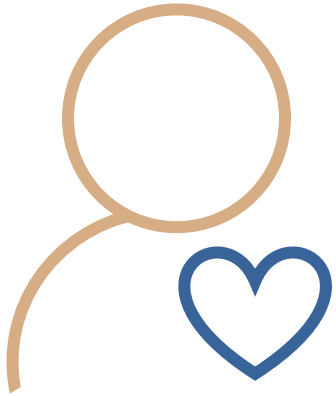
Performance update for Hywel Dda Univerity Health Board

as at 30th September 2020



Click one of the boxes below to navigate to that section of the report

Executive summary

Due to the current COVID-19 pandemic the format of this report has been temporarily amended to account for changes in performance management across Wales and to provide an update on COVID-19 for the Hywel Dda area.

COVID-19

Confirmed COVID cases as at 30th September 2020	Suspected & confirmed COVID patients admitted 1st-30th September	Confirmed COVID patients discharged 1st-30th September	Confirmed COVID patients who died in one of our hospitals in September
1,623	157	107	0

Non-COVID

To provide staff with more capacity to deal with the COVID-19 pandemic, we have only included narrative within this report for our key deliverable areas. However, we continue to collect and monitor data across all areas, see the performance overview matrix for the latest data. Below is a summary for our key deliverable areas:

- **Where are we meeting target?**
  - 55.4% of stroke patients were admitted to a stroke unit within 4 hours in September 2020 (target 54%).
  - In September, 93.8% of stroke patients were assessed within 24 hours by a specialist stroke consultant (target 85.3%).
  - 96% of babies had the recommended 3 doses of the '6 in 1' vaccine by their 1st birthday between Apr and Jun;
  - 98.7% of non-urgent suspected cancer patients commenced treatment within 31 days of being referred.

- **Where have improvements been made?**
  - The target for speech and language therapy for stroke patients increased to 34.6% this month, compared with 9.6% in August;
  - Performance in respect of the Single Cancer Pathway increased by 2% from the previous month;
  - The number of patients waiting over 8 weeks for a diagnostic decreased from 6,380 in August to 5,918 in September;
  - The number of patients waiting more than 14 weeks for a specific therapy improved for the 3rd sequential month from 1,613 (June) to 793 (Sep). Waits for all Therapies improved in September except in Podiatry which have risen from 336 in August to 350 in September. Pulmonary Rehabilitation waits remain relatively unchanged with 252 patients waiting over 14 weeks in September;
  - During April '20 to June '20, 1.04% (582) of adults attempted to quit smoking using a smoking cessation service. This is higher than the same period in the previous year;
  - There has been a small reduction in sickness absence between July (5.27%) and August (5.25%).

- **Where is improvement needed?**
  - The 65% target was not met for ambulances arriving within 8 minutes to calls for patients with life threatening conditions (50.6%);
  - 222 ambulance handovers were reported as taking longer than 1 hour during September 2020;
  - 78.1% of patients were seen within 4 hours in A&E/MIU (target 95%) and 491 patients spent longer than 12 hours (target 0);
  - Reporting has been stood down for of non-mental health patients with delayed transfers of care. However, census day patient count for Mental Health has continued and saw 5 patients delayed in September '20. i.e. they were medically okay to leave hospital but needed another form of support in place for them to leave;
  - The % of urgent suspected cancer patients who commenced treatment within 62 days of referral declined by 3.2% from the previous month to 82.8%;
  - 10 planned procedures were cancelled by us in August for non-clinical reasons;
  - There were 38,399 patients in September who had a delayed follow-up outpatient appointment, this is an increase of 342 from the previous month;
  - 43.8% of high risk Ophthalmology patients waited no more than 25% over their clinical target date which is below the 95% target;
  - The number of patients waiting over 36 weeks from referral to treatment increased from 15,698 (August) to 17,857 (September);
  - The percentage of patients waiting less than 26 weeks from referral to treatment has further declined to 48.9%;
  - In September we reported 8 C.difficile infections, 33 E.coli infections and 7 S.aureus infections;
  - Performance for complaints receiving a final or interim reply within 30 working days declined this month at 63%. This is a 20% decrease when compared to the same period last year (September 2019: 83%);
  - In August 19.7% of children/young people received a neurodevelopmental assessment within 26 weeks, a 1.9% decline from the previous month and considerably below the 80% target;
  - In August 28.3% of adults waited less than 26 weeks for a psychological therapy, declining by around 5% from the previous month;
  - Between April and June, 90.3% of children had 2 MMR doses by age 5;
  - Staff appraisals are below target with a 1.2% deterioration from the previous month;
  - 84.2% of staff have completed their mandatory training (target 85%);
  - Performance for Consultants and SAS Doctors with a current Job Plan fell to 36% in September. Due to the impact of COVID-19, this is significantly below the target of 90%;
  - We have a financial plan with a year-end projected deficit of £25.0m. The current financial position at the end of September is £12.5m deficit against a deficit plan of £12.5m.

- **Impact of COVID-19**
  - Staff absence increased due to COVID initially but this is slowly reducing, around 2% of staff are self-isolating and 0.4% are off due to COVID sickness;
  - Some staff have been deployed from their substantive posts to assist with COVID-19 planning (e.g. field hospitals) and reset plans (i.e. restarting elective procedures);
  - Most elective procedures and outpatient appointments were cancelled to create capacity for staff training and COVID-19 patient admissions, we are now increasing the volume of urgent patients assessed and treated where it is safe and feasible to do so (see the Planned Care section for further details);
  - Staff are taking additional time for donning and doffing personal protection equipment;
  - To avoid inpatient admission where appropriate, the temporary physical redesign of acute hospital facilities to accommodate separate COVID & Non-COVID pathways has led to some patients receiving extended clinical assessments within Emergency Departments beyond the 4 hour threshold;
  - Where possible, staff have shifted to working from home which has required additional IT infrastructure and resources;
  - Since April 2020, we have commissioned Werndale Hospital to support urgent cancer outpatient and surgical pathways. Plans are being progressed in accordance with the Welsh Government guidance to further increase the volume of cancer diagnostic and surgical cases undertaken at acute sites;
  - Mental Health and Learning Disability patients have had reduced leave (i.e. attending social activities or shopping) to limit their risk of exposure.

Our 36 key deliverable measures

Latest data

25	2	4

All Wales rank

All Wales data is available for 31 of the 36 key deliverable measures. Of these, Hywel Dda UHB ranked in the top 3 for 45% of measures:

① 2 measures
② 5 measures
③ 7 measures
④ 7 measures
⑤ 6 measures
⑥ 2 measures
⑦ 2 measures

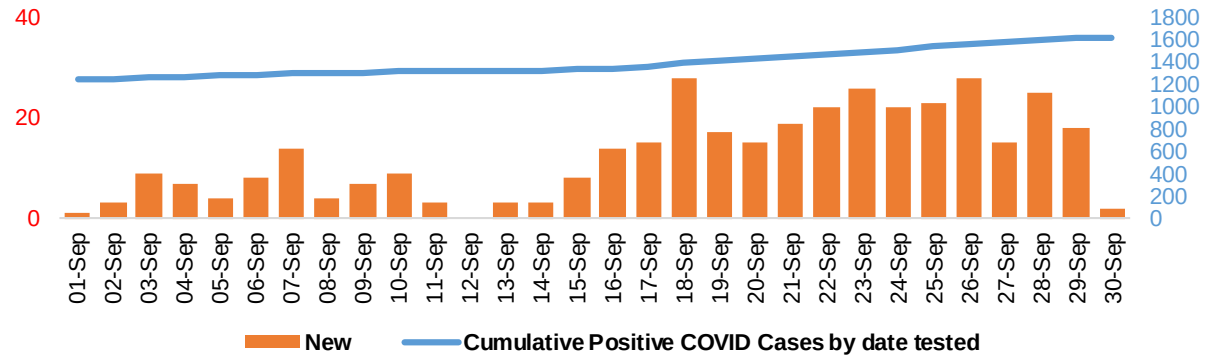
COVID-19

The COVID-19 pandemic has already had a massive impact on our staff and services and we expect that this will continue well into 2020/21. As an organisation we are rising to the challenge and we will do so for as long as is needed.

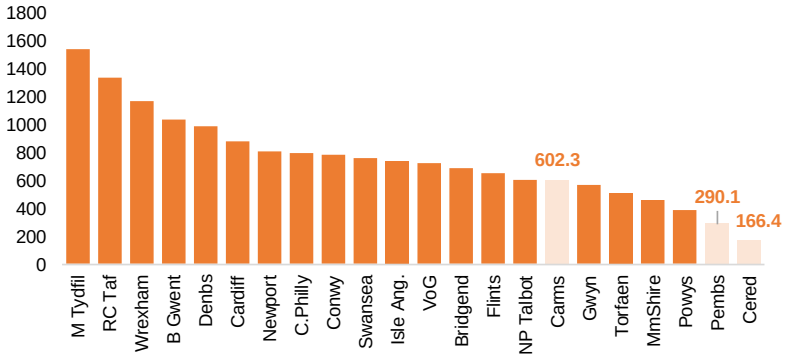
Confirmed cases

As at 30th September 2020, there were 1,623 confirmed cases of COVID-19 for Hywel Dda residents, an increase of 377 cases from 31st August 2020. The highest number of new positive cases tested were on 18th and 26th September with 28 new cases reported on each day. Population rates for confirmed cases are seen to be lower in Hywel Dda than in many other local authority areas. On 30th September 2020, Ceredigion and Pembrokeshire had the lowest local authority rates in Wales (Ceredigion: 166.4 per 100,000 population, Pembrokeshire: 290.1 per 100,000 population). It is important to note that the local authority rates may be skewed due to testing variation in each area and therefore should be used as a proxy.

Daily and cumulative confirmed cases for Hywel Dda by date of testing



Confirmed cases per 100,000 resident population



Supporting our staff

We have established a COVID command centre which is open 7 days a week. Staff are able to contact the command centre by email or phone with all COVID related queries e.g. staff testing, personal protective equipment (PPE), wellbeing support. In September the command centre had on average 150 calls per day which is an increase from 52 per day in August (4,448 calls in September overall). The COVID call centre line is used by all key workers and families, the rise in calls was due to children returning to school and the increase in cases in Llanelli. In addition, our Staff Psychological Wellbeing Service has changed the way they work to offer one to one support services to staff.

Personal Protective Equipment (PPE)

We continue to closely monitor our PPE stock levels and orders to ensure sufficient levels are maintained to protect our staff and patients.

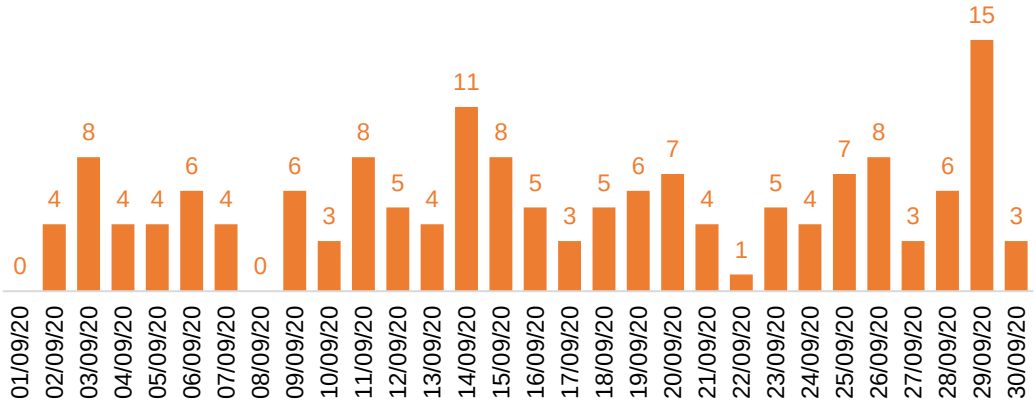
Admissions

Despite a decrease in confirmed cases over the same period, the number of COVID (confirmed and suspected) admissions to our four acute hospital sites reduced from 183 in August to 157 in September; 0 in Bronglais General Hospital (BGH), 40 in Glangwili General Hospital (GGH), 19 in Prince Philip Hospital (PPH) and 98 in Withybush General Hospital (WGH). This is an average of 5 COVID admissions a day across the Health Board during September and approximately 5% of all inpatient admissions. Non-COVID inpatient admissions averaged 105 per day over the same period.

The Health Board have 5 field hospitals across Hywel Dda to provide increased capacity should the need arise. This additional capacity will provide flexibility to care for additional COVID patients if demand for acute hospital care exceeds threshold levels. To be fully operational, a small lead in time would be required, however contingency plans are in place should this potential capacity be required.

* It is important to note some of the suspected COVID cases were shown to be negative when tested.

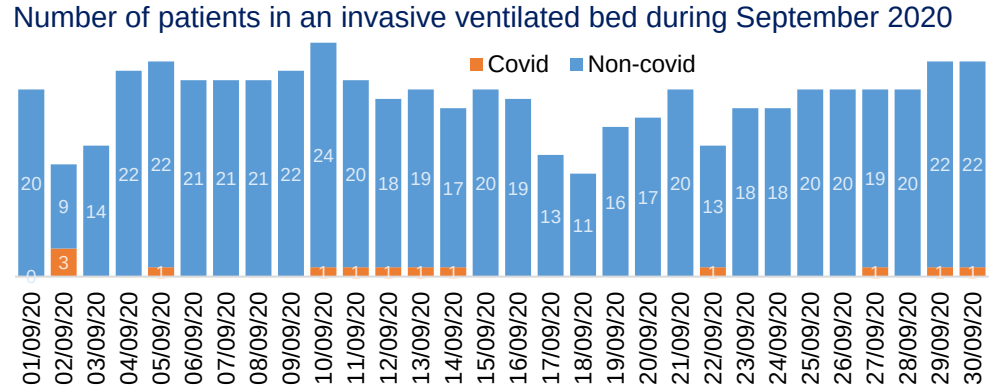
Hywel Dda daily COVID* admissions during September 2020



Intensive care

In September we had more than sufficient capacity to treat all patients (COVID and non-COVID) who required ventilating.
The Health Board is monitoring ventilated bed use, consumables and medication requirements on a daily basis to ensure sufficient capacity continues. Additionally we are modelling future capacity in order to accurately plan anticipated demand for and availability of ventilated beds.

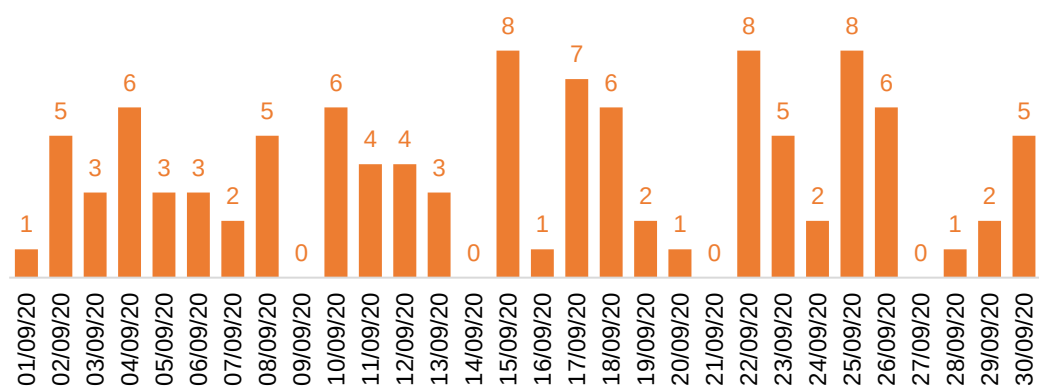
Number of patients in an invasive ventilated bed during September 2020



Discharges and deaths

Between 1st and 30th September, 107 COVID (confirmed and suspected) patients were discharged from hospital alive. No patients died in our hospitals during September after being admitted and subsequently having a confirmed diagnosis of COVID-19.

Number of COVID patients discharged during September 2020



For the latest figures on COVID-19 confirmed cases and deaths, see the Public Health Wales dashboard which is updated daily and can be accessed: https://phw.nhs.wales/topics/latest-information-on-novel-coronavirus-COVID-19/

Key performance areas

This section includes summary information on some of the key areas that we prioritised to make improvements in 2019/20, we continue to monitor these in 2020/21 during the COVID-19 pandemic. The impact of COVID on performance is detailed within each service report below. The reporting time period and frequency differs by indicator. See the performance overview matrix for details.

		Target	12m previous	Previous period	Latest data	Met plan?	All Wales rank	Notes **
Unscheduled care	Ambulance red calls	65%	68.5%	54.5%	50.6%	No	6th out of 7	Carms 49.2%, Cere 50.0%, Pembs 52.8%.
	Ambulance handovers over 1 hour	0	406	117	222	No	3rd out of 6	Ambulance handover delays decreased considerably from September 2019 (-184).
	A&E/MIU 4 hour waits	95%	80.3%	80.2%	78.1%	No	2nd out of 6	In Sep '20 there was a 17% reduction in the number of new attendances compared to Sep '19. Trajectory was met for 12 hour waits.
	A&E/MIU 12 hour waits	0	910	306	491	Yes	2nd out of 6	
	Non-mental health delayed transfers of care	12m↓	54	n/a	n/a	n/a	3rd out of 7	Due to COVID-19, DTOC census patient number monitoring has been suspended until Sep'20. Latest Mental Health data is based on unverified numbers from the National DTOC database.
	Mental health delayed transfers of care	12m↓	7	11	5	Yes	5th out of 7	
Stroke and cancer	Admission to stroke unit <4 hours	54.0%	39.0%	56.9%	55.4%	No	1st out of 6	Compliance for admissions to a stroke unit within 4 hours is below target at GGH (20%) and consultant assessment within 24 hours is below target at BGH (84.6%). Improvements in speech & language minutes though compliance lowest at GGH (11.9%) and PPH (14.4%).
	Assessed by stroke consultant <24 hours	85.3%	96.1%	96.7%	93.8%	No	2nd out of 6	
	Stroke patients - speech & lang. therapy	12m↑	38.9%	9.6%	34.6%	No	n/a	
	Urgent suspected cancer	95%	75.7%	86%	82.8%	No	3rd out of 6	Latest reported performance relates to Aug '20. There was 1 Non Urgent and 15 Urgent Suspected Cancer breaches in Aug '20. SCP compliance has increased by 2%.
	Non urgent suspected cancer	98%	96.4%	92.2%	98.7%	Yes	5th out of 6	
	Single cancer pathway	12m↑	76.7%	79%	81%	n/a	4th out of 6	
Planned care and therapies	Hospital initiated cancellations	5%↓	100	15	10	No	4th out of 7	Cancelations due to admin error (1), staffing (1), Emergency Admission (2) & Other (6).
	Delayed follow-up appointments (all specialties)	12m↓	43,853	38,057	38,399	No	n/a	Reduced outpatient capacity due to social distancing requirements.
	Ophthalmology patients seen by target date	95%	56.1%	42.8%	43.8%	No	5th out of 7	Lower performance primarily due to patient cancellations, high risk treatment is continuing.
	Diagnostic waiting times	0	391	6,380	5,918	No	2nd out of 7	462 fewer breaches. Clinically led validation arrangements are prioritising urgent referrals.
	RTT – patients waiting 36 weeks+	0	452	15,698	17,857	No	2nd out of 7	The number of patients waiting > 36 weeks for treatment increased by 2,159 from Aug '20 to Sep '20 and is 17,405 higher than Sep '19.
	RTT – patients waiting <=26 weeks	95%	86.5%	54.5%	48.9%	No	3rd out of 7	
	Therapy waiting times	0	426	946	793	No	3rd out of 7	Audiology performance improved: 490 patients waiting over 14 weeks in Aug, 338 in Sep.
Quality and safety	C.difficile	<=25	38.38	40.21	37.76	Yes	5th out of 6	The cumulative reduction rate has been reinstated Apr 20 –Sep 20. Compared to April 19 – Sep 19: • C.diff cases reduced by 1% • E.coli cases reduced by 27% • S.aureus cases reduced by 19%
	E.coli	<=67	109.44	74.24	79.14	No	5th out of 6	
	S.aureus	<=20	29.56	24.13	23.79	Yes	3rd out of 6	
	Serious incidents	90%	30.8%	50%	67%	n/a	n/a	In Sep '20, 2 out of 3 SIs were closed within the WG timescale. There was 1 Never Event.
	Complaints	75%	83%	70%	63%	No	4th out of 9	The number of complaints received doubled this month, contributing to a 7% performance decline.
MH +	Children/young people neurodevelopment waits	80%	34.64%	21.6%	19.7%	No	7th out of 7	The service is expected to have an increased waiting list going forward as the number of therapeutic intervention face to face appointments has been reduced.
	Adult psychological therapy waits	80%	57.9%	33.2%	28.3%	No	6th out of 7	
Population Health	'6 in 1' vaccine	95%	95.1%	95.5%	96.0%	Yes	5th out of 7	The schools immunisation programme was restarted on 29th June 2020 as schools reopened.
	MMR vaccine	95%	92.2%	90.0%	90.3%	Yes	7th out of 7	
	Attempted to quit smoking	5%(ytd)	0.87%	3.5%	1.04%	n/a	4th out of 7	COVID-19 presents a risk to smokers accessing cessation support services and due to the pandemic, CO levels are not currently recorded.
	Smoking cessation - CO validated as quit	40%	49.7%	30.3%	n/a	n/a	3rd out of 7	
	Childhood obesity	n/a	n/a	n/a	n/a	n/a	4th out of 7	Carms 13.0%, Pembs 10.6% and Cere 10.3%
Workforce & finance	Sickness absence (R12m)	12m↓	4.90%	5.27%	5.25%	Yes	4th out of 10	Slight increase in in-month sickness from 4.38% in August '19 to 4.45% in August '20.
	Performance appraisals (PADR)	85%	77.0%	70.2%	69.0%	No	1st out of 10	Despite a fall in compliance, highest in Wales as of June. Medical appraisals remain suspended.
	Core skills mandatory training	85%	80.6%	82.4%	84.2%	No	4th out of 10	Lowest compliance in fire safety (74.4%), IG (76.1%) and L1 moving and handling (79.7%).
	Consultants/SAS doctors - current job plan	90%	52%	42%	36%	No	n/a	Increased COVID activity in September has impacted performance.
	Finance - deficit	£25m	£12.6m deficit	£31.8m deficit	£12.5m deficit	Yes	n/a	Board's financial position at the end of Sep is £12.5m deficit against a deficit plan of £12.5m.

+ Mental Health & neurodevelopment ** BGH: Bronglais General Hospital GGH: Glangwili General Hospital PPH: Prince Philip Hospital WGH: Withybush General Hospital. HDUHB/HB: Hywel Dda University Health Board/Health Board

Essential services update as at 30th September 2020

This section provides an overview on essential service provision in Hywel Dda during the COVID-19 pandemic. Essential services guidance has been produced by the Welsh Government and can be accessed on their website: https://gov.wales/nhs-wales-COVID-19-operating-framework-quarter-2-2020-2021.

❶ Essential services that we are currently unable to maintain and our actions to address

Out of Hours services

- As the Carmarthen base rota has stabilised with the support of GP coordination, the Pembrokeshire position has destabilised in respect of sickness episodes amongst the salaried workforce and so the overall service risk remains elevated. Cover at the Llanelli base remains extremely limited during weekend hours;
- *Attend Anywhere* online software has been purchased to support virtual consultations, thus reducing potential risk for staff and patients. Furthermore, additional IT equipment has been procured to support more flexible working to increase service readiness. The benefits of this investment are unlikely to be seen in the next couple of months where risks to service provision are likely to increase, especially if any further increase in COVID demand is seen;
- The decision to support rationalisation of overnight base cover has been a success in improving service stability for 6 nights of the week. Saturday is the exception and predominantly in Carmarthenshire, but this is being closely monitored with potential for improvement ahead of winter;
- Ongoing shortages in shift fill remain mitigated by a continued focus amongst the clinicians to complete in the region of 80% of activity at the telephone consultation stage, as opposed to face to face assessment. This has increased the capacity available to deal with demand. In retrospect, service escalation levels are often lower than predicted because of this increase in capacity. Should fill rates reduce, however, a potential of delays in patient care/service delivery remain possible;
- Work by service leads to procure a new IT solution which will enhance access to Out of Hours (OOH) clinicians and improve governance of rota provision within the OOH teams is continuing.

❷ Essential services that are being maintained in line with guidance

Access to primary care services
General Medical Services
Community pharmacy services
Red alert urgent/emergency dental services
Optometry services
Community Nursing/Allied Health Professionals services
111

Life-saving or life-impacting paediatric services
Paediatric intensive care and transport
Paediatric neonatal emergency surgery
Urgent cardiac surgery (at Bristol)
Paediatric services for urgent illness
Immunisations and vaccinations
Infant screening (blood spot, new born, hearing, 6 week physical
Community paediatric services for children

Other infectious conditions (sexual and non-sexual)
Other infectious conditions
Urgent services for patients

Mental health (MH), learning disability services & substance
Crisis services (including perinatal care)
Inpatient services at various levels of acuity
Community MH services that maintain a patient's condition stability
Substance misuse services that maintain a patient's condition

Therapies e.g. tissue viability/wound care, rehabilitation increase in functional decline, patients not appropriate for remote or digital support, admission avoidance.

Palliative care

Blood and transfusion services

Safeguarding services

Acute services
Urgent eye care
Urgent surgery
Urgent cancer treatments

Life-saving medical services
Interventional cardiology
Acute coronary syndromes
Gastroenterology
Stroke care
Diabetic care
Neurological conditions
Rehabilitation

Termination of pregnancy

Neonatal services
Surgery for neonates
Isolation facilities for COVID-19 positive neonates
Usual access to neonatal transport and retrieval

Renal care-dialysis

Urgent supply of medications and supplies including those required for the ongoing management of chronic

Additional services
Health visiting service - early years
Community neuro-rehabilitation team
Self-management & wellbeing service
School nursing services

Diagnostics

❸ Intermediate services that are being delivered

Maternity services

❹ Normal services that are continuing

Emergency ambulance services

For further details see the July 2020 Board paper entitled '*9. COVID-19 Report including ratification of COVID-19 Operational Plan for Quarter 2 2020/21, Field Hospitals and Winter Plan*' and accessible: https://hduhb.nhs.wales/about-us/your-health-board/board-meetings-2020/'.

Unscheduled care

Executive Lead: Director of Operations

Senior Responsible Officer(s): General Managers

How did we do in September 2020?

50.6% of ambulances arrived to patients with life threatening conditions within the 8 minute target. 52.1% arrived within 9 minutes and 58.7% within 10 minutes.

222 ambulances waited more than 1 hour at our hospitals to handover their patient to an Accident and Emergency (A&E) department/Minor Injury Unit (MIU).

11,526 patients attended an A&E/MIU in September as a new attender. Of these patients, **78.1%** were seen and treated within 4 hours of arrival but **1,000** patients waited longer and **491** patients waited over 12 hours; There has been a 17% reduction in the number of new attendances compared to Sep '19 and 29% year to date.

In September there were 3,316 emergency admissions compared to 3,725 in Sep '19, to our hospitals of which 2,081 (63%) were admitted via A&E/MIU. On average medical emergency patients stayed in hospital for 9 days (Sep '19 - Sep '20).

How do we compare to our all Wales peers?

	Ambulance reaching patients with life threatening conditions within 8 minutes	6th out of 7
	Ambulances waiting > 1 hour to handover a patient	3rd out of 6
	Patients being seen and treated within 4 hours in A&E/MIU	2nd out of 6
	Patients waiting more than 12 hours in A&E/MIU	2nd out of 6

Impact of COVID

Ambulance Service

- Additional COVID-19 infection control requirements affect efficiency;
- Staff shielding (following Welsh Government risk assessment) and an increase of staff reporting COVID like symptoms, which has further reduced our ability to deploy the maximum number of resources;
- Modelling has shown that on average, responding to calls requiring full level 3 Personal Protective Equipment will add 4 minutes to a red call as a result of the donning process.

Unscheduled Care

There are early signs of an increase in COVID confirmed and suspected hospitalisation rates although these remain significantly lower than other Health Boards at the present time.

- Maintaining COVID and non-COVID streams at front door and on the wards. Creation of a 3rd stream for planned (elective) surgery;
- Donning doffing and COVID swabs results taking up to 36 hours;
- Staffing - absence through shielding, self-isolation and sickness;
- Non-COVID emergency demand returning to normal activity levels;
- Early evidence from clinical staff of higher acuity of patients who have presented late – potentially due to fear of COVID especially elderly patients;
- Increasing COVID testing demand from care homes/agencies, nursing and residential homes are reducing flow and causing discharge delays also putting additional workload pressure on the acute sites for COVID testing;
- Increasing number of medically optimised patients and some delays in re-ablement and Long Term Care (LTC) package availability due to both COVID concerns, staff shortages and LTC assessment and placement delays.

Risks

Ambulance Service

- Ambulance staff must don PPE for all calls, and higher specification PPE where procedures produce airborne particles or respiratory droplets;
- Significant increase in lost hours notification to handover resulted in the equivalent of 45 x 11.5 hour double manned shifts being lost from production. 52 hours were lost at Morriston Hospital;
- Military support withdrawn and vehicles needing deep clean have go to Tredegar;
- The time taken for ambulances to become operational post patient handover extended due the need to remove PPE and vehicle cleaning;
- Increasing staff numbers reporting COVID like symptoms and therefore self-isolation. Increased abstractions following the opening of schools, with children being sent home with COVID like symptoms.

Unscheduled Care

- Existing vacancies, and staffing for both the Red (suspected COVID symptoms) and Green (no suspected COVID symptoms) zones in Emergency Departments (ED) with Registered Nurses (RN) and Health Care Support Workers (HCSW);
- Vacancies and sickness in Community Teams/Hospitals negatively impact the efficient transfer of some patients from acute sites;
- Increased waiting times in ED - Junior doctors called back to their speciality rotas. Agency RN and Doctor availability has improved but this will change if COVID cases begin to increase. In addition, a high proportion of agency RNs fit into the Black, Asian, Minority Ethnicity (BAME) group and would be exempt from working in high risk areas. This will place additional stress upon existing teams;
- General and Emergency Medicine rotas in WGH are extremely fragile, lack of middle grades in A&E GGH;
- The GP Out of Hours service is often not covered at the weekend.

What are we doing?

Ambulance Service

- Local and senior pandemic teams have been stood up;
- Revised performance plan has been introduced;
- An accelerated role out of Public Access Defibrillators continues;
- 72% of staff have completed e-learning for the launch of the trauma network which went live on 14th September.

Unscheduled Care

- Patients screened at the front door for potential COVID symptoms;
- HCSW recruitment above normal levels to provide staff for acute and community hospitals;
- Previous reduced COVID incidences allowed conversion of Red back to Green capacity, however, sites remain in a state of readiness to reverse back to Red capacity if required;
- Portable cabins, for external streaming facilities to work in conjunction with A&E by late November;
- Ambulatory care reopened at GGH & PPH to enable GP medical assessment outside of A&E. Further ongoing planning reviews to implement Same Day Emergency Care service to reduce emergency admissions by a third;

Bronglais

- Recruitment – newly appointed Colorectal Surgeon to start January 2021. Consultant in Frailty and Care Of The Elderly appointed substantively in September. Unfortunately, the applicant for the post of Acute Stroke Physician withdrew;
- Our Associate Specialist in Acute Stroke Medicine is acting up in to the Consultant role and is undertaking training to gain the *Certificate of Eligibility for Specialist Registration* qualification and enable substantive appointment. The Advanced Nurse Practitioner role in Acute Stroke has been appointed;
- 10 newly qualified nurses joined in September, 2 more senior nurses are joining the Dyfi Ward team during October;
- From mid-October, planned care activity will ramp up to the next phase as dual lists will run on 2 days each week i.e. 2 further operating lists per week including the established daily lists on the other 3 days;
- Relocation of the Cardiorespiratory service to larger premises on site will enable greater throughput for cardiac and respiratory diagnostics – this move will be complete by mid-October;
- Winter plan, including the ability to flex the site plan should COVID incidents increase, is in the final stages of development;
- Patient flow improvement continues to ensure timely discharge of patients. The discharge to assess model is being progressed as much as possible to minimise the risk of hospital acquired infections.

Glangwili

- Consultant presence at bed management meetings to aide flow and decision making in regard to confirmed/suspected COVID patients and weekend plans;
- Detailed patient reviews as to treatment and discharge plan reinstated, led by the clinical, nursing and management leads. Recommenced Improvement Cymru plans and introduction of R sheet (discharge plans) to improve accuracy of discharges and escalation of delays;
- Quarter 3/4 2020/21 planning underway to ascertain what additional actions required to manage winter pressures including the potential use of field hospitals.

Prince Philip

- In light of increased COVID activity in the Llanelli area, the COVID escalation plans have been refreshed and discussed widely with staff groups;
- Encouraging Minor Injury Unit patients to wait in cars if possible to maintain social distancing in the waiting room;
- New Red and Green streaming pathway unit will be delivered in November;
- Prioritising PPH space for acute services and develop plans to move non-acute and administrative services off hospital sites.

Withybush

- Green/Red Clinical Decision Units established enabling access for both GP direct and ED medicine referrals, reducing attendance and length of stay in the ED. Continued screening of General Medicine (GM) referrals and ambulance conveyances in order to avoid unnecessary admissions;
- An additional GM Doctor requested to cover weekend day shift to reduce patient waits, for assessment and onward referral/discharge, additionally to secure staff to run Ambulatory Care 7 days a week;
- Weekly meetings organised *WGH site position and recovery meeting* resolve some of the blockages in the patient discharge pathways, the meeting includes all service areas involved with discharge;
- Pit Stop model and safety huddles to be implemented into the ED in week commencing 12th October, to improve timely assessment processes and flow. This has been delayed due to HCSW shortfalls;
- Strong drive continues on medical recruitment including short term locum cover until appointed candidates arrive from overseas;
- Acute Frailty Assessment Unit (short stay) has now opened. This team will filter patients out of the General Medical. There have been some promising outcomes so far, seeing an increased weekly discharge profile.

Delayed Transfers of Care

Executive Lead: Director of Therapies & Health Science/Director of Operations

Senior Responsible Officer(s): Service Delivery Manager/Assistant Director

How did we do in September 2020?

Due to COVID-19, non-mental health DTOC census patient number monitoring has been suspended until September 2020.

Mental Health DTOC census delays are being captured, there were **5** in August 2020.

How do we compare to our all Wales peers?

Non-mental health patients aged 75+ DTOC	3rd out of 7
Mental health patients DTOC	5th out of 7

Impact of COVID

- Experiencing a community response allowed our population to develop a trust and understanding that care can be delivered safely at home. We have also cared for an increased number of people at end of life at home;
- Increased capacity for *Intermediate Care Assessment* and *Rapid Response to Care* provision, also to support patient 'turnaround at front door' and increased care availability to maintain people in their own homes;
- Relaxation of lawful/regulatory frameworks has reduced DTOC resulting from the assessment and commissioning processes, this has led to reduced DTOC from family disputes;
- The service has retained its robust response to the provision of care and support across all three counties, however, services will need to be reviewed in light of expected winter pressures;
- Fragility of the domiciliary care sector could be further compromised due to workforce retention;
- Staff absences across all sectors due to COVID – shielding, quarantine, track and trace;
- Staff isolation through children returning to school, sent home with seasonal illnesses resulting in family self-isolation;
- Limited capacity for rapid processing of same day swab testing prior to discharge compromises patient discharge and flow. This might become more of an issue if COVID numbers rise and the ability to reassure Homes that they are safe to accept discharges will impact on patient flow;
- Health and social care staff availability has been impacted due to the lack of structured availability and timely COVID test and results;
- Lack of Elderly Mental Illness nursing bed availability and Nursing Homes who are able to provide care to patients with higher levels of complexity;
- Capacity of the Long Term Care team to undertake *Nursing Needs Assessments* which will impact on patient flow;
- Health Protection Zone has now been introduced in the Llanelli area; community transmission has increased in this area, which is having an impact on available staffing in the community;
- The return of the student population has resulted in pockets of COVID positive groups which could impact on local services.

Risks

- Non-mental health
- Retaining staff in the domiciliary care sector;
- Any new COVID outbreaks in the care home sector;
- Public Health Wales guidance for no admissions from care homes until 28 days after the last positive test result and limited admissions during recovery period once the 28 days is lifted;
- Residential and care homes requiring:
  - residents to have a recent negative COVID test before they are returned from hospital (ward or ED);
  - residents to be returned to the home within 6 hours of being discharged from an ED;
- Staff absence (shielding, vulnerable, child care) across the community has improved with schools reopening. However, if there is a cluster in a school this could have a further impact as staff will need to provide urgent childcare;
- Staff returning into the workplace remains challenging as guidance is not clear in relation to staff who are providing face to face care;
- Length of time it takes to receive swab results compromises patient discharge and flow;
- Acuity of patients has increased with complex discharge requirements;
- Medically optimised patients remaining in acute and community hospital beds, with access to long term packages of care re-emerging as a significant constraint to discharge;
- Lack of Elderly Mental Illness nursing beds causing delays for these vulnerable individuals with specialist needs;
- Changes to isolation period for COVID - from 30th July, people who have tested positive for coronavirus will have to self-isolate for 10 days instead of 7 days. The 10 day period starts from the day symptoms start, or if asymptomatic from the day a test is taken. Quarantine regulations could also impact on staffing levels;
- Localised lock downs will impact on patient flow across county border areas.

- Mental health
- Challenges around identification of placements resulting from actions to reduce spread of COVID;
- Increased acuity levels within inpatient settings.

What are we doing?

- Non-mental health
- Work collaboratively with the Local Authorities to further develop capacity within *Discharge 2 Recover and Assess* (D2RA) pathways, to ensure attainment of standards as outlined in the Welsh Government *Discharge Requirements* and *Primary Care & Community Framework* (PCCF). A specific task group has been established to focus on D2RA pathway 3 and 4;
- Enhance rapid response to bridging care and sustain by embedding into D2RA pathway;
- Increase Intermediate Care beds for people not yet able to return to embargoed care and residential homes;
- Implementation of hospital same day based swab testing and processing for patients requiring placement;
- Strengthen intermediate care response in the community through embedding of standards outlined in the National Institute for Health and Care Excellence, the National Audit of Intermediate Care and COVID-19 PCCF to support conveyance/admission avoidance where appropriate;
- Integrate essential service provision between Primary Care and Community services for Long Term/Chronic Conditions management;
- Embed *Telehealth* solutions where possible and appropriate to support *Intermediate, Palliative and Proactive Care* pathway;
- Improved integration of end of life care across the healthcare system and ensure adherence to palliative care principles and standards;
- Develop population approach to D2RA pathways and our Discharge Teams i.e. ensure they are equally applicable to vulnerable adults, frail older patients and those with Mental Health/Learning Disabilities;
- Scoping is being undertaken looking at the capacity within the existing provider in supporting individuals with greater complexity;
- Work collaboratively with the Universities, Public Health and Local Authorities to manage any outbreak in the Student population.

- Mental health
- Community Teams focusing on providing support to avoid admission where possible with a multidisciplinary approach to review patient flow;
- Remote working and improved digital technology/platforms have been embraced which has assisted in maintaining links and improving attendance at care planning meetings;
- An ICF bid has been submitted for increased capacity to facilitate discharge and liaison. Improvements have been made to internal and external pathways to reduce delays as far as possible;
  Closer working with Long Term Care to deal with more complex cases and collate more detailed information regarding placement challenges and budget constraints.

Stroke

Executive Lead: Director of Therapies & Health Science/Director of Operations **Senior Responsible Officer(s):** Service Delivery Manager/Assistant Director

How did we do in September 2020?

55.4% of patients presenting at our 4 acute hospitals in September with a stroke were then admitted to a dedicated stroke unit within 4 hours (a 16.4% decline over September 2019).

60 of the 64 (**93.8%**) patients admitted with a stroke in September were assessed by a specialist stroke consultant within 24 hours (a 2.3% decline over September 2019).

More than a third (**34.6%**) of stroke patients had the recommended amount of speech and language therapy (SALT) in hospital during September. The 12 month improvement target was not met.

How do we compare to our all Wales peers?

Admission to stroke unit within 4 hours	1st out of 6
Assessed by stroke consultant within 24 hours	2nd out of 6
Stroke patients - speech and language therapy	n/a

Impact of COVID

- Teams are adapting to a new way of working by means of virtual clinics instead of face-to-face appointments as a result of the COVID pandemic;
- Community teams are reviewing post discharge to provide additional rehabilitation at home where appropriate;
- An NHS Improvement report has found that the psychological wellbeing of post-stroke patients has noticeably declined due to the impact of the COVID pandemic;
- During the initial COVID outbreak, all sites had an increase in therapy on site due to a lack of out-patient activity. This is now under review with multiple professionals returning to their substantive roles;
- Speech and language teams was initially deemed an aerosol generated procedure (AGP) and staff were required to carry out therapy in an AGP room with staff dressed in full PPE. This impacted on the time spent with the patient on actual therapy;

Risks

- There continue to be issues regarding complex discharges back into the community which leads to reduced capacity within the units. None of the 4 sites has an *Early Supported Discharge Team* that could help with reducing length of stay;
- All 4 sites are now showing an expected number of admissions after an initial reduction at the start of the COVID pandemic, however, we are now seeing normal unscheduled care activity returning and units are unable to ring fence beds. There is an added risk with a reduction of beds in the units due to social distancing guidance;
- There is still an issue with insufficient therapy resource on our ability to provide the recommended levels of rehabilitation support. The Delivery Unit (DU) have conducted an in-depth review of therapy resource;
- There is a backlog of stroke and transient ischemic attack (TIA) patients to be reviewed;
- SALT remains a major risk in relation to therapy input for stroke patients, however, we should see an improvement as it is no longer deemed an AGP, reducing the infection control measures needed;
- Each site has seen a significant rise in admissions which adds pressure to the stroke units.

What are we doing?

- A meeting has been set up on 14th October to look at how to respond to patient needs in the community and psychological wellbeing of post-stroke patients as a result of the impact of the COVID pandemic;
- The HB is interviewing for a stroke lead on 20th October. The stroke lead will support the service delivery manager to achieve a safe, effective and efficient delivery of services, including implementation of best practice and guidance, ensuring that the principles of prudent healthcare are at the forefront of service planning and delivery;
- The DU have completed a formal review of the therapy service in Hywel Dda and actions are being worked out with the therapy team for how best to provide therapy and improve outcomes for patients;
- WGH is working on an *Early Supported Discharge* project as part of the discharge pathway planning work;
- We are negotiating with North Bristol NHS Trust for provision of improved imaging for thrombectomy;
- Site meetings to discuss performance and outcomes are to be reinstated.

Cancer

Executive Lead: Director of Therapies & Health Science/Director of Operations **Senior Responsible Officer(s):** Service Delivery Manager/Assistant Director

How did we do in August 2020?

During August 2020, **82.8%** (72/87) of cancer patients who were referred by their GP as urgent with suspected cancer, commenced treatment within 62 days of their referral. This represents a 3% decrease compared to the previous month.

98.7% (76/77) of patients who were not on an 'urgent suspected cancer' pathway commenced treatment within 31 days from the date the patient agrees to the treatment plan being offered to them.

In August, **81%** (2% increase/increase to previous month) of patients covered by the SCP were treated within 62 days of the point of suspicion.

How do we compare to our all Wales peers?

Urgent suspected cancer	3rd out of 6
Non urgent suspected cancer	5th out of 6
Single cancer pathway	4th out of 6

Impact of COVID

- Tertiary surgery was suspended due to COVID in late March;
- Suspension of any aerosol generated diagnostic tests and surgery in line with Royal College guidance has caused delays;
- Suspension of local surgery for those patients requiring intensive care/high dependency (ITU/HDU) support post operatively and further restrictions in clinical criteria that apply e.g. patients whose BMI (body mass index) exceeds 35 and have existing comorbidities;
- As per the *Wales Bowel Cancer Initiative*, the Faecal Immunochemical Test (FIT10) in the management of urgent patients on the colorectal pathway, as an alternative was introduced on the 15th June;
- USC imaging reduced for certain aerosol generating procedures;
- Bronchoscopies have been limited in line with national guidance;
- As per the 6 levels of *Systemic Anti-cancer Therapy* (SACT), all levels are still currently being treated across the Health Board on all 4 sites;
- Werndale Hospital has been commissioned to support cancer outpatient and surgical pathways from April 2020;
- Joint working progressed with regional multi-disciplinary teams for tertiary center surgeons to provide outreach surgery in Gynaecology and Urology.

Risks

- Complex pathway delays: the nature and complexity of tumours for some patients do not support rapid diagnosis and treatment due to the need for multiple investigations and multi-disciplinary team reviews;
- Tertiary (specialist) centre capacity pressures at Swansea Bay University Health Board continue to significantly compromise service;
- Local diagnostic service capacity pressures within Radiology service;
- The new *Single Cancer Pathway* significantly increases diagnostic phase, placing added pressure on diagnostic capacity;
- Suspension of local surgery for patients requiring ITU/HDU and aerosol generated diagnostic investigations.

What are we doing?

- We are continuing to escalate our concerns regarding tertiary centre capacity and associated delays;
- The HB has secured recurrent investment from Welsh Government (£340k per annum) to invest in diagnostic and tracking teams;
- We are logging all patients who are not having treatment due to patient choice or cancelled by hospital on clinical grounds due to COVID; As of August 2020 there are currently 4 patients who are refusing to attend the hospital due to COVID;
- All urgent suspected cancer and imaging investigations continue as usual;
- Elective surgery for high acuity cancer patients with green pathway and green ITU/HDU commenced at PPH and BGH on 6th July 2020, and at WGH 13TH July 2020;
- We currently have 2 patients on our surgical backlog. One patient has been offered a number of dates but has been unable to attend, and one patient that can't be dated due to medical reasons.
- As per the *Wales Bowel Cancer Initiative*, the use of FIT10 screening in the management of urgent suspected cancer patients on the colorectal pathway during the COVID-19 pandemic has been implemented. This has significantly cut back on the number of patients requiring Endoscopy or any further investigations.

Planned care

Executive Lead: Director of Operations

Senior Responsible Officer(s): General Manager Scheduled Care

How did we do?

10 patients had their procedure cancelled within 24 hours in August 2020. The low number of booked patients is a reflection of the current restrictions to elective surgery due to the pandemic.

In September **48.9%** waited less than 26 weeks from referral to being treated (RTT) and **17,857** patients waited beyond 36 weeks.

In August 2020 **43.8%** of eye care patients (5,193/11,864) were waiting in or within 25% of their target date. 97.2% of patients have been allocated a high risk factor (HRF) status leaving 479 (2.8%) patients waiting for an allocated HRF status.

In September **22,098** outpatients waited beyond 100% of their target date for a follow up appointment (all specialities).

How do we compare to our all Wales peers?

Hospital initiated cancellations	4th out of 7
Referral to treatment (RTT) <=26 weeks	3rd out of 7
RTT – patients waiting 36 weeks or more	2nd out of 7
Ophthalmology patients seen by target date	5th out of 7
Delayed follow-up appointments	Not available

Impact of COVID

- Hospital initiated cancellations
  - Increased due to cancellation of elective procedures and are now reduced because of less activity.

- RTT
  - Decreased capacity due to stringent infection control requirements;
  - The need to prevent patients having major surgery while they have COVID except for life, limb or sight-saving procedures, as their outcomes are likely to be poor;
  - Significant public concern about attending acute hospitals.

- Eye care
  - A drop in compliance is partly due to the COVID pandemic which has led to some patients choosing not to attend hospital appointments;
  - The provision of Ophthalmology services have been swiftly reconfigured to meet essential urgent care where required;
  - Routine surgery and face to face outpatient activity has been postponed;
  - Due to the population demographics, the majority of patients require hospital transport which has affected attendance;
  - The telephone triage of *Emergency Eye Casualty* by a senior clinician has reduced attendance by 50% with patients being managed via other routes, including Independent Prescribers in Optometric Practices;
  - Increased collaborative working with Community Optometric practices;
  - Ophthalmology relocated to Werndale to support the emergency service.

- Follow-up appointments
  - We are unable to deliver previous services, initial recovery of the 2019/20 position will be slowed by lack of capacity, infection control requirements and continued peaks of COVID.

Risks

- Hospital initiated cancellations
  - Numbers are affected by the current restrictions on safe elective surgery bed availability and fluctuating pressures relating to pandemic demands including appropriate safe bed distancing and consistent availability of protected locations for elective patients who have been self-isolating.

- RTT
  - The team are currently identifying risks due to reduced capacity across all stages inclusive reduced diagnostics. This will clearly identify the gap which will need a Health Board forward plan to resolve once we are confident cancer/urgent elective care is sustainable;
  - There is a significant risk regarding ward staffing vacancies to support elective activity.

- Eye care
  - New patients can wait longer due to a shortage of consultant ophthalmologists. Capacity being used to cover the *Emergency Eye Care* service can also impact on waiting times;
  - Outpatient appointments have been lost with approximately 166 new and 392 follow-up appointments not taking place.

- Follow-up appointments
  - Reduction in capacity, albeit face to face capacity, has impacted on the follow up list. This is being addressed with the rollout of virtual functionality, this is not without clinical challenge mainly due to confidence levels. The list continues to be validated virtually to ensure clean data. The team are working with both governance and safeguarding to ensure safety on process of virtual work.

What are we doing?

- Hospital initiated cancellations
  - Working to optimise available elective theatre lists, focusing on cancer pathways. Planning and collaborating with local patient flow teams to provide safe havens that promote safe elective patient stay.

- RTT
  - Capacity is being prioritised for category 1 & 2 patients following urgent pathways
  - Patients will be offered treatments in-line with policy across the sites to enable equity of time and care delivery;
  - Complex pre-assessment and screening pathways are in place including social isolation pre and post operatively with pre COVID screens at 72 hours;
  - The Health Board now have a revised post COVID watchtower monitoring programme.
  - Our plans for Q3/4 will enable the recommencement of urgent orthopaedic treatments

- Eye care
  - Maintained treatments and reviews for imminently sight threatening or life threatening conditions;
  - Although compliance had dropped, clinicians have been triaging patients waiting beyond 25% of their target date. This has led to an overall reduction in the number of patients on the R1 waiting list. This has ensured the correct clinical prioritisation of high risk patients is being undertaken and high risk patients are offered appointments first;
  - Postponed any patients on longer than an 8 week follow up. These patients have been put onto a COVID crisis holding category which is being reviewed by clinicians going forward;
  - Patients due back at 8 weeks or less are having their notes reviewed by a doctor to determine the appropriate action;
  - Senior input is available via telephone or email at all times and a consultant is on site at GGH from Monday to Friday;
  - All clinicians are reviewing clinics and contacting patients in advance;
  - The clinical team continue to see all ages of patients in the intravitreal injection therapy service including *wet aged macular degeneration, retinal vein occlusion* and *diabetic macular oedema*. This only applies if the patient is well and has no symptoms of COVID. Some patients do not want to attend due to risks, therefore there is a virtual clinical review happening weekly. This will change if and when the Royal College of Ophthalmology guidelines change.

- Follow-up appointments
  - We are encouraging virtual functionality, this is being rolled out but limiting factors include supporting staff at the pace of delivery and rollout. Face to face contact is being used if absolutely necessary for urgent patients.

Diagnostics

Executive Lead: Director of Operations **Senior Responsible Officer(s):** General Manager Scheduled Care

How did we do in September 2020?

5,918 patients waited over 8 weeks for a diagnostic test in September 2020 which is **462** fewer compared to the previous month.

How do we compare to our all Wales peers?

	Diagnostic waiting times	2nd out of 7

Impact of COVID

Performance has been affected because the number of patients that can be seen is reduced due to COVID precautions.

- Radiology
  - Some AGP (aerosol-generating procedures) investigations have been changed to alternative imaging;
  - Imaging capacity has significantly reduced due to infection control procedures required;
  - There are increases in referrals marked as urgent or urgent suspected cancer possibly due to late presentation.

- Endoscopy
  - We are currently delivering 46% overall activity in line with the National average of 40-50% post COVID activity;
  - All priority one (P1) patients are dated within 2 weeks;
  - Faecal Immunochemical Tests continue in line with National Endoscopy programme guidelines;
  - Business case completed and approved for introduction of capsule endoscopy service to further support reduce demand for scoping capacity.

- Cardiology
  - Some services have been moved off site e.g. cardiac monitors to facilitate 2 metre distancing for staff and patients;
  - 7 day working has been established to maintain social distancing and increase the number of diagnostic tests undertaken;
  - Recent increased number of referrals for Cardiology Diagnostics following the initial reduction in referrals at the height of COVID;
  - No resumption of Trans-oesophageal Echo or Dobutamine Stress Echo due to staff capacity and space constraints.

Risks

- For all areas capacity pressures, equipment failure and COVID precautions are impacting the service's ability to meet the 8 week diagnostic target.

What are we doing?

For all areas demand and capacity optimisation, outsourcing, clinical validation, recruitment and revising pathways continues.

- Radiology
  - Maintained services for urgent and suspected cancer work;
  - Most referrals have been kept and are monitored and reviewed regularly in discussion with other services;
  - We have maintained dialogue with colleagues across Wales for a review of the overall picture and possible solution to assist with the recovery. There is opportunity to evaluate referral pathways and ways of working to establish the new normal;
  - Additional capacity for computerised tomography (CT) has been acquired but delays in implementing the demountable solution has delayed recovery.

- Cardiology
  - Consultant review of diagnostic referrals on waiting list;
  - Cardiac CT is resuming at BGH and being scoped for PPH to reduce waiting times and avoid an invasive angiogram procedure (where clinically indicated);
  - Current in-sourcing of echocardiograms to support internal capacity to meet demand;
  - Diagnostic Angiography capacity increasing for 3 to 4 patient lists at PPH;
  - Cardio-physiology demand and capacity review on-going to identify prioritised actions to support further resumption of cardiology diagnostics.

Therapies

Executive Lead: Director of Therapies & Health Science **Senior Responsible Officer(s):** Assistant Director

How did we do in September 2020?

793 patients waited longer than 14 weeks for a therapy appointment. Services with the longest waits include; Podiatry (350), Audiology (338), Pulmonary Rehabilitation (252) Occupational Therapy (104)*.

** Waiting times for MH&LD patients are not included in this report as the data is not currently available due to a change in reporting systems this month.*

How do we compare to our all Wales peers?

	Therapy waiting times	3rd out of 7

Impact of COVID

- The Podiatry patients waiting are those non-urgent who require physical therapy, delays due to service restrictions as a result of the COVID pandemic. Occupational Therapy continues to be affected for the same reason although the service is deploying use of digital technology to support access e.g. *Remote Environmental Assessments*;
- Our virtual and remote service provision is now embedded within therapy services.

• Audiology

- Audiology still has service restrictions as to the reduced number of appointments available as a result of the pandemic;
- Audiology telephone follow-up consultations are now embedded in service provision. Only patients who require a face to face (F2F) appointments remain on the follow up list;
- Virtual consultations (phone) are conducted to help reduce the amount of time patients have to spend in the department;
- Audiology GP Assessment referrals are gradually increasing but are still lower than pre-pandemic with only 80 new referrals received across the HB in September 2020. This equates to a 71% declined when compared to September 2019.

Risks

- Reduction in clinical estate availability for therapy services provision due to estates being repurposed as part of acute COVID response;
- Reduction in clinical staff workforce due to shielding, and non-patient contact risk assessments for vulnerable/high risk staff;
- Reduced clinical efficiency due to physical distancing, infection, prevention and control requirements to operate safely;
- Access to suitable digital platforms at scale to support virtual therapeutic interventions, particularly applicable for Occupational Therapy.

• Audiology

- The cessation of routine Audiology clinical activity (assessment and subsequent hearing aid fittings) continues to impact on the service's ability to meet Referral to Treat (RTT) diagnostic targets;
- Limited access to suitable digital platforms to support patients;
- Reduction in clinical capacity due to supporting Ear, Nose and Throat (ENT) and availability of additional locations to provide services from.

What are we doing?

- Service capacity and efficiency provision impacted by the need for physical distancing compliance, Infection Prevention and Control practice, including physical decontamination between patients and clinical estate availability to address F2F clinical treatment requirements. Where appropriate, services are restarting pathways although capacity is reduced;
- Virtual and remote service provision being successfully implemented within therapy services with positive impact on RTT. Requires additional information and communication technology and deployment of digital platforms at scale as part of phase II deployments;

• Audiology

- COVID pre-appointment information is now sent with all Audiology appointment letters;
- Postal hearing aid repair service embedded at all locations;
- Urgent and routine adult patients are now being seen but there are still only limited appointments available;
- Urgent and routine paediatric appointments continue to be arranged
- Support for ENT clinics at GGH, PPH & WGH;
- Where clinically suitable, new patients are assessed and fitted with a hearing aid on the same day;
- Tinnitus waiting lists have been significantly reduced due to staff up-skilling to conduct telephone consultations.

Executive Lead: Director of Nursing, Quality and Patient Experience **Senior Responsible Officer(s):** Assistant Directors of Quality

How did we do in September 2020?

Clostridioides difficile (C.difficile) Infection is caused by a bacteria in the bowel that releases a toxin causing diarrhoea and bowel damage. September 2020 saw 8 cases reported, 5 of which were GP samples. This is 1% fewer than in the same timeframe of 2019/20, while the all Wales figure shows an increase of 18% in the number of cases. Cumulative rate for Hywel Dda has reduced from last month to **37.76** per 100,000 population. GGH reported two cases this month which is an improvement on previous months.

Escherichia coli (E.coli) blood stream infection (BSI). In September 2020 we reported 33 cases, a total of 153 cases this year in comparison with 211 in 2019/20 equivalent to 27% fewer cases. Cumulative rate for Hywel Dda is **79.14** per 100,000 population, increased from last month. This is similar to the picture being seen across Wales where there has been a decrease of 25% in the number of cases. Nearly half the cases this month were in GGH with 2/3rds being from the community.

Staphylococcus aureus (S. aureus) BSI. September 2020 reported 7 cases, 6 of which were present on admission to hospital. This gives a total of 46 cases year to date, 11 cases (19%) fewer than in 2019/20, while the all Wales figure shows a decrease of 10% in the number of cases. Cumulative rate **23.79** per 100,000 population, a reduction to last month.

In September, we reported 1,323 incidents of which 1,147 were patient safety related. Welsh Government asks Health Boards to ensure that there is timely and proportionate investigation of all incidents, and wherever possible, serious incidents are reviewed and closed within 60 working days. There were 3 serious incidents due for closure in September of which 2 were closed in the agreed timescale (**66.7%**), 1 Never Event was reported in September 2020.

63% of complaints were closed within 30 working days in September. The Health Board has received nearly 50% more complaints in September which are being *Managed Through Putting Things Right* (MTPR) than the previous month. Despite this additional workload, we continue to resolve a high number of complaints received and have closed a higher number of complaints than average this month (the second highest total in the year to date).

How do we compare to our all Wales peers?

C.difficile infections	5th out of 6
E.coli infections	5th out of 6
S.aureus bacteraemias (MRSA and MSSA) infections	3rd out of 6
Serious incidents assured in a timely manner	Not available
Timely responses to complaints	4th out of 9

Impact of COVID

- Infections
  - The increase in E.coli BSI this month has been seen in Carmarthenshire. There is concern that isolation is leading to reduced fluid intake in the elderly living alone or with isolated individuals.

- Incidents
  - Senior members of the Quality Assurance and Safety Team and Quality Improvement Team continue to meet regularly to ensure that there is connection between incident themes and the quality improvement work.

- Complaints
  - There was a marked decrease in the number of complaints received by the Health Board between April and June this year. Since July, we are seeing an increasing trend in the number of complaints being received via email and telephone. The main themes of the complaints are clinical treatment/assessment, communication and appointments.

Risks

- Infections
  - There are increasing numbers of winter viruses currently being reported, primarily Rhinovirus. This is leading to an increase in requests for COVID screening as the symptoms are similar, placing increased pressure on the screening process;
  - The demand on Personal Protective Equipment remains high but this is carefully monitored and Procurement continue to monitor demand and source supplies.

- Incidents
  - It is essential that there is a timely and proportionate formal review of each serious incident undertaken and that an improvement and learning action plan is developed and implemented to address the care and service delivery problems identified through the formal review.

- Complaints
  - There is a risk that the Health Board will continue to receive a higher number of complaints into the organisation because of the impact of COVID and this will put increased pressure on current resources.

What are we doing?

- Infections
  - Care Homes that identify residents as needing a COVID screen are also being asked for a respiratory screen. This is identifying issues early and they are being supported by Community Infection Prevention staff and Local Authorities;
  - Working with the Therapies service to safely interpret their professional guidance within the remit of Infection Prevention and Control;
  - Support staff with COVID isolation queries relating to family members and schools;
  - Work with Estates in identifying priorities for improvement work, identifying areas where improvement to the environment will improve the ability to decontaminate areas;
  - Work with Test, Trace and Protect Teams to support contact tracing in hospital COVID cases in patients and staff;
  - Work with Health & Safety and Occupational Health and ensure consistent advice is given to staff and issues are dealt with in a logical and uniform manner;
  - Ensure that the Infection Prevention Team that are able to vaccinate are updated and able to do so over the next few weeks to reduce the risk of respiratory infections to staff and patients.

- Incidents
  - As at 30th September 2020, there were 25 serious incidents open over 60-days. This is an improvement on the position reported last month where 26 serious incidents were overdue. The Quality Assurance and Safety Team continue to monitor and scrutinise the quality of these investigations;
  - Since 1st April 2020, 5 Never Events have been reported to Welsh Government (3 wrong site surgery and 2 retained foreign object post procedure). 4 formal reviews have concluded and the relevant directorates have developed improvement and learning plans to address the issues identified. For the Never Event, where the review is ongoing, a control group has been established to ensure that there is a timely formal review of the incident and to ensure that the closure form is submitted within the 60 day timescale.

- Complaints
  - The Patient Support Services department are utilising colleagues from other teams to assist with the increased number of telephone calls into the department to support the resolution of complaints within 30 working days.

How did we do in August 2020

19.7% of children and young people (277/1,407) waited less than 26 weeks to start a neurodevelopment assessment; combined figure for autistic spectrum disorder (ASD, 23.8%, 246/1,033) and attention deficit hyperactivity disorder (ADHD, 8.3% 31/374).

28.3% of adults (465/1,645) waited less than 26 weeks to start a psychological therapy with our Specialist Mental Health Service.

How do we compare to our all Wales peers?

	Children/young people neurodevelopment waits	7th out of 7
	Adult psychological therapy waits	6th out of 7

Impact of COVID

- Neurodevelopmental assessments
  - No Face to Face ASD/ADHD clinics held since the end of March 2020;
  - Delayed recruitment and anxiety to engage in Face to Face assessments.
  - New ways of working include exploring virtual clinics for new patients (telephone or attend anywhere). ADHD: telephone and *Attend Anywhere*, urgent Face to Face conducted together with Face to Face monitoring for potential side effects of Children and Young People who have commenced and or changes to medication.

- Psychological therapies
  - Increased the number of telephone assessments undertaken for adult psychological therapies;
  - Piloting *Attend Anywhere* as an alternative platform to deliver adult psychological services.

Risks

- Neurodevelopmental assessments
  - Delays can impact on the quality of life for patients and their families;
  - ASD: growing demand verses resources and difficulties in recruitment;
  - ADHD: historical referral backlog and vacancies within the team.

- Psychological therapies
  - Increased demand from primary and secondary care;
  - Vacancies and inability to recruit into specialist posts;
  - High waiting lists for both individual and group therapy;
  - Lack of a robust IT infrastructure.

What are we doing?

We are transferring our mental health patient records to a new system called *Welsh Patient Administration System* (WPAS) to allow timelier reporting.

- Neurodevelopmental assessments
  - Each mental health team is working with the all Wales performance Delivery Unit to undertake demand and capacity exercises;
  - Waiting list initiatives have been utilised;
  - Additional resources identified for a sustainable ASD service;
  - Efficiency and productivity opportunities are being explored;
  - An additional part-time community GP post has been recruited.
  - Actively reviewing and managing referrals and referral pathways;
  - A process mapping exercise is underway alongside the Delivery Unit;
  - An active recruitment plan is being developed;
  - Weekend clinics are being considered to increase assessment;
  - ADHD service advertising for consultant paediatrician. Speciality doctor recruited, due to commence Jan 2021.
  - Validation exercises are underway within the ADHD service;
  - Agency practitioners are being utilised to address the waiting list.

- Psychological therapies
  - A team restructure is underway;
  - Assessments are being undertaken either face to face or virtually;
  - Therapeutic appointments have been commenced utilising a blended approach of *Attend Anywhere, Face to Face* and *Walk and Talk* therapy;
  - Waiting list initiatives are being utilised;
  - A demand and capacity exercise will be undertaken with all staff to ascertain capacity in caseloads;
  - A review of all modalities will be undertaken to ensure prudent delivery of therapy in line with local and national policies/guidelines;
  - The use of evidence based group work is being evaluated to consider increasing capacity and reduce time waiting for therapies.

Population Health

Executive Lead: Director of Public Health

Senior Responsible Officer(s): Immunisation, Smoking and Obesity Leads

How did we do?

Between April and June 2020, **96.0%** of children had received 3 doses of the '6 in 1' vaccine by their first birthday, an increase in uptake on the previous quarter (95.5%).

The MMR vaccine is also given as a single injection and protects against mumps, measles and rubella (German measles). It is given within a month of a baby's first birthday then again when the child is around 3 years 4 months. In Hywel Dda, between April and June 2020, **90.3%** of children received 2 doses of the MMR vaccine by their 5th birthday, compared to 90% in the previous quarter.

During April '20 to June '20, **1.04%** (582) of adults attempted to quit smoking using a smoking cessation service. This is higher than the same period in the previous year.

Due to the COVID-19 pandemic, carbon monoxide (CO) levels were not recorded but 63.4% of recorded patients self-reported a quit during April '20 – June '20.

Obesity is a risk factor for many life-threatening conditions including diabetes, heart disease, bowel cancer and stroke. The most recent data (2017/18) shows that **11.8%** of 4-5 year olds and **23.0%** of adults aged 16+ living in Hywel Dda are obese.

How do we compare to our all Wales peers?

3 doses of the '6 in 1' vaccine by age 1	5th out of 7
2 doses of the MMR vaccine by age 5	7th out of 7
Smokers who attempted to quit	4th out of 7
Smokers CO validated as quit	3rd out of 7
Children aged 4-5 year who are obese	Not available

Impact of COVID

- Vaccines
  - Routine childhood immunisation programmes are a high priority and have continued, albeit in line with social distancing and PPE requirements in place;
  - The schools immunisation programme was restarted on 29th June 2020 as schools reopened.

- Smoking
  - Smokers are no longer CO validated at 4 weeks post quit date due to the potential risk of COVID-19 transmission in exhaled air;
  - All consultations are now provided via telephone;
  - Medical Humanities Research Centre (MHRC) approval received to supply Nicotine Replacement Therapy (NRT) via post in case there was an issue with access to community pharmacies and supply. This has yet to be fully implemented. Those unable to access NRT via a local pharmacy were posted their medication directly by their advisor by recorded delivery. Calls were made to each pharmacy to check their capacity and all stated they are still happy to process pharmacy letters for the smokers' clinic.

- Obesity
  - Managing the COVID pandemic has been and remains, an organisational priority for Public Health Wales. As such, the 2018/19 Child Measurement Programme report and the release of official statistics has not been possible;
  - Children will not have been measured universally in 2019/20 so the latest data that we have on childhood obesity in Wales is for 2017/18;
  - It is likely that school health nursing teams will focus (rightly) on immunisations and vaccinations going forward in 2020/21, so again, measurements for the coming year may not be done universally across Wales.

Risks

- Vaccines
  - Both vaccines are safe and effective, however pockets of the population resist childhood vaccination for cultural and ethical reasons;
  - Rurality causes difficulty for some families to attend clinics due to a lack of transport and the road networks in some parts of the counties;
  - The risk of COVID19 has raised concerns among parents/guardians, who may delay bringing infants and children for routine childhood immunisations,
  - leading to a decrease in uptake of all childhood immunisations, including the 6in1 and MMR;
  - The need for social distancing has significantly impacted on the way 'baby clinics' are traditionally run. Less infants, children and their families can safely attend their GP surgeries/clinics at any given time, hence more time is required for clinics. This can impact on uptake

- Smoking
  - Ensuring clear pathways are in place and used to help people quit smoking. This is especially important for inpatients and primary care.

- Obesity
  - Develop a weight management service/approach for children.
  - Ensuring that there is sufficient capacity within the weight management services to support adults to manage their weight.

What are we doing?

- Vaccines
  - We will aim to share vaccination uptake data with GPs as Public Health Wales are looking at providing enhanced localised uptake data throughout this COVID19 pandemic. This will enable GPs to more easily identify, plan, and target specific groups of patients;
  - Maintaining immunisation programmes is a key priority to protect public health from other preventable infections at this time. Welsh Government have advised that immunisations should continue in line with clinical advice and scheduled timings during this period as far as possible, as set-out in both a Joint Committee on Vaccination and Immunisation(JCVI) statement and in the Welsh Health Circular below:
    Link to JCVI statement
    Link to Welsh Health Circular
  - This advice has been shared with all those providing the childhood immunisation programme in Hywel Dda UHB. Advice on social distancing and use of PPE has also been shared with those providing this service. By being able to reassure parents/guardians that social distancing measures are in place will hopefully address their concerns, minimising the risk of them non-attending, and ensure continued high uptake rates.

- Smoking
  - Posters and training delivered to hospital sites. This work will need to be revisited post COVID. We are also looking into lanyard prompts to assist staff with the pathway and prescribing guidance.
  - In Primary Care, a revised pathway was created and following a successful pilot in a GP practice in Llanelli, 4 further practices came on board;
  - Paused recruitment of pharmacists and pharmacy technicians; Pharmacy referrals processed via Community and Secondary Care who are able to provide telephone support to relieve the burden on pharmacies;
  - Local Community and Secondary Care teams are offering telephone support and the referrals are being spread evenly throughout the teams and weekly team catch ups are taking place;
  - The current situation for community pharmacists is that CO validation is no longer provided. Level 3 services are continuing where pharmacists are comfortable taking on new clients and have the facilities to hold consultations taking into account social distancing requirements.
  - As CO readings are currently suspended, a document has been produced to ensure that support is still offered to pregnant women and that the impact of CO exposure is still discussed even where a reading is not being taken.

- Obesity
  - On the 4th August Welsh Government wrote to Health Boards outlining the current position regarding the *Healthy Weight Healthy Wales* delivery plan. The first two years of the plan placed a significant emphasis on early years, children and families to influence healthier choices. However, in light if the impact of coronavirus, a number of the interventions planned through the £5.5m allocation have had to be paused or postponed until a future date. The allocation will be used to strengthen the specialist level 3 multi-discipline team weight management service in line with National Standards and to extend the reach of the service for the benefit of children and families, recognising there is currently no provision for them;
  - In addition, a proportion of the Hywel Dda allocation would be used to fund the digitalisation of the *Nutrition Skills for Life* programme with a particular focus on the early years;
  - Weight management services are offered to adults with chronic conditions.

Workforce and finance

Executive Lead: Director of Workforce/Medical Director/Director of Finance

Senior Responsible Officer(s): Assist. Directors/Reval. & Appraisal Manager

How did we do?

5.25% of full time equivalent (FTE) staff days were lost due to sickness in the cumulative 12 month period September 2019 to August 2020. Whilst sickness rates have been somewhat higher due to COVID, the actual in-month rate for August 2020 was 4.45% which represented a slight increase from the previous month (4.39%), but a decrease from the same month last year (4.71%). Our rates remain the lowest of the larger Health Boards in Wales.

69% of our non-medical staff have completed their individual performance appraisal and development review (PADR) with their line manager in the previous 12 months. Hywel Dda is currently first in Wales for PADR compliance rate as of month of June 2020.

84.2% of our staff have completed their level 1 training which consists of the UK Core skills mandatory training modules such as manual handling, safeguarding and information governance.

36% of our Consultants and Specialty and Associate Specialist (SAS) doctors have a current job plan.

The Health Board's financial position at the end of August is a **£6.5m** (year to date (YTD) £31.8m) **deficit** against a deficit plan of £2.1m (YTD £10.4m). The additional costs of COVID-19 in the month was £10.7m. The improvement in Month 5 from Month 4 is due to a reduction in the fixed term cohort, negotiated rent reduction at a Field Hospital site and improvement in Central Income as lockdown restrictions eased

How do we compare to our all Wales peers?

Sickness absence	4th out of 10
Performance appraisal and development review	3rd out of 10
Level 1 core skills training framework completed	4th out of 10
Medical staff with a current job plan	Not available
Finance	Not available

Impact of COVID

- Absence
  - There was an increase in COVID related absence levels in April and May 2020, however, this has reduced over the summer.
- PADR
  - The compliance rate has fallen slightly for non-medical roles from the previous month, but Hywel Dda is maintaining the compliance rate which has seen the organisation rise to first across Wales for this measurement;
  - All clinical supervisions have been suspended until October 2020.
- Core skills
  - The core skills compliance rate has remained stable throughout COVID.
- Job planning
  - The total number of job plans reduced in accordance with the suspension of job plan reviews during the early stages of the pandemic;

    The number of reviews undertaken in July did increase on the month prior however, since the most recent rise in COVID cases, we have seen a slight drop in the number of reviews undertaken in September. This has been further impacted by the high number of staff changes which have occurred over the last couple of months and the increased focus on the recommencement of services.
- Finance
  - Aligning the strategic response to current demand modelling indicators between Welsh Government, Gold Command and operational teams; Further developing the Opportunities Framework to revisit the way in which our services were delivered pre-COVID in the context of accelerating the Health Board's Strategy.

Risks

- Absence
  - There has been a notable increase in sickness rates since the new All Wales Management of Attendance Policy was introduced;
  - Whilst the COVID pandemic continues, there is a risk that we will experience fluctuations in staff absence.
- PADR
  - Achieving the PADR target has become slightly more difficult with COVID due to employees being redeployed and assigned to different services. This may cause delays with PADRs being completed to timescale as notifications are not be necessarily being received by the existing line manager.
- Core skills
  - Despite an increase in core skill compliance, this could drop. The situation will be closely monitored.
- Job planning
  - Consultants and SAS doctors are not working to current job plans.
- Finance
  - We have a Financial Plan with a year-end of £25.0m deficit. A refined full year financial forecast was completed during August, further refining a 'realistic' assessment of the cost base and assumptions. Welsh Government have funded certain additional costs incurred as a direct consequence of COVID, however, there is no certainty of future funding arrangements. Without additional funding from WG, the Health Board will not achieve its revenue funding limit. Similarly, discussions are on-going for additional funding to support the non-delivery of the Health Board's savings target.

What are we doing?

- Absence
  - The Operational Workforce teams have re-commenced sickness reviews with Line Managers;
  - Sickness audits are due to start again shortly and will be conducted online through *Microsoft Teams*;
  - Online *Managing Attendance at Work* training to help support managers with absence will commence in October;
  - Managers are being actively encouraged to complete Risk Assessments with staff to ensure that they are adequately supported in the workplace and the right adjustments are in place to support staff as a preventative measure to absence;
  - Assisting in reviews and risk assessments for staff who are returning from shielding.
- PADR
  - Organisational Development (OD) has held informal virtual meetings to support leaders with PADRs when requested. This is in light of the Managers Passport and bespoke Performance Management development opportunities being stood down due to COVID;
  - A PADR training video for managers will be available by the start of October. The video will outline the operational process with a little theory to highlight the benefits that regular performance conversations and annual PADRs bring to the organisation. A virtual development session was piloted for IT leaders and was highly successful. A timetable of this session will be developed to compliment the operational video.
- Core skills
  - Continuing to offer on-line/telephone support;
  - Reminding managers of the importance of allowing staff the time to complete their mandatory e-learning modules.
- Job planning
  - A further 12% of job plans are awaiting sign off on the online system, with another 27% in draft awaiting completion;
  - The Medical Directorate will provide a comprehensive status report of job plan reviews for each service area to Service Delivery Managers, General Managers and Clinical Leads;
  - Service Delivery Managers will be reminded of the need to complete any outstanding job plan reviews and to ensure that initial job plans are in place for new staff members;
  - Technical support and guidance will continue to be provided;
  - Support relating to terms and conditions of service will continue to be provided by Medical Staffing.
- Finance
  - Internal budget holder accountability statements in relation to the 2020/21 budget were replaced with a *Delegations and Finance Delivery* letter, in light of the COVID pandemic. These clarify the continuation of existing financial control principles and the importance of existing governance processes and frameworks, stating the significance of decision making in response to, and the accurate recording of the financial impact of COVID;
  - Performance monitored monthly through System Engagement meetings for the highest risk Directorates;
  - An extensive review of savings and cost reduction opportunities is to be established as we plan to, 'return to exit' the current pandemic; Feedback/clarity from Welsh Government is being sought as to the levels of additional revenue and capital funding available.