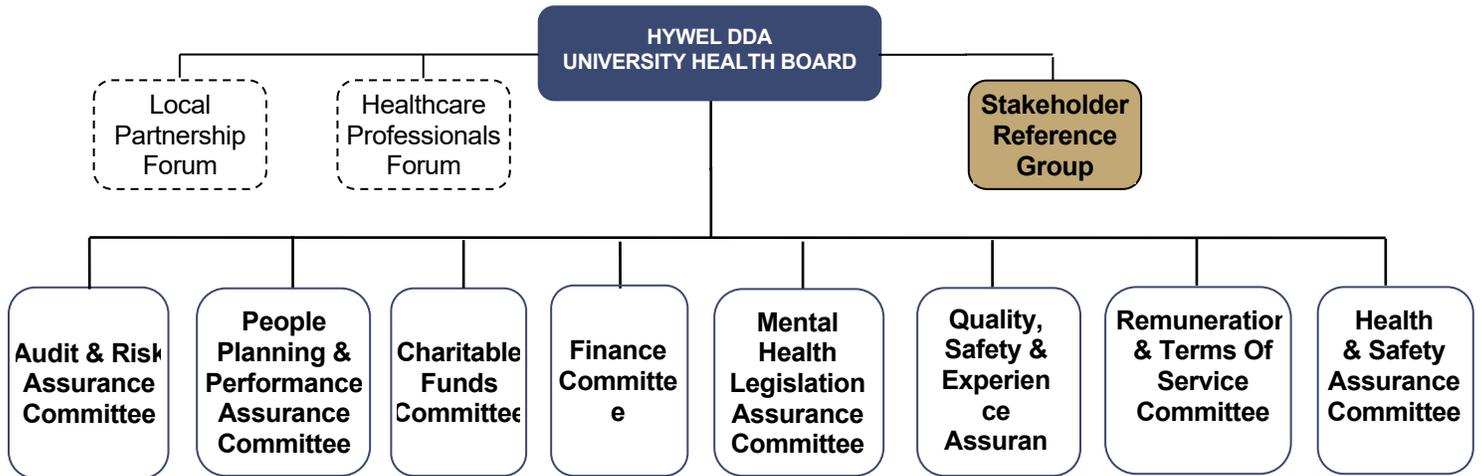
- Choose Well Hospital Monitor. The website indicates the typical time an individual is likely to spend in A&E and Minor Injury Unit.

	<ul style="list-style-type: none"> <li>• “I Stumble”, a falls assessment tool. This should be used to perform a health assessment and check for injury. The app is designed by paramedics and will tell you when you need to call for an ambulance and when to lift an individual.</li> </ul> <p>Amanda Williams to forward links of both resources to Gaynor Megicks.</p> <p>The SRG thanked WAST for their hard work under the pressures of the current climate and noted that it was good to hear of the excellent projects underway to reduce pressure, improve performance and services.</p> <table border="1" data-bbox="280 607 1445 723"> <tr> <td data-bbox="280 607 456 723"><b>ACTION</b></td> <td data-bbox="456 607 1445 723"> <ul style="list-style-type: none"> <li>• Amada Williams to forward link of the Choose Well Hospital Monitor and the “I Stumble ” app for Gaynor Megicks to send to SRG members</li> </ul> </td> </tr> </table>	<b>ACTION</b>	<ul style="list-style-type: none"> <li>• Amada Williams to forward link of the Choose Well Hospital Monitor and the “I Stumble ” app for Gaynor Megicks to send to SRG members</li> </ul>	
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<b>SRG(20)39</b>	<p><b>Recommendation to the Board</b></p> <ul style="list-style-type: none"> <li>• SRG felt that winter plans should be set by September/October of each year and that a more proactive approach is needed by Welsh Government.</li> <li>• The Third Sector can play an important role in supporting winter pressures and more investment within the Third Sector should be considered, with adequate time for planning and mobilisation of staff.</li> <li>• Concern regarding the continuity and sustainability of projects due to time limitations on Transformation Fund monies.</li> </ul>			
<b>SRG(20)40</b>	<p><b>Any other business</b></p> <p>SRG agenda items for the 3 April 2020 Meeting;</p> <ul style="list-style-type: none"> <li>• Arrangements to recruit an SRG Chair successor</li> <li>• Transformation Programme Update</li> <li>• Transformation Programme Leads Updates</li> <li>• Learning Disability Charter – The Dream Team</li> <li>• Update on the Implementation of Transforming Mental Health and Learning Disability Services</li> <li>• Digital Platforms Update</li> </ul>			
	<p><b>Date, time and venue of next meeting</b></p> <p>10am to 1pm  Friday 3 April 2020  Caer Suite  Mid and West Wales Fire and Rescue Service Headquarters  Lime Grove, Carmarthen SA31 1SP</p>			

TABLE OF ACTIONS - STAKEHOLDER REFERENCE GROUP

MINUTE REFERENCE	ACTION	LEAD	PROGRESS
SRG(18)16	To invite a representative from the Health Board's newly formed Equalities Forum	Anna Bird	Ongoing Forum still not established
SRG(18)16	SRG to become responsible for SI/TH and direct future work on behalf of the Health Board.		On going
SRG(19)23	Future agenda item - Mental Health Update	Gaynor Megicks	Future meeting completed attending 3 April meeting (stood down)
SRG(19)24	Transformation Bid - Martyn Palfreman provide a full report at the next SRG meeting	Gaynor Megicks	Update scheduled for April meeting (stood down)
SRG(19)26	Regional Engagement Group update required at the next SRG meeting	Gaynor Megicks	Update scheduled for April meeting (stood down)
SRG (19)08	Martyn Palfreman to attend the next SRG to provide an update on the transformation fund	Gaynor Megicks	Scheduled for inclusion on October agenda
SRG(19)11	Vice Chair nominations to be held at the next SRG Meeting	Gaynor Megicks	Scheduled for inclusion on October agenda
SRG(20)34	Chair nominations to be tabled at the next SRG meeting	Gaynor Megicks	Complete: Approval of Chair included on October agenda.

SRG(20)35	<p>Invitation to be extended to the programmes strategic leads to attend SRG meetings provide an updates of the transformation programmes</p> <p>Programme 1: Proactive, technology-enabled care  Programme 3: Fast-tracked consistent integration  Programme 7: Creating connections for all – 3 April Meeting</p>	Gaynor Megicks	Agenda Item Lead for Programme 7 invited for 3 April meeting (stood down)
SRG(20)35	Update on the evaluation toolkit at the next meeting	Gaynor Megicks	Scheduled for inclusion on October agenda
SRG(20)35	Outcomes Framework to be shared with SRG at next meeting	Gaynor Megicks	Scheduled for April meeting (stood down)
SRG(20)36	Draft Assurance Framework to be share with SRG in due course	Louise O'Connor	To contact LoC when available
SRG(20)37	To make contact with the new Regional Armed Forces Covenant Liaison Officer for representation on SRG	New Committee Clerk	Complete
SRG(20)37	Copy of the presentation to be circulated to members		Completed
SRG(20)38	Amada Williams to forward link of the Choose Well Hospital Monitor and the "I Stumble " app for Gaynor Megicks to send to SRG members	Amanda Thomas/Gaynor Megicks	Completed Sent via email 27.01.20



**STAKEHOLDER REFERENCE GROUP**

**TERMS OF REFERENCE**

Version	Issued to:	Date	Comments
V0.1	Hywel Dda University Health Board	25.03.2010	Approved
V0.2	SRG	08.06.2010	Approved
V0.2	Board (Standing Orders)	22.07.2010	Approved
V0.3	SRG	14.01.2011	Approved
V0.3	SRG	29.03.2011	Approved
V0.4	SRG	20.09.2011	Approved
V0.5	SRG	17.07.2012	Approved
V0.5	Board (Standing Orders)	27.09.2012	Approved
V0.6	SRG	22.01.2013	Approved
V0.6	Board (Standing Orders)	26.09.2013	Approved
V0.7	SRG	27.01.2014	Approved
V.08	SRG	15.10.2015	Approved
V.09	SRG	12.01.2017	Approved
V.09	Hywel Dda University Health Board	26.01.2017	Approved
V10	SRG	05.02.2018	Approved
V.10	Hywel Dda University Health Board	28.03.2019	Approved
V.11	Hywel Dda University Health Board	26.09.2019	Approved
V.12	SRG	06.10.2020	

## STAKEHOLDER REFERENCE GROUP

### 1. Constitution

- 1.1 The Stakeholder Reference Group (SRG) has been established as an Advisory Group of the Hywel Dda University Health Board (HDdUHB) and was constituted from 1<sup>st</sup> June 2010.

### 2. Membership

- 2.1 The membership of the Group shall comprise:

**Chair** Nominated from within the membership of the SRG by its members and approved by the Board

**Vice Chair** Nominated from within the membership of the SRG by its members and approved by the Board.

**Members** The membership is drawn from within the area served by the University Health Board (UHB), and ensures involvement from a range of bodies and groups operating within the communities serviced by the UHB. It is the role of SRG members to represent fairly and fully the interests and views of those bodies and groups.

There shall be no minimum or maximum requirement in terms of membership size. In determining the number of members, the Board shall take account of the need to ensure the SRG's size is optimal to ensure focused and inclusive activity.

The membership of the SRG will also serve as the membership of the Reference Group to advise the West Wales Regional Partnership Board (RPB), especially on matters of integration and seamless health and social care.

The membership of the SRG is made up of representatives from the following sectors with the number of representatives in brackets ():

#### **Sector/ Organisation**

- Armed Forces Covenant Representative (1)
- Carer representation (3)
- Citizens Advice (1)
- Fire & Rescue Service (1)
- Hywel Dda Community Health Council (CHC) (1)

- HDdUHB Independent Board Member (1)
- HDdUHB Director representation (1)
- HDdUHB Public Health representation (1)
- Housing Associations (1)
- Independent Sector (1)
- Mental Health representation (1)
- Natural Resources Wales representation (1)
- Patient representation (3)
- Public Service Boards representation (3)
- Siarad Iechyd/ Talking Health Member (3)
- Third Sector (CAVO, CAVS & PAVS) (1)
- Town and Community Councils (3)
- West Wales Care Partnership/ Regional Partnership Board (1)
- Welsh Ambulance Services NHS Trust (WAST) (1)

**Total (29)**

Additional organisational representation may be co-opted as appropriate and will include:

- Office of the Police and Crime Commissioner
- Strategic Partnerships, Diversity and Inclusion
- Local Health Board County Directors
- Mental Health
- Planning
- Engagement
- Patient Experience
- Youth Forums
- Transformation

This membership will be reviewed by the Chair and Lead Director on an annual basis.

**In attendance** The UHB may determine that designated Board members or UHB staff should be in attendance at SRG meetings. The SRG's Chair may also request the attendance of Board members or UHB staff, subject to the agreement of the UHB Chair.

**By invitation** The SRG shall make arrangements to ensure designated CHC members receive the SRG's papers and are invited to attend SRG meetings. This linkage is key, and needs to be formalised through the Hywel Dda CHC Executive Committee.

## 2.2 Member Appointments

Appointments to the SRG shall be made by the Board, based upon nominations received from stakeholder bodies/ groups. The Board may seek independent

expressions of interest to represent a key stakeholder group where it has determined that formal bodies or groups are not already established, or are operating within the area and may represent the interests of these stakeholders on the SRG.

The nomination and appointment process shall be open and transparent, and in accordance with any specific requirements or directions made by Welsh Government. The appointments process shall be designed in a manner that meets the communication and involvement needs of all stakeholders eligible for appointment.

Members shall be appointed for a period specified by the Board, but for no longer than three (3) years in any one term. Those members can be reappointed but may not serve a total period of more than five (5) years consecutively. The Board may, where it considers it appropriate, co-opt members to the SRG on an interim or short-term basis to fulfil a particular purpose or need.

The **Chair** shall be nominated from within the membership of the SRG, by its members, in a manner determined by the Board, subject to any specific requirements or directions made by Welsh Government. The nomination shall be subject to consideration by the UHB, who must submit a recommendation on the nomination to the Minister for Health and Social Services. The appointment as Chair shall be made by the Minister, but it shall not be a formal public appointment. The Constitution Regulations provide that the Welsh Ministers may appoint an Associate Member of the Board, and the appointment of the Chair to this role is on the basis of the conditions of appointment for Associate Members set out in the Regulations.

The Chair's term of office shall be for a period of up to two (2) years, with the ability to stand as Chair for an additional one (1) year, in line with that individual's term of office as a member of the SRG. That individual may remain in office for the remainder of their term as a member of the SRG after their term of appointment as Chair has ended.

The **Vice Chair** shall be nominated from within the membership of the SRG, by its members, following the same process as that adopted for the Chair, subject to the condition that they be appointed from a different sector/ organisation from that of the Chair. In the SRG Chair's absence, the Vice Chair shall also perform the role of Associate Member on the LHB Board.

The Vice Chair's term of office will be as described for the Chair.

- 2.3 A member's tenure of appointment will cease in the event that they no longer meet any of the eligibility requirements determined for the position. A member must inform the SRG Chair as soon as is reasonably practicable in respect of any issue which may impact on their eligibility to hold office. The SRG Chair will advise the Board in writing of any such cases immediately.
- 2.4 The UHB will require SRG members to confirm in writing their continued eligibility on an annual basis.
- 2.5 The membership of the Group shall be determined by the Board, based on the

recommendation of the UHB Chair, and subject to any specific requirements or directions made by Welsh Government.

### 3. Quorum and Attendance

- 3.1 A quorum shall consist of no less than one third of the membership and must include the Chair or Vice Chair of the Group. If a meeting is not quorate, any decisions made must be ratified at the next quorate meeting of the SRG.

### 4. Principal Duties

- 4.1 The purpose of the SRG is to provide:
- 4.1.1 Early engagement and involvement in the determination of the UHB's overall strategic direction;
  - 4.1.2 Advice to the UHB on specific service improvement proposals prior to formal consultation; as well as
  - 4.1.3 Feedback to the UHB on the impact of the UHB's operations on the communities it serves.
  - 4.1.4 The SRG has responsibilities under the Equalities Act 2010.

### 5. Operational Responsibilities

- 5.1 The SRG will, in respect of its provision of advice to the Board:
- 5.1.1 Provide a forum to facilitate full engagement and activate debate amongst stakeholders from across the communities served by the UHB, with the aim of reaching and presenting, wherever possible, a cohesive and balanced stakeholder perspective to inform the UHB's decision-making. NB. Even when the SRG is unable to reach a consensus, it has an important role as a forum through which to draw the UHB's attention to the full range of views.
  - 5.1.2 The SRG shall represent those stakeholders who have an interest in, and whose own roles and activities may be impacted by the decisions of the UHB and vice-versa. The SRG's role is distinctive from that of CHCs, who have a statutory role in representing the interests of patients and the public within their geographic areas.

### 6. Agenda and Papers

- 6.1 The Group's secretary is to hold an agenda-setting meeting with the Chair and the Lead Director at least **six weeks** before the meeting date.
- 6.2 The agenda will be based around the Group's work plan, matters arising and requests from SRG members. Following approval, the agenda and timetable for papers will be circulated to all Group members.

- 6.3 All papers must be approved by the relevant Director.
- 6.4 The agenda and papers for meetings will be distributed **seven days** in advance of the meeting.
- 6.5 The minutes and action log will be circulated to members within **seven days** to check the accuracy. The minutes must be an accurate record of the meeting which capture the discussions that take place.
- 6.6 Members must forward amendments to the Group's secretary within the next **ten days**. The Group's secretary will then forward the final version to the SRG Chair for approval.

## 7. Management of Meetings

- 7.1 The Group will meet quarterly and will agree an annual schedule of meetings consistent with the UHB's annual plan of Board business. Additional meetings will be arranged as determined by the Chair of the SRG in discussion with the Lead Director.
- 7.2 The Chair of the Group, in discussion with the Group's secretary, shall determine the time and the place of meetings of the Group and procedures of such meetings.
- 7.3 The Board's commitment to openness and transparency in the conduct of all its business extends equally to the work carried out by others to advise it in the conduct of its business.

## 8. Authority

- 8.1 The SRG may offer advice to the UHB through the following mechanisms:
  - 8.1.1 at Board meetings, through the SRG Chair's participation as an Associate Member;
  - 8.1.2 in written advice; and
  - 8.1.3 in any other form specified by the Board.

## 9. Reporting and Assurance Arrangements

- 9.1 The SRG Chair is responsible for the effective operation of the SRG:
  - 9.1.1 Chairing Group meetings;
  - 9.1.2 Establishing and ensuring adherence to the standards of good governance set for the NHS in Wales, ensuring that all Group business is conducted in accordance with its agreed operating arrangements; and
  - 9.1.3 Developing positive and professional relationships amongst the Group's membership and between the Group and the UHB's Board and its Chair and Chief Executive.

- 9.2 The Chair shall work in close harmony with the Chairs of the UHB's other advisory groups, and, supported by the Board Secretary, shall ensure that key and appropriate issues are discussed by the Group in a timely manner with all the necessary information and advice being made available to members to inform the debate and ultimate resolutions.
- 9.3 The Chair of the SRG will be appointed as an Associate Member of the UHB Board. The Chair is accountable for the conduct of their role as Associate Member on the Hywel Dda University Health Board to the Minister, through the UHB Chair. They are also accountable to the Hywel Dda University Health Board for the conduct of business in accordance with the governance and operating framework set by the UHB.
- 9.4 The Group's Chair shall:
- 9.4.1 Report formally, regularly and on a timely basis to the Board on the Group's activities. This includes written updates on activity after each meeting and the presentation of an annual report reviewing the Group's activity and effectiveness against the ToRs within 6 weeks of the end of the financial year;
  - 9.4.2 Bring to the Board's specific attention any significant matters under consideration by the Group.
- 9.5 The requirements for the conduct of business as set out in the UHB's Standing Orders are equally applicable to the operation of the Group.

## **10. Relationship Accountabilities with the Board and Other Committees of the Board**

- 10.1 The SRG's main link with the Board is through the SRG Chair's membership of the Board as an Associate Member.
- 10.2 The Board should determine the arrangements for any joint meetings between the UHB and the SRG.
- 10.3 The Board's Chair should put in place arrangements to meet with the SRG Chair on a regular basis to discuss the SRG's activities and operation.

## **11. Secretarial Support**

- 11.1 The Board Secretary will ensure that the SRG is properly equipped to carry out its role by:
- 11.1.1 Ensuring the provision of governance advice and support to the SRG Chair on the conduct of its business and its relationship with the UHB and others;
  - 11.1.2 Ensuring that the SRG receives the information it needs on a timely basis;
  - 11.1.3 Ensuring strong links to communities/ groups;
  - 11.1.4 Facilitating effective reporting to the Board;

11.1.5 Enabling the Board to gain assurance that the conduct of business within the SRG accords with the governance and operating framework it has set.

11.2 The Group's secretary shall be determined by the Board Secretary.

## **12. Review Date**

12.1 These terms of reference and operating arrangements shall be reviewed on at least an annual basis by the Group for approval by the Board.

# Strategic Discover Report

Applying the initial learning from our pandemic response to the health and care strategy  
July 2020



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**‘Out of a bad situation with COVID-19 [came] the opportunity for us to change our way of work with immediate effect. It was the stimulus to be innovative and dynamic, being able to continue to provide safe and timely care to our patients. It has brought us all together more and it is amazing what can be achieved as a team and with the support of each other and our patients.’**

## Section 1: Introduction



Hello, my name is Sioned, my family and I live in West Wales. Yesterday I watched a television programme about the COVID-19 pandemic and its affect in care homes. This disease has been awful for our communities and I have felt anxious for my own and my family's safety. But our local services have responded so well to protect us all.

My Mum, Mari, has dementia and is quite frail. Dad and I care for mum at home but she spends some time in a local care home so we can have a break. Mum was in the care home during the pandemic and became unwell so the care staff called 111 for advice. The doctor on call came to the home to see mum and using technology she was able to contact us so we could see mum and we could all agree an advanced care plan should mum's health get worse. It was so reassuring for Dad and me to be able to see and talk with mum as we weren't allowed to visit her because of the virus. Mum too felt better to see us when the doctor was with her especially as the doctor had to wear the protective clothing called PPE so it was quite frightening for her. We were so pleased mum did not have to go into hospital and we were reassured as both mum and the staff were tested for the coronavirus. We feel safe and able now for mum to come back to her home with dad.

The way care has been delivered has really changed during this pandemic and we have all had to get used to the social distancing and using technology. Whilst we may not have had as much face-to-face contact with services, we have been able to access information, support and advice when we needed it. This time has really made us think about taking more responsibility for our own health and well-being and to value the support of our local communities in taking care for each other especially as all our lives will be very different for some time yet. This pandemic has also made us really appreciate our frontline workers and the care they provide.



## Section 1: Introduction

Hywel Dda University Health Board is delighted to present our Strategic Discovery Report: 'Applying the initial learning from our Pandemic response to the delivery of our health and care strategy.'

The report aims to bring together our learning and innovation across the local health and care system to ensure that we learn collectively from the pandemic and our response to it; celebrate and authorise the changes and practical application of this learning that we have been able to achieve together; and confirm our commitment to continue to transform our services today and over the lifetime of the Health and Care Strategy ensuring that we maximise the impact of our learning.



Maria Battle  
Chair



Steve Moore  
Chief Executive

### Opening message from the Chair and Chief Executive

A lesson from the history of previous pandemics is that they all come to an end. The crisis' brought about by the emergence of the novel coronavirus known as COVID-19, has been the first of this scale in the lifetime of the NHS. This demonstrates how mercifully infrequent such events are and this pandemic, like all previous ones, will come to an end at some point.

We must not, however, lose this precious opportunity to learn from the events of these past few months. We have seen many positive developments arising in our response to the crisis in the midst of the negative impact experienced by individuals and local services. This report attempts to draw these positive changes out of recent experience without sugar coating what many people have been through. Not every impact or change has been beneficial and there will be much to do in the months and years ahead to recover, but to capture those beneficial changes in the way we organise our services and how we work is an opportunity that we should not miss. This Discovery Report attempts to do just that.

I want to pay tribute to our amazing staff for their flexibility, commitment and dedication through this period and also to our communities for the way they have come together to support the most vulnerable, reorganising just how challenging and concerning this period has been for everyone.

# Thank you!

## Section 1: Introduction

Hywel Dda University Health Board and the Local Authorities of Pembrokeshire, Carmarthenshire and Ceredigion provide services across approximately one quarter of the landmass of Wales. We have the challenge of providing a range of services and support creatively across both very rural and more urban communities. The population we serve is estimated to be 384,000, and is predicted to grow to 410,000 by 2036. Our population is ageing, there are fewer people aged 25-44 and more people aged over 55 compared with the rest of Wales, with a projected rise in those aged over 65 from 88,200 in 2013 to 127,700 by 2033. Whilst this is good news that people are living longer, it brings with it challenges for our health and social care services, especially responding to and planning for our ‘new normal’ COVID-19 environment.

The approach adopted in bringing this report together has been to collate initial intelligence gleaned from a number of sources and bringing this into the key areas of learning to inform our collective priorities and ambition. This has involved:

“**Looking Back**” at the history of previous pandemic responses and presenting some of the findings from our research about previous pandemics (and potential pandemics), including the H1N1 Swine Flu of 2009-10, the Spanish Flu of 1918, and the Black Death.

“**Looking Out**” at global learning and research, and the Welsh context; and a deep dive of recognised thought leaders in the field of health and care, and related policy areas. Specifically this involved accessing research, blogs, web-posts, COVID-19 pandemic guidance and learning from organisations such as:

- **Improvement Cymru**
- **Health Foundation**
- **Kings Fund**
- **Advisory Board**
- **NHS Confederation**
- **Welsh Government**

“**Looking in**” at our system responses, changes and learning as a Health and Care partnership, which has included findings from our Health Board engagement with around 100 clinical, operational and corporate leaders across the organisation. The purpose of this engagement was to discover more about the changes to Health Board services due to COVID-19, and their impact. Pembrokeshire, Ceredigion and Carmarthenshire Local Authorities have undertaken a similar exercise which has enabled us to capture the whole system learning and provide an overview of our findings within this report. We triangulated our findings with relevant performance data, detailed information about service changes, and wider learning about COVID-19 in order to inform the outputs of this report.



**'I think the health board have done a tremendous job in their response to the pandemic and have continued to keep all staff in the loop – the daily videos have been great.'**

## Section 1: Introduction

This report, however, does not contain and analyse all intelligence related to the Health and Care system response to the COVID pandemic locally, as we are continuing to learn and analyse our experiences and outcomes as part of an ongoing discover process. It is therefore important to acknowledge that this is an initial strategic view of the learning, innovation and service change as a result of our response to the pandemic that will require more detailed analysis as we progress with our identified priorities.

Our initial analysis has resulted in a wealth of information, learning and data about COVID-19. However, our focus was in trying to understand what this information tells us about our ability to expedite delivery of our strategy, *'A Healthier Mid and West Wales: Our future generations living well'*. This strategy reflects 'A Healthier Wales', the long term plan for health and social care in Wales. We wanted to understand whether any of the changes implemented in response to the pandemic take us any closer to delivering our strategy; whether some of our ambitions have already been realised; and whether any of our design assumptions need to change as a result of how our services and communities adapted in response to the pandemic. This includes consideration of the impact of lockdown and new ways of working on our ambitions for delivery in line with the Well-being of Future Generations (Wales) Act 2015, such as reduced car journeys, exercise, pollution and local sourcing.

Health and care services are only one part of a complex system that needs to work better together to improve health and well-being outcomes for our population. We developed our vision for the strategy from the shared ambitions of our partners as set out in the well-being plans of Carmarthenshire, Ceredigion and Pembrokeshire Public Services Boards and the vision set out through the Regional Partnership Board. Similarly, this report aims to reflect our shared learning about the pandemic across the Health Board and three counties and communities.

In this report we therefore present a summary of the initial learning that is relevant to the Health and Care Strategy under the following areas, which reflect the key ambitions in our strategy:

- **Population health and wellbeing**
- **Integrated community network - Social Model for Health**
- **Delivering a sustainable hospital network**
- **Transforming Mental Health & Learning Disabilities**
- **Enablers**



Although we were able to triangulate the findings of our engagement with information from several other sources – including quantitative performance data – there are many gaps in our knowledge and understanding. For example, due to the short timeframe in which we worked, we did not undertake engagement with patients and members of the public, or with wider groups of staff from a range of levels and professions. We do not yet fully understand the reasons behind the changes in public behaviour which resulted in less demand for services. It is also important to note that the impacts of changes to services are not known at present, and will emerge over time.

We do not yet have the whole picture about the impact of the COVID-19 pandemic. However, what we do have is a valuable body of rich information and learning about how we as a Health Board and Local Authorities, as well as other organisations around us and generations before us, have responded to a pandemic.

## Section 1: Introduction

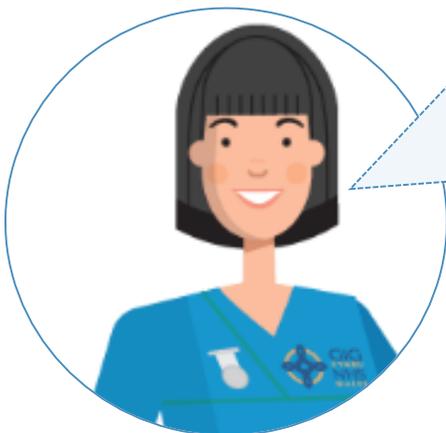
In 'Looking Forward' from our initial learning, within the report we explore which areas of the Health & Care strategy and resulting programmes of work need to be refreshed as a result of our learning about the pandemic, and the significant changes made as partner organisations and communities during this time.

Specifically, we set out the following:

- **Which areas of work require a decision by the Board**
- **Which changes and innovations require authorisation to be embedded into business as usual, or continue to be implemented**
- **Which areas of work should be celebrated as examples of excellent practice or innovation in response to the pandemic**
- **Which areas of work we need to find out more about, in order to add value to our delivery of the strategy**

We will use our approach of 'continuous discovery' for any areas of work that we need to find out more about. We use the term 'continuous discovery' to describe how we continuously learn about a subject matter or issue relevant to the strategy, and feed our learning back into our overall programme of work or individual projects, continuously adding value to our transformation work. We will do this in addition to the more specific 'discover' phase at the beginning of each individual project or piece of work.

This report provides us with an important opportunity to celebrate the achievements of our staff and communities during the initial response to the pandemic, and acknowledge the passion and commitment to making real change in a very pressurised environment to ensure our population are best served.



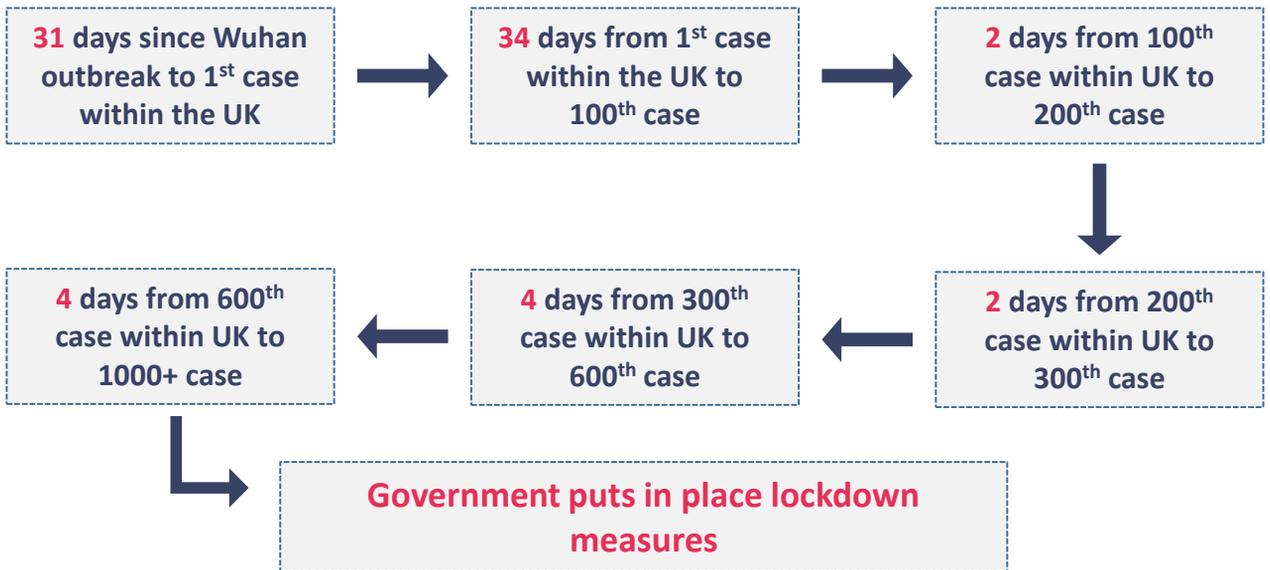
**'There was a sort of 'Call to Arms' element when we had to prepare nursing for COVID - this was exceptional, everyone came together, everyone pulled out all the stops and did what was necessary to get us ready for the 'Tsunami of COVID'. We upskilled staff - i.e. CPAP training, Venous puncture training for Healthcare Support Workers. All of this enabled staff to be less afraid to be deployed to other areas to support. They realised the necessity to support as a consequence of COVID. It's important how the Health Board and the senior teams don't lose this skill-set [...] The upskilled staff have embraced this opportunity and we need to maintain that skill-set and momentum.'**

## Section 2: Looking Back

### Context and timeline for the pandemic

The diagram below highlights the speed with which the virus spread across the globe, and the urgency with which services needed to prepare for the pandemic.

### UK timeline of COVID-19



### Timeline for Hywel DDa

The response to the COVID-19 pandemic has galvanised every part of the Health Board. Whilst it would be understandable to view the preparations as having begun with the inaugural GOLD meeting on 16th March, the executive team has acted as GOLD command from the outset of the pandemic, ahead of the main group being established. The foundation for our response had been in train in the previous eight weeks. The timeline over page indicates some of the key events and decisions made during this period of time.

Hywel Dda was the first Health Board in Wales to have a community testing regime; the first COVID testing unit in Wales, sited in Cardigan and the first health board in Wales to complete build of 9 field hospital sites across Carmarthenshire, Pembrokeshire and Ceredigion.

As a Health and Care system we need to ensure that we are prepared for events of this nature which are likely to happen again, and the learning contained within this report will assist us with the planning for such events.



## Section 2: Looking Back

### Timeline for Hywel Dda

#### Key:

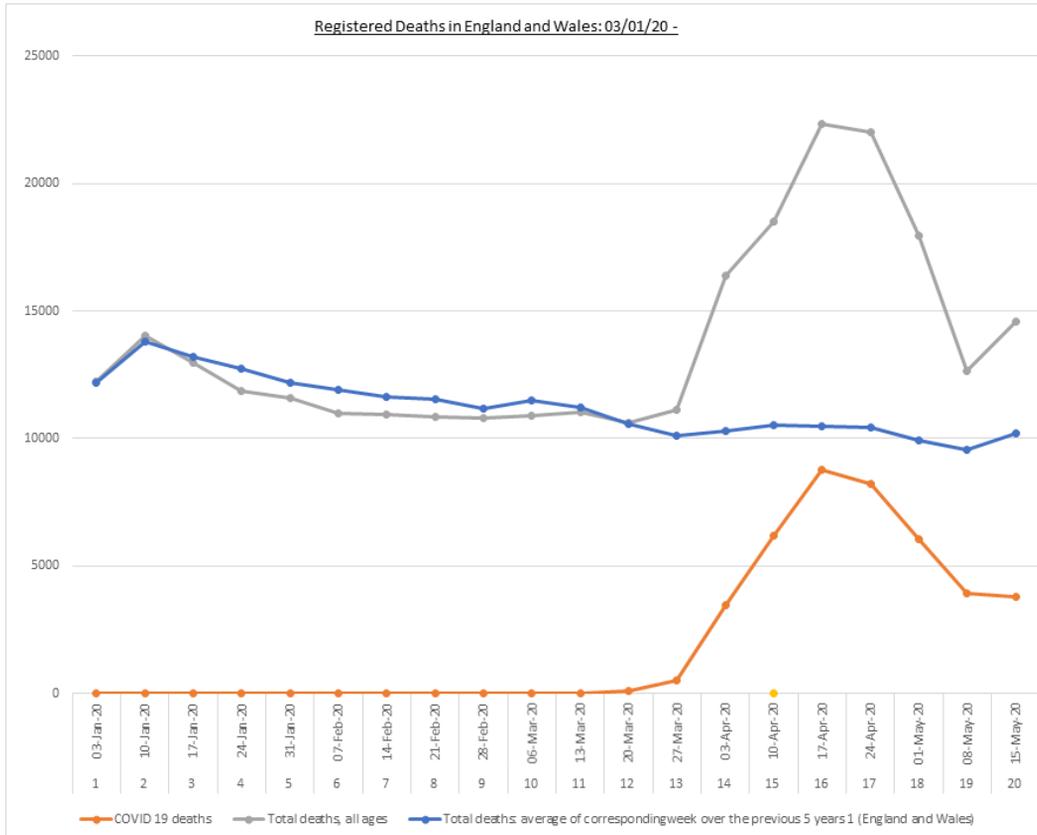
\*PHW – Public Health Wales    \*PPE – Personal Protective Equipment    \*WG – Welsh Government  
 \*CMO – Chief medical Officer    \*RWCS - Reasonable Worse case scenario



## Section 3: Looking Back

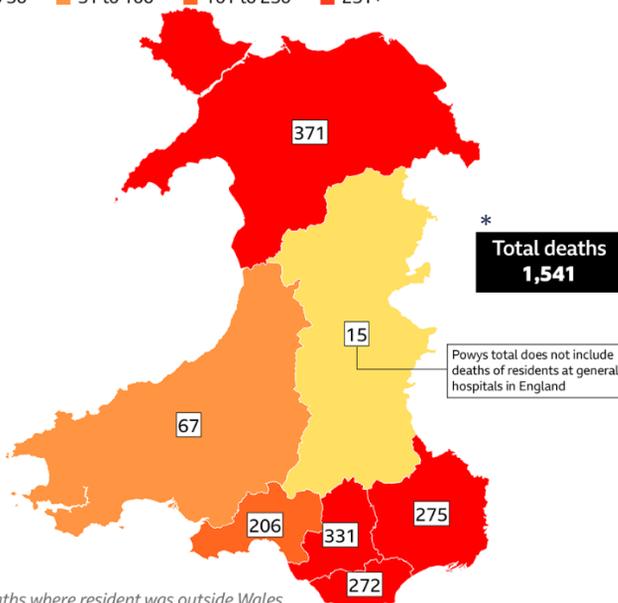
### Learning from previous pandemics: COVID-19 deaths

This graph based ONS data of registered deaths in England and Wales (03/01/2020 – 15/03/2020) tracks COVID-19 related deaths, all deaths and compares both with an average of the previous 5 years.



### Suspected Covid-19 deaths in lab confirmed cases by Local Health Board

■ 0 to 50   
 ■ 51 to 100   
 ■ 101 to 250   
 ■ 251+



This map produced with data from PHW shows the number of deaths per Health Board in lab-confirmed COVID-19 cases. Our Health Board area has had relatively few lab-confirmed deaths.

\* 4 deaths where resident was outside Wales

## Section 3: Looking Back

### Learning from previous pandemics and potential pandemics

History tells us that pandemics always come to an end and that in our response to them, there is significant learning, innovation and transformation. Social changes occurred alongside changes to organisations and institutions. In considering our own learning from the COVID-19 pandemic to date, it has been essential to look back at what history tells us

- 2009–2010: H1N1 swine flu
- The many returns of cholera
- 1918: The Spanish flu
- Severe acute respiratory syndrome
- The Black Death
- Ebola



#### Key lessons learnt

##### Public health

- Strong association between early, sustained, and layered application of non-pharmaceutical interventions and mitigating the consequences of a pandemic
- Public Health tools are most effective when used in a timely, efficient and equitable manner

##### Workforce

- The health care professional population is disproportionately affected during previous pandemics, both through illness and death
- Clinical care is compromised as a result of:
  - Lag in newly qualified personnel due to loss of personnel through death
  - Lack of suitable practical training opportunities during a pandemic and post pandemic due to an overstretched and reduced healthcare workforce

##### Effective Communication

- Effective, credible communication depends on having accurate, up-to-date information

##### Surveillance

- Global influenza detection networks need improvement
- Modern healthcare systems based on just-in-time staffing and supplies, and “right-sizing,” usage heightens the requirement from rapid detection and communication about potential pandemics
- Compared with SARS and MERS, COVID-19 has spread more rapidly, due in part to increased globalization

##### Public trust and prevention

- Community-level prevention and outbreak control measures appear to be dependent on public trust in relevant authorities and information. Low institutional trust and belief in misinformation were associated with a decreased likelihood of adopting preventive behaviours, including acceptance of vaccines

More information is available in appendix 1

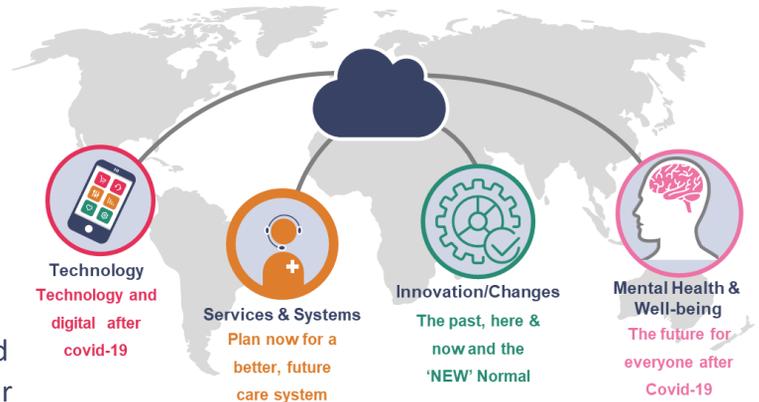
## Section 4: Looking Out

### Global learning

This section contains a snapshot of our learning from across the globe about the COVID-19 pandemic. Detailed information about our learning from research, blogs, web-posts, COVID-19 pandemic guidance and thought leaders such as the Advisory Board and King’s Fund can be found in Appendix 2.

#### Learning from this pandemic

The COVID-19 pandemic is far from over, there are key learning points that are already evident, and will inform the future of systems - ranging from health to procurement - for years to come. There has been a global reaction to the pandemic, individual countries have shaped their response to it through the lens of their own political and cultural system.



There have been pockets of excellence and a growing body of good practice to learn from, it is fair to surmise that so far there is no whole system ‘gold standard’ to follow.

#### Technology and innovation

The successful, rapid and system-wide uptake of telemedicine and virtual treatment platforms in health systems has been one of the greatest outcomes from COVID-19. Whilst the place of technology in health has been on the horizon for a decade, uptake globally has been relatively slow and patchy.

The COVID-19 pandemic, empirically demonstrates telemedicine’s transformative effect on healthcare delivery and the rapid shift in telemedicine adoption among both patients and providers

NHS-wide	Pre-pandemic	End of April
Virtual visits	5%	90%
Wait times	3 week	Same-day



“We transformed **80 practices** in two weeks to not only remote working, but also hot and cold sites all with a standard operating model. Now, we’re trying to put the same protocols in urgent care across the system. It’s been an astonishing achievement.

Chair of a progressive ICS  
England, UK

## Section 4: Looking Out

### Global learning

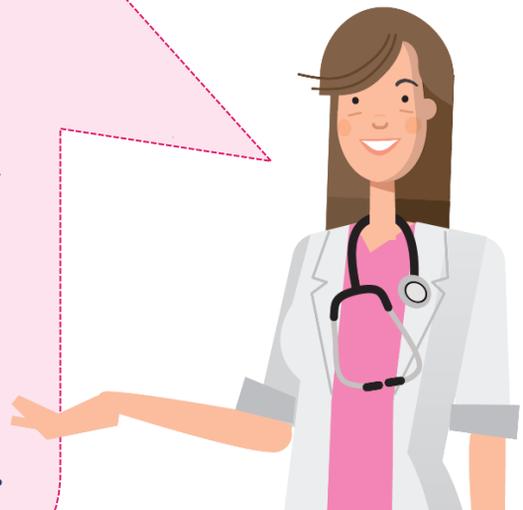
#### Public Health emergency planning

Whilst the world has seen pandemics before (and will again), there is evidence that Health and Care systems that have adopted a public health approach to emergency planning have had greater success in minimising the impact on their population. Health systems that have had the greatest exposure to previous pandemics (from Severe Acute Respiratory Syndrome (SARS), H1N1 (swine flu), Middle East Respiratory Syndrome (MERS).) have developed and adopted whole system protocols have been seen lower case numbers and mortality.

There is evidence that Health Care providers who had formalized and detailed emergency plans in place - often as a result of planning for natural disaster such as weather events - have been shown to have been able to respond more rapidly and more effectively than other systems.

#### How Ochsner Health (US) started Covid-19 planning 'long before anyone was aware of this disease'

*In some ways, planning for the COVID outbreak happened long before anyone was aware of this disease. Our experience preparing for weather-related natural disasters has led to the development of a comprehensive Disaster Management team. Having those resources in place prior to this outbreak has been a tremendous asset for the organization. Once COVID-19 became known, Ochsner employees began receiving updates from a COVID-19 response team on how the health system was preparing for the outbreak. Our Infectious Disease clinicians and other administrative leaders in the organisation led this response team. Our Supply Chain team immediately began their preparations to ensure we had sufficient supplies through this outbreak and have been working around the clock*



#### Public Health response in South Korea

- Empowered its Centre for Disease Control with greater decision-making authority to respond to outbreaks
- Amended its Medical Device Act to establish an emergency use authorization policy
- Created an Office of Risk Communication as part of a command centre to provide public guidance on how to identify untrustworthy information during a crisis

## Section 4: Looking Out

### Global learning

#### Optimising data

Better outcomes to curb the prevalence of COVID-19 have been seen in countries that have been able to mobilise effective operational responses with data. It is accepted that many countries have access to good data sets and modelling resources. There is a marked difference between systems that have been able to harness the data for operational use.

#### Taiwan

- **“Entry Quarantine System”** developed and granted to all hospitals, pharmacists, and clinics access to patient travel data within 4 days of inception.

#### South Korea

- **28 types of surveillance data** including GPS location, credit card records, CCTV footage were made available to aid contact tracing system.

#### Supply and services

COVID-19 has highlighted the fragility of global supply chains. The global marketplace is particularly sensitive to events that disrupt physical and social norms. The most pressing example is the manufacture and transportation of Personal Protective Equipment (PPE). Some of the major factors contributing to the fragile market include:

- Just in time purchasing, resulting in minimal surplus stock within systems
- Geographical concentration of manufacturing impacted by manufacturing shut down and worker quarantine
- Fragmented global responses characterised by export bans of masks
- Transport and shipping constraints caused by roadblocks and quarantine measures, and lower availability of transportation



## Section 4: Looking Out

### Global learning

#### Personal protective equipment (PPE)

The challenge all health and care systems face in sourcing quality PPE at scale, for a prolonged period of time, has produced some novel responses. Examples of innovations include:

- Decontamination techniques for masks and other PPE or paraphernalia so enable their reuse
- Limiting availability to specific personnel to ensure limited supply is targeted to the right people
- Engineer workspaces to remove the requirement for PPE

##### The method:

Specialised equipment vaporises hydrogen peroxide, which permeates the layers of the mask to eliminate the virus without degrading the mask material

##### The evidence:

FDA-funded study demonstrated N95 respirators still met performance requirements after decontamination with hydrogen peroxide vapour in the laboratory setting over 50 times



#### University of Nebraska Medical Center

##### The method:

UNMC staff hang N95 respirators on wires in a room with two UV light towers. UV lights are turned on for three to five minutes to decontaminate masks, which can be reused multiple times

##### The evidence:

A literature review by UNMC showed ultraviolet germicidal irradiation (UVGI) inactivates human respiratory viruses, including coronaviruses, on N95 models without affecting fit and filtration



#### Rapid lockdown measures

Evidence suggests that countries that were able to halt inbound travel were better placed to avoid large population outbreaks. Nations that closed their borders were more successful than other countries that did not restrict international access.

#### Early lockdown measures

Evidence shows that early national 'lockdown measures' were more successful at flattening the peak of the virus.

Country	Covid cases before national lockdown put in place
Czech Rep.	150
Portugal	448
Austria	504
France	5,423
Spain	7,641
Italy	9,172

## Section 4: Looking Out

### Global learning

#### Mental health and wellbeing

##### Our workforce

In studies on the topic of COVID-19, health professionals report a high prevalence of anxiety and depressive symptoms among the workforce that can be directly associated with the following factors:

- COVID-19 exposure - providing crisis care in the 'Covid world' including the psychological impact of loss of life and sustained periods of pressure
- Material resources - lack of resources including PPE, pharmaceuticals and equipment to provide safe and quality care
- Human resources - over stretched workforce
- Personal factors - Isolation, separation and anxiety about personal networks and loved ones

#### Our population

Studies suggest that various psychological problems and mental health issues including stress, anxiety, depression, frustration, are becoming more pronounced. This is due to the socio-economic crisis and uncertainty of this rapid and massive worldwide event. Mental health and wellbeing needs to be clearly recognized as a public health priority for system leaders and policy makers.

There has been a concerted effort by statutory and third sector organisations to provide online and phone services to health and care workers, and the wider population (including children and young people) during the COVID-19 pandemic.

Some concrete examples of resources include:

- The Department of Health and Social Care has a [Care Workforce COVID-19 app](#), providing health and social care workers with practical information and health and wellbeing support
- The [Queen's Nursing Institute's offers a listening service](#), providing emotional support to registered nurses working in the community
- Open Change has [visual resources about coronavirus for health and social care workers](#), looking at stress, coping and resilience, difficult conversations, and care homes
- King's Health Partners has a [collection of staff health and wellbeing resources for coronavirus](#).
- [The Care Workers Charity](#) provides financial support for people working in the care sector

#### Rehabilitation

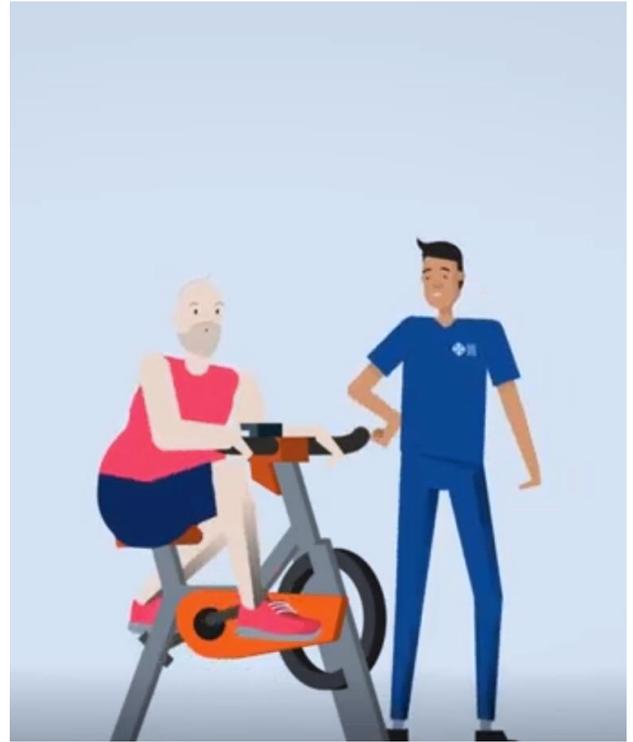
Evidence suggests that COVID-19 survivors do not face a uniform recovery and return to living independent lives. Studies show that there will be a surge in long term rehabilitation demand due to the life altering and limiting effects of COVID infection.

## Section 4: Looking Out

### Global learning

Rehabilitation is a core part of what people need to recover and return to living independent lives. There is a need to plan for the anticipated increased demand for rehabilitation of people affected both directly and indirectly by COVID-19.

Rehabilitation addresses the impact of a health condition on a person's everyday life by optimizing their functioning and reducing the experience of disability. Rehabilitation expands the focus of health beyond preventative and curative care, to ensure people with a health condition can remain as independent as possible and participate in education, work and meaningful life roles. The recent four Nations statement by the Chief Allied Health Professions Advisers reflected growing evidence of the impact of the pandemic for four discrete population groups, as shown below.



<b>POPULATION</b> <b>1</b>	<b>People post Covid-19: those recovering from extended time in critical care and hospital and those with prolonged symptoms of Covid-19 recovering in the community</b>
<b>POPULATION</b> <b>2</b>	<b>People awaiting paused urgent and routine planned care who have further deterioration in their function</b>
<b>POPULATION</b> <b>3</b>	<b>People avoiding accessing services during the pandemic who are now at risk of harm e.g. disability and ill-health</b>
<b>POPULATION</b> <b>4</b>	<b>Socially isolated/shielded groups where the lockdown is leading to decreased levels of activity and social connectivity, altered consumption of food, substance misuse, the loss of physical and mental wellbeing and thus increased health risk</b>

## Section 4: Looking Out

### Looking out: The Welsh NHS confederation: New ways of working

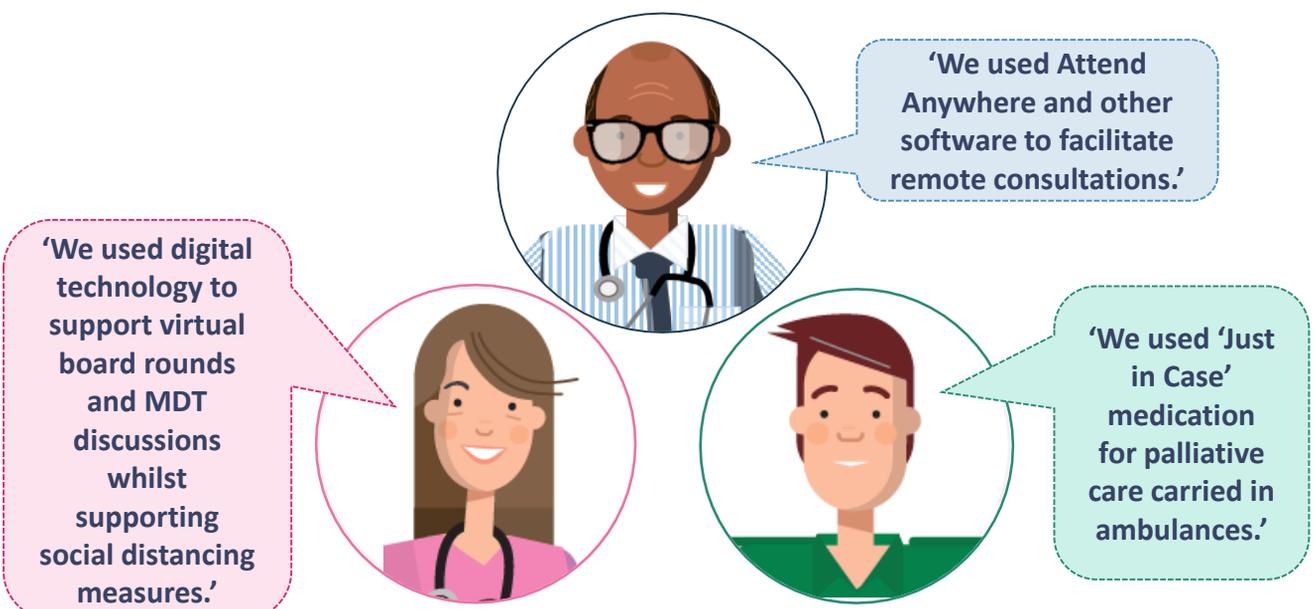
The Welsh NHS Confederation (WNHSC) was requested by its members to capture information on the learnings from COVID-19. Through the course of research, several studies and exercises with similar aims were identified, carried out by organisations including the Bevan Commission, Welsh Government, other Health Boards, the Welsh Council for Voluntary Action (WCVA), and NHS Regional Innovation Hubs.

The following examples of new ways of working established in response to COVID-19 were captured - notably, many of these examples were identified in our own engagement within Hywel Dda:

- *Working remotely has increased and is viewed positively*
- *There have been reductions in levels of governance/bureaucracy with most comments of this nature praising the increase in pace*
- *Organisations report using tools such as Skype, Microsoft Teams, Zoom and WhatsApp to communicate both with internal colleagues, other organisations*
- *Sense of camaraderie amongst staff and support for each other. Greater empowerment with less sense of support from management/senior leaders*
- *Increased communication, e.g. daily COVID emails*
- *Examples of redeployment and restructuring some services*
- *Establishment of staff well-being areas and support sessions*

*Extract from 'New Ways of Working: Update for Chairs', by Jane Green, WNHSC, 10 June 2020*

Here are some examples of innovations to services that were captured by the research:



## Section 5: Looking In

### Our findings through engagement

The response to the pandemic has highlighted that population health, care and support is everybody's business. The Health Board and Local Authorities that constitute the Hywel Dda footprint are united in their intention to look back over this period of time and learn lessons both collectively and individually. The findings will build on the long tradition of partnership working that has been a success in the region.

Partners have all taken steps to learn from recent events in order to highlight the successes, uncover the challenges, and begin to determine the direction of travel for resources and services in the future. Partners have approached this task in different ways.

#### Community Health Council (CHC) engagement via 'Survey Me'

We analysed feedback from Hywel Dda residents to a National Community Health Council survey. The survey asked people:

- to provide feedback about their experience of specific NHS services during the COVID-19 pandemic;
- to give suggestions as to how the NHS in Wales could do things differently in an emergency.

We analysed the 43 responses received via the survey. Since the responses were service-specific, they have not been themed, but rather have provided a high-level summary of findings, along with examples of comments from patients and their family members or carers.



## Section 5: Looking In

### Community Health Council (CHC) engagement via 'Survey Me' – our findings

#### What worked well

When asked to share their experience of using specific NHS services, people shared positive experiences about the following:

- Despite the changes to how care was delivered, many people said they received 'excellent care' or 'great care'
- Using community venues for clinics and surgeries

#### Use of a community venue to hold a blood clinic

'I'm really impressed with this service from the NHS. It is a real credit to the NHS and those with the vision to make it happen in the heart of the community.'

#### Home visits

'My parents have been given great care through this pandemic with home visits but also before this.'

#### Information and reassurance

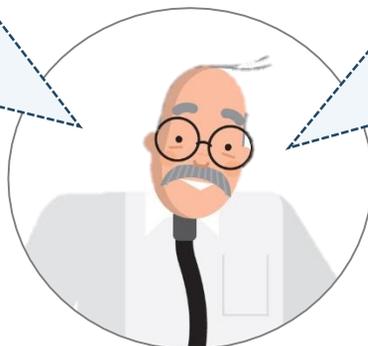
'Nurse is always on the ball, she's amazing and has supported me through email and phone calls throughout, always giving great information too and reassurance.'

#### What worked less well

Respondents noted negative experiences due to the following:

- Difficulties in contacting clinicians across primary and acute settings
- Many respondents reported feeling anxious or frustrated whilst waiting for outpatients appointments, scans, screening, injections, or urgent surgery, or going without regular check-ups
- Concerns about ongoing symptoms
- Going for long periods of time without pain relief, with pain worsening
- Services that had been suspended slow to restart, given low numbers of people with COVID-19
- Potential risks and negative impacts of delayed diagnostics and treatment (for example, impact on cancer prognosis)

'Procedures need to be undertaken with appropriate risk assessments in place with a gradual return to healthcare for people who need pain relief like me as well as much needed cancer care and treatments and other urgent cases that are deemed appropriate and urgent.'



'I fractured my leg four weeks ago and I have not been offered any follow up appointments or physiotherapy. I appreciate the need to minimise hospital visits at this time, but my fracture was nasty and I would have liked some follow-up, even if via video chat.'

## Section 5: Looking In

### Community Health Council (CHC) engagement via 'Survey Me' – our findings

#### Mixed feedback

Many respondents reported a mix of positive and negative feedback – they understood that clinicians were doing their best to adapt and deliver services during the pandemic, but that nevertheless this can have negative impacts on patients.

'Due to the pandemic I've had my appointments via phone. It has meant that the vital tests that I need are delayed which means my condition will probably worsen. However each specialist department have tried their hardest to offer advice, support and hopeful timescale where scans and operations could be done.'

#### Services slow to re-start

Some respondents noted that services are slow to re-start, especially given the low numbers of COVID patients.

'I am still waiting for urgent surgery, we keep hearing "COVID-19 has not gone away", well guess what, neither has all the other urgent clinical conditions.'

'I was taken into hospital on Monday 23rd March, the day the lock-down commenced. [...] I received first class treatment despite the difficult conditions within the hospital and I came home on 4th April, some 12 days later. I am awaiting [appointments for further surgery]. I have heard nothing about either appointment to date but this is expected due to the on-going situation with Covid19. I had a fairly bad flare-up yesterday which was very painful so I hope to hear something soon.'

#### What could be done differently

When asked how NHS services in Wales could do things differently in an emergency, people suggested:

- That clinics are appointment only and run to time
- That more information is provided in supermarkets where people who are not online can access it
- Providing more clinics and surgeries in community venues
- Improve communication with patients who are waiting for appointments or treatment
- Letters for patients who are shielding should have been 'more tailored'
- Keep information and signage up to date



'Create your pandemic strategy so that little disruption is in place.'

## Section 5: Looking In

### Our findings through engagement

#### Health Board’s clinical, operational and corporate engagement

Within Hywel Dda Health Board, we wanted to find out about the changes and innovations that had taken place due to COVID-19 preparedness, and apply this learning to expediting our strategy, 'A Healthier Mid and West Wales'. We were aware that the pandemic had forced many clinical services and corporate functions to work in radically different ways. For example, we knew that many clinical services had introduced new virtual services at pace, and that the Health Board’s ambitions around digitally enabled care could be realised as a result of this. It was important for the Transformation Programme Office to gain a fuller understanding of the changes and innovations that had taken place, and what had enabled these changes, so that we could build upon existing innovations in delivering our transformation programmes.

We knew that we had a small window of opportunity to engage with clinicians before some services were reintroduced, and whilst their experiences were fresh in their minds. With this in mind, we designed a detailed and robust engagement exercise to enable us to gather this important learning from our key leaders across clinical, operational and corporate areas of work within the Health Board and beyond. Due to the short timeframe, the scope of this engagement was limited to around 160 people. Within weeks, we captured the views of more than 100 senior leaders, mainly through virtual one-to-one interviews. Some people responded to the online version of our questionnaire.

We were overwhelmed by people’s appetite to take part in this engagement, and how much information they shared with us. Several people told us how important it had been for them personally to take time out of their busy schedules to reflect on the changes that had taken place – not only to services, but to their personal lives and those of their patients or teams. This represents hundreds of hours of people’s time, and we have gathered a body of detailed and useful information as a result. We would like to take this opportunity to thank every person who took part in the engagement – it was a privilege to listen to you, and to learn from your experiences.



Office 365



The results of the engagement – both one-to-one interviews and online questionnaires – were all uploaded and saved in Office 365 Forms. We used Braun and Clarke’s 6-step framework for Thematic Analysis to analyse the responses to our engagement – this is a robust approach that is widely used to analyse qualitative data. Further details about this approach are available in Appendix section 3

## Section 5: Looking In

### Our findings from the transformation engagement – What worked well

We asked people to tell us what changes and innovations had worked well, and what had enabled those changes. Some of our findings about what people felt worked well are summarised below.

A copy of the proforma on which our questionnaire and interviews were based is available in appendix 3, along with the high-level results of our thematic analysis.

#### Common vision and shared goals

Almost unanimously, people told us how powerful it had been for teams and departments to work towards one clear goal: to prepare for and manage our response to the pandemic. Although in reality teams have many different objectives, how can we create a smaller number of clear goals for the organisation in future, to continue to mobilise change? How can we sustain the sense of working towards a common goal across the whole system?



**'I'd like to see us change the way we look at plans and priorities and strategy going forward. We tend to include everything [in our plans]. We need to get behind single issues that we can all contribute to. We need to be brave. We need to prioritise one issue we can all get behind – something common to us all in service delivery – for example transport. We can make such a massive difference. We end up dividing everything up between us. We never look at the core issues. We need to be far more focused. We need to take a task and finish approach. We may all have more than one objective, but we need a single priority.'**

#### Empowerment and autonomy to act

One strong theme in our engagement was that people valued having the autonomy and freedom to make decisions within the framework of the command structure, and that this led to efficient and effective decision making. People that we interviewed told us that decisions about services were 'clinically led and need-driven', and benefited from having a lighter touch governance structure in place, without the need to submit detailed reports and wait for decisions to be approved. Decisions were made quickly through having regular, short, focused meetings, and through an increased multi-disciplinary approach to decision making. They told us that 'local decisions were made by local teams', and that they felt empowered to 'get on and do'.

#### Workforce flexibility and 'can do' culture

We heard many positive examples of staff flexibility and adaptiveness in response to the pandemic; of people's willingness to work outside traditional role boundaries, take on additional responsibilities, and support changes to services and rotas.

#### Camaraderie

This was the word used most to describe the working culture during the pandemic.

## Section 5: Looking In

### Our findings – What worked well (continued)

#### Working digitally

Another strong theme in our engagement was how the introduction of Microsoft Teams had changed our ways of working. People told us that this enables remote working, with less paper and less travel. It facilitates collaboration, with people connecting across sectors, and jointly working on documents.

#### Technology enabled care

As well as enabling staff to work remotely, people gave us numerous examples of how technology had been used to introduce virtual consultations with patients. We heard about assessments and clinics taking place through smartphones and patient platforms such as Attend Anywhere. We also heard how we need to ensure that we retain some traditional methods of providing patient care appropriate to patient’s needs.

#### Restructured services and pathways

We heard countless examples of how services had been restructured in terms of where and how they are delivered to patients. Some examples involved a shift to delivering services in community settings, and changes to staff rotas. We also heard examples of how restructured pathways led to admission avoidance and early supported discharge from hospital and all hospitals divided into red & green zones

#### Integrated, collaborative partnership working

Examples were given of streamlined pathways between primary, community (including local authority), and acute care, along with examples of how staff had worked across traditional boundaries and sectors, breaking down silos. These examples of partnership and integrated working are relevant to our ambition to take a whole system approach to transforming health and care.



‘Some changes have been fantastic: increased access, consultation over the phone, medication delivered when providing abortions at home early on. We have managed more terminations than ever before – access to services was previously rigid. We undertook approx. 1500 consultation through telephone triage, and we have also been posting out contraception. We were lucky to pilot online STI testing for the whole of Wales, and we’re in a good position to continue. This keeps patients out of A & E (those who don’t get tested early and develop more serious problems). The only people we have seen face to face are those requiring urgent treatment. We are monitoring the impact of this by patient surveys.’



‘We changed whole pathways within 2 weeks. We were given the freedom to do it. I didn’t need to write an SBAR or get Exec approval. We had clinical approval and [the changes] were led by clinicians. This was a good opportunity where we gathered everyone together and as we had limited time we had to get it done. Previously, logistically it wasn’t coming together with clinicians.’

## Section 5: Looking In

### Our findings – What worked less well

We asked people to tell us about any changes and innovations they felt had worked less well during our response to the pandemic. Here is a summary of what they told us.



**“[We are] trying to minimise home visits which is the right thing to do but there is something that you lose not doing face to face assessment. Impact of this would cause us some concern longer term. Starting to think about reintroducing these home visits on a risk assessed basis, worry about if you're not in that persons environment your missing lots of vital information. Current [technology] put in place such as WhatsApp are adequate but not the same as seeing someone at home. Need to establish criteria where home visit is needed, people could potentially be at risk as they haven't had the forensic assessment.”**

#### Limited strategic planning

For some people, the pandemic highlighted the limited strategic planning in place to prepare the organisation for large scale events or issues such as this. Some people mentioned that care homes were not brought into the overall strategic planning early enough. Others mentioned the need for longer term, joined-up workforce planning.

#### ‘Knee-jerk decisions’

People were concerned about how many standard / routine services had stopped (for example, diagnostics), and how slow the organisation is in planning to re-start services. Some standard training stopped during the pandemic, and some respondents worried about the impact of this on workforce skills.

#### Potential impacts on patients

In general, we heard many comments about the potential impact of changes to services or suspended services on patients, highlighting the need for patient and public engagement to understand the impact of the pandemic.

#### Limited controls and due diligence

The risks of a lighter touch governance were noted, particularly the risks of unchecked, maverick behaviours. Some people noted a disconnect between Gold decisions and frontline delivery, and between the Bronze groups, which relied on Bronze Chairs to connect on key issues.

#### Lack of timely data

People mentioned the lack of access to real-time data projections throughout the pandemic.

This led to planning and decisions based on out-dated information.

#### Workforce pressures

The pandemic highlighted existing workforce gaps and under-resourced teams.

**‘In future, if there is a second wave, we need to consider how we work differently, plan what it might look like. There was a knee-jerk response. Initially there was an element of crisis response.’**



## Section 5: Looking In

### Our findings – What else did people tell us?

Here are some other examples of what we heard during the engagement:

**‘Day to day management worked jointly with all departments – there were no silos. We set up a hub made up of various departments (Medicine, Nursing etc.) where we made decisions working together, supporting decisions on rotas etc. [...] To achieve social distancing we had to introduce 7 day working. This brought us working closer together.’**

**‘Rapid rollout of E-consult and Attend Anywhere platform onto an already mature IT infrastructure across Primary Care [has worked well]. Reduced ability for face to face consultation due to social distancing has enabled the model to be rapidly adopted by all practices.’**

**‘The development of a community hub led by the third sector. Pre-COVID we were trying to stimulate conversation. 55 new community organisations have been set up in the past 2 months [...] 550 people volunteering with these, massive galvanisation within communities in Pembrokeshire to support each other.’**



**‘I noticed an outpouring of support to the NHS which we have never seen before. Monetary contributions were up by 95%. There was an outpouring of gifts: local restaurants were delivering food to our staff and hospitals; the WI were supplying toiletries; and the sewing community were delivering laundry bags to our hospitals for staff to use. We have seen the community getting together and saying thanks to the NHS. This has shown how the community are very proud of what we do and the NHS. Whereas we sometimes see the reverse (complaints, criticism of services etc.), during COVID we are seeing the positive. We need to harness the communities’ support for the NHS.’**

**‘As a Physiotherapist we have high levels of sensory knowledge we utilise as part of assessment and intervention – working remotely, not actually seeing/touching people – if this is the way to go it is a big concern to me. For example with children – therapeutic touch is essential – if you can’t hold their hand or provide hands on treatments etc.. There is a risk that we lose some of this in the future with need to social distance [...] How have people been impacted upon through lack of [...] hands on rehabilitation e.g. with stroke patients?’**

### How we’re going to feed the engagement learning into our Transformation Steering Group?

- Communicate and share what we have learned from patients, staff and stakeholders
- Feed outputs into our continuous discovery approach and into specific discover phases for individual priorities and projects
- Continue to utilise all the intelligence in our check and challenge approach with our wider stakeholders

## Section 5: Looking In

### Themes – Design assumption

The design assumptions shown in the infographic below are the ambitions that underpin our health and care strategy. They were agreed with our clinical reference group in developing our strategy. These assumptions about what will happen to patient flow (irrelevant of the detailed geographical location of sites) are based on our learning from these areas:

- Learning from our engagement with communities, who want local services for unplanned care but are willing to travel for planned care as long as it goes ahead
- Learning about models of community-based planned and emergency care in Northumbria, Somerset, Scotland, Christchurch and other areas of good practice
- Working with modelling experts who have worked elsewhere to look at what happens to the flow of patients when good practice is applied
- Engagement and agreement with clinical leaders across the organisation

During our engagement, we asked respondents whether the changes that have taken place due to COVID-19 have any impact on these design assumptions.

<p><b>Population</b></p>  <p>Impact of increase in the population over 7 years (to 2024/25)</p>	<p><b>Site changes</b></p>  <p>Flow of patients to nearest site providing required service*</p>	<p><b>Admission avoidance</b></p>  <p>Reduction to existing levels of emergency admissions for ACS conditions</p>	<p><b>Bed discharge</b></p>  <p>Reduction in lengths of stay to the median of the peer group</p>	<p><b>Outpatient change</b></p>  <p>Reduction in follow-up outpatient appointments</p>
<p><b>A&amp;E/MIU change</b></p>  <p>Reduction in overall level of A&amp;E &amp; MIU attendance <small>(net 0% change against demographic growth over 7 years)</small></p>	<p><b>A&amp;E/MIU proportions</b></p>  <p>Attendances currently presenting at A&amp;E will present at MIUs instead</p>	<p><b>Acute to community step-down – beds</b></p>  <p>Patients in an acute bed will step down to a community bed within 72 hours of admission</p>	<p><b>Acute to community step-down – outpatients</b></p>  <p>New and follow-up appointments will take place in a community setting</p>	<p><b>Daycase community hub shift</b></p>  <p>Daycases for medical specialties will take place in a community setting</p>

### We found that:

- There is a level of ambiguity around the wording used within some of the design assumptions (people said that they are ‘open for interpretation’)
- There is a lack of familiarity with the design assumptions
- There is a level of scepticism around their purpose, and how they would be achieved
- There is a perception that they may be used as performance targets, impacting behaviours
- People’s views were sometimes service specific – it is difficult to draw general conclusions about the assumptions based on these views
- We received a low response rate to the questions about design assumptions – some results are not therefore statistically significant

## Section 5: Looking In

### Field Hospitals

Hywel Dda UHB's Field Hospitals (FH) design and build phase began in earnest on 20<sup>th</sup> March 2020. Preliminary discussions had taken place before this point with Local Authority colleagues noting the scale and challenge in being able to provide suitable healthcare facilities for the projected surge in patients due to the COVID 19 pandemic. The Design and Build 'kick off' discussion on the 20<sup>th</sup> March noted the magnitude of the challenge – namely to create in excess of 1000 beds, effectively doubling the Health Board's current bed capacity. This number was based on the data modelling for the projected number of COVID-19 patients at the peak of the pandemic.

As part of the discussion, there was an allocation of work streams to lead officers to drive activity. Although following a formal project and programme management approach it was noted that all involved would need to work at pace and vigour, across professional and organisational boundaries along with flexibility to achieve the goal.

During the FH Design and Build Phase there were significant challenges but there was an overall 'hand in glove' approach to working together with all professions involved in the process such as nursing, therapies, infection prevention & control, estates, procurement, human resources, information technology, medicine, clinical engineering, pharmacy and finance along with programme and project management. The collaboration with local authority partners namely, Carmarthenshire, Pembrokeshire and Ceredigion County Council enabled the joint delivery of these facilities in record time.

The end result of this intense period of true partnership working concluded with a handover session to operational colleagues on 24<sup>th</sup> April 2020. In 5 weeks, 9 Field Hospital locations were built in line with agreed specification and equipped across the three counties of Hywel Dda. This provided a maximum bed capacity of 975 beds and included:

- Ysbyty Enfys Scarlets (Barn - 259 beds)
- Ysbyty Enfys Scarlets (Stadium - 80 beds)
- Ysbyty Enfys Selwyn Samuel (143 beds)
- Ysbyty Enfys Llanelli (121 beds)
- Ysbyty Enfys Caerfyrddin (93 beds)
- Ysbyty Enfys Carreg Las (128 beds)
- Ysbyty Enfys Aberystwyth (Plas Crug Leisure Centre - 52 beds)
- Ysbyty Enfys Aberystwyth (Penweddig School - 51 beds)
- Ysbyty Enfys Aberteifi (48 beds)

**'I am proud to be involved with Ysbyty Enfys Caerfyrddin – the level of care provided and processes put in place to ensure a high quality and safe environment in the timescales involved has been professionally rewarding, whilst hearing patient feedback noting how they feel safe and well cared for has been heart-warming.'**

**'The development of the Field Hospitals across Hywel Dda evidenced how the Health Board can work together as one and in partnership with key stakeholders. Within five weeks all involved worked against the odds to double Hywel Dda's bed base and put our region in an enviable position to tackle the challenges that are thrown our way due to the COVID pandemic.'**



## Section 5: Looking In

### Testing

Antigen testing is key to helping us track, trace and isolate people with COVID-19. The Health Board began testing people for COVID-19 in the early months of 2020 – specifically holiday makers returning from a small number of countries affected by the pandemic. We began testing people at home, but as the virus established itself in the population we developed a command centre to manage the process of testing and communicate with contacts, and established testing units in our three counties of Carmarthenshire, Ceredigion, and Pembrokeshire. As the number of people testing positive with coronavirus increased, in an effort to meet the demand for testing, Hywel Dda set up a total of 5 Coronavirus Testing Units (CTUs) across our communities – these are a mixture of walk-in and drive-through units.

Hywel Dda University Health Board was the first health organisation in the UK to establish a drive-through antibody test centre, sited in Carmarthen. We developed the healthcare workforce with phlebotomy skills to support the drive-through test centre. We are currently exploring whether this model could be further developed in future – for example, for vaccinations and primary care phlebotomy.

**The UK Department of Health drive-through testing centre in Carmarthen provides both antigen and antibody testing; It has 5 lanes, and can test up to 300 people per day.**

**‘We ensure that people who are symptomatic are well enough to travel to our drive-through centres – we won’t put people at risk.’**



An antigen test is a test to see if someone has a particular antigen in their blood or their body waste. An antigen is a substance that causes the body's immune system to react  
 An antibody test is a screening for things called antibodies in your blood. Your body makes these when it fights an infection. The more antibodies you have in your blood the greater your ability to fight the infection.

## Section 5: Looking In

### Testing

#### Testing staff and key workers

We commenced testing staff who had symptoms of COVID-19 on the 18<sup>th</sup> March. We supported some very sick staff members and their families, providing advice and guidance via our command centre.

#### Testing in care homes

The Health Board was very proactive in its approach to testing – for example, we began testing symptomatic residents and staff in care homes before the national guidance was issued, took steps to work with care homes to undertake the testing correctly, training staff, establishing support groups across homes and extending our employee welfare service.

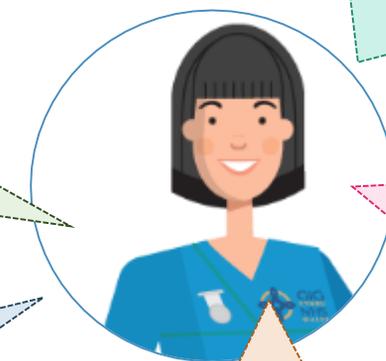
#### Testing unpaid carers

Hywel Dda was also the first Health Board in Wales to test unpaid carers who were symptomatic. As testing for key workers came into effect, we recognised that support was needed for unpaid carers. During the pandemic many people took on the role of a carer to family members who were shielding. We recognised that they needed access to testing, and put a protocol in place.

**‘Other Health Boards weren’t testing care homes until much later than us, and we were ahead of them by 6-7 weeks. Some Health Boards didn’t offer training to care homes, they just dropped off swabs to the care homes which worried me. We trained carers to lessen the footfall at the homes - the rationale also being that they knew their residents best and were able to take the test at more appropriate times of the day for some residents. The only issue with this was we found that we would train a carer one week and by the following week they may have forgotten what to do due to nervousness.’**

**‘Some of the challenges have been around getting test results back in a timely manner.’**

**‘We have done in excess of 12,000 swabs for residents and staff in care homes.’**



**‘It was a privilege to be there on the phone to support people when they needed us.’**

**‘It has been challenging listening to people when they are so obviously unwell. Some people were so breathless they could not finish their sentences. We had to tell some people to put the phone down and dial 999 – that was hard.’**

## Section 5: Looking In

### Personal Protective Equipment (PPE) and Infection Prevention & Control (IPC)

Appropriate personal protective equipment (PPE) is critical to protecting frontline workers and patients, and to stop the spread of the virus. The guidance around PPE has evolved several times during the course of this pandemic. The PPE provision has been reviewed in line with these National Guidelines.

In response to the current COVID-19 crisis, a PPE Cell was established within Hywel Dda Health Board to provide clarity on the appropriate use of PPE across the different user groups and to model and report current and forecasted demand and supply. Membership of this cell is integrated with colleagues from Local Authorities/ Social care/ Domiciliary Care, Primary Care, Community Services, Mental Health and Learning Disabilities, and Acute care – that is, all key organisations involved in delivering health care to our population. This arrangement has developed relationships and enabled mutual aid thus supporting the resilience of stock of PPE across the Hywel Dda geographical area.

We have reviewed and strengthened the distribution of supplies in the organisation via our ‘equipment hubs’ which has had a positive impact on the logistic arrangements across the organisation.

The Health Board has also undertaken additional risk assessments in specific scenarios to consider the views of various professional/ expert groups e.g. the Royal Colleges and UK Resuscitation Council, and we have adapted our practice to reflect these guidelines and the outcome of risk assessments. We have also achieved the following:

- Our local procurement leads have worked closely with local suppliers and NHS Wales Shared Services Partnership (NWSSP) to ensure that at no point did we run out of equipment
- Our Executive Director of nursing sits on the National PPE Sourcing and distribution group thus we are actively engaged in the modelling and planning for any future waves of COVID-19 and other respiratory infection that will present during the winter period
- We are cognisant of the current uncertainty in relation to the continued supply of the 3M 8833 FFP3 respirators and are proactively looked to switch masks to a more assured supply chain. This requires further fit testing which is underway
- We have considered a number of strategies for managing acute shortages of PPE during the COVID-19 pandemic, including: strategies to conserve PPE by optimising use e.g. administrative controls, minimising requirement for PPE, extending time that PPE can be used, supporting rational and appropriate use of PPE and reiterating basic infection control measures in line with national guidance; contingency planning for extreme circumstances e.g. PPE Cell and re-processing opportunities; and temporary measures in the context of extreme PPE

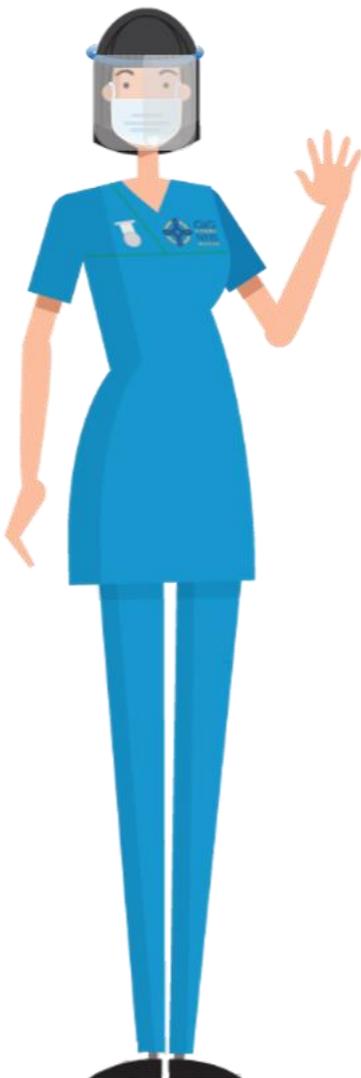


## Section 5: Looking In

### Personal Protective Equipment (PPE) and Infection Prevention & Control (IPC)

Alongside this activity we are considering the circular economy approach for the future with the aim of eliminating waste and the continual use of resources with a resulting positive impact on the pollution and carbon emissions and our local economy. We are not reprocessing or reusing any PPE, apart from scrubs. We have considered the scenario if supply of the PPE were to become critical and have considered the published evidence on specific technologies that could be used to reprocess equipment in order to manage critical supply problems. Work on testing and validating new technologies to support re-processing of PPE is currently being undertaken by the UK Government and we will continue to review further guidance as it emerges.

Continuing with our response to the COVID-19 crisis, the PPE Cell has continued to operate to support the acute sites with a timely and controlled process to distribute the vital PPE supplies to our staff and patients alike. Daily reporting on local stock levels and goods issues has been embedded and an executive summary is being fed into the daily command centre dashboard.



Our remodelled internal ordering and logistical process has significantly reduced the number of requestors and delivery points, to allow for an increased service to operate across non acute services, with robust controls in place, managed by each service point of contact. Ongoing review and escalation processes are in place, as are combined local and national procurement sourcing activities and infection prevention and control guidance adherence discussions.



We will continue to review the sustainability of our current approach to PPE with the stakeholders involved, and look to provide a clear medium term solution on the basis that an increased need for PPE will remain for the foreseeable future.

## Section 5: Looking In

### Personal Protective Equipment (PPE) and Infection Prevention & Control (IPC)

**During the course of the pandemic we learnt the following in relation to sourcing and using PPE and Infection prevention & control (IPC):**

- A need to refocus the IPC team support and advice to be more community and primary care focused rather than secondary care/hospital focused, as burden of the infection was within the community
- A number of changes in national PPE guidance meant there was some loss of confidence in the Infection Prevention and control Team
- Due to demand a need to urgently increase capacity of the IPC so they could respond to community demand
- Local Authority recognition of importance of IPC to their service. This has led to investment in 1 county to support the Local Authorities.
- An integrated approach of Health Board, care homes and Local Authorities e.g. IPC team went into advise care homes on zoning, isolation rooms, education, use of PPE
- Delays in national guidance led to local service implementing local measures. They utilised their experience and learning from previous infection outbreaks to develop local approach.
- A need to physically support parts of care system e.g. undertaking observational support visits to support home managers to protect residents
- Development of an integrated PPE cell where key players from across the system were pulled together to provide expertise and mutual support e.g. mask test fitting for care homes undertaking aerosol generating procedures Continuous Positive Airways Pressure (CPAP) and supply/demand
- A need to develop local procurement chains and source directly. We have demonstrated we have some capability e.g. visors and gowns
- A need to explore ability to reprocess PPE kit. This needs a focused approach which could make financial savings and impact positively on the environment e.g. less waste

The following timeline shows how rapidly the guidance around PPE changed during the pandemic:

- ▶ 10<sup>th</sup> Jan - PPE guidance published
- ▶ 14<sup>th</sup> Feb - Revised guidance published
- ▶ 6<sup>th</sup> March - Changes to mask recommendations
- ▶ 21<sup>st</sup> March - New guidance for surgical mask / FFP3
- ▶ 23<sup>rd</sup> March - Separate guidance for AGP's and Non-AGP's
- ▶ 27<sup>th</sup> March - Revised section for AGP's & Theatre
- ▶ 2<sup>nd</sup> April – New tables describing PPE across clinical settings
- ▶ 10<sup>th</sup> April - Updated guidance
- ▶ 17<sup>th</sup> April – Guidance on PPE shortages
- ▶ 24<sup>th</sup> April - Clarification on AGP's
- ▶ 3<sup>rd</sup> May - Guidance on use of FFP2

## Section 5: Looking In

### Staff wellbeing

During the course of the pandemic our ways of working changed dramatically. Some staff came into daily contact with COVID-19 patients and this had an impact on their contact with families. Some members of staff were shielding, and many others began working from home. Our engagement suggests that some staff feel guilty working from home, and some managers find it hard to adjust to managing their staff remotely.

During our clinical, operational and corporate engagement many people praised the wellbeing resources being published in the daily emails – they said that these were both helpful, and gave an important message about staff wellbeing being a priority for the organisation.

Some key messages from the **wellbeing survey** include:

- Staff difficulties adapting to ongoing changes
- The pace and nature of the changes and how they are managed
- Inconsistency in management and conflicts
- Ongoing concerns re catching/ spreading COVID-19
- Staff looking after each others' welfare

Demands for the emotional wellbeing service decreased at the onset of COVID-19, but during June the demand for these services was the highest we have ever seen.

'I think the updates and communication/signposts have been excellent. If this can continue it would be great.'

'Some managers find it hard to adjust to staff working from home and are insisting on data – we need to change that culture.'

'We have encouraged staff to use the wellbeing resources. The availability and updating of the resources was great and much appreciated. We are concerned about the long term impact on staff.'



## Section 5: Looking In

### Command centre

During the pandemic we established a command centre, which successfully provided the following:

- A single communications hub for call handling
- Excellent, swift and bi-lingual patient and staff response to all enquiries about COVID-19
- Human response to support anxious staff – whether about testing, PPE, IPC, HR issues, guidance,
- It grew, developed and flexed to fit the need of the moment with the crisis
- A hub of experts to support the call handlers and to provide the organisation with one definitive decision / truth
- Expanded to include partner organisations for testing and to support care home pathways
- The Communication team were able to go to one single source for decisions and information

Our future vision

- To expand this success to cover the breadth of all Health Board activity
- To provide **ONE SINGLE** telephone and email point of contact – the **HYWEL DDA HUB**
- To consider switchboard facility incorporated
- To link with the patient appointment online booking and call handlers
- All specialist teams (primary care, patient support, staff support, routed through this single point of contact – streamlining), providing greater access and better experience
- To develop incident response / emergency incident and business continuity cell through this HUB

### Our single command centre hub highlights include:

- A single telephone number for all staff enquiries with high quality call handling and excellent customer care
- A single log of all guidance and advice with an expert team assembled to understand, analyse, synthesise, approve and agree single Hywel Dda implementation of all guidance (Public Health, Clinical staff and Human Resources)
- All testing was co-ordinated in the command centre
- Expert stations were developed and worked together

**‘The Health Board has set up a Command Centre for staff to ring with their queries. This was great because I was able to contact them for advice about working in the ‘red zone’ at work. This would mean having daily contact with COVID patients and I was really worried about the risk of infecting my family members, who are very vulnerable.’**



## Section 5: Looking In

### Supportive Communities

#### Supportive Communities

One of the standout responses to the COVID-19 challenge has been the growth in community-led initiatives. The Health Board has been committed to supporting resilient communities, as evidenced by the work through the regional Transformation Fund. Having a clear, present and very palpable crisis has brought individuals, neighbours and communities together with a speed that arguably could not have been replicated through funding initiatives alone.

There are tangible examples of how grass roots organisations are being supported to become sustainable entities. One exemplar is in Pembrokeshire, where a Community Hub has been formed. Primarily as a vehicle to support shielding people in the County, the Hub is staffed with redeployed call centre workers, Delta Wellbeing officers, and Pembrokeshire Association Voluntary Service (PAVS) workers. It has been housed in a newly leased building and has supported 96 new groups to become sustainable, through advice and assistance from PAVS; as well as co-ordinate the resources they offer with the needs of vulnerable people in Pembrokeshire. Two organisations are piloting a digital platform for referrals and service provision.

One of the most interesting points to note is that many of the organisations in question offer support with areas of need that sit outside of the usual health and social care remit - notably housing issues and financial hardship. This speaks more closely to a developing population health response, and has the potential to build a stronger base of community resources going forward.

Community organisations face challenges in being financially viable and COVID secure. Ceredigion Association of Voluntary Organisations (CAVO) in Ceredigion has undertaken a piece of engagement to highlight the challenges and opportunities for the sector.



#### The take away findings include the challenges of:

- The challenge of ensuring places of work and service are safe for users and workers
- The challenge of PPE and suitable guidance and training
- The challenge of providing digital services to vulnerable people who may be digitally excluded and/or find virtual support unhelpful
- The challenge of learning how to deliver a professional virtual service
- The challenge of retaining the volunteers and safeguarding the wellbeing of staff and volunteers during this time of upheaval

## Section 5: Looking In

### Charities

#### Hywel Dda Charities

The communities in our Health Board have provided us with the most incredible outpouring of goodwill and support, on a scale that we have never experienced before, not simply through ‘Clap for Carers’ and the myriad of rainbow pictures in windows, but through financial donations, food for staff, and homemade PPE.



## Elusennau Iechyd HYWEL DDA Health Charities

Our community has wrapped its arms around the NHS and for that we are all extremely thankful. These are some examples of how our communities have helped our effort to tackle the virus:

- Our Charity has seen a 95% increase in financial donations.
- Local restaurants were delivering food to our staff and hospitals
- The Women's Institute (WI) were supplying toiletries
- The sewing community produced laundry bags and scrubs
- Offers for transport
- Offers of staff discount

There is a real opportunity to revise the ‘ask’ for our charities in future about how they can support the NHS through charitable giving. More strategic planning is needed as well as a clear understanding of what support we require as an organisation. The charity requires a clearly defined role in supporting proactive rather than reactive expenditure to both improve patient experience and support staff welfare and well-being.

This is also an opportunity to harness the support of our local communities to help us implement our strategy. One of our ambitions is to take a whole system approach to our health and care, and our communities play a key role in that.



**“As a member of staff I feel valued by the health board as I received small wellbeing gift, using the charitable funds they received.”**

## Section 5: Looking In

### Volunteering

#### Volunteering

#### 3<sup>rd</sup> Sector Feedback

There has been a marked increase in people wanting to engage in volunteering. Feedback from Third Sector leaders suggest that:

- Working digitally is a more accessible offer for volunteers, as well as making recruitment more accessible (versus physical events)
- Furlough may have resulted in a greater number of people who are available and willing to volunteer – this may change
- The COVID-19 crisis has galvanised people who have not traditionally volunteered, to investigate the opportunities
- There is a very real opportunity to harness the community response long term through volunteering

#### Hywel Dda Experience.

Prior to COVID 19, 415 volunteers were on board, initially 390 withdrew leaving a capacity of 25 which further reduced to 16. In response to the volunteer call during COVID-19, the following has taken place:

**471 interviews with potential volunteers were completed**

**146 were not progressed**

**207 were offered places in the volunteer pool and invited for induction training**

**118 did not respond**

**Of the 207, 124 have completed training with 83 still in the process**

Together with pre-COVID volunteer capacity; this now takes our volunteer pool to 140. Roles for deployment include:

- **Transporting equipment/staff**
- **Check and chat volunteers**
- **Gardeners**
- **Community response drivers**

Wave 2 (potential further 120 volunteers) has been put on hold pending further clarification on the operation of our Field Hospitals. There is further potential to work with partners across Health and Social Care, and Third Sector in developing appropriate roles and deployment opportunities for volunteers.

## Section 5: Looking In

### What we need to learn more about

So far, our engagement has been limited to senior members of staff who led change during the initial response to the pandemic. We understand less about the experience of front line staff, patients, and our communities during the pandemic at this stage, but will continue to bring together our learning about their experiences throughout our ‘continuous discovery’ approach. Following this engagement, our intention is to expand the initial Discover phase, working with our partners across the whole system to gather more information that will help us deliver our transformation programmes.

In our strategy, we made a commitment to listen to the voices of our population. The next step is for us to engage with patients, carers, and service users, including people with protected characteristics (as defined under the Equality Act 2010), and people who may be vulnerable. Listening to what matters to people, and what their needs are in relation to how we deliver services, will inform our whole system approach to designing and delivering health and care services.

Some work is already underway which may help us understand how recent changes have impacted upon particular groups of people, including the following:



### Unpaid carers

358 unpaid carers responded to the Regional Carers Survey, and provided views about how they could best be supported through the pandemic. Analysis of the feedback included the following:

- Lockdown placed increasing pressures on unpaid carers due to ‘shielding’ requirements and respondents felt they had no choice but to continue supporting the person they care for despite some statutory services being withdrawn e.g. day centres. However, some cared for people are benefitting from more contact time with their unpaid carer.
- ‘Keeping in touch’ calls, emails, and video calls are essential, and virtual contact with support and peer groups is highly valued, since it supports the mental health and emotional wellbeing of unpaid carers.
- Financial issues: some unpaid carers reported having had to take unpaid leave, whilst for others, lockdown has made caring easier because of new home working arrangements.
- There is some disquiet that paid carers have been given £500 by Welsh Government, but unpaid carers have not been similarly recognised.
- Carers aged 18 and under were concerned about falling behind with schoolwork and worried about schools being understanding of caring responsibilities. The ‘wellbeing pack/ bag’ for carers of this age group was well received.

## Section 5: Looking In

### What we need to learn more about (continued)

#### People who require interpretation and translation services

Concerns have been raised about Syrian refugees who (supported under the Refugee Resettlement programme) did not receive the translation and interpretation services available to them at a number of GP practices. Patients have also experienced that some departments in both will not use interpretation services, despite the efforts of the Partnerships, Diversity and Inclusion team to promote these services.

A range of options exist for providing interpretation services to support patient care. These include: Face-to-face interpreters who may be booked for specific appointments; a 3-way telephone interpretation service via Language Line and a new “Insight App” provided via the Wales Interpretation and Translation Service which has been loaded onto the new ward-based devices to facilitate access to immediate interpretation services. This supports effective patient care, and ensures that patients are treated with kindness, dignity and respect. Further work is needed to ensure that everyone who requires translation or interpretation services receives it.

#### Black, Asian and Minority Ethnic staff and communities

We know that the COVID-19 virus has impacted disproportionately on Black, Asian and Minority Ethnic people (BAME). BAME staff were at particular risk during the pandemic our chairperson leads on a Health Board wide advisory group on BAME, and engagement work with BAME staff is underway within the organisation, to understand their experience of the pandemic, themes identified and what support they may need. We interviewed a small number of BAME staff as part of our engagement. Further work is needed to understand the impact and future support needs of staff and communities who are at a higher risk of the virus, since the virus may continue to impact on us for months to come.



#### People with sensory loss

We have heard about changes to services and how they are delivered as a result of the pandemic but we need to understand how some of these changes may impact differently on people with sensory loss to ensure that new ways of delivering services are accessible to them and they are not disadvantaged. Making full use of interpretation services will help to mitigate challenges e.g. provision of on-line or telephone interpretation.

There are many examples of guidance and good practice that can help us with this. The Guide Dogs campaign ‘Be There’ shares 3 tips to help us support people with sight loss. The Wales Council for Deaf People and Wales Council for the Blind have produced guidance about making meetings accessible for people with sensory loss.

#### Next steps

Further engagement is needed to assess the impact or potential impact of changes to services on some of the above groups of people and others. This work will be led by the strategic enabling group: ‘Better ways to connect: Continuous engagement, diversity and inclusion’.

## Section 5: Looking In

### What we need to learn more about (continued)

#### Children and young people

Children being away from school may have impacted on their formal education and their interaction with their peers. This may lead to some short and longer term negative impacts e.g. communication delay, anxiety. This area will need to be carefully considered over the next few months and especially as children return to full time schooling in September.

#### People living in areas of high social deprivation

COVID-19 has had a proportionally higher impact on the most deprived areas in community especially in relation to deaths. The socio-economic impact of the pandemic including the loss of employment may increase this further. Further work is needed to understand this impact within the areas in the Health Board including parts of Llanelli, Pembroke Dock and Cardigan.

#### People who are digitally excluded

We know from our Public Service Board that as many as 12% of people in Hywel Dda may be digitally excluded, and many more may not be using digital services for a variety of reasons. During the pandemic a large number of services were delivered virtually; we need to understand the impact of this, and how we can ensure that people who are digitally excluded can continue to access services.

**'I am living on my own at the moment as my wife is in a care home and I am really worried as I can not see her. The care home has an iPad they can use, but I don't know how to use those things. It would make me so happy if I could go somewhere where the public can access computers and if they had someone who could help me to use one. This would mean I could see Mari and could also stay connected with my daughter or perhaps I could see my doctor as I know they're using this method to assess people. Maybe somewhere like my local library or a food shop will introduce a service like this and I am sure there are volunteers who could help people like me.'**



**'It's taking me along time to recover after catching coronavirus and I'm still not right. I had a lot of time off sick whilst I was in hospital and after getting home and now they're talking about laying off people at work. I think they're going to have to let me go. I don't know how we're all going to manage on one income – I've been worried sick. Sioned's going to try to get more hours, but she's not well herself because of all the stress.'**

## Section 6: Looking Forward

### Assessing our learning against the existing strategy

Our strategy ‘*A Healthier Mid and West Wales: Our future generations living well*’ describes:

- **Our 20 year vision for the population health outcomes for current and future generations; and**
- **Our 10 year health and care strategy.**

Improved health and wellbeing is a cornerstone of the strategy, signaling a move away from a reactive care system that responds to illness and toward a pro-active population health system that promotes staying well. Accordingly, the strategy sets out our 20 year population health vision which is built upon our three Public Service Boards’ wellbeing plans, as follow:

***‘Our shared vision is a Mid and West Wales where individuals, communities and the environments they live play and work are adaptive, connected and mutually supportive. This means people are resilient and resourceful and enabled to live joyful, healthy and purposeful lives with a strong sense of belonging.’***

Our 10 year health and care strategy has people and communities at its heart. It will deliver whole system change to realise our population health ambitions, and signals a fundamental shift from our current emphasis on hospitals to a focus on working in partnership with people and communities to keep people well in or close to their own homes.

The strategy will be delivered in an integrated way with partners. Board meeting held in public in 2018, Pembrokeshire, Carmarthenshire, and Ceredigion local authorities confirmed their commitment to delivering the strategy in partnership.

In this section of the report we triangulate the findings from our engagement with information about service changes, performance data, and learning across the system, and assess these in terms of the key ambitions set out in our strategy, which are:

- Population health and wellbeing
- Integrated community network – A Social Model for Health
- Delivering a sustainable hospital network
- Transforming Mental Health and Learning Disabilities

We also assess our learning about the strategic enablers, which are:

- Digital, data, informatics and modelling
- Procurement and local sourcing
- People and potential empowering our workforce
- Capital, estates, infrastructure and planning
- Better ways to connect: continuous engagement, diversity and inclusion
- Continuous Improvement and Service Improvement (CI and SI)
- Value, innovation, research and development
- Corporate governance, legal, risk and contracts
- Finance



## Section 6: Looking Forward

### Mapping our changes and innovations against our strategic ambitions

Our clinical, operational and corporate engagement provided a valuable body of information about innovations and service changes that have been implemented in response to COVID-19. The themes that emerged from the interviews resonate with other datasets including the Community Health Council service tracker, and the quarter 2 Welsh Government COVID-19 response report.

Some themes show novel ‘work-arounds’ that offer a specific response to managing services during a pandemic. Other themes offer insight into the progress being made towards some of the ambitions in our strategy, such as outpatient transformation, digital roll out and service integration.

We analysed and grouped all the service changes and innovations that staff told us about into the list shown in the table below. We then mapped these changes against the 4 key ambitions in our strategy - the diagram below shows which changes support which strategic ambitions:

Innovation highlighted through the Clinical Engagement	Population health and wellbeing	Integrated community network – social model for health	Delivering a sustainable hospital network	Transforming Mental Health and Learning Disabilities
7 day rota - the provision of services over extended hours and/or 7 days, both in acute and community teams	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
MDT working - joined up working between different parts of the workforce in a more formal manner, including daily briefings, and decision making.	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Pathways - innovative pathways in response to COVID-19 and the introduction of improved pathways at greater pace than pre-COVID development	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Upskilling - Using different teams to provide care outside of their specialism. Upskilling staff with additional skills and/or working at the top of their registration for greater periods of time.	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Virtual Triage - provision of services via telephone contact rather than face to face	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	
Virtual outpatient services - transforming outpatient appointments to virtual platforms (including telephone). Enhanced the speed of planned roll out and/or introduced to business areas previously outside project scope.		<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>

## Section 6: Looking Forward

### Mapping our changes and innovations against our strategic ambitions

Innovation highlighted through the Clinical Engagement	Population health and wellbeing	Integrated community network – social model for health	Delivering a sustainable hospital network	Transforming Mental Health and Learning Disabilities
Community Provision - move from acute site to community/ home treatment	✓	✓	✓	✓
Digital Platforms - introduction of various digital platforms for patient facing and corporate facing functions	✓	✓	✓	✓
HUB development - formation of various hub models (HB and 3rdSector) to enable better access, better resource allocation and continuity of service during COVID	✓	✓	✓	✓
Workforce development - innovative roles developed for a more responsive staffing cohort	✓	✓	✓	
Locality Leadership - decision making lead by local system leaders in response to the population health requirements of their communities	✓	✓	✓	
System integration - the joined up planning and resource allocation of health social care and 3 <sup>rd</sup> sector services	✓	✓	✓	
Agile working - enabling staff to work from home / alternative sites reducing travel time, costs and enabling more workforce to remain in work (whilst shielding)	✓	✓	✓	✓
Palliative care provision - innovative pathways for increasing palliative care in the community in a timely/ patient focussed manner	✓	✓	✓	
Site redesign - the reconfiguration of the estate to provide safe care for all despite the pandemic.	✓	✓	✓	✓

## Section 6: Looking Forward

### Assessing our learning against the existing strategy (continued)

Our assessment considered which areas of the strategy have already been delivered, partly delivered, or could be built upon, and which areas of the strategy need to be refreshed as a result of COVID-19 and the changes that have taken place.

Our assessment sets out the following:

- Which areas of work should be celebrated as examples of excellent practice or innovation in response to the pandemic
- Which changes and innovations require authorization to be embedded into business as usual, or continue to be implemented
- Which areas of work require a decision by the Board
- Which areas of work we need to find out more about, in order to add value to our delivery of the strategy

We will use our approach of 'continuous discovery' for any areas of work that we need to explore and progress further. Our approach to continuous discovery is further explained in section 7 of this report, and includes learning from qualitative and quantitative sources.

In this section we also explain how an accelerated design event, held over two virtual sessions in mid-July 2020, has helped us to agree our priorities for transformation for the next 12 - 18 months.



## Section 6: Looking forward

### Population health & wellbeing

A population health approach recognises that while access to healthcare services plays an important role in keeping people well and treating people when they are ill, a wide range of other factors (e.g. our behaviours, housing, education and employment) have a far greater impact on population health.

A population health approach to transforming services has been a cornerstone of the HDdUHB strategy. In planning services for our 'new normal' an emphasis on addressing the population health challenges has become more urgent, due to our particular population demographic and the additional risks posed to frail and older people by COVID-19.

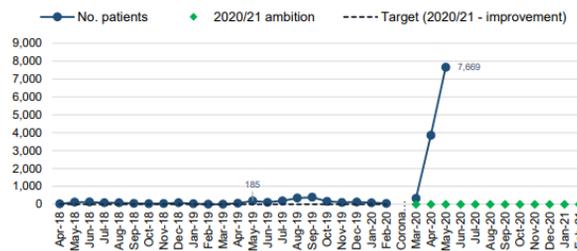
#### Impact on screening, diagnosis, referral and treatment

Referrals to acute specialities	09 Mar 20	16 Mar 20	23 Mar 20	30 Mar 20	06 Apr 20	13 Apr 20	20 Apr 20	27 Apr 20	04 May 20	11-May-20	18-May-20	25-May-20
GP Referral	1,403	1,009	541	429	342	406	540	563	525	733	807	604
Consultant Referral	433	188	200	165	115	121	144	147	127	171	131	125
Other eg from ED, domiciliary, emergency admission, self-referral	34	38	33	19	15	17	22	34	32	40	37	59
GDP or Community Dental or Optometrist Referral	474	253	233	147	76	107	146	115	128	133	118	75
<b>Total</b>	<b>2,344</b>	<b>1,488</b>	<b>1,007</b>	<b>760</b>	<b>548</b>	<b>651</b>	<b>852</b>	<b>859</b>	<b>812</b>	<b>1,077</b>	<b>1,093</b>	<b>863</b>

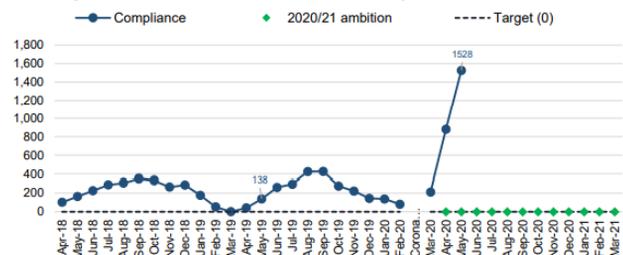
Due to the decision to suspend certain services at the start of the pandemic:

- There has been a marked decrease in referrals from all sources, most notably from primary to secondary care. The data is for all specialisms, and as such it is possible to surmise that the backlog of referrals will prove a challenge to manage, and coupled with the negative impact of delayed referrals will result in more advanced illnesses in patients who present.
- There has been a rise in numbers of patients waiting over 8 weeks for a specific diagnosis., including radiological diagnostic tests. Radiology stopped for all but urgent and Unscheduled Care cases from March 20<sup>th</sup> 2020.
- The number of patients waiting longer than 14 weeks for treatment with therapy services has risen. Whilst many appointments have been taken remotely, for some services areas a physical intervention is required and this has not been possible. This is expected to have a marked negative impact on health outcomes in the medium to long term.
- **Our current performance on 36 week waits is the worst** the Health Board has ever recorded following 2 years of being the best performer in Wales.
- Between March and May 2020, the Health Board has seen a 49% reduction of urgent suspected cancer referrals when compared with the same time period the previous year. The referrals rates have now largely recovered due to the proactive efforts of the Cancer team to encourage patients to access care.

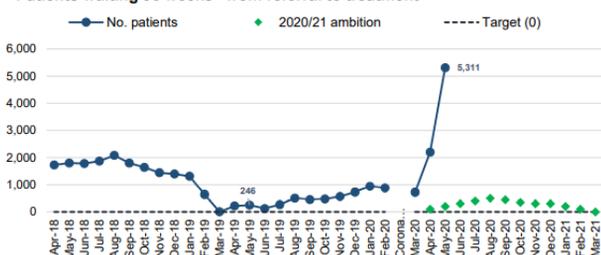
Patients waiting 8 weeks+ for a specified diagnostic



Waiting more than 14 weeks for a specific therapy



Patients waiting 36 weeks+ from referral to treatment



## Section 6: Looking forward

### Population health & wellbeing

#### Screening and self management

The COVID-19 response has meant that there has been the need to provide services differently. There have been a number of innovations rolled out in relation to screening and self management that have enabled the population to remain in receipt of treatment and have enhanced our ability to target those most in need.

It is important to note that the Corporate Safeguarding team has continued its business as normal. Its biggest change has been the move to virtual meetings. This means that in partnership with our Local Authority colleagues, safeguarding our vulnerable people has continued to be a priority. Some examples of screening and self management include:

- The FIT test (stool test) has been introduced as part of a screening programme and has been used in different areas for endoscopy. Currently patients are being graded according to their level of FIT and the results are being used to stratify the waiting lists.
- Paediatric Speech and language therapy, has rolled out its virtual service that has **embedded patient voice into the triage and referral process** and met the objectives of Care Aims Intended Outcomes Framework. This has resulted in better use of the team and better engagement with parents and carers as they are part of the decision making process about interventions
- Older Adults in **Care home** settings have been supported and relationships with providers have improved significantly. This has helped to maintain residents in their home rather than escalating unnecessarily to acute sites. All patients are able to access acute care when appropriate. In addition there has been a concerted effort to ensure Advanced Care Plans are in place for residents.
- The jointly commissioned Gofalwyr Ceredigion Carers in Ceredigion is continuing to **support unpaid Carers** and responding to the social distancing measures by adapting ways of working and increased support via telephone. Carer Support Groups are being supported via technology where possible (e.g. zoom). The provider is making proactive calls to identify requirements for support, address issues and concerns particularly those created by self-isolation. The Provider is supporting some carers with essential shopping & collection of medication and emergency plans. Service delivery hours have extended in some areas to include evenings and weekends.
- Opportunities to embrace Technology Enabled Care (TEC) and associated remote patient monitoring have been explored. A particularly successful initiative includes remote oximetry monitoring of COVID +ve patients at home. Following medical assessment at the 'front door' of hospital and / or on the hospital ward, patients' discharge home is expedited through the provision of remote monitoring by GPs. Patients are provided with oximeters and supported to self monitor their blood oxygen levels. Care pathways are in place 24/7 to ensure that should the patient deteriorate that they are supported to return to the hospital urgently. TEC enabled care pathways that support the virtual ward format based on various consultation platforms and telephone support could be rolled out to other services such as Acute Response Team (ART), Crisis Response, Diabetes service and the Community Oxygen Service.

## Section 6: Looking forward

### Population health & wellbeing

#### Prevention

Some preventative services have adopted new ways to deliver their services. For example:

- In 2 counties, 4 nurses fill wellbeing gaps of those up to age 25 who fall into schools and ‘education elsewhere’, based in colleges. An emotional wellbeing pack has been developed which has gone out to all education hubs (paper and digital resource).
- Bilingual YouTube videos have been made accessible to all Health Boards, to enable health promotion video streaming into classrooms. Currently the developers are in the process of making school nursing health promotion videos. e.g. hand washing.

#### Sexual health service

- Telephone triage, introduced on the 18<sup>th</sup> March 2020 to maintain the sexual health service, has provided care for over 1200 patients. The service maintained contraception for patients with the introduction of a postal service, and has maintained the provision of emergency contraception, including emergency intrauterine devices. The service has signposted patients to access on-line testing for sexually transmitted infection where appropriate, provided treatment for most Sexuality Transmitted Infections (STIs) utilising the postal service..
- The service has centralised management of test results and provided training for other staff groups i.e. midwives and abortion care nurses to provide oral contraception as well as developing a new pathway for the provision of abortion care.

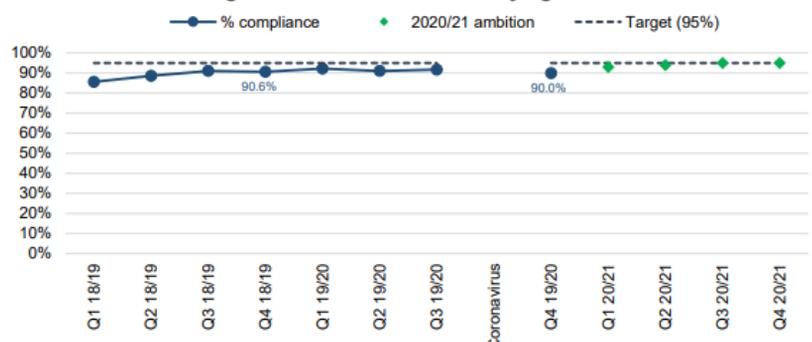
#### Early years (Health Visiting Service)

- Centralised services, with a provision of a duty phone in each County, generic email account and hubs.
- Social media has been utilised e.g. HDdUHB Facebook page to get out public health messages.
- Developed better partnership working including the development of a pathway with midwifery for new births including a handover form.
- Better partnership working with Local Authorities, with more integrated working between Flying Start service and generic services.
- Use of technology to improve communications with families.

#### Immunisations

Whilst the ‘6 in 1’ vaccine programme has managed to remain on target the risk of COVID-19 has raised concerns among parents / guardians, who may delay bringing their child for routine childhood immunisations, leading to a decrease in uptake of all childhood immunisations.

**% children receiving 2 doses of MMR vaccine by age 5**



**HDdUHB remains below the target for % of children receiving 2x doses MMR. This is an ongoing issue and may risk being exacerbated further.**

## Section 6: Looking forward

### Population health & wellbeing

#### Early intervention behaviour change

There has been a decline in the number of people presenting to our services. Total Attendees at Accident & Emergency (A&E) (new representations) over the period shows a concerted dip from March 2020. However presentations have more recently started to increase. All site presentations remain significantly lower than pre- March 2020 figures. Emergency Admissions to all acute sites from A&E (not GP direct admissions) showed a drop. The downward trend continues in Withybush General Hospital (WGH), but has reverted to an upward trend in other sites.

The conversion rate for emergency admissions has changed across all sites. There has been a reduction in emergency admissions from new attenders during this period. This warrants further investigation as the fact that fewer attendees required admission raises the question about the acuity level of patients being conveyed to Accident & Emergency. Questions are:

- Is this as a result of the implementation of the Welsh Ambulance Service Trust (WAST) COVID conveyancing pathway?
- Is this as a result of the introduction of the Care Home Algorithm?
- Is this evidence that acutely unwell people are choosing to remain at home due to anxiety about the safety of hospitals?
- Is this evidence of a lowering of acute medical emergencies?
- Is this evidence that people are not willing/able to use GPs for minor injuries?

The current population in the Hywel Dda area is lower than on average. With no University students, no holiday makers or second home owners. Therefore all actual numbers need to take account of this.

The quantitative data shows a reduction in demand. However all Emergency Department (ED) pathway redesign needs to be reviewed to confirm any causal link.

There has been a decrease in the number of contacts with GP services in HDdUHB compared to 2019.

There has been small reduction in the number of calls coming into the Out Of Hours (OOH) 111 service (total calls recorded on Aadastra). A possible reason could be the impact of calls being diverted off to the specific COVID pathways, particularly in the earlier months, although further analysis is required.

Out Of Hours calls are being dealt with differently. Completion of calls by telephone advice has increased and face to face consultations have decreased. Possible reasons are:

- Change in behaviour by the clinicians
- Greater acceptance of 'remote' consultations by patients who are wary of coming to a hospital setting

#### Average Daily GP Contacts per 100,000 Pop -



## Section 6: Looking forward

### Population health & wellbeing

#### A need for greater focus on prevention and early intervention

Due to the urgent need to act swiftly, our response to the pandemic has been reactive rather than proactive in the main. However we now need to focus our energies on prevention and early intervention.

#### Proactive intermediate care

In response to the potential crisis in Care and Nursing Homes a whole system algorithm was developed through the Community Bronze Group, in collaboration with all acute teams. The pathway provides clarity over the potential care and treatment of COVID-19 positive patients in care settings. Its purpose is to support care in the most appropriate setting.

#### Data

A lot has been learnt about modelling from the pandemic. Prior to COVID-19 the data projections used in the health board were primarily ad hoc requests for trends and general dashboard development, pathway development, metric development and data development. The 'ask' for COVID-19 was different - translating demand into beds occupied. Going forward, having an in-house Modelling Cell to produce Health Board- specific service models will allow a faster and more tailored data service and realistic planning.

#### Locality working

Our ability to flex community provision to meet surges in demand, as we experienced during this emergency period, may be hampered by devolving management of specific services to locality (Cluster footprint) level. The latter was our original intention outlined in 'A Healthier Mid and West Wales' strategy. Strategic planning and delivery against need and demand should be considered at County level; this not only recognises that need and demand differs across geographical area and time, but it also allows us to mitigate pressures in demand for care jointly with our Local Authority partners and achieve equity of outcomes at smaller population level rather than equity of services.

#### Chronic conditions

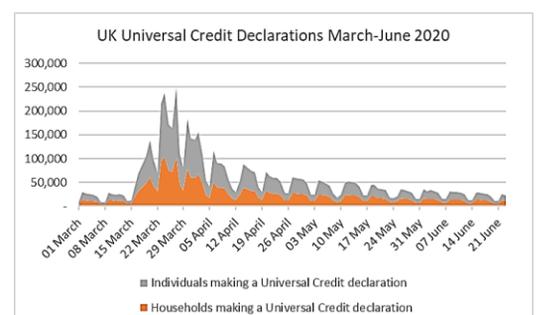
Embrace technology and a social model for health and wellbeing. Proactive Care pathway development jointly with Local Authorities is developing and includes wider determinants of health interventions for example leisure and housing.

#### Rehabilitation

Following the pandemic the longer term rehabilitations needs of our population will need to be determined and support delivered to enable people to become as independent as possible and participate in meaningful life roles.

#### Socio-economic impacts of the pandemic

We need to undertake further work to understand the socio-economic impacts of the pandemic on the health of our local population. We need to understand the extent of job losses locally, how this and other factors impact on people's diet and activity, and whether we need to adjust our services and the support we offer as a result.



## Section 6: Looking forward

### Population health & wellbeing

#### To celebrate:

- Ceredigion Carers' Unit's continued support for unpaid carers
- Delta connect and it's work to engage shielding people in Carmarthenshire
- Introduction of Pembrokeshire intermediate care hub including single point of access
- Introduction of the Pembrokeshire integrated community hub with social care, health and third sector to support community resilience
- Establishment of acute eye care hubs and including working with optometrists.
- Introduction of enhanced community pharmacy opening hours and range of services.
- Whole system algorithm developed supporting Care & Nursing Homes.
- Use of Technology to support patient care
- Screening & Services support
- Strengthening of self management
- Consistency of safeguarding services

#### To authorise (continue, embed or adopt):

- Approaches to promote self - management services including TEC provision in intermediate and virtual care support services
- Alternative ways of providing services e.g. sexual health, early years services, GP appointments
- In-house modelling cell as part of capacity/ demand planning
- Recommence screening programmes
- Focused immunisation & vaccinations delivery
- Delivery of a whole system approach to focus on prevention & early intervention supporting physical and mental health across all ages
- Collaboration between community and speciality/ consultants to deliver seamless care
- System roll out of WCCIS for Health Board following the pilot in Ceredigion
- Continuation of the revised Eye pathway to provide community optometric care

#### To decide:

- Review whole system emergency planning approach
- Discover and design our approach to long term condition management
- Discover the socio economic impact of pandemic to inform service delivery
- Scope the Rehabilitation requirements for our population post COVID



**'[What worked well was] the ability to work remotely on a multiagency basis. Teams has allowed me to communicate with Local Authority colleagues. We have a virtual platform to load information. Development of relationships with Local Authority colleagues. This has fast tracked our working together. This pandemic has highlighted the need for care co-ordination role to respond in a timely manner.'**

## Section 6: Looking forward

### Integrated community network - Social Model for Health

A social model recognises that there are a host of influences on our health and wellbeing, including those that are individual, interpersonal, organisational, social, environmental, political and economic. It moves us beyond the focus on biology, physiology and anatomy that is characteristic of a medical model for health. The adoption of a social model requires us and our partners to think differently about health and wellbeing and to come together to contribute toward keeping people well in their own communities, recognising people as key partners in securing better health and wellbeing.

#### Whole system response

The response to the pandemic has seen greater levels of partnership and integrated working than ever before. This has occurred within the Health Board as well as with partner organisations. A theme throughout the engagement work was the benefit of a clear, shared goal and outcome. This has led to a number of service innovations that have been part of previous programmes of work, but have not moved at pace. The emergency response to COVID-19 proved to be an enabling factor.

Some concrete examples include:

#### Integrated trace team

Via the integrated COVID-19 response meeting, preparation continues to train and develop local and regional surge capacity for a track and trace service. Workforce capacity currently includes:

- Carmarthenshire Contact Tracing and Advice Team:

Two Environmental Health Practitioner Team Leaders with a core team of 5 Contact Tracers and 12 Contact Advisors (and surge capacity of up to 38 Contact Tracers and 60 Contact Advisors)

- Ceredigion Contact Tracing and Advice Team: Two Environmental Health Officer Contact Tracing Managers (with an additional Officer for surge) with a core team of 5 Contact Tracers and 12 Contact Advisors (and surge capacity of up to 8 Contact Tracers and 24 Contact Advisors)

- Pembrokeshire Contact Tracing and Advice Team:

Five Environmental Health Practitioners and four Lead Officers, each role rostered to provide leadership to the Local Contact Tracing Team and Regional Response Cell on a daily (8-8, 7 days a week) with a core fully operational team of 12 Contact Tracers and 12 Contact Advisors.

#### Policies

- Development of Regional 'Care Home Risk & Escalation Management Policy', approved and implemented by all four organisations and wider providers. This piece of work has fast tracked integrated working on a three county basis. Whilst integration for both policy and commissioning has been a work in progress for many years, the pace and scale of this is incredible, and has been recognised as an exemplar by Welsh Government.
- Development of Regional guidance documents including 'Hospital Discharge Requirements', 'Intermediate Care Principles' and Standards', Palliative Care Principles and Standards' and 'Proactive Care Principles and Standards'. to ensure a consistent approach to standards and performance outcomes across the whole Health Board footprint.

## Section 6: Looking forward

### Integrated community network - social model for health

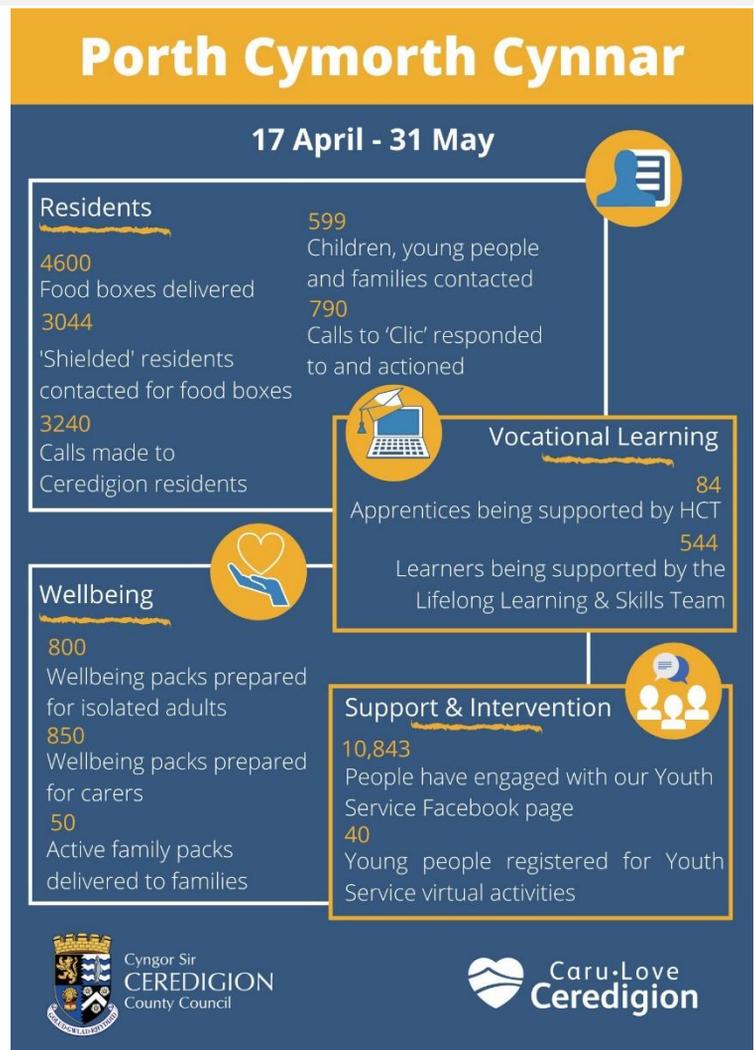
The voluntary sector has been a major contributor in the community response to COVID-19. Across our Health Board are communities have taken the lead in providing essential support for some of their most vulnerable residents.

Some examples of **community resilience** include:

- Ceredigion Association of Voluntary Organisations (CAVO) has adapted to engaging digitally with third sector groups. Digital tools have enabled better links with third sector groups and as a result there has been an increase in engagement. Volunteer week in June 2020 saw far more people than usual engage in activities.
- The Pembrokeshire Community Hub has been led by Third Sector organisation and the local authority with 55 new community organisations set up within 2 months, supported with Pembrokeshire Association of Voluntary Services (PAVS) including over 550 people volunteering. Galvanisation within communities in Pembrokeshire to support each other has fast-tracked pre-COVID efforts attempting to stimulate conversations across communities.

#### In Ceredigion to date:

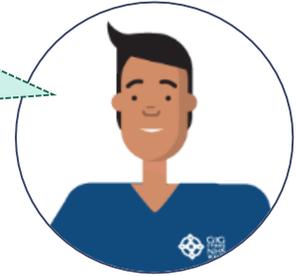
- 800 wellbeing bags distributed via community groups to vulnerable adults (isolation and loneliness)
- Welfare calls provided to 89 clients who had suspended their domiciliary care packages as a result of COVID-19
- Welfare calls provided to 90 vulnerable residents who would ordinarily receive a service from the mobile library.
- Community Resource lists updated 3 times a week
- Test, track and trace in-house scheme throughout COVID-19



## Section 6: Looking forward

### Integrated community network - Social Model for Health

**“In Pembrokeshire a District Nurse Hub has been established, which co-ordinates new referrals for District Nurses, and allocates to teams as appropriate and receiving 20-30 enquiry calls per week. Community Nursing team have reviewed their caseloads and adapted their focus to most needs. This will all help inform the future District Nursing model.”**



There is an integrated end of life pathway, with partnership working between palliative care services, nursing home providers, Primary Care and Secondary Care to deliver an innovative person centred service in the community. Across the organisation community resource teams have utilised technology to enable flexibility in professional roles, which has reduced the duplication of professional input to individual patients within the community.

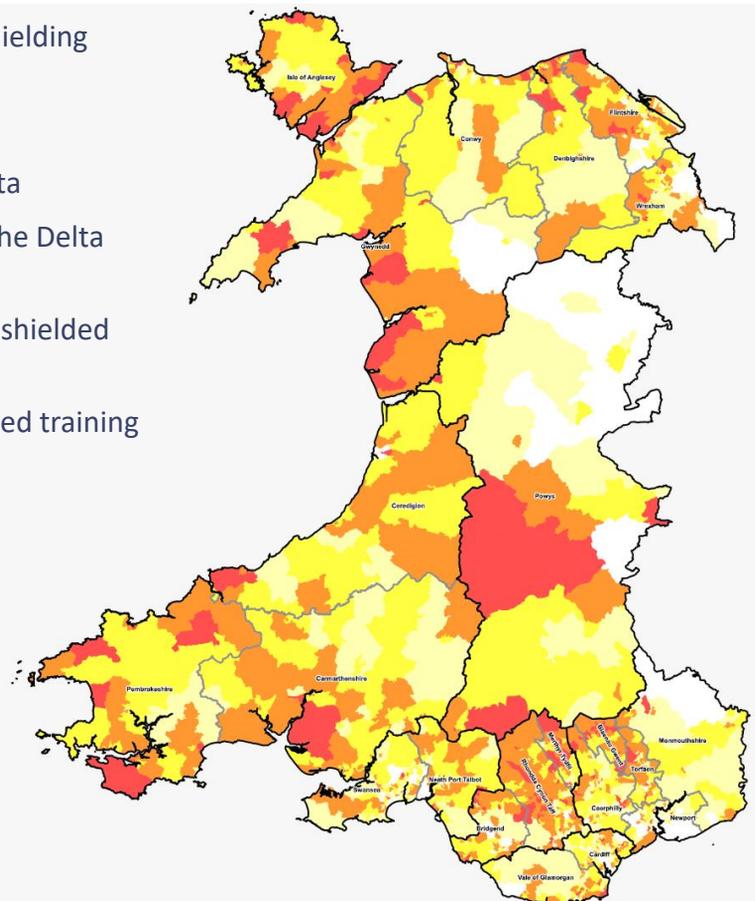
Looking forward, we need to be flexible in our approach to commissioning community services, such as Primary Care, Dental, Optometry and Pharmacy services.

In Carmarthenshire Delta Wellbeing has provided a number of virtual services for shielded people and patients stepping down from our acute hospital, acting as the single point of access for members of the community. This has delivered:

- Delta CONNECT Outbound calls to shielding 9000 people.
- Delta providing Test, track and trace
- 4518 enquiries were received by Delta
- 546 people have been signed up to the Delta CONNECT scheme
- 13,581 proactive calls were made to shielded people
- 38 members of the team have received training to act as Contact Tracers

The map shown here illustrates the proportions of people shielding across Wales

All shielded residents by LSOA rate/1000	
<span style="color: red;">■</span>	52 to 109 (198)
<span style="color: orange;">■</span>	43 to 52 (556)
<span style="color: yellow;">■</span>	36 to 43 (557)
<span style="color: lightyellow;">■</span>	28 to 36 (422)
<span style="color: white;">■</span>	3 to 28 (176)



## Section 6: Looking forward

### Integrated community network - social model for health

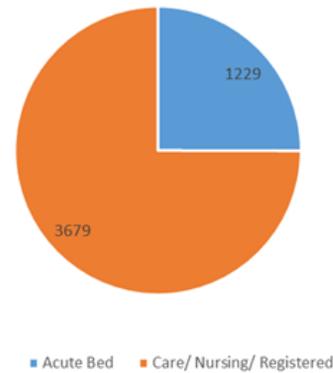
#### Long term care

The COVID-19 pandemic has brought into sharp focus the integral part that long term care plays in the whole health and care system. Our Health Board commissions services with 185 individual registered providers, making up three times greater bed capacity than all our acute sites combined. The registered sector accommodates some of our most vulnerable community residents, and has come under immense strain during the crisis. Many of the challenges were present prior to COVID-19.

There are examples of closer and better working relationships having been formed during the last few months. Examples of this include:

- The use of virtual check ins with providers, enabling the Long Term Care Team to have more regular and targeted interaction with providers. This has allowed a much greater presence and build stronger and more positive relationships with managers and staff
- Provision of training, virtual and face to face for testing and PPE. This can continue on a need basis, reducing travel and time costs for providers, and therefore increasing engagement in sector improvement
- The instigation of a 'Matron's meeting' organised by the Long Term Care team between registered professionals in all the homes. This has increased inter-agency collaboration and support, allowing a forum to solve problems and provide peer support
- Regionally agreed policies and procedures – including the Care Home Algorithm, and the Escalation and Management Policy. These were designed and agreed between primary, secondary, community and social care to ensure the safety and sustainability of the sector

Bed Location: Acute setting Vs Registered Provider



[W]e have been doing a weekly skype meeting with the care home Manager or Clinical lead. We contact them a week before and provide them with a list of names that we want to review and we give them a copy of the assessment in readiness for the skype call, so they are prepared for the review and can provide us with the information we have asked for. ....It has shown us the reality of IT and that we can still fulfil our statutory duties in a different way. It has facilitated more opportunities for us to have contact with care homes daily and feedback from the homes is immensely supportive there has been a solidarity around COVID and has demonstrated to them that we truly care what happens to staff and the residents etc. it has kept us engaged.



[T]he whole [episode] has given me a much better appreciation of how hard care staff work in those environments, long days of 12hr shifts working in not always air conditioned environments, the heat etc in some care homes it was horrendous for carers as homes were not air conditioned and some are very old buildings and not built for purpose. There were people working in the red zones for 12 hours day after day and yet their sickness levels were zilch, staff wanted to come in and support their residents. For example; one carer lost her mum to COVID and she still continued to work 12hr shifts in the Nursing home whilst trying to arrange the funeral and deal with her own grief, this just demonstrated the sticking power of staff. I have a new appreciation of how hard they work in those homes.

## Section 6: Looking forward

### Integrated community network - social model for health

There are a number of on-going challenges that have been exacerbated by the COVID-19 crisis. A challenge around operating three varying systems / paperwork and guidance issued from different Social Care departments has caused confusion and delay within the system. The amount and ever changing guidance as the crisis evolved has been overwhelming for providers – especially when they are commissioned by different Local Authorities simultaneously.

The long running issue of sector sustainability has been evident during the pandemic with a continued issue of suitable estate and adequate funding remaining a key challenge. Whilst there has been a relaxation of the regulation and assessments for care commissioning, and there has been a greater acceptance of placements, this has not been without cost, both financial and social for the health Board and for residents and their carers.

**‘Care homes have been the greatest area of impact on populations and risk [...] not hospitals. [The pandemic] brought social care challenges to the fore and has made health care colleagues realise they are a critical part of the system – i.e. if we don't look after social care the health system is not sustainable.’**



**‘On reflection the volume of national guidance and more locally developed requirements for reporting etc was very overwhelming for the homes and where providers have homes in different counties it was difficult for them to keep up with differing expectations. We were all tapping ourselves on our back but in care homes they were inundated, they didn't know if they were coming or going’**

## Section 6: Looking forward

### Integrated community network - social model for health

#### To celebrate:

- Acknowledge work involved in developing the Health Board wide care home risk and escalation management policy
- The resilience of our communities and support for NHS and front line workers
- Restructured all community services to provide safe red and green zones for patients and staff
- Dedication and commitment of staff to find innovative solutions to provide acute services across primary and community care
- Use of check-ins. Training & support with long term care providers
- Improve communication & peer support between care homes
- Continuation of the development of the virtual ward

#### To authorise (continue, embed or adopt):

- Approaches to promote self-management
- Virtual support for self-management to people in care homes
- In-house modelling cell
- Daily health & social care including WAST communication forums
- Community based phlebotomy services
- Integrated end of life pathways
- Single point of contact for health and social care
- Proactive monitoring service to keep people well
- Restructured pathways, supporting people to remain in their community as part of whole system design

#### Decide:

- Conduct further analysis in relation to hospital admissions
- Further analysis to inform integrated locality ways of working
- Finalise integrated policies and principles for supported living, domiciliary care, palliative care, intermediate care
- Undertake a care commissioning, regulation and assessment review
- Review flexible 7 day service requirement
- Review and agree a risk stratification approach
- The development of community pan for dental services

Note: These are all subject to the Strategic Enabling Groups setting out the engagement needed, feasibility, timescales, costs and other requirements.

## Section 6: Looking forward

### Delivering a sustainable hospital network

**Helping those who need the most specialist health and care support through a network of hospitals across Mid and West Wales. Our strategy includes a future hospitals model which has a new hospital located in the south of the region as our main site within a network of hospitals that includes: Bronglais General Hospital in Aberystwyth, Glangwili Hospital in Carmarthen, Prince Philip Hospital in Llanelli, and Withybush Hospital in Haverfordwest. The strategy describes the core services that are planned to be offered at each hospital site.**

Our Health and Care strategy, 'A Healthier Mid and West Wales', sets out the need to deliver a sustainable and integrated hospital network to support our population. This integrated hospital network being to support the broader population health approach of care closer home via enhanced community provision and new ways of working to allow delivery of services to be as flexible as possible to our communities, and support our hospital system.

The model as outlined within the Health & Care strategy is to embed our hospitals within our communities, and be a key part of our wider health and care system delivering a broad range of services for the people living in Mid and West Wales. They will play an important role in providing clinical excellence and specialist support when it is needed, whether at that is to undertake highly skilled surgery or treating people who are severely and acutely unwell. This includes care that is planned, such as an individual's need for a hip replacement, or in times when care is more critical in nature and an urgent response is required.

The hospital network will also facilitate high quality education and research for students, trainees and existing staff. The sites and facilities will promote well-being of the workforce, reduce reliance on paper, and use the latest carbon efficient, infection control design knowledge.

#### What we learnt during the pandemic

There has been a wholesale adoption of new ways of working across our hospital in order to continue to treat patients whilst COVID-19 has been in force.

#### Building whole-hospital pathways.

In a matter of days our acute sites reconfigured to meet the emerging threat. This included the establishment of red and green zones to enable safe spaces to treat COVID-19 positive patients, whilst also ensuring non-COVID emergency admissions could be treated. Managers and clinicians worked quickly to meet the staff and skills challenges in our workforce. The amount of effort and speed with which staff were required to make these changes should not be underestimated.

These changes were underpinned by strong local leadership and the clear co-ordinated efforts of all team members. Local management, clinical leads, nursing and therapies teams have developed working relationships that were not previously as integrated and aligned.

**'We completely changed the whole hospital in 11 days- we had red and green zones and dedicated doctors, nurses, therapists and radiographers for each of the zones.'**



**'All innovation that has taken place is due to local decision making & no committees. We all got together and decided what was right for us and all has been done locally.'**

## Section 6: Looking forward

### Delivering a sustainable hospital network

#### Use of technology

Improving services through the use of technology is a cornerstone of our strategy, and technology has been a significant enabler to many of the changes to hospital services that we have seen throughout the pandemic to date. Examples of these changes include utilising telephone Multi-Disciplinary-Team (MDT) follow-ups following surgery (rather than face to face) and the use of communications platforms such as Skype and Microsoft Teams to communicate with colleagues and patients alike for a variety of specialisms alleviating the requirement to attend face to face appointments.

#### Virtual outpatient services

Out of necessity and to enable safe and sustainable outpatient services, has come one of the most profound transformations to the way the Health Board provides treatment. Similarly to the reconfiguration of acute settings, the shift to virtual consultations and virtual outpatient services was swift and in the most part successful. This has enabled shielded patients to maintain some level of service, and has had a positive impact on waiting lists and turnaround times (in some areas of services).

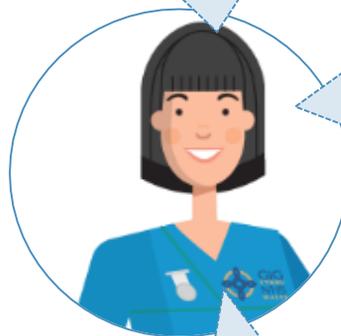
#### Acute and community integration

In line with our strategic aim to embed the hospital network into the communities it serves, there has been progress in joining up community and acute services in response to COVID-19.

Some concrete examples of service changes include:

- Chemotherapy patients are being seen in the Community, rather than in acute settings
- There has been an increase in home births, as women are avoiding acute sites, and have been supported to do so by the Midwifery lead units
- Haematology patients who need regular blood tests, are being seen in community centres located outside hospital premises

**'The biggest change has been the virtual clinic work in outpatients - I mean for us we've been going on about this for years, getting the clinicians on board has been hard, and they've been angelic on how wonderful it is. We're now looking at this across all the services for all the sites. For us as a team, we are used to being mobile on different sites and we've tended to work more virtually.'**



**'Orthopaedics [have been] trying for last 2 year to deliver fracture clinics virtually, implemented across 3 sites in 2 weeks.'**

**We have also moved to telephone follow up conversations and this has worked very well – especially for elderly patients looking to minimise exposure. The difference has been 70% of face-to-face discussions now being down to around 10%.**

## Section 6: Looking forward

### Delivering a sustainable hospital network

#### Changes to scheduled care

Planned care, including various cancer treatments, have been suspended for a period of time in order to avoid unnecessary risks to patient welfare. These services should resume and focus on preparation for surge in COVID-19 cases anticipated where safe to do so.



I have been waiting such a long time to have my hip replaced and am really worried now that I am never going to get it done. I'm in constant pain and really struggle to walk for long and sleep at night. This is really affecting my daily activities especially as I care for my wife, Mari. I know the hospital had to stop all operations that weren't urgent but I've no idea when they will start again. I'm also worried will it be safe for me to have an operation as I don't want to catch the virus in there.

During lockdown I found that I was often unable to hear what people said. I contacted the audiology service but due to the pandemic I was unable to attend any of the hospital sites in person. Thankfully, they said they had a new postal repair service and I posted my hearing aid to them. My hearing aid was returned a few days later working perfectly.

#### Our future model for a sustainable hospital network

Following the changes that have taken place in response to the pandemic, and the different ways in which services have been reconfigured across sites, a piece of work is now needed to consider and refresh the model for our network of acute and community hospitals in future. This includes a consideration of the most appropriate model of care for our new planned and urgent care hospital. This piece of work also needs to take into account how demand for services has or will change as a result of our different ways of working.

## Section 6: Looking forward

### Delivering a sustainable hospital network

#### To celebrate:

- Whole scale adoption of new ways of working
- Acknowledge the ability of service leaders to carry out change at pace to deliver a safe environment supported by professional judgement
- Acknowledge continuation of urgent surgery using independent sector i.e. Werndale Hospital
- Restructured all hospital services to provide safe red and green zones for patients and staff

#### To authorise (continue, embed, or to adopt):

- Use of technology (digital first approach)
- Ongoing small scale changes being carried out (within a defined framework) being led by service leads
- New ways of working across primary, acute and community i.e. breakdown of boundaries
- Implementation of digital platforms for MDT follow ups
- Risk stratification approach to increase home birth choice
- Streaming in emergency departments
- Admission avoidance pathways
- Early supported discharge for appropriate conditions e.g. stroke, fracture hip
- Locality hub and spoke model
- Embed our workforce flexibility & can do culture
- A SAFER approach e.g. timely senior decisions
- The utilisation of outpatient model using digital platforms
- To continue to adopt our MDT approach to caseload management

#### To decide:

- Review process of risk stratifying waiting lists linked to ensure appropriate follow-ups
- Review process for streamlined governance and decision making process
- Develop a criteria-based system for new patient referrals
- Discover modelling patient flows across hospitals and communities
- Re-commence regional networks
- Review capital programmes e.g. Cross hands, Llanelli Wellness village
- Review Out of Hours service design
- Agree an approach to pathway redesign and confirm priorities
- Discover and design the emergency paediatrics pathway
- Consider and refresh the model for our acute and community hospitals in future, including a consideration of the most appropriate model of care for the new planned and urgent care hospital

Note: These are all subject to the Strategic Enabling Groups setting out the engagement needed, feasibility, timescales, costs and other requirements.

## Section 6: Looking forward

### Transforming Mental Health & Learning Disabilities (MHL D)

The ‘Transforming Mental Health’ programme has worked collaboratively with service users, staff, partners and the Community Health Council (CHC) to co-produce a future model for mental health services, built from learning from engagement, co-design, international collaboration and public consultation. Transformation work to deliver our strategy generates opportunities for Mental Health and Learning Disability services to align with wider services where appropriate throughout implementation.

#### Transforming Mental Health services

The vision for transforming mental health services was co-produced, with the aim to provide:

- **24 hour services** – anyone who needs help will be able to access a mental health centre for immediate support at any time of the day or night;
- **No waiting lists** – when referred, people will receive first contact with services within 24 hours and their subsequent care will be planned in a way that ensures the support they receive is consistent;
- **Community focus** – a move away from admitting people to hospital when it isn’t the best option; providing community services where people can stay when they need some time away from home, or require extra support or protection;
- **Recovery and resilience** – not focusing services purely on treating or managing symptoms but assisting people with mental health problems to live independent, fulfilling lives.

#### What have we learnt during our response to the pandemic?

A core principle for transforming mental health services was the development of 24/7 community services throughout Hywel Dda. The integration of Community Mental Health Teams to deliver a 24/7 drop in service was being piloted before the pandemic at Gorwelion Community Mental Health Centre, in Ceredigion. During the pandemic, our Mental Health and Learning Disability services have built upon this by successfully implementing the co-location and integration of Crisis Resolution Teams (CRTs) and Community Mental Health Teams (CMHTs) in Haverfordwest, Carmarthen and Llanelli to provide 7-day mental health services.

The development of temporary Central Assessment Unit (CAU) at Morlais inpatient unit, Carmarthen, is a key aspect of the delivery of the Transforming Mental Health programme and has partially been delivered as a response to COVID-19. A CAU model has been temporarily developed and tested at Bryngofal inpatient unit in Llanelli and the learning from this will inform the CAU development in Morlais.

“COVID-19 has given us an opportunity to accelerate some of our transformation of Mental Health and Learning Disability services. We have brought together our Community Mental Health teams and Crisis Resolution Home Treatments Teams so that people have access to mental health assessments without the need to go to a hospital. Whereas we thought this journey would take us 2 years, the pandemic has forced us to make it happen now.”

“Working during the pandemic I have noticed much more of a sharing of responsibilities and roles, a willingness from the staff to help each other out and support each other to do the best for the patient at that time. In Pembrokeshire we have been able to integrate community mental health teams to provide increased access to services and a consistent approach to mental health care.”

## Section 6: Looking forward

### Transforming Mental Health and Learning Disabilities (MHL D)

#### Places of safety for people in mental distress

The progression of alternative 'Section 136' provisions across Hywel Dda to support a Central Assessment model and Emergency Departments have been partially delivered. (Section 136 of the Mental Health Act gives the police the power to remove a person from a public place when they appear to be suffering from a mental disorder, to a place of safety. The person will be deemed by the police to be in immediate need of care and control as their behaviour is of concern.) An integrated Third Sector/Health Board alternative 'place of safety' in Gorwelion has been developed with the Police, Local Authority and Third Sector and is operational.

Following the pandemic, we also need to build upon the integration of health and third sector 'out of hours' sanctuaries and hospitality bed provisions across the Hywel Dda area.

#### Transport

A commitment of the Transforming Mental Health Services programme was to develop transport systems to meet the requirements of the model. A pilot conveyance scheme to support service users to and from inpatient settings is now operational. It is anticipated the scheme will provide learning for a new transport model, support inpatient flow and add capacity to the workforce.

#### Single point of contact

Due to competing priorities in both Health and Social care settings the work to develop a Single Point of Contact has halted over the last few months. Options for development of this service with Social Care and 111 were being discussed and a model was in development prior to the pandemic.

#### Early and easy access to mental health services

Our strategy emphasises the development of Mental Health services that allow early and easy access for service users. The pandemic has provided opportunities to review and change the service delivery model to provide closer links with the third sector and extended support. There is predicted to be a significant increase in referrals to primary mental health services as COVID restrictions are eased, and this service will provide essential support to service users.

#### Emergency liaison service

The development of a Mental Health and Learning Disabilities Emergency Liaison Service is continuing at pace. A service specification is being agreed through Older Adult and Adult Teams, and a pilot will commence in Carmarthenshire in July 2020.



**'Learning Disabilities services have developed easy read materials to ensure that the community are aware of changes to services and their community during the pandemic'**

## Section 6: Looking forward

### Transforming Mental Health and Learning Disabilities (MHL)D

#### Technology enabled care

Digital ways of working and technology enabled care were strong themes for Mental Health and Learning Disabilities staff who took part in the Health Board's recent staff engagement to learn from the pandemic.

Senior staff from within the Directorate are testing the 'Attend Anywhere' digital platform functionality in terms of its ability to provide avenues for service user interventions. Initial indications are of a clear and intuitive system without the need for the patient to download software. It could be used in a number of ways including Mental Health Act (MHA) assessments where a patient's solicitor will be able to join an Multi-disciplinary team meeting remotely on a secure line without attending a ward, where appropriate. Further testing and investigation is ongoing. Medicine Management and Mental Health Assessments have been carried out as usual through the use of digital platforms.

#### Third sector commissioned services

All third sector-commissioned services have adapted service provision to offer telephone/online services on a 3-county basis where possible during the pandemic. A list of third sector services has been developed and distributed for staff and service users detailing services offered and has been updated regularly.

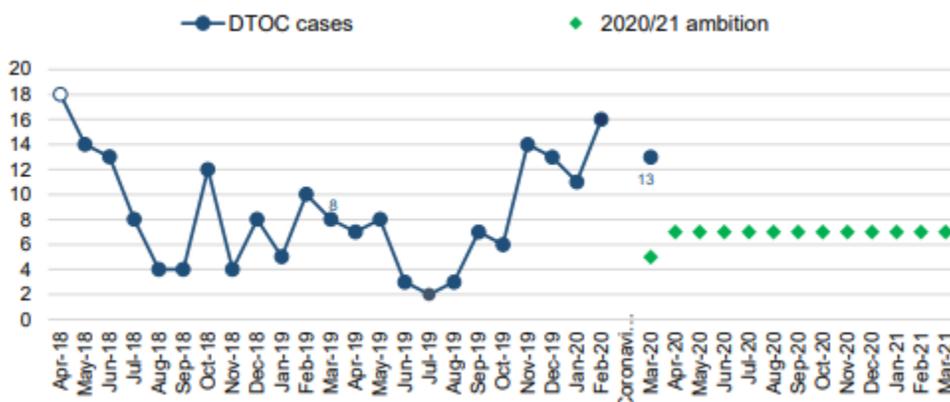
#### Evaluation of changes due to the pandemic

All COVID-19 projects will be evaluated within an agreed framework. By September 2020 we will have meaningful data with which to inform future developments.

#### Rise in emergency admissions

There has been a sharp rise in emergency admissions. There have also been challenges securing appropriate placements for people who present to services. Alternative placements are being used, but many settings are not suitable for people in mental distress.

**Mental Health DTOC cases (12 mth reduction target)**



## Section 6: Looking forward

### Transforming Mental Health and Learning Disabilities (MHL D)



**'Parts of our mental health services are using digital platforms to enable virtual access to psychological therapies. This ensures that people get timely support, reducing the impact of lengthy waiting times for people who need psychological support.'**

During the pandemic Lianne, who is known to Mental Health services in Pembrokeshire, began developing symptoms of anxiety.



**It was a Sunday afternoon, early during lockdown, when I started becoming anxious. I'd been worried about my son on the Saturday night, and by Sunday night my anxiety increased to the point that I was unable to function.**

**I was worried and agitated and needed to speak to someone about my symptoms and medication.**

**I knew that the Community Mental Health Team had started working on weekends, so I phoned them. They reassured me, offered advice, and supported me with my medication.**

**Being able to speak to someone on the Sunday meant that I didn't have to go to Hospital Emergency Department or ring the Mental Health Crisis Team, which I have done on weekends in the past when the anxiety was unbearable. I got help when I needed it, before I reached crisis point.**

## Section 6: Looking forward

### Mental Health and Learning Disabilities (MHLD)

#### To celebrate:

The at pace progression on the following projects:

- Integration and co-location of 7 day Community Mental Health teams in Pembrokeshire and Carmarthenshire
- Working with the police, local authorities and third sector in developing a jointly run Health Board and third sector alternative provision in Ceredigion
- Working with third sector organisations to provide and promote Hywel Dda wide technology enabled support for service users during lockdown

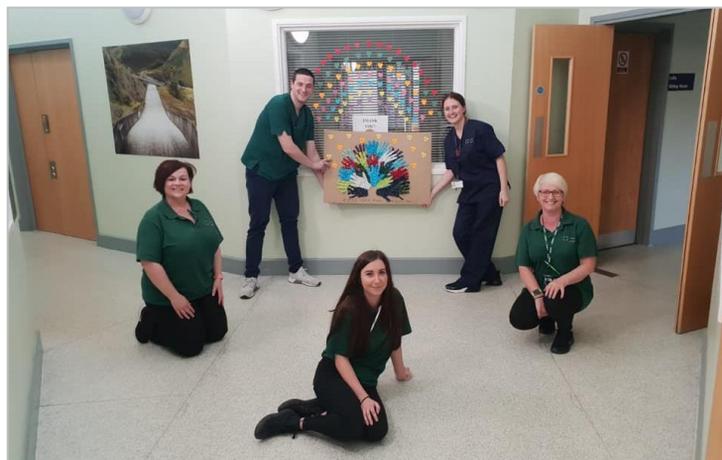
#### To authorise (continue, embed or adopt):

- To complete an Organisational Change Policy (OCP) process for Adult Community Mental Health Teams in Pembrokeshire and Carmarthenshire
- To embed the co-located and integrated way of working in the Community Mental Health Teams in Pembrokeshire and Carmarthenshire to provide a 7 day service
- Commence scoping the requirements and develop Discover reports for Transforming Older Adults Mental Health and Specialist Child and Adolescent Mental Health Services programme of work
- Integration of health and third sector out of hours sanctuary / hospitality Section 136 bed provision

#### To decide:

- Scoping the requirements and developing Discovery Reports for Transforming Older Adult Mental Health and Transforming Specialist Child and Adolescent Mental Health Services S-CAMHS programme of work

Note: These are all subject to the Strategic Enabling Groups setting out the engagement needed, feasibility, timescales, costs and other requirements.



## Section 6: Looking forward

### Enablers

During our engagement we asked people what had enabled the changes and innovations to take place. Here is a summary of what people told us, along with our learning from other sources of information.

#### Digital, data, informatics & modelling

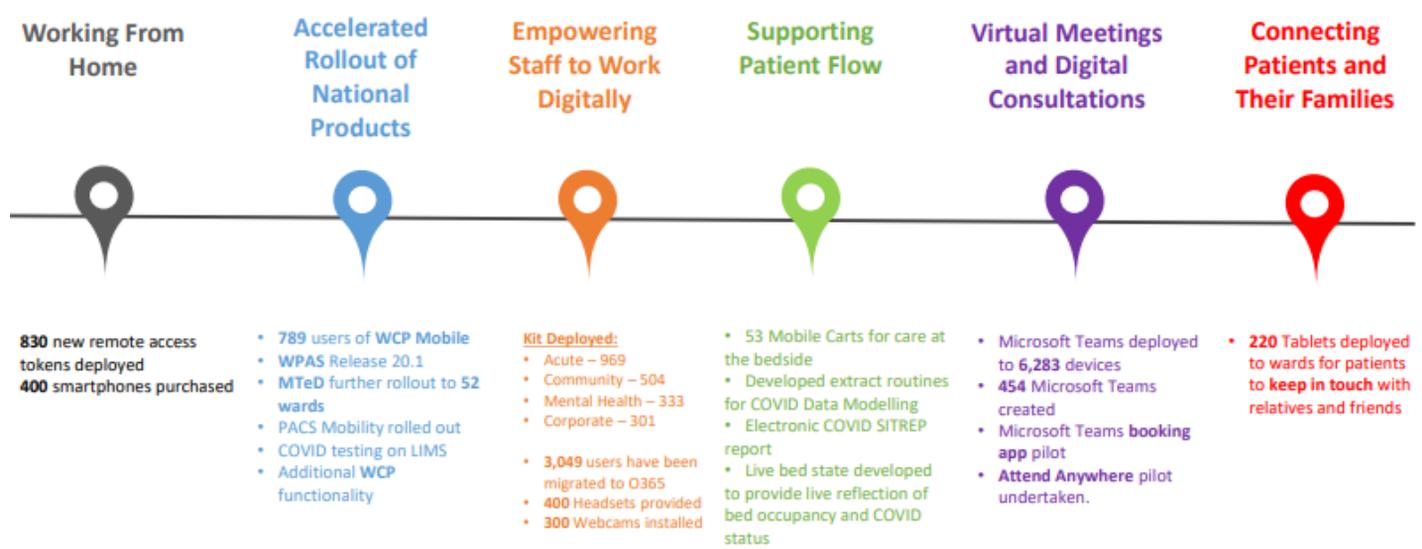
Technology enabled care and working digitally were two key themes which came out of the staff engagement. Examples of **technology enabled care** are described through this report, but include:

- The use of new patient platforms e.g. virtual fracture clinic and ‘Attend anywhere’, smart phone assessments and telephone consultations; 46 out of the 48 GP Practices have Attend Anywhere “live” and in use; E-Consult is in place in 75% of practices
- Intensive Therapy Unit (ITU) step down model
- Modelling patient flows across hospital / community
- A new Phone and Photo Advice and Guidance service, (Consultant connect) was launched on 15<sup>th</sup> June linking GPs directly to teams of NHS Consultants via mobile phones, and is now available to Hywel Dda GP practices.



**'I wish I could use a computer, I'm totally out of it. Can't get food, nobody answers the phone; Can't get my medicines, haven't had any medications for two weeks. Can't find out when I can see a doctor; I've been told to email the surgery - can't do that. Why isn't anybody considering people like me?'**

Working digitally is a key theme which has underpinned the change throughout. The infographic below shows the scale and magnitude of the change. This has enabled people to work within across teams and organisations. It has also led to remote working, and less travel.



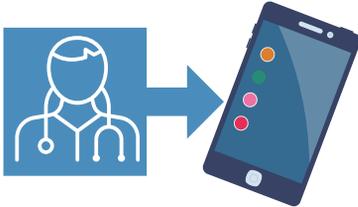
## Section 6: Looking forward

### Enablers

#### Digital, data, informatics & modelling



These images show how iPads were used to facilitate 'virtual visiting' of COVID patients



#### Modelling of COVID-19 patients during the pandemic – what we learnt

During the pandemic, teams needed to make decisions about services in order to prepare for the increased demand for services due to COVID-19. Decisions were made based on the data modelling about the likely number of COVID-19 patients requiring hospitalisation during the early months of 2020.

- Before the pandemic, the data projections used in the Health Board were primarily ad hoc requests for trends, general dashboard development, pathway development, metric development, and data development.
- The ask during the pandemic was different - translating demand into numbers of beds occupied. This change of requirement took some time to translate into a workable system.
- The changes to cohorts included in the COVID-19 model caused about 2 weeks of delay due to the need to validate the methodology, change the structure of the demand models and simulation.
- Earlier clarity around the 'ask' would have resulted in the delivery of a more comprehensive model more quickly. However, that was not possible due to COVID-19 being an evolving crisis.
- Ratios for COVID-19 pathways were produced by a clinical group at a national level.
- Modelling data must be of sufficient quantity and quality to be reliable. Hywel Dda University Health Board has in-house data on actual treatment types for COVID-19 patients, but as yet there is insufficient quantity to establish what the ratios should be within our Health Board with confidence. This will be a challenge for any data modelling going forward.

**I have converted 80% of my follow up appointments to phone and discharge. It should be noted that my follow-ups are mainly post-operative lumps. Use of Microsoft Teams has allowed teaching of junior staff and MDTs. I am the Cancer Lead for South West Wales Head and Neck (Swansea, Bridgend and HD) and I can lead the region using Teams. I type my own clinic letters now straight into Welsh Clinical Portal and GPs can see it immediately. This leads to improved communication with GPs.'**

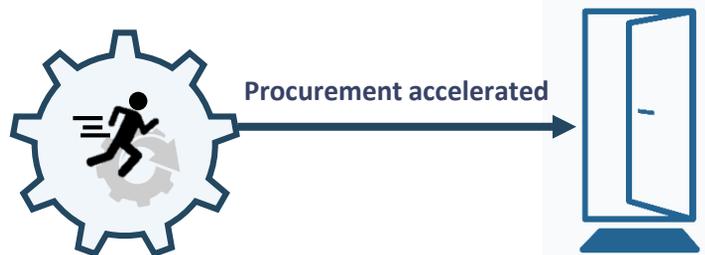


## Section 6: Looking forward

### Enablers

#### Procurement & local sourcing

Procurement have been involved in the provision of a range of goods and services such as PPE, equipment for field hospitals and the procurement of digital systems. The procurement team have had the ability to switch supply both utilising **NHS Wales Shared Services Partnership (NWSSP)** national resources as well as gap filling with local suppliers. This has allowed the health board to move quickly to respond to requests.



Securing PPE supplies has highlighted the importance of implementing a local supply chain strategy and sourcing directly from suppliers. We have demonstrated we have some capability to do this – e.g. visors. This needs to now move forward at pace. This would positively impact economically on Hywel Dda communities and making our communities sustainable.

There is also a need for an improved inventory management which can be assessed by clinicians including visibility of stock. There is also a need to review the use of frameworks for supply and demand.

The procurement function needs to be involved in the early stages of any transformation programme to ensure that there is timely provision of good and services to maintain the pace of transformation. This is especially important to digitally enabled services.

We have commenced a piece of work scoping the potential of local sourcing of equipment so that we support the local economy where this is possible. We can also explore sourcing food locally.



## Section 6: Looking forward

### Enablers

#### People and potential, empowering our workforce

Some of the main themes coming out from the staff engagement were in relation to the importance of working across teams, sectors, and directorates which enabled problem-solving at pace. The importance of having multiple roles embedded in MDTs and a skill mix was also referred to along with the importance of having senior clinical decision makers early in the pathway. There was reference to:

- Working outside role boundaries
- Having flexible and responsive staff rotas
- Agile and flexible working

We also heard that we need to build reflection and ‘sense-making time’ into our business as usual and our organisational learning, culture and agility.

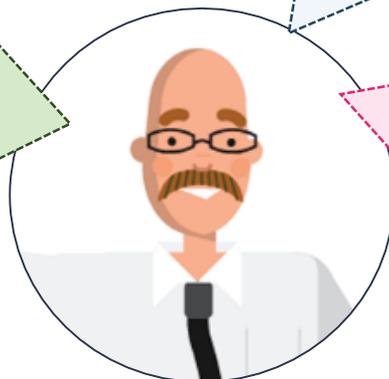
During the pandemic, recruitment happened at pace and at scale to respond to the demand. Moving forward there needs to be a balance between timely recruitment, managing risk and local involvement in deployment of our staff.

#### 7- day working – Pharmacy and Medicines Management

‘Extended hours and 7-day working [has worked well]. This has been achieved through changes to rotas and working patterns in discussion and agreement with the staff across the four sites. Bronglais Hospital has not moved to 7-day service due to concern on increased pressures on a small number of staff and no indication from the service that it is required. This is a priority area identified in the Health Board’s pharmacy three-year plan and delivering **A Healthier Mid and West Wales.**’

#### Mental Health Services

‘We co-located Adult Mental Health Crisis Resolution Teams (CRTs) and Community Mental Health Teams (CMHTs) in Haverfordwest and Carmarthen to ensure these CMHTs are operational 7 days a week, on a 9am-5pm basis. CRTs remain 24/7. Gorwelion in Aberystwyth had merged teams and provided 7-day week cover prior to COVID.’



#### Workforce Culture

‘A key learning from our COVID experience has been allowing professionals and teams to come together to problem solve and do the right things for patients and the importance of being trusted to do that.’

## Section 6: Looking forward

### Enablers

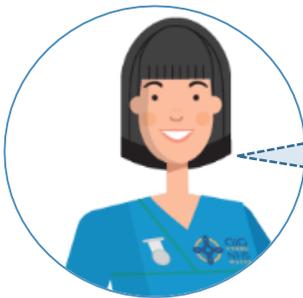
#### Capital, estates, infrastructure and planning

During our engagement the estates department was praised for being responsive in adapting the environment to meet the requirements of COVID-19. People also told us that this experience of planning for a pandemic highlighted a need for the organisation to have robust contingency plans in place in advance, so that we are ready for critical incidents in the future.

#### We heard that:

- Better estate planning and future strategic overview of clinical engineering services is needed
- Effective and real (dynamic) risk assessments need to take place for all sites
- Future estates strategy needs to be flexible to respond to future pandemics and events

One key area of learning from the perspective of Public Health is the need for a more consistent and effective approach to business continuity planning for large scale incidents. Planning for such incidents needs to be owned at an Executive / Board level, rather than by a small number of individuals with a remit around public health or emergency planning.



**‘The Estates department were fantastic and were quick in meeting our requirements to adapt the environment. Normally this takes a lot of time and agreement on funding.’**

#### Better ways to connect: Continuous engagement, diversity and inclusion

##### Transformation engagement

During our engagement, we asked respondents how we could continue to capture learning from staff. A large number of people said how valuable the engagement had been for them, as a way to take stock and reflect on what they had learnt during the initial course of the pandemic. Several people suggested going back to them again to ask how things had changed. There was a great deal of appetite from staff to continue engaging with them in future. The Transformation Programme Office intend to continue engaging with staff around our transformation work. Further details about our approach to Continuous Discovery is included in section 7.

##### Engagement with Black and Minority Ethnic staff (BAME)

We now know that Black and Minority Ethnic staff were at particular risk during the pandemic. the Occupational Health team have supported the workforce during this difficult period, in particular supporting individuals with regards to COVID-19 testing, pregnancy risk assessments and risk assessments for the BAME (Black, Asian & Minority Ethnic) workforce. The BAME advisory group will also be influential in our planning.

Within our short timeframe, we did not have capacity to engage with wider groups of staff across the organisation, or undertake patient engagement. Further engagement is needed to understand wider staff and patient experiences.

## Section 6: Looking forward

### Enablers

#### Better ways to connect: Continuous engagement, diversity and inclusion communication

It was acknowledged even before a pandemic was declared in the UK that effective, credible communications with our staff, communities and stakeholders would be an essential part of any response to COVID-19. This would rely on the organisation having trust with its audience and providing them with accurate and up-to-date information.

The Corporate Communications Team was embedded into the command and control structure from its inception. This provided an immediate mechanism for communicating critical decisions and key messages to our audiences. A COVID Communications Strategy was established early on to focus on key outcomes and priorities in an environment of high demand. The objectives are:

- To provide clear information to staff and communities which protects our ability to provide safe care to those who need it most;
- To establish ourselves as a trusted, authoritative source of information on the pandemic within the west Wales community;
- To reach large audiences with potential to change behaviours in support of public health messages;
- To protect the well-being of our staff and communities, including their mental health, by recognising and valuing their contributions;
- To demonstrate the corporate and clinical leadership and reassurance that Hywel Dda University Health Board and our partners are making the best decisions on behalf of our communities.

#### Our communication highlights include:

- Launching a COVID-19 resource on our new website which is more accessible for our audiences, including those with sensory impairments
- Providing leadership to staff through regular updates from the Executive Team in written and video format
- A social media campaign to establish ourselves as the local 'go to source' for accurate health information in West Wales during the pandemic – this increased our audience from 13,415 in early February to 41,657 in late February 2020
- Reaching non-digital audiences through broadcast interviews and work with print media; commissioning local radio adverts; and visible poster campaigns within healthcare environment and partners

**Risks to Black and Minority Ethnic staff**  
 'Despite being [in the] high-risk group as a Black and Minority Ethnic member of staff I volunteered for these clinics. We are one of the few HBs in Wales to offer face to face appointments [...]. We have no problem accessing PPE [...] I work with 4 doctors all from Black and Minority Ethnic backgrounds and all want to continue to work. I am the only surgeon in this area and if I don't do it patients will suffer I have no option but I have been afraid. I have two kids and a wife who is shielding. I shower before leaving the hospital, go in the house through the back door and shower before meeting the family.'



## Section 6: Looking forward

1

### Enablers

#### Better ways to connect: Continuous engagement, diversity and inclusion

#### What did we hear in the media and from our social media audiences?

Here are some common themes:

- Staff were worried about the **availability and appropriateness of PPE** – we issued staff communications, videos and visuals to help health and social care staff; we signposted offers of help from our communities to a dedicated COVID enquiries resource; and we reassured staff and community through involvement in media interviews and responses
- Fear that the health service would not be able to cope with **demand** – we mitigated this through joint statements with Local Resilience Forums partners, visuals, media releases and broadcast interviews about the field hospitals, redeployment of staff and preparations for the pandemic response
- **Safety to access services when you need to** has been a worry for our audiences – we mitigated this by providing videos in the areas of primary care and cancer (more to follow); by working with ‘real’ local people to demonstrate the advantages of attending and providing reassurance over safety; and through a wellbeing campaign during Mental Health Week, with ongoing signposting
- **Frustration at test results for COVID-19 taking too long** – currently through responses that results are shared as soon as they are available; and feeding this feedback into the planning processes locally and nationally so they can inform development
- **Worry over contact tracers and scams** in operation nationally and locally – we mitigated this through media releases, social media and poster campaign, including patient literature, to warn about scams and confirm the information contact tracers will and will not ask for



## Section 6: Looking forward

### Enablers

#### Continuous improvement and service improvement

One of the strongest themes resulting from our engagement was that people felt they had freedom and autonomy to implement changes. They told us that ‘local decisions were made by local teams’, and that decision making was swift and clinically led, and based on need. Staff felt empowered to make the changes needed to adapt their services to the pandemic.

A large number of the changes and innovations that staff told us about were enabled by having lighter touch governance in place, with regular access to decision makers who met on a daily basis. Changes and innovations were implemented at pace. Staff were empowered to ‘get on and do’.

These new ways of working ultimately led to the greatest service improvements.

People told us that, on the whole, the decision-making structures established during the pandemic worked well. They valued:

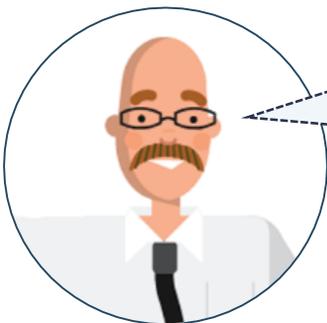
- Daily Multidisciplinary Team and stakeholder meetings
- Short and focused discussions

**‘[What worked well was the] breaking down of red tape and process in enabling things to happen. Easier to access and get decisions made - cannot underestimate that. Certain amount of breaking down of barriers in enabling decisions to happen quicker – more rapid testing of innovation rather than multiple layers of authorisation.’**

#### Value, innovation, research and development

We heard that the awareness of the role of our Research and Development Department increased due to the publicity on television about research and recovery studies. People have become more aware of the role of research.

Recruitment of outpatients for studies has stopped. However, a greater number of inpatient from wards have been recruited for studies.



#### Research and Development

**‘[We have had increased] recruitment of inpatient from wards, which has made hospital staff more aware of us. Medical staff have become more aware of us and what we are doing which is fantastic for our PR.’**

We also heard that:

- Some recent studies had stopped due to the focus on COVID-19
- Teams are undertaking rapid testing of innovations rather than waiting for authorisation

## Section 6: Looking forward

### Enablers

#### Corporate governance, legal, risk & contracts

As mentioned earlier, one of the strongest themes resulting from our engagement was that people felt they had freedom and autonomy – not only to implement changes, but to make decisions within a lighter touch governance structure.

On the whole, people valued the new command structure established, and believed that it enabled:

- More effective and efficient decision making
- Problem solving by Bronze groups
- Freedom to act within a framework
- More emphasis on individual accountability
- Quicker procurement routes
- Personal ownership of risk, rather than corporate management of risk

However, some people reported that this increased emphasis on individual accountability resulted in a small number of people displaying ‘maverick’ behaviours, and that more ‘due diligence’ was needed around some changes and innovations introduced. In future, having clear objectives will ensure we take the correct approach to our governance.



**‘[Having a] clear structure [worked well]: Gold, Silver, and Bronze where quick decisions were made and we knew when these meetings were happening whereas the systems currently in place take much longer. In reality we need some middle ground, we need a structure where we can update/inform and papers aren’t necessarily what we need – lighter governance and less bureaucracy. Bringing people in from different Directorates, there was freedom to problem solve. They were relatively senior colleagues who had their own structures in place but in the room they could bounce off each other and learn, which was very important.’**

#### Finance

Many people mentioned that decisions during COVID-19 were driven by clinical and operational needs rather than financial constraints. They also reported that decisions around financial decisions were swifter.

When asked what needs to change in future, some people suggested the need to take an ‘invest to save’ approach to finance rather than ‘penny pinching’ – that this would lead to more long term savings for the Health Board.

A number of people mentioned the benefit of being able to order IT equipment they needed because ‘the budgetary stops on issuing IT equipment have been removed.’

**‘Staff were given permission to do what they needed to do, and we were not constrained by finance directing what we do, and all the bureaucracy built into the health service. Transformation was clinically and need driven rather than constrained by finance.’**

## Section 6: Looking forward

### Enablers: Matters to be celebrated, authorised, or decided

Strategic Enabler	To celebrate	To authorise (continue, embed or adopt)	To decide
<b>Digital, data, informatics and modelling</b>	<p>The phenomenal pace and scale of change.</p> <p>The rollout of multi-media boards to support multi-disciplinary working across professional groups.</p>	<p>The focus on working digitally and technology enabled care (GP video consultation, attend anywhere and consultant connect, remote monitoring and diagnostics), needs to be maintained.</p> <p>Our strategy moving forward needs to be fit for the digital age.</p>	<p>We need to maintain a focus on ensuring that we offer the right equipment to our staff from the day they join to empower them to continue to work in an agile flexible way, including care home residents and staff.</p> <p>To scope the development of community digital hubs to support patients who are not digitally enabled to access services through new technologies.</p>
<b>Procurement and local sourcing</b>	<p>Sourcing equipment at scale and at pace from local and national sources.</p>	<p>Continue with the plan for a medium term solution for procuring PPE, including care homes.</p>	<p>Develop a local supply chain strategy including food to help sustain the local economy and population wellbeing, and to encompass all major business continuity threats.</p>
<b>People and potential empowering our workforce</b>	<p>Scale and pace of recruitment.</p> <p>The commitment of staff throughout the pandemic – particularly those at high risk.</p> <p>Staff Psychological Wellbeing Service planning and provision.</p> <p>Agile training provision for new recruits and upskilling existing staff whilst adapting to new social distancing requirements.</p>	<p>Agile and flexible working., including home working.</p> <p>A cultural change programme in the pursuit of joy at work.</p> <p>Continue flexible approach to utilising roles and skills across the organisation.</p>	<p>Revise the approach to recruitment.</p> <p>Capitalise on MS Teams capability to underpin agile and home working across corporate functions and clinical teams.</p> <p>Capitalise on MS Teams capability to underpin agile and home working across corporate functions and clinical teams.</p>

Note: These are all subject to the Strategic Enabling Groups setting out the engagement needed, feasibility, timescales, costs and other requirements.

## Section 6: Looking forward

Enablers: Matters to be celebrated, authorised, or decided: Continued..

Strategic Enabler	To celebrate	To authorise (continue, embed or adopt)	To decide
<b>Capital, estates, infrastructure and planning</b>	How responsive the estates department was in adapting the environment.		<p>Whether contingency or business continuity planning requires different governance to ensure that organisational planning lessons learnt from this pandemic are embedded into future plans.</p> <p>Strategy for aligned drive through services e.g. phlebotomy, vaccinations and immunisations, antibody testing</p>
<b>Better ways to connect: continuous engagement, diversity and inclusion</b>	<p>Engagement with over 100 key leaders to learn from the pandemic.</p> <p>The willingness of staff to engage and share experiences with us.</p>	<p>The Transformation Programme Office continue to engage with staff and patients – both formally, during consultation, and informally, through ‘continuous discovery’.</p> <p>Undertake further joint piece of engagement work with Local Authority partners as required.</p> <p>Establish Hywel Dda hub – whole organisation single point of contact.</p>	

Note: These are all subject to the Strategic Enabling Groups setting out the engagement needed, feasibility, timescales, costs and other requirements.

## Section 6: Looking forward

Enablers: Matters to be celebrated, authorised, or decided: Continued..

Strategic Enabler	To celebrate	To authorise (continue, embed or adopt)	To decide
<b>Continuous Improvement (CI and SI)</b>	How teams worked at pace to make changes and innovations to adapt services due to the pandemic.	Empower and support teams to continuously improve in a timely way.	
<b>Value, innovation, research and development</b>	How proactive staff have been in rapidly testing innovations.		
<b>Corporate governance, legal, risk and contracts</b>	The command structure enabled effective /efficient decision making during the pandemic.		Review the understanding of the governance structure and how we work within it.

Note: These are all subject to the Strategic Enabling Groups setting out the engagement needed, feasibility, timescales, costs and other requirements.



## Section 6: Looking forward

### Accelerated Design and Outputs

On the 15th and 17th July, the Transformation Steering Group (TSG) held an Accelerated Design session with key leaders and change agents from across the system. This was facilitated by collaborative design experts. The session allowed the group to consider new ideas, collaborate across the system and problem solve with the energy required to sustain change. The session had the following aims:

1. To relaunch the delivery of our health and care strategy by:
  - Reconnecting everyone
  - Reconfirming our joint commitment
2. To share everything we have learnt from the COVID pandemic
  - How we organised ourselves and made decisions
  - The positive changes we made to our service delivery models
  - The changes we have seen in public behaviour
3. To introduce TSG – its role and function
4. To introduce the initial focus areas for further transformational change

Day 1 gave us an opportunity to hear about the feedback from the clinical and operational engagement undertaken post COVID. This was focussed on the key lessons learnt across the system and the key enablers which underpinned the transformation change. We also had an opportunity to hear about case studies from across the world and then reflect on our local experience. We broke up into four teams to look at:

- **Joy at work**
- **Technology Enabled Care**
- **Social Model for Health**
- **Decision making, empowerment and leadership**

We initially focussed on a future state to enable us to think through what key actions we would take over the next year to enable us to win awards in these areas. We also considered the challenges and how we overcame them. We turned these actions into clear commitments.

Throughout the session we used tools such as 'slido' to test the actions and commitments with the wider group. We then utilised this feedback to refine our commitments.



## Section 6: Looking forward

### Accelerated Design and Outputs: Continued...

Day 2 saw us break into four teams to focus on the key parts of the care model:

- **Prevention**
- **Access & Co-ordination**
- **Treatment**
- **Discharge, transfer & ongoing support**

In each group we considered the key support or services required and then as groups we prioritised these to 2/3 emerging priorities. For each priority we explored the key benefits, key outcome measurements, key enablers and barriers.

The outputs of the accelerated design session is a set of emerging priorities for each part of the care pathway and a clear plan for building the next steps. These will become a key area of focus for the Transformation Steering Group moving forward.



***“Thank you for today, one of the most energetic delivery focussed sessions I have been in in my 40 Years in the NHS, congratulations on the approach and delivery”***



## Section 7: How we will work together to deliver

### Organising ourselves more efficiently to support our transformation journey

In order to support our transformation agenda we have acknowledged the need to have a set of arrangements in place that allow decision making to be comprehensive, flexible, adaptive and responsive.

As such, we have reviewed our existing Health and Care Strategy delivery arrangements and recognised a need to change. We have noted the learning due to the COVID-19 pandemic and the flexible way of operating that has allowed us to deliver the required change to continue delivering healthcare services in a time of great flux.

In 2018, the Board approved our Health and Care Strategy, A Healthier Mid and West Wales – Our Future Generations Living Well. This also included approval to develop appropriate governance to deliver on our promise within this strategy.

As part of this promise, we developed three distinct programmes of work namely: Transforming our Communities, Transforming our Hospitals and Transforming Mental Health and Learning Disabilities. This being supported by a Strategic Enabling Group.

Although progress has been made in this programme structure, the learning that we have gained from the pandemic has evidenced how dynamic and transformational we can be when working in a more streamlined, joined-up, and efficient way.

As such, we are changing our approach in supporting the way we assist the Board to make decisions, in order to continue feeding the appetite for change that has been evidenced across large sections of the Health Board that may otherwise have had limited engagement with our transformation journey to date.

Therefore, we are implementing a new transformation governance system within the Health Board. This consists of a Transformation Steering Group (TSG) led by our Chief Executive in conjunction with key Board Members and Executive Officers.

#### Transformation Steering Group – Membership

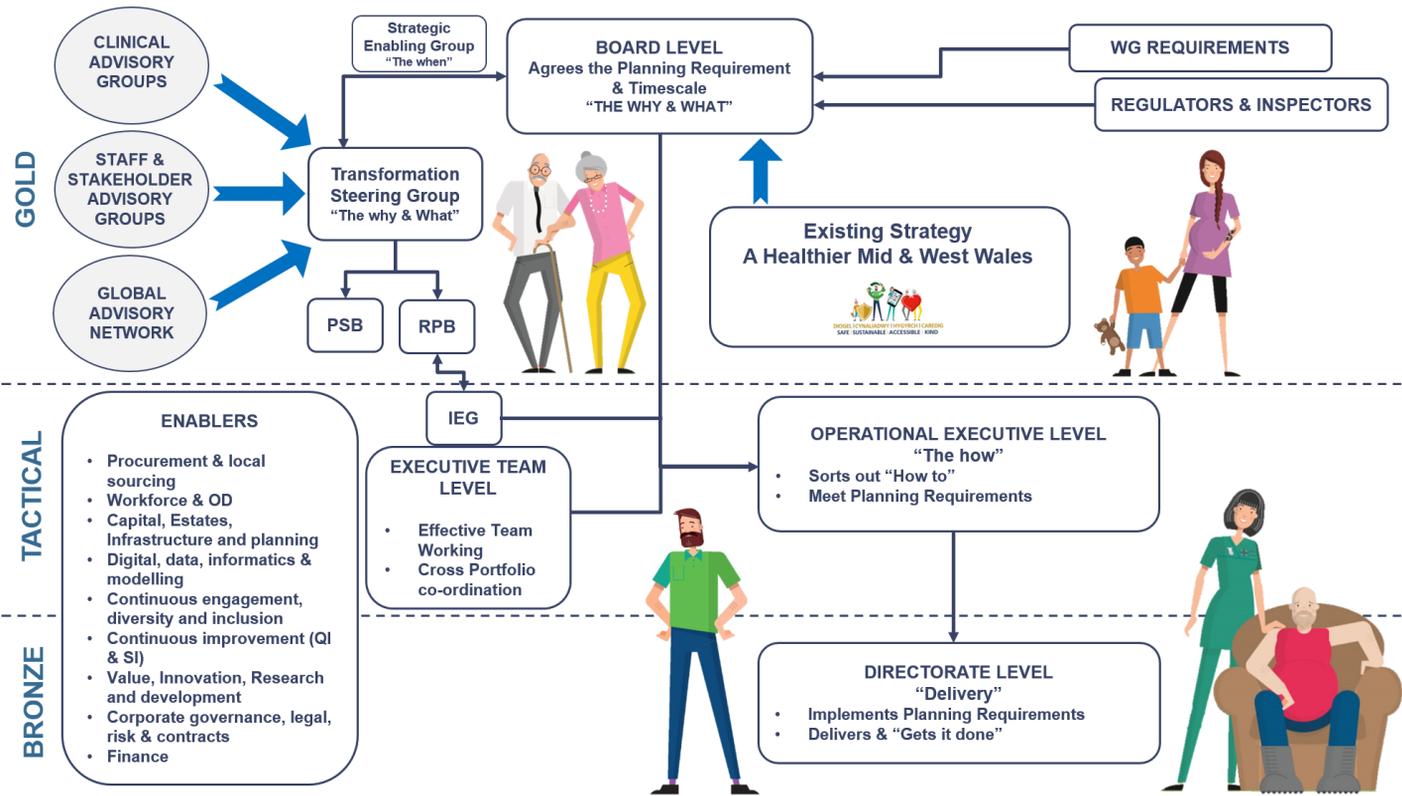
- ▶ Chief Executive
- ▶ Chair
- ▶ Vice-Chair
- ▶ Independent Board Member
- ▶ Medical Director and Deputy Chief Executive Officer
- ▶ Director of Finance and Lead for Strategic Enablers
- ▶ Director of Planning, Performance, Informatics and Commissioning

#### In attendance:

- ▶ Director of Operations & Tactical Chair
- ▶ Director of Primary, Community & Long Term Care
- ▶ Strategic Programme Director
- ▶ Chief Executive - Local Authority

## Section 7: How we will work together to deliver

### Governance to support our transformation journey



## Section 7: How we will work together to deliver

### Governance to support our transformation journey

#### The TSG's purpose is:

1. To learn from the pandemic and our response to it
2. To translate that learning into practical applications
3. To transform our services today and the over the lifetime of our health and care strategy

#### This group will do this by digesting ongoing intelligence from multiple sources such as:

- Our public
- Our staff
- Regional Partnership Board
- Public Services Board
- Clinical Advisory Groups
- Staff & Stakeholder Advisory Groups
- Global Advisory Networks

#### The TSG will in turn commission the Strategic Enabling Group to assess timescales over which changes can be enabled. This will require assessments of constraints and opportunities in the following areas:

- ▶ Support our communities to support us: Procurement & local sourcing
- ▶ Workforce & OD
- ▶ Capital, Estates, Infrastructure and planning
- ▶ Better ways to connect: Digital, data, informatics & modelling
- ▶ Continuous engagement, diversity and inclusion
- ▶ Continuous improvement (QI & SI)
- ▶ Value, Innovation, Research and development
- ▶ Corporate governance, legal, risk & contracts
- ▶ Finance

The resulting outputs will form planning objectives for the Board's considerations, composing three elements:

The **'why'** – expressing why this is important using our Teulu Jones family or our own staff to describe the difference it will make, in narrative form;

The **'what'** – a clearly articulated planning objective – specific enough to be clear but not so specific as to limit opportunities to innovate in their delivery;

The **'when'** – A clear timescale over which the objectives are expected to be achieved.

## Section 7: How we will work together to deliver

### Our commitment to continuous engagement

Our recent piece of engagement with clinical, operational, and corporate staff signals our commitment to engaging and listening to people’s views.

We intend to build on this work by continuing to engage with our staff, patients, and communities to find out what is important to them as we deliver our strategy.

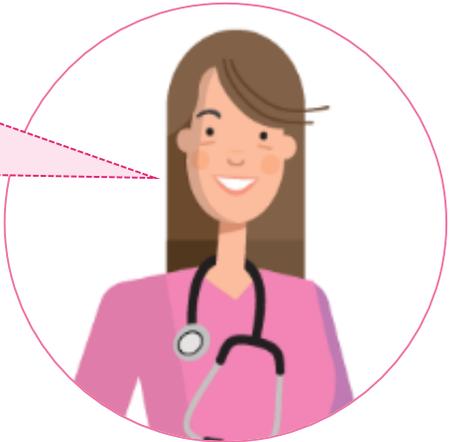
Our health and care strategy belongs to everyone – it is therefore important to us that we proactively listen to the voices of patients and staff as we continue our transformation work, so that services really reflect what matters most to us all.

The Board has already approved a Continuous Engagement Framework for Hywel Dda, which provides the basis for any continuous engagement we will undertake, taking into account the richness and diversity of our own workforce and communities, and the importance of hearing from people with protected characteristics (as defined under the Equality Act 2010).

We want to make it easier for people to engage with us in a range of ways – whether formally, through surveys and consultation, or informally, through social media or individual conversations.

We are also committed to feeding the results of our engagement back to the people we engage with – whether staff or patients or members of the public – as part of our ongoing communication with the organisation and across the whole system. This report is an example of how we feed back what we heard.

**‘What the Transformation Programme Office (TPO) is doing in gathering feedback is exactly what should be done. But it’s so important we feed this back. So that people feel listened to and action is taken or an explanation of why not.’**



**‘What you are doing in terms of engagement is really, really, important [...] Check-in conversations are important to capture timely reflections [...] and far better than emailing surveys out.’**

## Section 7: How we will work together to deliver

### Our approach to continuous discovery

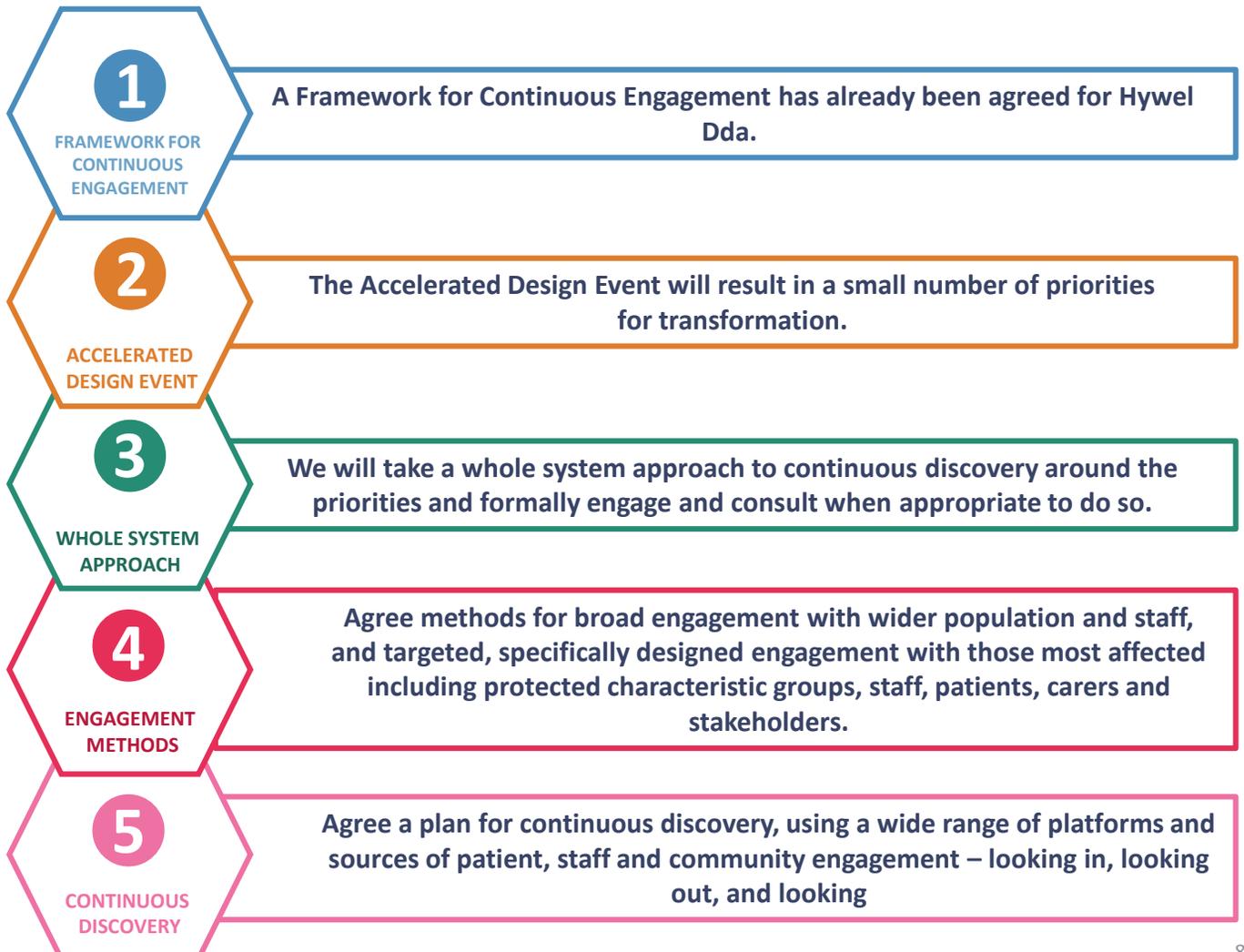
*Engagement forms only a part – albeit an important one – of continuous discovery.*

Continuous discovery encompasses all the knowledge, data, views, perspectives, experience, learning, and any other information relevant to our strategy, collated from a wide range of sources. This information – both qualitative and quantitative – will be gathered and analysed on a continuous basis, and fed into our ongoing work to deliver the strategy.

This practice of continually collating information will be in addition to the more detailed engagement we will undertake during the ‘discover’ phase for individual projects. During each ‘discover’ phase we will link in with internal colleagues for advice around patient and staff engagement, and equality, diversity and inclusion, especially where formal consultation is necessary.

**The following diagrams illustrate how:**

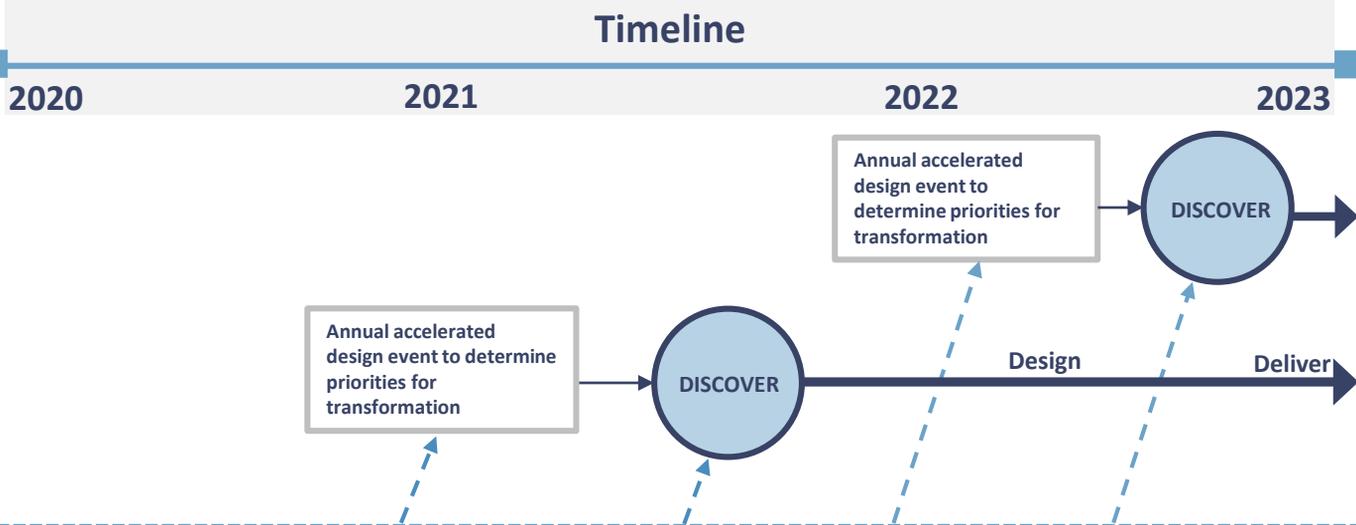
- Our detailed plan for continuous discovery will be based on the priorities agreed at the accelerated design event;
- The learning and intelligence we gather through the process of continuous discovery will continuously inform and add value to our work as we deliver the strategy.



## Section 7: How we will work together to deliver

We will continuously add value to our work through feeding learning in as we progress

# Expediting our strategy, 'A Healthier Mid and West Wales'



### Continuous Discovery: Looking Out, Looking in, Looking back

Continuous discovery will pull in qualitative and quantitative information from a range of sources, including the following:

#### Qualitative

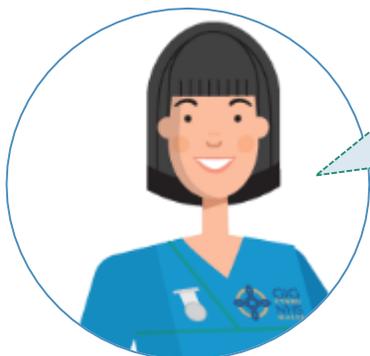
- Stories, reflections, and feedback from clinicians, staff, public, social media, stakeholders, partners, Board, groups of people with protected characteristics (as defined under the Equality Act), CHC, patient and carer experiences, Patient Reported Experience Measures (PREMs)

#### Quantitative

- Performance data, financial and workforce data, clinical incidents and complaints, financial impacts (positive and negative), value based outcomes, Patient Reported Outcome Measures (PROMs), service improvement information, review of decision making, health and care strategy review, research and development

#### Other (looking out)

- Research and learning from national and regional networking and partnerships, learning from Health Boards and other organisations in Wales and beyond



'Sometimes [we] have to have conversations with people like yourselves. When doing the day job, I don't necessary think it's part of transformation. [This engagement] helps me think about what we've done'

## Section 8 : Closing Message

Throughout this report we have presented our initial learning from our response to the COVID-19 pandemic, through the eyes of our patients and staff. A significant number of people have contributed to this report including operational and corporate teams, Local Authority, Third Sector and other partners, The Community Health Council and a number of national and international think tanks.

We would like to acknowledge and thank everyone for their time and influence on the content of this report.

We will end the report with some stories from our Hywel Dda family (Teulu Jones) which demonstrate the impact of the change to the type of services and methods of delivery, based on real feedback heard from patients and staff.



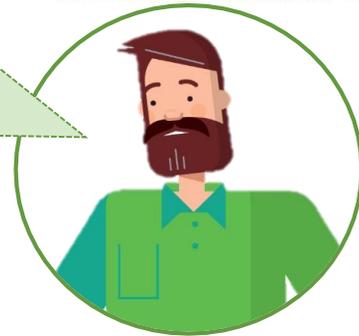
Libby Ryan-Davies  
Strategic Programme  
Director

# Thank you!



"I fell off my bike and broke my wrist recently. The virtual fracture clinic was really supportive and the technician who phoned me answered all my questions. It was so helpful to not have to go back to the hospital to receive this. I did go back to the hospital a few weeks later and my plaster was changed to a softer one which was much more comfortable.

At this appointment I was given clear advice on when and how to remove this cast and the physiotherapist gave me exercises I could start as part of a self-management plan. I was discharged but I was happy I could get in touch via phone or email if I had any concerns. I followed all their advice and now I am back on my bike"



### What would happen to Gareth before the pandemic?

Gareth goes to his local minor injuries unit where he is assessed and has a X ray which shows he has broken his wrist. His wrist is put in a plaster cast and he is discharged home with a leaflet on how to take care of his plaster. A few days later he attends a fracture clinic in the hospital and has another X ray. Following this he is reviewed by an orthopaedic consultant and his plaster is trimmed. He is asked to re-attend another clinic appointment in 2 weeks. At this clinic hospital appointment his plaster is changed for a new one and he has another X ray, he is reviewed again by another orthopaedic consultant and is asked to attend again in 4 weeks' time.

He attends the clinic again 6 weeks after his injury and his plaster cast is removed. At this appointment the consultant refers him to the local physiotherapy department to support his recovery. Gareth's referral is added to the physiotherapy waiting list and he waits a few weeks before he is assessed by a physiotherapist and is given exercises to continue to support his rehabilitation.

Gareth attends the fracture clinic at 12 weeks following his injury and is reviewed by the consultant who discharges him to the care of the physiotherapy service.

### What would happen to Gareth since the pandemic?

Gareth goes to the local minor injuries department where he is assessed and has a X ray which confirms he has broken his wrist. His wrist is put into a plaster cast and he is discharged home with information about his injury, advice regarding looking after his plaster, the contact details of how he can contact a virtual fracture clinic. The information sheet also includes a QRF code that links him to physiotherapy videos to help in his rehabilitation.

The following day Gareth's X rays and his clinical notes are reviewed in a virtual fracture clinic by an orthopaedic consultant. Following this review a management plan is developed and a summary is dictated and sent to Gareth. This is also copied to his GP.

The same day Gareth gets a phone call from the plaster technician who is supporting the virtual clinic. The technician verbally outlines the management plan to Gareth and provides him with further information and answers any questions Gareth has.

Gareth attends a face to face review at 2 weeks in his local hospital and following a X ray is reviewed by a consultant.

Gareth's plaster cast is changed at this appointment to a softcast which he is able to remove himself. He is given instructions on how and when to remove this cast and the physiotherapist advises him on information and exercises to support his rehabilitation and advises that he can also seek advice from his community pharmacist if he needs to. Gareth is discharged from the clinic but he is able to access again via email if he has concerns about his recovery.

At 6 weeks as instructed Gareth removes his plaster himself and starts his physiotherapy exercises, assisted by the information and video links he's been provided with.

Gareth doesn't need to access the clinic for any further support and is able to return to his usual activities and is back on his bike within a few months.



“I am recovering from that coronavirus. I feel safe here in my care home as I know the girls and they look after me. I nearly had to go into hospital and I was very frightened but a doctor came here to see me. He used an iPad to contact my family and we all had a chat and agreed that the best place was for me to stay here. We also agreed what would be best for me if I got worse. I felt so much better that I could see and talk all this through with the doctor with the support of Sioned and Alun as I find things confusing at times. It feels good to have things settled and I am so pleased that I could stay here”

### What would happen to Mari before the pandemic

Mari becomes unwell in her care home and as there is no clear management plan around her care the staff ring 999. Mari waits for an ambulance transfer to the local district general hospital and unfortunately as the A&E department is very busy she waits for many hours for an assessment and diagnostic tests she requires. During this time Mari is lying on a trolley in the department. After many hours it is felt that Mari needs to be admitted and she is transferred to a general medical ward. Mari is very frightened due to her unfamiliar surroundings and she becomes quite agitated, this is a challenge for the nursing staff to manage within a busy ward environment and they are afraid she will fall as she keeps getting up to go home. Mari's behaviour is now quite different to how it was before she was admitted and she is therefore referred for an assessment by the mental health liaison team. This assessment will inform her discharge planning and whether she can return to her own home or if she requires long term care placement in a suitable care home.

### What happens to Mari since the pandemic

Mari becomes unwell in her care home and the staff contact 111 service. A doctor on call visits her there and reassures the staff. The doctor assesses Mari and using an iPad they involve Mari's family in planning her care and an advanced care plan is developed. Mari is able to connect with her family using the iPad so she also feels reassured by her husband Alun and her daughter Sioned. Mari's care continues to be supported by her GP and she remains in the care home and is not admitted to the hospital. The GP supported by the Consultant Geriatrician enabled this approach and the digital platforms supported the development of an advanced decision with the support of her family, allows for review of Mari's condition by health care professionals and also connected Mari to her family. Mari and the staff are tested as part of screening plan for care homes.



“I just had my baby in Glangwili Hospital as I was considered high risk during my pregnancy. The 1 stop ante-natal clinics were so helpful so I could get my scan, bloods and see the consultant all in 1 place.

Whilst on the post-natal ward the midwives talked to me about my choices for contraception. I wanted to use the pill and I was given a 6 month supply before I left the hospital. This was such a relief as when I got home I was so busy with my baby and was scared of going out with my baby and my son to any clinics to get contraception and I was also afraid of getting pregnant again”

### What would happen to Lianne before the pandemic?

Lianne is a high risk pregnancy and is under Consultant Obstetric Led Care. She is in the latter stages of her pregnancy. Lianne attended the District General Hospital for an ultrasound scan of the baby's wellbeing and to have some blood tests in the morning. In the afternoon Lianne then had to travel to her local health facility to see her named Consultant Obstetrician. Her named Consultant Obstetrician facilitates a Consultant led Antenatal Clinic once a week in this health facility fifteen miles away from the District general Hospital. This health facility does not have the scanning facilities or phlebotomy services. Lianne therefore has to visit two facilities to receive care, which is time consuming for Lianne. Her baby is delivered at Glangwili General Hospital Maternity Department as planned and she is advised prior to discharge from the maternity services regarding the need to use contraception to avoid any unwanted future pregnancies. Lianne has to wait a number of weeks before she is able to attend her GP or Sexual Health Clinic to discuss her contraceptive choices. Lianne is then prescribed the Progesterone Only Contraceptive Pill at this consultation and is relieved as she was fearful of becoming pregnant again.

### What would happen to Lianne since the pandemic?

Lianne is a high risk pregnancy and is under Consultant Obstetric Led Care. She is in the latter stages of her pregnancy. Lianne attended the “1 stop clinic” at her local District General Hospital where she had an ultrasound scan, blood test and is assessed by the Consultant Obstetrician at the same morning appointment. This saved Lianne travelling to another local health facility to be reviewed by the Consultant Obstetrician who would organise her plan of care based on the ultrasound scan results. Lianne delivers her baby in Glangwili General Hospital as planned.

Whilst on the post-natal ward and prior to going home the midwife discusses with Lianne her choices with regards to contraception. Lianne is prescribed the progesterone only contraceptive pill and she leaves the postnatal ward with a 6 month supply of contraception. This approach alleviates Lianne's anxiety of a potential unwanted pregnancy and her needing to leave her home with her young baby to attend a Sexual Health Clinic or GP for assessment to discuss choices of contraception. This new way of working was possible by collaboratively working with the Sexual Health and Pharmacy teams in providing training to all our hospital and community midwives.



'My family and I have had a terrifying few months since I caught coronavirus and I feel lucky to be alive. I was put on a ventilator for weeks as I could not breath. However, when I woke up I could not move at all so I had to learn to speak, eat and walk again. This was made harder as I get so tired so quickly, I have never ever felt like this before.

I am pleased to be home now but I do feel frightened. I have not seen anyone since I am home. The physiotherapist has phoned me a few times to see how I am getting on and to give me advice, but I would like to see someone, as I am still not able to do so many things and feel weak, breathless and I tire quickly. I have thought about trying a gym to try to get my strength back but they are all closed. I am also struggling as I have flashbacks from when I was in critical care and I find it hard to accept what has happened to me. I am embarrassed to tell my friends this is how I feel. I am also worried about my job, as I know there is a risk they could let me go especially as I am off sick now. We are really struggling with money too as we've lost some of my income and we needed that to support our family.

I know my wife is also struggling as she could not visit me in hospital and does not know how best to help me now I am home. She's working so hard as a frontline worker in the NHS. We are both just trying our best to get through this and return to normal.'

### What would happen to Rhys before the pandemic

Rhys is 52 year old lorry driver living with his wife Sioned. Rhys started to feel unwell so his wife bought him to A&E and he was admitted to a medical ward. His condition deteriorated and he was therefore transferred to the critical care unit to be put on a ventilator.

Rhys was ventilated for 23 days. During this time Sioned and his daughter Lianne were able to visit him regularly. The multidisciplinary team in critical care agreed a rehabilitation plan for Rhys as the evidence supports the benefit of early rehabilitation as well as focusing on respiratory care and supporting weaning him from the ventilator. This plan was significantly delivered by the therapists and included passive and active exercises. The physiotherapy technical instructors also supported Rhys as due to his level of weakness and deconditioning he required 2-3 members of staff for every rehabilitation session. Rhys was transferred from the unit to a ward and here therapists worked with Rhys to improve his functional ability e.g. standing, toileting, dressing. Staff then outreached into the community to support Rhys's rehabilitation once he was discharged home safely. Rhys was also invited to attend a critical care patient support group after discharge. The team worked with Rhys and his family to achieve his personal goals, supporting his physical and mental health recovery.



### What would happen to Rhys since the pandemic?

Rhys started to feel unwell in March 2020 with shortness of breath and fatigue so his wife bought him to A&E. He was swabbed at the hospital and as his observations were normal, he was sent home. However, 2 days later, he felt worse so he returned to the hospital and was admitted to a COVID red ward. He was treated with CPAP (continuous positive airway pressure) on the ward but he deteriorated and was therefore transferred to the critical care unit to be put on a ventilator.

Rhys was ventilated for 23 days. During this time he was unable to have a family member with him and though he had access to an iPad he was too unwell to use it. He remained in the unit for 36 days. Multi-disciplinary rehabilitation was limited in the unit and every session required 2-3 members of staff and these were not delivered at weekends. However, having worked with the physiotherapists when he left the unit Rhys could sit independently on the side of the bed.

Rhys was transferred to a COVID ward in the hospital. His rehabilitation continued with a new team staffing this area but interventions were limited as treatment could only be delivered within his room. Here he was treated by a physiotherapist and occupational therapist as Rhys had lost many skills and had to learn to speak, eat, dress himself and walk again. His rehabilitation was challenging as he was very weak and he fatigued very quickly. Rhys spoke to his family daily whilst on this ward using the ward iPad.

Once Rhys was medically fit and COVID-19 negative, he was transferred to a general medical ward where he received 8 days of rehabilitation by a different therapy team. Rhys went to 4 wards during his admission and was seen by many different staff members. He was discharged home to his wife and was walking with a wheeled zimmer frame.

At home Rhys was contacted over the telephone by the community therapists but no face to face rehabilitation was provided due to the lack of video facilities and that he did not meet the criteria for a urgent home visit. Rhys was not followed up in critical care patient support group, as they had no access to video facilities to continue these groups. Rhys did not have access to a structured rehabilitation programme.

## Section 10: Appendices

**Section 1: Looking Back**

**Section 2: Looking Out**

**Section 3: Looking In**



## Appendix 1 – Looking back

### Timeline of COVID-19 – High level medical insight

The timeline below shows some of the key events and decisions made in response to the pandemic at a UK and Wales level.

#### December 2019

- **31 December 2019**  
Coronavirus first reported in Wuhan, China.

#### January 2020

- **30 January 2020** WHO declares that COVID-19 is a Public Health Emergency of International Concern (PHEIC).
- **31 January 2020** **First UK coronavirus cases confirmed**

#### February 2020

- **1 February 2020** The UK Govt launches public information campaign *'Catch it, Bin it, Kill it'*.
- **28 February 2020** **Wales' first coronavirus case confirmed**

#### March 2020

- **3 March 2020** UK Government publishes Coronavirus action plan for the UK and devolved nations.
- **5 March 2020** **COVID-19 made a notifiable disease in Wales.**
- **11 March 2020** WHO declares COVID-19 a Pandemic.
- **12 March 2020** The UK moves into the delay phase. Risk to the UK moves from 'moderate' to 'high'.
- **13 March 2020** **WG announces the suspension of a number of NHS services including non-urgent outpatient appointments and non-urgent surgical admissions and procedures**
- **16 March 2020** updated advice around whole-household self-isolation
- **18 March 2020** **Schools close in Wales**
- **19 March 2020** The Coronavirus Bill 2019 - 21 is introduced in the House of Commons.
- **20 March 2020** Mandatory businesses closures.
- **23 March 2020** Mandatory closure of caravan parks, campsites and tourist hotspots
- **23 March 2020** **Lockdown commences.**
- 26 March 2020 relaxation of local authority duties relating to assessing and meeting needs for care and support.
- **27 March 2020** CVUHB announces that the Principality Stadium in Cardiff will become a temporary hospital to provide 2,000 extra beds to the NHS.
- **28 March 2020** **new coronavirus testing plan for Wales. This includes the introduction of a new antibody test**

## Appendix 1 – Looking back

### Timeline of COVID-19 – High level medical insight

#### April 2020

- **2 April 2020 Video consultation service made available to all GP practices in Wales.**
- **2 April 2020 Publication of UK-wide PPE guidance.**
- **13 April 2020** Additional £40m to support adult social care services during the coronavirus pandemic
- **18 April 2020** WG review of the coronavirus testing regime published.
- **19 April 2020** £6.3 million three-month package of additional support for hospices in Wales
- **24 April 2020** Revision of the ‘stay at home’ message.
- **24 April 2020** WG *Framework for Recovery* published
- **27 April 2020** COVID-19 Death in Service Scheme for NHS and social care frontline workers established in Wales.
- **28 April 2020 review of the mechanism for reporting COVID-19 deaths in Wales published.**
- **28 April 2020** UK government confirms UK is past the peak

#### May 2020

- **5 May 2020 WG Public Health Protection Response Plan published**
- **13 May 2020 WG testing strategy published**
- **16 May 2020** Care home residents and staff are able to access tests via the UK portal.
- **18 May 2020** coronavirus symptoms checker is updated to include loss of smell or taste.
- **18 May 2020** home testing kits made available via an online booking service.
- **9 May 2020 WG revises ‘stay at home’ to ‘stay local’**

#### June 2020

- **1 June 2020** WG two changes for people who are shielding exercise outdoors an unlimited number of times a day. Secondly, they can meet with another household outside
- **8 June 2020** The Health Protection (Coronavirus, International Travel) (Wales) Regulations 2020 come into force.
- **9 June 2020** WG recommend the use of three layer face coverings.

## Appendix 1 Looking back

### Learning from previous pandemics

#### Historical Influenza Pandemic Waves

A pattern of multiple waves, characterized all three 20th-century pandemics, each of which caused increased mortality for 2 to 5 years

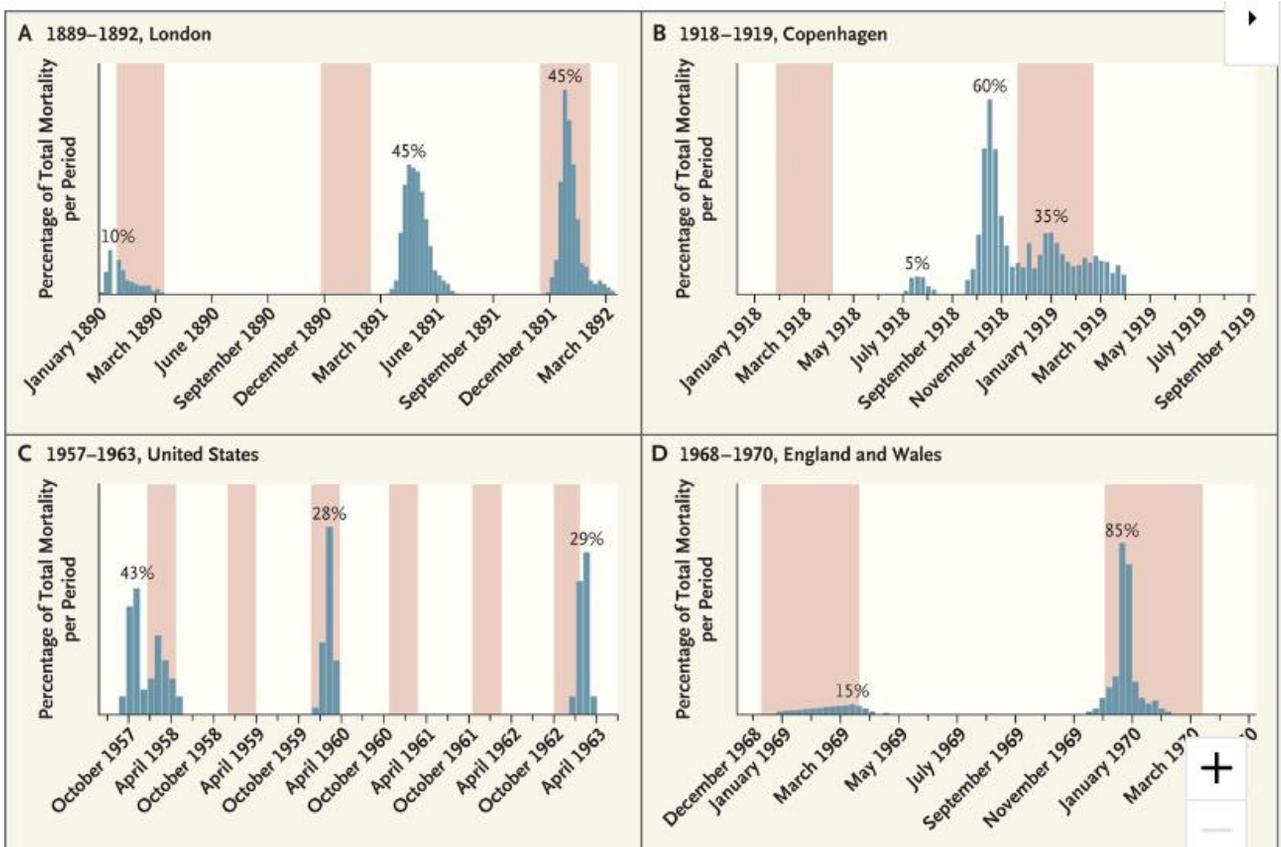
#### Mortality Distributions and Timing of Waves of Previous Influenza Pandemics.

Proportion of the total influenza-associated mortality burden in each wave for each of four previous pandemics is shown above the blue bars. Mortality waves indicate the timing of the deaths during each pandemic.

- **The 1918 pandemic (Panel B) had a mild first wave during the summer, followed by two severe waves the following winter.**
- **The 1957 pandemic (Panel C) had three winter waves during the first 5 years.**
- **The 1968 pandemic (Panel D) had a mild first wave in Britain, followed by a severe second wave the following winter.**

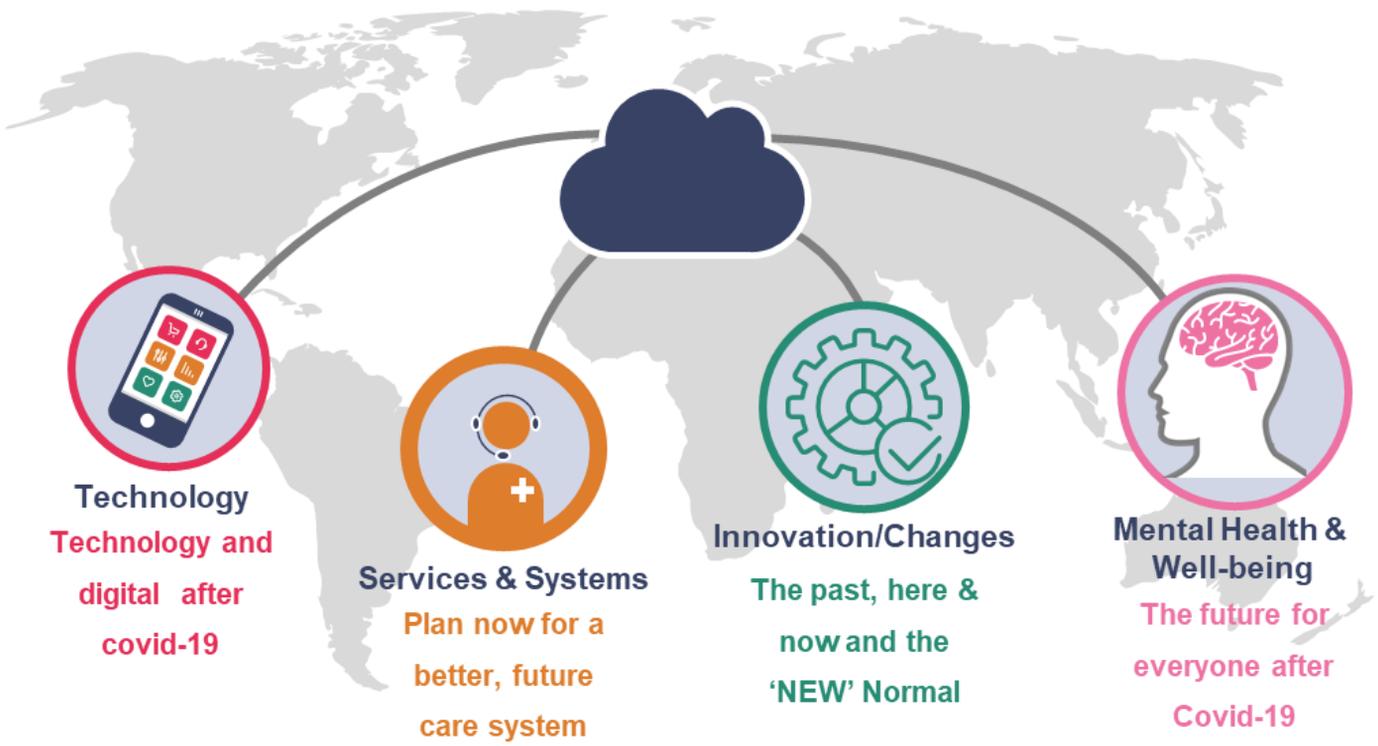
The shaded columns indicate normal seasonal patterns of influenza.

Read resource form the NEW ENGLAND JOURNAL of MEDICINE article [here](#)



## Appendix 2: Looking out

### Global learning



### Technology - Technology and digital after covid-19

- > **How Covid-19 is transforming telehealth - now and in the future**  
Read what the Advisory Board has to say [here](#)
- > **Secure messaging and virtual visits can act as “tele-triage” methods to help hospitals manage capacity**
  1. Actively promote telehealth services to patients
  2. Ensure the necessary technology is working properly
  3. Support frontline clinicians
- > **How COVID-19 shows the urgent need to address the cyber poverty gap**  
Read the World Economic Forum article [here](#)



Advisory Board presentation



## Appendix 2: Looking out

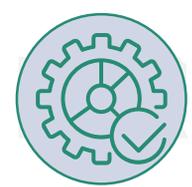
### Global Research



#### Services & Systems - Plan now for a better, future care system

- It's a dimmer switch, not an on/off switch.**

➤ **Restarting services won't happen all at once.**  
 Read the Advisory Board Blog [here](#)
- **NHS Reset: Reset, not just recovery | Niall Dickson**  
 Read this blog from the NHS Confederation [here](#)
- **NHS Reset: Time for the partnerships we always needed**  
 Read another NHS confederation blog [here](#)



#### Innovation / Changes The past, here & now and the 'NEW' Normal

- **Supporting analysts to share and collaborate in the crisis period and recovery**  
 Read the Health Foundation article [here](#)
- **Coronavirus scenario planning – 12 situations hospital leaders should prepare for.**  
 Read the Advisory Board research here [here](#)



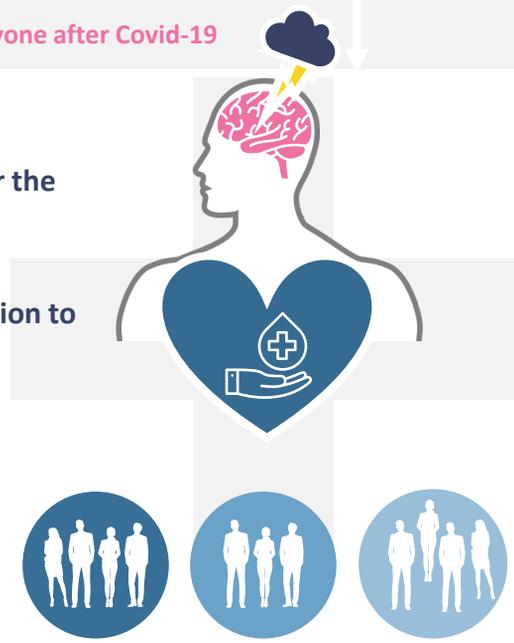
## Appendix 2: Looking out

### Global Research



### Mental Health & Well-being *The future for everyone after Covid-19*

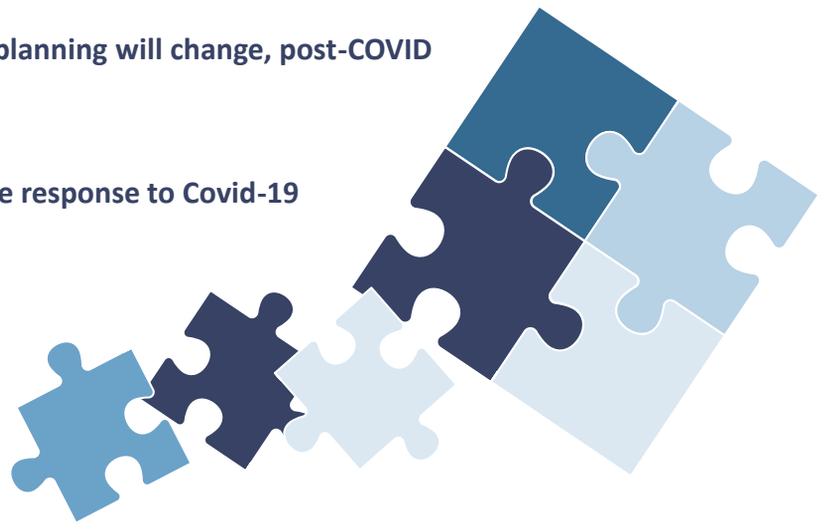
- > **A forward view: supporting mental health during and after the COVID-19 emergency.** Read the NHS Confederation article [here](#)
- > **Amid the upheaval of the pandemic, nurses can use reflection to process their experiences and improve practice.** Read the Nursing Standard article [here](#)
- > **We will need to understand the trauma that occurs in individuals and which affects populations, which will be experienced in different ways.** Read the NHS Confederation 5 principles [here](#)



### Vital Research covering other areas



- > **Recovery of surgical services during and after COVID-19** Read the article from the Royal College of the Surgeons of England [here](#)
- > **The 'new normal' – how strategic planning will change, post-COVID** Read the Advisory Board article [here](#)
- > **3 ways nursing leaders can lead the response to Covid-19** Read the Advisory Board article [here](#)



## Appendix 3: Looking in

### Clinical, operational and corporate engagement

#### Purpose of our engagement, and responses by area of business

The main purpose of this engagement was to find out if preparations for the COVID-19 pandemic resulted in changes and innovations upon which the organisation could build in expediting our health and care strategy, 'A Healthier Mid and West Wales'.

We had a short window of opportunity to learn from people's experiences whilst they were fresh in people's minds, and before many clinical services were reintroduced.

With this in mind, the Transformation Programme Office engaged with key leaders across the organisation through virtual one-to-one discussions and an online survey, resulting in 85 detailed interviews and responses (a 54% response rate) in the first 9 days.



Responses by Area of Business



- Medical
- Hospital managers and county
- Nursing
- Therapies and Health Science
- Pharmacy
- Corporate
- Partner Organisations
- Anonymous

(\*Anonymous responses have not been included in this analysis. Responses with input more than one person were counted as one response.)



[Link to staff videos](#)

## Appendix 3: Looking in

The questions we asked, both in our virtual discussions and our online questionnaire, were based on the proforma below:

### LOOK BACK

- What has worked well & why? How can we prioritise, embed and strengthen?
- What didn't work & why? What needs to change in future to make sure this doesn't happen again?
- What is the impact of suspended and or scaled back services?

### IMPACT ON DESIGN ASSUMPTIONS

- |  |  |
|--|--|
| <ul style="list-style-type: none"> <li>➤ <b>Site changes</b> - Has your recent experience enabled you to provide different services across sites?</li> <li>➤ <b>Admission avoidance</b> - Is a 40% reduction to levels of emergency admissions for ACS conditions ambitious enough?</li> <li>➤ <b>Length of Stay</b> – Have you seen any changes that has reduced length of stay?</li> <li>➤ <b>Are the following statements ambitious enough?</b></li> <li>➤ <b>Outpatient change</b> – 25% reduction in follow up outpatients appointments</li> <li>➤ <b>A&amp;E MIU change</b> – 4.3% reduction in overall level of A&amp;E &amp; MIU attendance</li> </ul> | <ul style="list-style-type: none"> <li>➤ <b>A&amp;E to MIU presentations</b> – 30% attendances presenting at A&amp;E will present at MIUs instead</li> <li>➤ <b>Acute to community step-down beds</b> – 50% of patients will step down to a community bed within 72 hours of admission</li> <li>➤ <b>Acute to community step-down</b> – outpatients – 90% new and follow-up appointments will take place in a community setting.</li> <li>➤ <b>Daycase community hub shift</b> – 50% daycases for medical specialities will take place in a community setting</li> </ul> |
|--|--|

### FORWARD LOOK

- Has our experience impacted on our future care model? (consider services within community, acute (new vs. re-purposed), primary etc)
- What do we want services to look like longer term?
- What do we no longer need?
- What needs to shift dramatically?
- What gaps still need to be filled?

### CULTURE

- What have you noticed that has been different about working with your colleagues in these times?
- Have you noticed or experienced any changes to your role or those of other professionals, health care staff working around you?
- What has been the one best thing about working together through this experience that you would want to take forward?
- Do you have any ideas in relation to how the Health Board supports staff well-being longer term?
- Has there been some great learning for a) you personally? b) your team? c) Hywel Dda?

## Appendix 3: Looking in

### How we analysed the responses

#### Thematic analysis

We used a version of **Braun and Clarke’s 6-step framework for Thematic Analysis** to analyse the responses to our conversations and online questionnaire.

Thematic analysis is widely used in a variety of contexts to analyse qualitative data. This approach usually involves peer reviewing and triangulating potential themes with colleagues, and asking whether the themes make sense in the overall context of what we heard and read. This makes it a robust approach, and prevents us jumping to conclusions about key themes based on our own assumptions.



Most team members were involved in the analysis, and checked their understanding of the results with each other before reporting back on the key themes.

The team has undertaken initial analysis of the results (shown below), and is now undertaking more detailed analysis of the responses. This will be included in the final discovery report.

## Appendix 3: Looking in

### Themes – WHAT WORKED WELL

<b>COMMON VISION &amp; SHARED GOALS</b>	<ul style="list-style-type: none"> <li>• One clear goal, re. COVID preparation and management</li> <li>• Clear roles and responsibilities</li> </ul>
<b>RESTRUCTURING SERVICE DELIVERY</b>	<ul style="list-style-type: none"> <li>• Locality hub and spoke model – IV antibiotics (ART)</li> <li>• 7 day a week services – e.g. Community mental health</li> <li>• PPH phlebotomy, transferred to community</li> <li>• District nursing</li> </ul>
<b>TECHNOLOGY ENABLED CARE</b>	<ul style="list-style-type: none"> <li>• Use of new patient platforms e.g. virtual fracture clinic &amp; attend anywhere</li> <li>• Smart phone assessment</li> <li>• Telephone consultations</li> </ul>
<b>WORKING DIGITALLY</b>	<ul style="list-style-type: none"> <li>• Connecting through MS teams on multi-agency basis</li> <li>• Remote working, less paper, less travel</li> </ul>
<b>EMPOWERMENT &amp; AUTONOMY TO ACT</b>	<ul style="list-style-type: none"> <li>• Local decisions by local teams</li> <li>• Empowered to make decisions &amp; introduce changes</li> <li>• Quicker procurement routes</li> <li>• Ownership of risk, not corporate management of risk</li> </ul>
<b>WORKFORCE FLEXIBILITY &amp; 'CAN DO' CULTURE</b>	<ul style="list-style-type: none"> <li>• Daily rounds</li> <li>• Working outside role boundaries</li> <li>• Flexible &amp; responsive staff rotas e.g. medical</li> <li>• Senior clinical decision makers early in the pathway</li> </ul>
<b>RESTRUCTURED PATHWAYS</b>	<ul style="list-style-type: none"> <li>• ED streaming</li> <li>• Admission avoidance e.g. Blue team</li> <li>• Specialty changes (ophthalmology)</li> <li>• Early supported discharge</li> </ul>
<b>CLEAR DECISION MAKING STRUCTURES</b>	<ul style="list-style-type: none"> <li>• Bronze problem solving with quick decision making</li> <li>• Daily MDT &amp; stakeholder meetings</li> <li>• Short and focused discussions</li> </ul>
<b>CHANGING PUBLIC BEHAVIOUR</b>	<ul style="list-style-type: none"> <li>• Self – management</li> <li>• Reduced service demand, reduced attendance at sites</li> </ul>
<b>INTEGRATED, COLLABORATIVE, PARTNERSHIP WORKING &amp; CAMARADERIE</b>	<ul style="list-style-type: none"> <li>• Streamlined pathway between primary care, community (inc. local authority) and acute</li> <li>• Working across traditional boundaries and sectors, breaking down silos</li> <li>• Corporate teams supporting operational teams</li> </ul>

## Appendix 3: Looking in

### What respondents told us about the strategic ENABLERS

<b>FINANCE</b>	<ul style="list-style-type: none"> <li>Transformation was clinically led and need driven rather than constrained by finance</li> <li>Budgetary constraints on issuing IT equipment had been removed</li> </ul>
<b>PROCUREMENT</b>	<ul style="list-style-type: none"> <li>Learning from Field Hospitals showed need for single point of contact (hub and spoke model)</li> </ul>
<b>WORKFORCE AND OD</b>	<ul style="list-style-type: none"> <li>Different roles embedded in MDTs and skill mixing improved decision making</li> <li>Working across teams, sectors, directorates enabled problem-solving</li> <li>Agile and flexible working</li> </ul>
<b>DIGITAL</b>	<ul style="list-style-type: none"> <li>Positive impacts on clinical ways of working</li> <li>Positive impacts on workforce, home working</li> </ul>
<b>WORKFORCE FLEXIBILITY &amp; 'CAN DO' CULTURE</b>	<ul style="list-style-type: none"> <li>Daily rounds</li> <li>Working outside role boundaries</li> <li>Flexible &amp; responsive staff rotas e.g. medical</li> <li>Senior clinical decision makers early in the pathway</li> </ul>
<b>CAPITAL, ESTATES, INFRASTRUCTURE, PLANNING</b>	<ul style="list-style-type: none"> <li>Swift in meeting operational requirements</li> </ul>
<b>DATA, INFORMATICS AND MODELLING</b>	<ul style="list-style-type: none"> <li>Developing an ITU step down model</li> <li>Streaming at the front door</li> <li>Modelling patient flows across hospital / community</li> <li>Better dialogue – swifter access to diagnostic results</li> </ul>
<b>CONTINUOUS ENGAGEMENT, DIVERSITY, AND INCLUSION</b>	<ul style="list-style-type: none"> <li>No respondents mentioned these areas specifically as enablers</li> <li>However, people appreciated being involved in this timely engagement, and wanted this to continue</li> </ul>
<b>CONTINUOUS IMPROVEMENT</b>	<ul style="list-style-type: none"> <li>New ways of working ultimately led to greatest improvements: decisions being clinically led, simpler governance, short daily meetings, swifter decisions</li> </ul>
<b>RESEARCH AND DEVELOPMENT</b>	<ul style="list-style-type: none"> <li>Recent studies had stopped – focus on COVID</li> <li>Rapid testing of innovations rather than waiting for authorisation</li> </ul>
<b>GOVERNANCE, LEGAL AND RISK</b>	<ul style="list-style-type: none"> <li>Devolving leadership to teams – staff development</li> <li>More effective, efficient decision making</li> <li>Freedom to act within a framework</li> <li>More emphasis on individual accountability</li> </ul>

## Appendix 3: Looking in

### Qualitative Analysis – What worked LESS well

<b>LIMITED STRATEGIC PLANNING</b>	<ul style="list-style-type: none"> <li>• Not bringing care homes into the planning early enough</li> <li>• Not enough focus on long term workforce planning</li> </ul>
<b>KNEE JERK</b>	<ul style="list-style-type: none"> <li>• Stopped too many standard / routine services e.g. diagnostics</li> <li>• Slow to plan re-start</li> <li>• Standard training stopped – risk of skills impact</li> </ul>
<b>PAPER-BASED SYSTEMS</b>	<ul style="list-style-type: none"> <li>• Not all patient records are available electronically</li> <li>• Access to information across whole system</li> </ul>
<b>JOINED UP WORKFORCE PLANNING</b>	<ul style="list-style-type: none"> <li>• Limited frontline involvement in recruitment &amp; staff allocation</li> <li>• Limited capacity to support training of new &amp; existing staff in parallel</li> <li>• Rapidly undertake training of staff in core skills</li> </ul>
<b>ACCESS &amp; BENEFIT OF TECHNOLOGY ROLL-OUT</b>	<ul style="list-style-type: none"> <li>• Lack of access to laptops, smart phones, headsets, tokens, webcams</li> <li>• Lack of clinically led, joined up digital roll out plan</li> <li>• Home workers need adequate equipment</li> </ul>
<b>DATA</b>	<ul style="list-style-type: none"> <li>• Lack of access to real time data projections</li> <li>• Planning based on out-dated data</li> </ul>
<b>WORKFORCE PRESSURES</b>	<ul style="list-style-type: none"> <li>• Highlighted under-resourced teams</li> <li>• Gaps in community resources across health and social care</li> </ul>
<b>CONTROLS &amp; DUE DILIGENCE</b>	<ul style="list-style-type: none"> <li>• Risk of unchecked maverick behaviour</li> <li>• Risk of retrospective patient concerns and claims</li> <li>• Usual governance mechanisms for BAU disappeared</li> </ul>
<b>COMMAND &amp; CONTROL</b>	<ul style="list-style-type: none"> <li>• Disconnect between Gold decision and Bronze / frontline delivery</li> <li>• Bronze groups didn't connect on all key issues - parallel meetings reliant on Bronze chairs</li> </ul>

## Appendix 3: Looking in

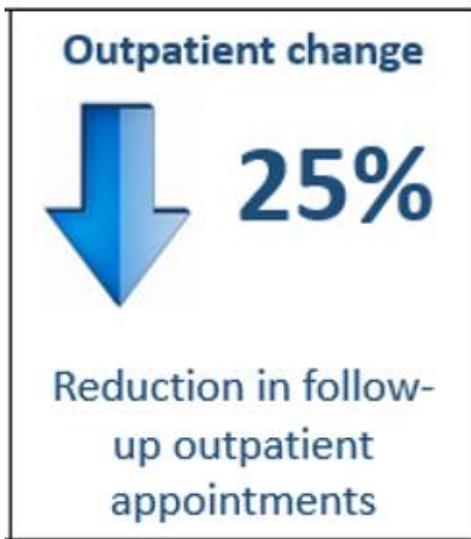
### Themes – CAPTURING LEARNING AND MEASURING RESULTS

<b>THE UNKNOWNNS</b>	<ul style="list-style-type: none"> <li>• We don't yet know the impact of service changes</li> <li>• We don't know how changes to services look from a patient's perspective</li> <li>• We haven't engaged with front line staff / managers</li> </ul>
<b>TIME TO THINK AND PLAN</b>	<ul style="list-style-type: none"> <li>• Services suspended and stopped: gave teams time to think more strategically and plan their services more effectively</li> <li>• Staff want to continue to have some 'time to think'</li> </ul>
<b>PROTECTED TIME TO REFLECT AND LEARN</b>	<ul style="list-style-type: none"> <li>• People appreciated having 'protected time to reflect'</li> <li>• Continue to give staff time to reflect on their experiences and share them with wider organisation</li> <li>• Need to capture staff stories</li> </ul>
<b>CONTINUOUS STAFF ENGAGEMENT</b>	<ul style="list-style-type: none"> <li>• The need for continuous engagement with staff</li> <li>• Follow up this engagement with further interviews / surveys to find out what has changed</li> <li>• Need true engagement – not just paper / online</li> </ul>
<b>PATIENT EXPERIENCE</b>	<ul style="list-style-type: none"> <li>• Need to find out the impact of service changes / innovations on patients</li> <li>• Patient experience / patient satisfaction surveys</li> </ul>
<b>PROMs and PREMs</b>	<ul style="list-style-type: none"> <li>• Better use of Patient Reported Outcome Measures and Experience Measures to assess outcomes and benefits for patients</li> <li>• People need to better understand PROMs and PREMs</li> </ul>
<b>RESEARCH AND AUDIT</b>	<ul style="list-style-type: none"> <li>• Need to use multiple sources of audit to measure impact, outcomes, benefits of changes</li> <li>• Qualitative and quantitative research</li> </ul>
<b>FEEDBACK</b>	<ul style="list-style-type: none"> <li>• Seek 360 degree feedback, internal and external</li> <li>• General theme that we need rounded feedback, to understand performance from all perspectives</li> </ul>
<b>PERFORMANCE METRICS</b>	<ul style="list-style-type: none"> <li>• Strong theme: the need to use waiting times / lists to measure benefits of innovations</li> <li>• Other measures such as care home admissions, therapy outcomes, staff productivity</li> </ul>

## Appendix 3: Looking in

### Themes – DESIGN ASSUMPTIONS

Reporting on the design assumptions has only been undertaken where the data was statistically significant



Enablers to realising the reduction:

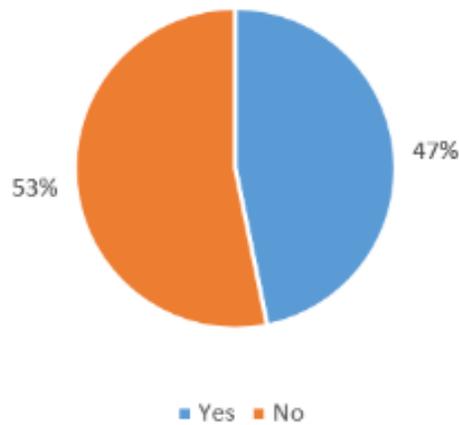
**PRIORITISATION BY BIGGEST IMPACT**

**ACCESSIBILITY TO SUPPORT**

**VIRTUAL MONITORING**

**PRIMARY CARE SUPPORTING FOLLOW UPS**

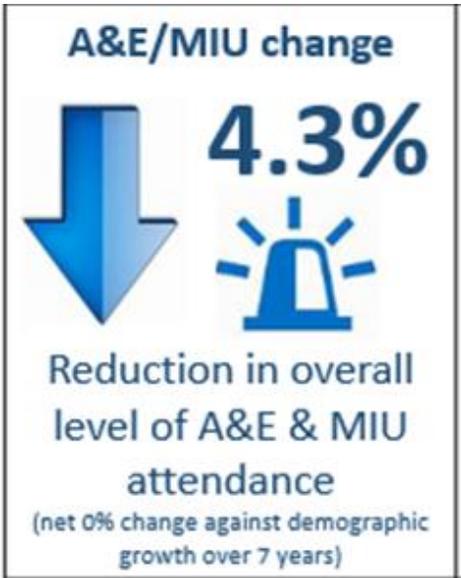
Is a 25% reduction in follow up outpatient appointments ambitious enough?



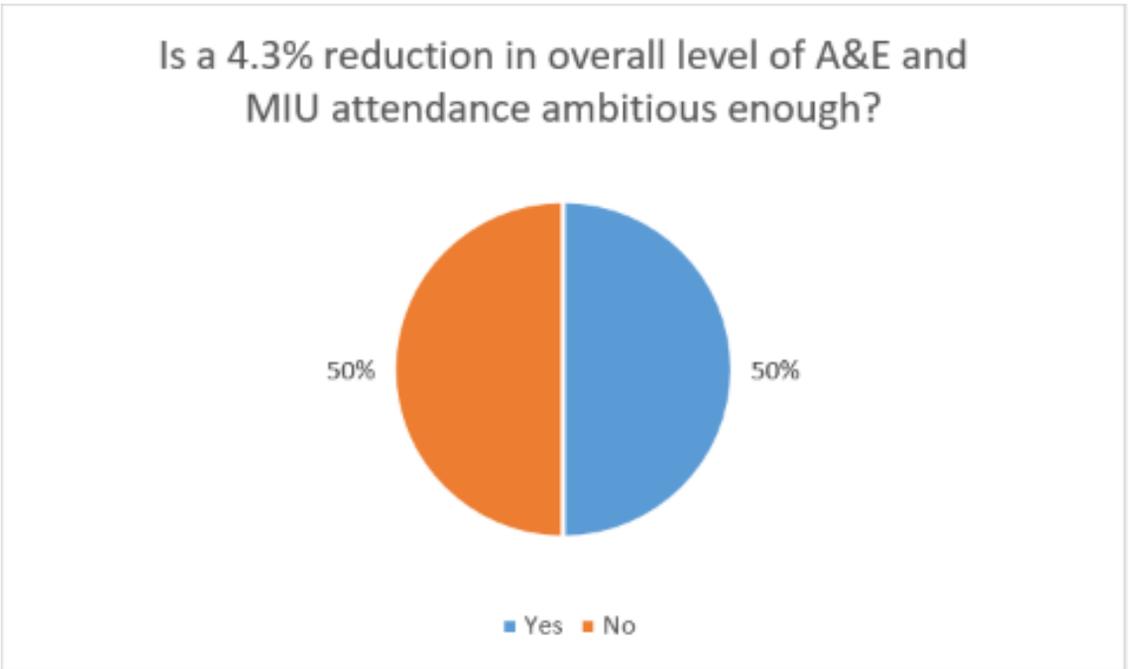
## Appendix 3: Looking in

### Themes – DESIGN ASSUMPTIONS

Reporting on the design assumptions has only been undertaken where the data was statistically significant



- Enablers to realising the reduction:
- INNOVATION IN AVOIDING ADMISSIONS
  - POPULATION HEALTH MESSAGING
  - REINFORCING MESSAGES ON SERVICES
  - REDUCE FAILURE DEMAND IN SYSTEM



## Appendix 3: Looking in

### Themes – WHAT PEOPLE WANT MORE OF / WHAT NEEDS TO CONTINUE

<b>INTEGRATED SERVICES</b>	<ul style="list-style-type: none"> <li>• Corporate services supporting operational services (co-location)</li> <li>• Continuing access to specialists and advice, whether clinical or corporate</li> </ul>
<b>CONTINUING AUTONOMY</b>	<ul style="list-style-type: none"> <li>• Decisions about services continue to be clinically led</li> <li>• Empower Triumvirates</li> <li>• Culture shift: from top-down to bottom-up</li> <li>• Governance to enable swift decision making</li> </ul>
<b>PROTECTED TIME TO REFLECT AND LEARN</b>	<ul style="list-style-type: none"> <li>• Continue to use new patient platforms, virtual consultations / follow-ups</li> <li>• Need a 'digital transformation' of services – build on recent innovations</li> </ul>
<b>WORKING DIGITALLY</b>	<ul style="list-style-type: none"> <li>• Build on recent experience / innovations</li> <li>• Better IT infrastructure, equipment, and parity across teams and sites</li> </ul>
<b>WORKING TO CLEAR GOALS</b>	<ul style="list-style-type: none"> <li>• Working to a small number of clear, common goals</li> <li>• Clarity from Executives</li> <li>• Clinical agreement on priorities</li> </ul>
<b>WHOLE SYSTEM APPROACH</b>	<ul style="list-style-type: none"> <li>• Whole system approach to service delivery</li> <li>• Acute, primary and community care</li> <li>• 'Whole hospital approach' to transformation</li> <li>• More community resources needed</li> </ul>
<b>STANDARDISED PATHWAYS</b>	<ul style="list-style-type: none"> <li>• Establish standardised pathways across sites</li> <li>• Sites continue to support each other</li> <li>• Ability to discharge patients at pace</li> </ul>
<b>INVEST TO SAVE</b>	<ul style="list-style-type: none"> <li>• Take 'invest to save' and a long-term view to budgeting and allocating resources</li> <li>• Need adequate resourcing</li> </ul>
<b>MDT WORKING</b>	<ul style="list-style-type: none"> <li>• Continued MDT working with access to specialist advice</li> </ul>
<b>WORKING CULTURE</b>	<ul style="list-style-type: none"> <li>• Support home working</li> <li>• Improved communications between different roles</li> <li>• We need new ways of working to build on what worked well during COVID</li> </ul>

## Appendix 3: Looking in

### Themes – WHAT PEOPLE WANT LESS OF / WHAT NEEDS TO CHANGE

<b>FACE TO FACE</b>	<ul style="list-style-type: none"> <li>• Less face to face consultations / follow-ups</li> <li>• Smaller cohorts of patients will continue to need face to face – need to review this</li> </ul>
<b>GOVERNANCE</b>	<ul style="list-style-type: none"> <li>• Less committee-based decision-making</li> <li>• Less use of long reports, SBARs</li> <li>• Less bureaucracy, red tape</li> <li>• Fewer meetings without a clear purpose</li> <li>• ‘We are over-governed’</li> </ul>
<b>RECORD KEEPING</b>	<ul style="list-style-type: none"> <li>• Less paper based systems</li> </ul>
<b>ESTATES</b>	<ul style="list-style-type: none"> <li>• Estates need to be reviewed</li> </ul>
<b>SILO WORKING</b>	<ul style="list-style-type: none"> <li>• Silo working between different departments / specialities, but also corporate / operational</li> </ul>
<b>REVIEW AND RESTRUCTURE</b>	<ul style="list-style-type: none"> <li>• Several areas of work mentioned as needing review and / or restructure, following changes due to COVID preparedness</li> </ul>
<b>TRAVEL</b>	<ul style="list-style-type: none"> <li>• Less travel to work, travel to appointments</li> </ul>
<b>PARKING</b>	<ul style="list-style-type: none"> <li>• With less travel to work / appointments, less use of hospital car parks</li> </ul>



“Safe, Sustainable, Accessible and Kind”

## Appendix 3: Looking in

### Questions emerging from our Engagement

**We asked people whether the changes and innovations they had described should be implemented for the longer term, and if so how soon (immediately / within 6 months / 12 months / 1 year / 2 years)?**

**The majority of respondents said that changes should be embedded immediately.**

*Q, How can we make it easier for people to continue introducing new changes and innovations to their practice?*

*Q, How can we make it easier for services to embed changes and innovations for the longer term?*

**One of the strong themes in our engagement was that people appreciated having the autonomy and freedom to make decisions within the framework of the command structure, and that this led to efficient and effective decision making.**

**People told us that decisions about services were ‘clinically led and need-driven’, and benefited from having a lighter tough governance structure in place, without the need to submit detailed reports and wait for decisions to be approved.**

*Q, How can we ensure that decisions about changes and innovations continue to be clinically led?*

*Q, How can our governance structures continue to support effective and efficient decision making in the longer term?*

**When we asked people how the working culture had changed**

**people told us that staff felt empowered to ‘just get on and do’.**

*Q, How do we maintain and enhance this culture of empowerment?*

**People told us how much they appreciated being listened to during this engagement exercise – having protected time to reflect on what they had learnt over the past months, and feeding that back.**

*Q, What do we need to put in place to continue learning from staff experience, and how can we make it easy for staff to share that learning?*

## Appendix 3: Looking in

### Questions emerging from our Engagement

**A large proportion of respondents told us that what worked really well – what brought staff and teams together – was working to one clear, common goal.**

**Clearly, the organisation does not work to only one goal or objective. However ...**

*Q, How can we create a smaller number of clear goals for our workforce?*

*Q, How can we sustain the sense of working towards a common goal?*

**Respondents noted the change in the behaviour of the public during COVID – we saw less people using services.**

**What we do not yet know is whether this change in behaviour was motivated by fear, or a wish to protect the NHS, or other reasons.**

*Q, What steps can we take to understand the reasons behind this change of behaviour?*

*Q, How can we use this change in behaviour as an opportunity to educate the public about appropriate use of NHS services?*

**Technology was cited as one of the main enablers of positive changes.**

**Technology enabled both changes to how we deliver services, and to how we work with each other (working remotely).**

*Q, How can we continue to support the digital roll-out?*

**People told us that staff had worked in a 'flexible and adaptive' way' throughout COVID**

*Q, How can we embed these new ways of working into our working culture?*

## Appendix 3: Looking in

### Service Changes

#### Welsh Government - Quarter One Plan – New Ways of Working

<b>PRIMARY CARE</b>	<ul style="list-style-type: none"> <li>• 46 out of the 48 GP Practices have Attend Anywhere “live” and in use</li> <li>• E-Consult is in place in 75% of practices</li> </ul>
<b>COMMUNITY</b>	<ul style="list-style-type: none"> <li>• Remote Oxymetry Monitoring (virtual ward). High risk COVID patients cared for in the community. A ‘virtual ward’ clerk coordinates referrals &amp; virtual ward doctors’ rota provide 24/7 monitoring</li> </ul>
<b>OUTPATIENTS</b>	<ul style="list-style-type: none"> <li>• Pursuing options to implement virtual review and looking at methods to reduce both acute site visits and a firm reduction in face 2 face consultations going forward.</li> </ul>
<b>DIGITAL</b>	<p>Testing, Implementation and Evaluation of:</p> <ul style="list-style-type: none"> <li>• Microsoft Teams, Attend Anywhere, Dr Doctor, Patient Knows Best, Consultant Connect</li> </ul>
<b>ACUTE CARE</b>	<ul style="list-style-type: none"> <li>• ED streaming systems</li> <li>• Admission avoidance – new clinical communications systems</li> <li>• Red &amp; Green sites</li> <li>• Digital technology to aid patient &amp; family communications</li> <li>• Virtual board rounds &amp; MDT discussions</li> <li>• Staff well-being areas and support sessions;</li> <li>• Redirection of pathways to support opening of CPAP designated &amp; COVID wards</li> <li>• Acute medical staff outreach support to care homes</li> <li>• Establishment of PPE hubs</li> <li>• Structured daily clinical handover &amp; briefing sessions</li> <li>• GP led virtual wards</li> <li>• Clinical management of patients led by Specialist Respiratory team,</li> <li>• Early enrolment onto national therapeutic research trials</li> <li>• Delivery of enhanced skills training for registered nurses and HCSW staff</li> <li>• Clinical Nurse Specialists to support the delivery of dedicated training</li> <li>• Full rota changes for medical staff to enable 24hr cover</li> </ul>

## Appendix 3: Looking in

### Service Changes

#### Community Health Council – Service Change Tracker Engagement with patients and the public on key areas, needed as part of our engagement plan

##### PRIMARY CARE

- Telephone consultations only and telephone triage. Face-to-face appointments only confirmed after an initial telephone or video consultation.
- E-consultations
- Some branch surgeries closed
- Local Assessment Centres - made up of healthcare professionals already working in the local community and GP practices

##### COMMUNITY

- Temporary Llandovery hospital MIU closure
- Llandovery hospital bed increase to manage patients
- Antioch Centre Phlebotomy service closed
- Community pharmacies - some patients may have a telephone consultation before attending.
- Suspension of routine dentistry service
- Suspension of routine optometry services
- Intermediate Care/ Co-ordination hub (Pembrokeshire)
- Pembrokeshire District nursing hub
- Palliative care – HB working with third sector

##### ACUTE CARE

- Routine outpatient appointment cancellations
- Routine elective surgery cancellations.
- Some delays in some cancer treatments
- Phlebotomy services at PPH closed to the community
- Some screening stopped (Breast, cervical, AAA, diabetic eye, bowel)
- Some cancer operations being done in Werndale
- Urgent only diagnostics are being undertaken
- Radiologists - Requests reviewed/triaged by Radiologists.
- Urgent and Cancer work is continuing.
- Urgent ENT cover (GGH only).
- Health visiting – immunisations
- Pathology - Point of Care Testing (POCT): staff are supporting an increased demand for POCT analysers in both acute and Field hospital locations, including staff training
- OOH - functioning as per rationalised model in winter plan. Clinicians triaging 80% of activity via the phone. Procurement of video consultation equipment to further reduce face to face activity
- Launch of a new CD service, meaning improved access to controlled drugs in the OOH period across the entirety of the HB.

## Appendix 3: Looking in

### Changes to Mental Health and Learning Disabilities

#### MHLD – New Ways of Working

<p><b>Older Adult MH</b></p>	<ul style="list-style-type: none"> <li>• Collapse of Memory Assessment Service into Older Adult CMHT to provide 7 day a week service, all referrals (both services) come to a single point of entry and are triaged/risk assessed for urgency and safety.</li> <li>• Development of new algorithm for triage of new referrals into OAMH services.</li> </ul>
<p><b>S-CAMHS</b></p>	<ul style="list-style-type: none"> <li>• S-CAMHS Crisis and Assessment Team has been identified as a critical service and has been strengthened.</li> <li>• The Early Intervention Psychosis (EIP) service has been reconfigured to provide a 7-day service and is working alongside the S-CAMHS Crisis Team</li> </ul>
<p><b>Learning Disabilities</b></p>	<ul style="list-style-type: none"> <li>• The CTLD service is providing virtual support for its service users. The intensity of virtual support is increased for higher risk individuals, with face-to-face capacity for those who require it pending risk assessment.</li> <li>• CTLD undertake welfare calls to keep in touch with patients and ensure they are remaining well.</li> </ul>
<p><b>ADULT MH/MHLD Directorate</b></p>	<ul style="list-style-type: none"> <li>• A jointly run Health Board and third sector soft 136 suite/alternative place of safety developed and operational in Aberystwyth, Ceredigion. An additional soft 136 is currently in development for Haverfordwest, Pembrokeshire</li> <li>• Co-location of Adult Mental Health Crisis Resolution Teams (CRTs) and Community Mental Health Teams (CMHTs) in Haverfordwest, Carmarthen to ensure these CMHTs are operational 7 days a week, on a 9am-5pm basis. CRTs remain 24/7. Gorwelion in Aberystwyth had merged teams and provided 7-day week cover prior to COVID -19 developments.</li> <li>• NHS Liaison COVID 19 service in development. A senior nurse manager has been recruited to lead the service that will aim to provide a single cross age/speciality liaison team with a single point of referral. The team will support DGHs, field hospitals and is scoping out the need to liaise with residential placements for bespoke packages of care for MHLD service users.</li> <li>• A conveyance scheme to support service users to and from inpatient settings has been developed and is now operational. It is anticipated the scheme will support inpatient flow and add capacity to workforce.</li> <li>• Clinical Coordinator posts expedited and are now providing nursing care and clinical coordination out of hours, seven days per week.</li> </ul>



Bwrdd Iechyd Prifysgol  
Hywel Dda  
University Health Board



# Hywel Dda University Health Board

## Annual Quality Statement

2019 to 2020

13<sup>th</sup> May 2020

# Bwrdd Iechyd Prifysgol Hywel Dda

## Datganiad Ansawdd Blynyddol

2019 i 2020

13 Mai 2020



**Mandy Rayani**  
Director of Nursing, Quality & Patient Experience



Standard for Health  
Health Research Authority  
Approved 15th March 2018  
Approved 15th March 2018

1000 LIVES  
O FFWYDIAU





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Bwrdd Iechyd Prifysgol  
Hywel Dda  
University Health Board

# *Ein Datganiad Ansawdd Blynyddol* **Our Annual Quality Statement**

## Ein cyfle

- i rannu gwybodaeth â chi ar lle yr ydym arni i sicrhau bod ein gwasanaethau yn diwallu anghenion lleol ac yn bodloni safonau uchel

## Our opportunity

- to share with you what we are doing to ensure that our services are meeting local needs and meeting high standards



Stand for Good  
Small logo with text





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# Themâu'r Datganiad Ansawdd Blynyddol

## *The Annual Quality Statement Themes*

**Staying Healthy** – how we ensure that people in Hywel Dda are well informed to manage their own health and wellbeing.

**Safe Care** – how we ensure that people in Hywel Dda are protected and supported from harm and supported to protect themselves from known harm.

**Effective Care** – the arrangements we have in place for people in Hywel Dda to receive the right care and support as locally as possible and are enabled to contribute to making that care successful.

**Dignified Care** – how we make sure people in Hywel Dda are treated with dignity and respected and treat others the same.

**Timely Care** – the arrangements we have to ensure that people in Hywel Dda have timely access to services based on clinical needs and are actively involved in decisions about their care.

**Individual Care** – how we treat people in Hywel Dda as individuals, reflecting their own needs and responsibilities.

**Staff and Resources** – the information we have available for people in Hywel Dda to understand how their NHS is resourced and make clear how we make careful use of them.



Stardd Iechyd  
Local Health Board  
Hywel Dda



# Cadw'n Iach

# Staying Healthy

## Priorities Areas - a few examples

- **Flu vaccination** – increased the number of flu vaccinations provided in Community Pharmacies – 9,368 vaccines administered
- **Smoking rates in pregnancy** – reduced the smoking rates in pregnancy – 67% of women gave up smoking during pregnancy

## Quality stories – a few examples

- **The Dream Team** – engagement with adults with learning disabilities to improve the advice and support available and also to work in collaboration on transformation of services



# Gofal Diogel

# Safe Care

## Priorities Areas - a few examples

- **Community NEWS tool** – launched a new National Early Warning Score (NEWS) tool for use in the community and GP practices to improve early recognition and treatment of sepsis
- **Pressure damage** – continued our commitment to reduce the number of incidences of avoidable pressure damage. Celebrating Teifi Ward achieving more than 120 days without a hospital-acquired pressure damage

## Quality stories – an example

- **Patient Safety Team of the Year Finalists** – recognised for our work to drive forward patient safety culture agenda through a programme of initiatives



## Gofal Effeithiol

## Effective Care

### Priorities Areas - a few examples

- **Quality of care and treatment plans** – established a programme of ongoing review of care and treatment plans in Mental Health and Learning Disabilities
- **Programmes of transformation** – integrated community network, health and well-being centres, hospital network, mental health and learning disability care and support network

### Quality stories – an example

- **Faecal Microbiota Transplant** – a new treatment for relapsing cases of *Clostridium difficile* infection



## Gofal Urddasol

## Dignified Care

### Priorities Areas - a few examples

- **Collaborative projects to improve communication** – collaborative care model for older people with a mental health and medical presentation

### Quality stories – example

- **My Charter** - our pledge to do what we can to ensure people with learning disabilities have the same rights and choices as everyone else.
- **Dignified day surgery** – ensuring dignified care is provided for transgender patients listed for planned surgery.

*My Charter pledge*



## Gofal Amserol

## Timely Care

### Priorities Areas - a few examples

- **Access to ophthalmology care** – introduction of an Optometry Cataract Enhanced Referral Programme
- **Waiting times for outpatient** – introduction of a digital platform to enable appointment via mobile phone or laptop

### Quality stories – examples

- **Twilight Sanctuary** – a ground breaking out of hours mental health service for adults in Llanelli.
- **Cardigan integrated care centre** – a modern, fit for purpose healthcare service including a GP practice, dental service and pharmacy



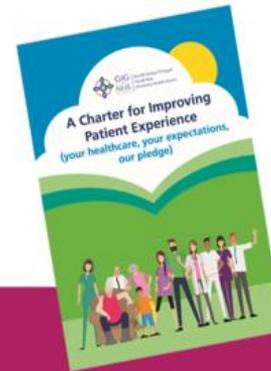
Noddfa Gyda'r Hwyr Llanelli

# Gofal Unigol

# Individual Care

## Priorities Areas - a few examples

- **Charter for improving patient experience** – your healthcare, your experience, our pledge



If it matters to you  
- it matters to us.

We are listening.



- **Welsh Language Standards** – preparing our staff

## Staff ac Adnoddau

## Staff and Resources

### Priorities Areas - a few examples

- **Aspiring Medical Leaders Programme** – focussing on real time organisational learning
- **Health Care Apprentice Programme** – becoming a registered nurse through work-based learning
- Our staff being honoured with **various awards**.



# *Rhai o'r blaenoriaethau allweddol ar gyfer 2020/21*

## Some of the key priorities for 2020/21

<b>Cadw'n iach</b> <b>Staying Healthy</b>	<b>Gofal Diogel</b> <b>Safe Care</b>	<b>Gofal Effeithiol</b> <b>Effective Care</b>
<p>Improve our population health and wellbeing by:</p> <ul style="list-style-type: none"> <li>• increasing the uptake of immunisations and vaccinations</li> <li>• increasing access to smoking cessation services.</li> </ul>	<p>Further develop the quality dashboard to enable Team to Board reporting</p> <p>Focus improvement activity on avoidable harm such as hospital acquired thrombosis, pressure damage, sepsis management and antimicrobial stewardship, in line with our organisational quality and safety priorities</p>	<p>Refresh our Quality Improvement Framework to reflect the progress made and the learning to come from it</p>

# Rhai o'r blaenoriaethau allweddol ar gyfer 2020/21

## Some of the Key priorities for 2020/21

<b>Gofal Urddasol</b> <b>Dignified Care</b>	<b>Gofal Amserol</b> <b>Timely Care</b>	<b>Gofal Unigol</b> <b>Individual Care</b>
<p>Expand the friends and family test to all services provided by the Health Board and publish the results</p>	<p>Deliver the single cancer pathway which significantly speeds up the time to treatment</p> <p>Complete the Stroke Service re-design programme which encompasses the entire stroke pathway, from prevention, through acute stroke care and rehabilitation, to life after stroke</p>	<p>Increase the opportunities for listening and learning from the patient experiences in our services including</p> <ul style="list-style-type: none"> <li>• scrutinising and sharing the learning through a new Listening and Learning from Events Sub Committee</li> <li>• publishing, implementing and evaluating our patient experience charter</li> </ul>

### Staff ac Adnoddau

### Staff and Resources

Deliver an Organisational Development Programme to progress the skills and change management tools we need to nurture the culture to deliver high quality services, whilst living our values and embodied in the Hywel Dda way

# *Casgliadau*

# Conclusions

2019/20 has brought us many challenges but also opportunities

- Delivering our goals in the context of COVID-19
- Dedication and commitment of staff
- Essential support to the NHS

We know there is more to do.....

Any comments on this Annual Quality Statement would be welcomed

<b>Enw'r Pwyllgor / Name of Committee</b>	Stakeholder Reference Group (SRG)
<b>Cadeirydd y Pwyllgor/ Chair of Committee:</b>	Hilary Jones
<b>Cyfnod Adrodd/ Reporting Period:</b>	Meeting held on 10 <sup>th</sup> January 2020
<b>Y Penderfyniadau a'r Materion a Ystyriodd y Pwyllgor / Key Decisions and Matters Considered by the Committee:</b>	
<p><b>Chair</b> Hilary Jones, Chair of SRG and Chief Executive of Bro Myrddin Housing Association informed the SRG members that she has been appointed Independent Board Member at Velindre NHS Trust. In view of this, Hilary Jones advised that she will be standing down as SRG chair. The SRG thanked Hilary Jones for her dedication to the role and wished her well in her new post. Arrangements will now be put in place to recruit Hilary Jones' successor.</p> <p><b>Winter Plan</b> Members were advised that Welsh Government has allocated funding for winter pressures to support integrated and community based solutions. The Regional Partnership Board (RPB) has received £2.062m and the Health Board £1.213m. Martyn Palfreman confirmed that the RPB plan has been developed in partnership at local level and Executive Directors from the Health Board meet on a weekly basis with Directors of Social Services for the three partner local authorities. The SRG acknowledged and support partnership working approach.</p> <p>SRG members were informed that the Health Board is currently under unprecedented pressures within our hospitals and services. The winter plans are being reviewed on a weekly basis with daily actions to relieve pressures on the system.</p> <p>The SRG raised the following:</p> <ul style="list-style-type: none"> <li>• SRG felt that winter plans should be set by September/October of each year and that a more proactive approach is needed by Welsh Government</li> <li>• The Third Sector can play an important role in supporting winter pressures and more investment within the Third Sector should be considered, with adequate time for planning and mobilisation of staff.</li> </ul> <p>SRG are mindful that our front line staff are working under difficult circumstances and would like to thank staff for their hard work and commitment.</p> <p><b>Regional Partnership Board</b> SRG Members were provided with an update on how the three transformation programmes successful in receiving Welsh Government funding were progressing. The following comments were made by SRG members:</p> <ul style="list-style-type: none"> <li>• The involvement of Welsh Ambulance Services NHS Trust (WAST) in the transformation workstreams was welcomed.</li> <li>• Members noted that early intervention actions are critical to reach individuals before crisis.</li> </ul> <p>A query was raised about how, with only 2 years of Welsh Government transformation funding, it will be possible to measure and sustain the programmes. Members acknowledged that there is a natural lead-in time before the programme goes live and can be evaluated which is at odds with the limited funding. Concern was expressed about the potential of</p>	

effective projects ending because there is insufficient evaluation data to feed into budget realignment discussions.

### **Patient Experience Charter**

The SRG were provided with an update and a draft copy of the Patient Experience Charter and poster. Members were thanked for providing their feedback on the draft Charter which had been incorporated into the current version.

The SRG were informed the Patient Experience Charter will be taken to Board in January 2020. The Charter will be launched in April 2020 during the national patient experience week and activities are being planned at all Health Board sites.

Comments made by the SRG included:

- Some disappointment that the Charter still has nearly as many points for patients and their carers, as for staff of the Health Board. Concern was raised that patients are very vulnerable when they are unwell and find it difficult to raise issues or concerns as they fear a negative reaction which might impact on their on-going or future care.
- The Charter needs to be made visible to staff and patients, therefore good promotion will be required. Members were provided with assurance that the information will be widely circulated including on social media and in patient letters, and will be made available and visible in all areas within the Health Board.

Members were advised of work currently being developed within the Patient Experience team which includes:

- Rollout of electronic feedback system
- Mandatory customer care training programme to be undertaken by all staff
- Bringing together of all Patient Experience Feedback in a new Listening and Learning Sub Committee
- Developing of an Assurance Framework which will be shared with SRG members in due course
- Participation in the Apprenticeship scheme to increase capacity for patient liaison
- Development of the Patient Advice and Liaison Service (PALS)
- Ongoing work to review appointment letters

### **Supporting Vulnerable Groups**

The Strategic Partnerships, Diversity and Inclusion team provided SRG members with an overview of their work to provide assurance that the Health Board are committed in developing an accessible and inclusive organisation, culture and environment not only for patients but also for its employees. Members were informed of the breadth of work ongoing to support vulnerable groups which include those who are homeless, asylum seekers, refugees, Gypsy and Travellers, substance misusers, armed forces veterans, EU migrants who are homeless or living in circumstance of insecurity. The SRG were pleased to hear of the excellent work being undertaken to support those who are vulnerable in our communities. Members commented that this work does make a difference to people's lives but often goes unseen.

### **Welsh Ambulance Service**

SRG members were informed that there has been significant pressure on WAST. This is due to hospitals throughout the area and beyond experiencing extraordinary pressure.

The SRG were provided with an update on WAST performance which included:

- 66.7% performance rate against 65% target.

- On a monthly basis working against a performance target of 52%. This is lower due to increased pressures.
- Ambulance sickness absence is the highest within the NHS. SRG were advised the service continually supports staff in the workplace and at home providing a holistic wellbeing approach.

Members were informed of the significant amount of work which undertaken on discharges and getting patients home safely, as well as preventing admission to hospital. Work includes:

- Improving performance times especially for elderly fallers and the vulnerable.
- In recognition of the high number of calls related to elderly fallers, WAST have provided Falls Training to over 1,000 people including many Nursing and Care homes. This has given staff confidence to get people off the floor more quickly.
- Advanced Paramedic Practitioners in post to provide support and respond to out of hours calls. After the patient has undergone GP triage, the Advanced Paramedic Practitioner is able to undertake home visits on behalf of the GP, enabling the GP to focus on more complex issues.

The SRG thanked WAST for their hard work under the pressures of the current climate and noted that it was good to hear of the excellent projects underway to reduce pressure, improve performance and services.

#### **Materion y mae angen Ystyriaeth neu Gymeradwyaeth Lefel y Bwrdd are u cyfer / Matters Requiring Board Level Consideration or Approval:**

- For consideration to be given to setting winter plans by September/October of each year, with a more proactive approach needed by Welsh Government
- In acknowledgement of the important role the Third Sector can play in supporting winter pressures, more investment within the Third Sector should be considered, with adequate time for planning and mobilisation of staff.

#### **Risgiau Allweddol a Materion Pryder / Key Risks and Issues/ Matters of Concern:**

Concern regarding the continuity and sustainability of projects due to time limitations on Transformation Fund monies.

#### **Busnes Cynlluniedig y Pwyllgor ar gyfer y Cyfnod Adrodd Nesaf / Planned Committee Business for the Next Reporting Period:**

##### **Adrodd yn y Dyfodol / Future Reporting:**

- Arrangements to recruit an SRG Chair successor.
- Transformation Programme Update
- Transformation Programme Leads Updates
- Learning Disability Charter – The Dream Team
- Update on the Implementation of Transforming Mental Health and Learning Disability Services
- Digital Platforms Update

#### **Dyddiad y Cyfarfod Nesaf / Date of Next Meeting:**

3<sup>rd</sup> April 2020