

Performance update for Hywel Dda University Health Board as at 31th May 2020

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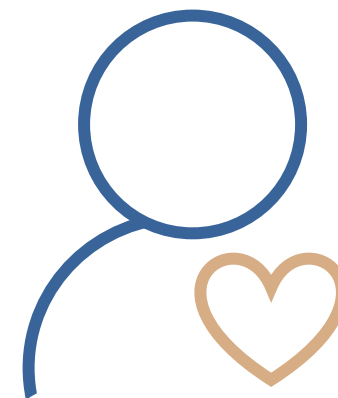
Unscheduled care

Cancer

Eye care

Population health

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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 31 st May 2020 1055	Suspected & confirmed COVID patients admitted 1 st -31 st May 403	Confirmed COVID patients discharged 1 st -31 st May 294	Confirmed COVID patients who died in one of our hospitals in May 17

Non-COVID

To provide the NHS with more capacity to deal with the COVID-19 pandemic, the Welsh Government have reduced national performance management requirements across Wales until the end of September 2020. The following are WG priority areas where measure reporting is continuing:

- **Where have improvements been made?**
 - 21 ambulance handovers were reported as taking longer than 1 hour during May 2020;
 - 86.7% of patients were seen within 4 hours in A&E/MIU (target 95%) and 56 patients spent longer than 12 hours (target 0);
 - Between January and March, 95.5% of babies had the recommended 3 doses of the '6 in 1' vaccine by their 1st birthday.
- **Where is improvement needed?**
 - Performance in respect of the Single Cancer Pathway declined by 5% from the previous month;
 - The 65% target was not met for ambulances arriving within 8 minutes to calls for patients with life threatening conditions (55.8%);
 - Between January and March, 90% of children had 2 MMR doses by age 5;
 - The percentage of non-urgent suspected cancer patients who commenced treatment within 31 days of referral has declined by 0.5%;
 - The percentage of urgent suspected cancer patients who commenced treatment within 62 days of referral declined by 13.3%;
 - 44.6% of high risk Ophthalmology patients waited no more than 25% over their clinical target date, a decline of 7.9% compared to April.
 - We have a financial plan with a year-end projected deficit of £25.0m. The current financial position at the end of May is £14.734 deficit against a deficit plan of £4.1m.
- **Impact of COVID-19**
 - Staff absence has increased due to COVID and in addition it is estimated 2-3% of staff are self-isolating;
 - Some staff have been deployed from their substantive posts to assist with COVID-19 planning (e.g. recruitment and establishing field hospitals);
 - Most elective procedures and outpatient appointments have been cancelled to create capacity for staff training and COVID-19 patient admissions;
 - Staff are taking additional time for the putting on and taking off (donning and doffing) of 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 ED departments beyond the 4 hour threshold;
 - Where possible, staff have shifted to working from home which has required additional IT infrastructure and resources;
 - Fewer therapy appointments have occurred due to the increased risk of face to face contact and reduced staffing;
 - Non-urgent diagnostic investigations have been deferred with urgent & cancer related diagnostic investigations receiving priority;
 - Mental Health and Learning Disability patients have had reduced leave (i.e. attending social activities or shopping) to limit their risk of exposure.

We are also continuing to locally monitor performance across the Health Board. The [performance overview matrix](#) gives the latest position for all areas other than catering and substance misuse; with the exception of substance misuse, for which we are reliant on NWIS and awaiting guidance, we aim to recommence performance reporting for these areas from next month (May's data).

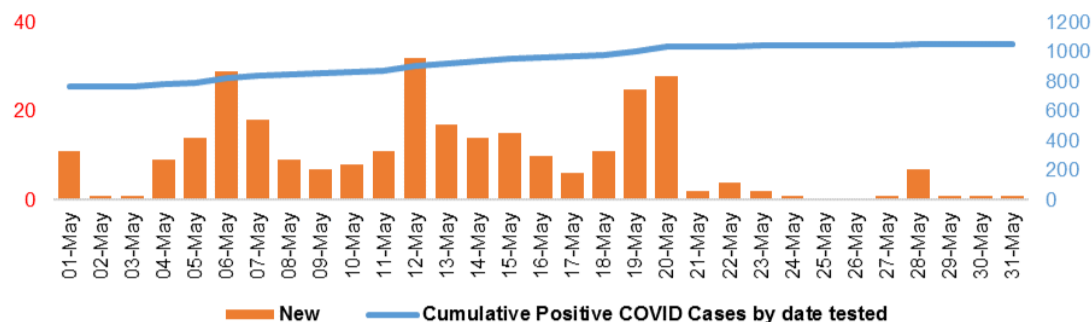


The COVID-19 pandemic has already had a massive impact on our staff and services and we expect that this will continue well into 2020/21. As an organisation we are rising to the challenge and we will do so for as long as is needed.

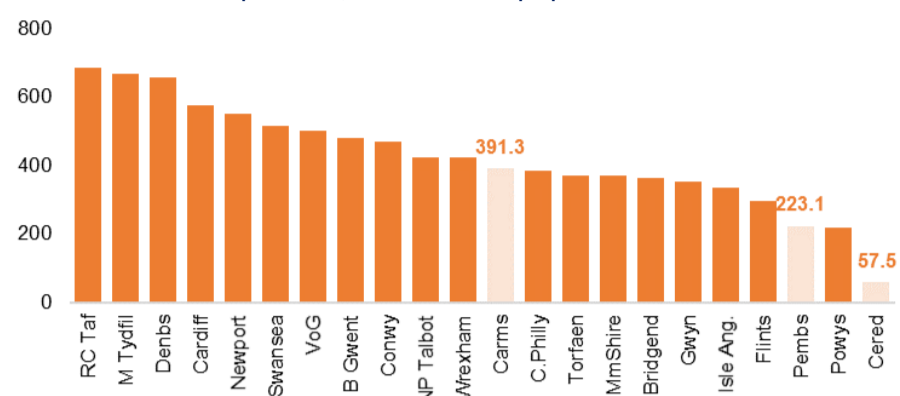
Confirmed cases

As at 31st May 2020, there were 1,055 confirmed cases of COVID-19 for Hywel Dda residents, an increase of 296 cases from 30th April 2020. The highest number of new positive cases tested was on 12th May with 32 new cases. Population rates for confirmed cases are seen to be lower in Hywel Dda than in many other local authority areas. On 31st May 2020, Ceredigion had the lowest local authority rate in Wales (57.5 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 from 7am to 9pm every day. 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 May the command centre had on average 99 calls per day from staff (3,062 in May overall). 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)

The availability of PPE is a concern for all key workers during the COVID pandemic. We are closely monitoring our PPE stock levels and orders to ensure sufficient levels are maintained to protect our staff and patients. We are grateful for the overwhelming support we have received from the community (e.g. local companies, schools, individuals) to help us with this.

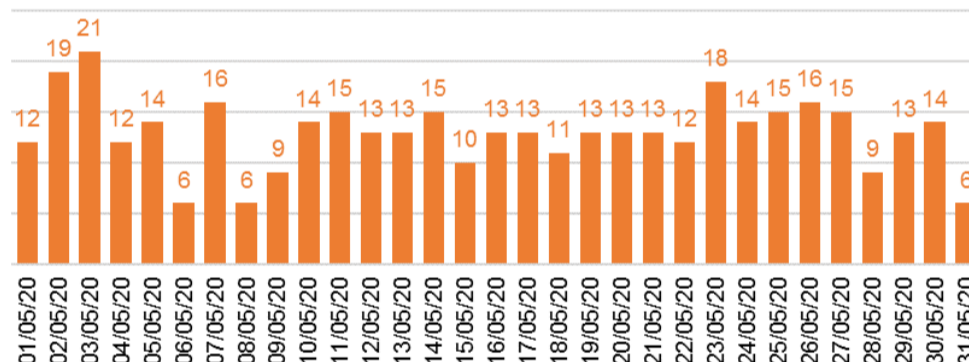
Admissions

Between the 1st and 31st May there were 403 COVID (confirmed and suspected*) admissions to our acute hospital sites; 25 in Bronglais General Hospital (BGH), 184 in Glangwili General Hospital (GGH), 67 in Prince Philip Hospital (PPH) and 127 in Wylabach General Hospital (WGH). This is an average of 13 COVID admissions a day across the Health Board and approximately 16% of all inpatient admissions. Non-COVID inpatient admissions averaged 71 per day over the same period.

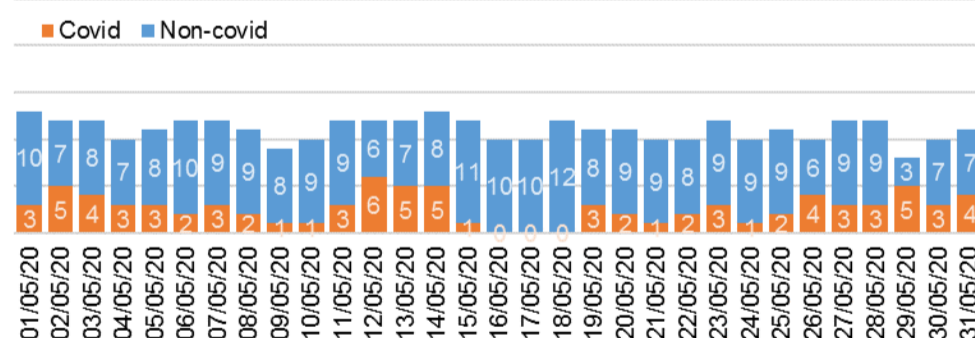
We have worked hard over the last 3 months to create 9 field hospitals across Hywel Dda. These new sites offer important flexibility for us to care for additional patients if the demand for acute hospital capacity exceeds threshold levels.

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

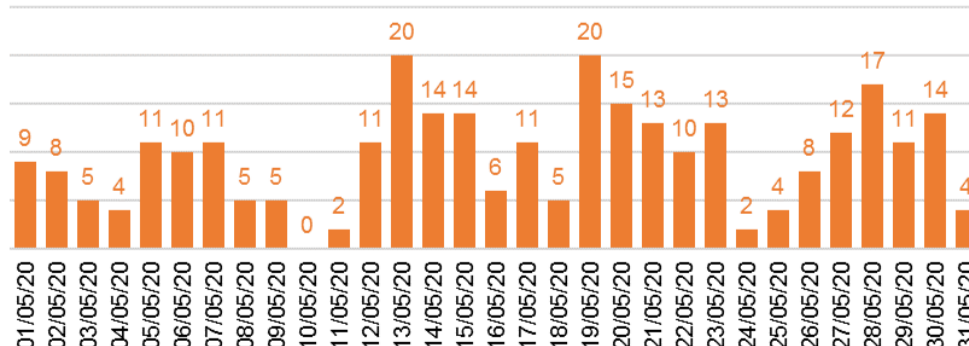
Hywel Dda daily COVID* admissions during May 2020



Number of patients in an invasive ventilated bed during May 2020



Number of COVID patients discharged during May 2020



Discharges and deaths

Between 1st and 31st May, 294 COVID patients were discharged from hospital alive. Sadly, 17 patients died in our hospitals during May after being admitted and subsequently having a confirmed diagnosis of COVID-19.

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/>



Non-COVID overview

This section includes summary information on some of the key areas that we prioritised to make improvements in 2019/20 and we are continuing in 2020/21. Due to the COVID 19 pandemic, we are providing data updates for all available indicators. However, to reduce the burden of our key operational staff, we have only included narrative for those areas Welsh Government have flagged as priority areas where measure reporting should continue. 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?	Notes **
Unscheduled care	Ambulance red calls	65%	59.9%	56.7%	55.8%	No	Carms 55.71%, Cere 56.4%, Pembs 55.8.1%. WAST are carrying out a deep dive into declining performance.
	Ambulance handovers over 1 hour	0	204	37	21	Yes	Ambulance arrivals decreased, however, handover to clear has significantly increased due to the need to remove PPE and clean vehicles.
	A&E/MIU 4 hour waits	95%	82.8%	86.5%	86.7%	Yes	In May '20 there was a 39% reduction in the number of new attendances compared to May '19. GGH had the highest 4 hour performance in May '20 (91.2%) and we met trajectory for both 4 and 12 hours performance. Where appropriate, some patients received extended clinical assessments within Emergency Dept. beyond the 4 hour threshold.
	A&E/MIU 12 hour waits	0	920	47	56	Yes	
	Non-mental health DTOC	12m↓	43	43	43	n/a	Due to COVID-19, DTOC census patient number monitoring has been suspended until Sep'20. Latest data is based on unverified numbers from the National DTOC database as at 3 rd June '20.
	Mental health delayed transfers of care (DTOC)	12m↓	8	8	11	n/a	
Stroke and cancer	Admission to stroke unit <4 hours	59.8%	58.1%	79.2%	63.6%	Yes	Due to COVID-19, data submission was suspended in March. Local data is now available from all 4 sites for March to May. Data gaps are being investigated in GGH for Mar/Apr and PPH for Apr/May. Whilst we are meeting HB targets, compliance is lowest for admission to a stroke unit within 4 hours at GGH (42.9%) and speech and language therapy at GGH (32.3%) and PPH (20.9%).
	Assessed by stroke consultant <24 hours	84.2%	95.9%	100%	95.8%	Yes	
	Stroke patients - speech and language therapy	12m↑	43.1%	46.3%	47.5%	Yes	
	Urgent suspected cancer	95%	87.5%	79.2%	65.9%	No	Reported performance relates to April '20. Performance decline is mainly due WG suspension of; routine diagnostic/surgical activity, tertiary pathways and all aerosol generated diagnostic interventions.
	Non urgent suspected cancer	98%	94.5%	96.4%	95.9%	No	
	Single cancer pathway	12m↑	84%	79%	74%	No	
Planned care and therapies	Hospital initiated cancellations	5%↓	148	1,072	700	No	During Apr '20, 676 of the 700 cancellations within 24 hours were in response to the pandemic.
	Delayed follow-up appointments (all specialties)	12m↓	39,425	33,882	35,471	No	The number of delayed follow-up appointments has increased due to non-emergency outpatient appointments being postponed in light of the pandemic.
	Ophthalmology patients seen by target date	95%	64.9%	52.5%	44.6%	No	Despite a 7.9% drop in performance, which is primarily due to patient cancellations, high risk treatment is continuing.
	Diagnostic waiting times	0	185	3,860	7,669	No	The cancellation of routine appointments has significantly increased the number of patients waiting beyond 8 weeks for Radiology & Cardiology diagnostic tests. Both services have confirmed that clinically led validation arrangements are in place to prioritise urgent referrals.
	RTT – patients waiting 36 weeks+	0	246	2,202	5,311	No	In line with the WG instruction to Health Boards, non-urgent pathways have been suspended. The number of patients waiting > 36 weeks for treatment increased by 3,109 from April to May '20 and is 5,065 higher than May '19.
	RTT – patients waiting <=26 weeks	95%	89.0%	78.7%	71.4%	No	
	Therapy waiting times	0	138	880	1,528	No	Highest rates for Physio (780), & Podiatry (489) – these are 'hands on' therapies.
Quality and safety	C.difficile	<=25	36.7	31.6	36.6	Yes	Cumulative reduction rate reporting has been stood down until July '20. As an interim measure we are reporting the rate per 100,000 population of infections.
	E.coli	<=67	110.2	78.9	76.3	Yes	
	S.aureus	<=20	30.6	31.6	15.3	Yes	
	Serious incidents	90%	7.1%	17%	12.5%	n/a	In May '20, 1 out of 8 SIs were closed within the WG timescale. There were no never events reported.
	Complaints	75%	52%	61%	63%	No	Continued reduction of time available for services to resolve investigations, however, this is now improving.
MH +	Children/young people neurodevelopment waits	80%	35.3%	22.9%	25.8%	No	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. Where suitable assessments have continued by telephone.
	Adult psychological therapy waits	80%	n/a	50.2%	45.5%	No	
Population Health	'6 in 1' vaccine	95%	92.8%	96.3%	95.5%	Yes	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, including the 6 in 1 & MMR.
	MMR vaccine	95%	90.6%	91.7%	90.0%	No	
	Attempted to quit smoking	5%(ytd)	3.4%	2.6%	3.5%	n/a	COVID-19 presents a risk to smokers accessing cessation support services and to be CO validated as quit.
	Smoking cessation - CO validated as quit	40%	49.7%	48.4%	30.3%	n/a	
Workforce & finance	Sickness absence (R12m)	12m↓	4.87%	5.19%	5.29%	No	Covid-related pressures impact on workforce performance: • Limited Occupational Health capacity but carrying out assessments for staff identified as vulnerable as required • Medical appraisals remain suspended until September • 5% increase in fire safety compliance (68.6%) in May
	Performance appraisals (PADR)	85%	80.0%	68.6%	67.4%	No	
	Core skills mandatory training	85%	81.0%	81.6%	82.7%	Yes	
	Consultants/SAS doctors - current job plan	90%	66%	78%	58%	No	No Job Plan reviews since mid-March due COVID-19 to be resumed as soon as possible.
	Finance - deficit	£25m	£6.018m deficit	£6.288m deficit	£14.734m deficit	No	Board's financial position at the end of May is £14.7m deficit against a deficit plan of £2.1m. Additional costs have been incurred in response to the COVID19 pandemic.

+ 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



The impact of COVID and our plans to reset

THE COVID pandemic has had a considerable impact on our services, the way we work and our performance; with both positive and negative impacts witnessed. This section outlines some of the changes we have had to make along with our plans to reset and move forward within the ongoing restrictions that COVID brings.

The accompanying [Performance Trend Charts](#) document provides data on how our performance has been affected by COVID-19 and how this compares to our planned trajectories for 2020/21.

Area	Impacts to performance (both positive and negative) and new ways of working	Our reset plans
Ambulance red calls	<p>Performance has been negatively affected by COVID infection control requirements.</p> <p>The service has incorporated the following new ways of working:</p> <ul style="list-style-type: none"> • Working/partnership across teams to problem solve and innovate; • Ensuring communicating channels are clear and regular; • Huge steps forward in digital – roll out of Office 365, iPads, Teams, Zoom, home working, video, education; • The redesign and transformation of recruitment and training processes. 	<ul style="list-style-type: none"> • Recruit and train more staff as agreed in demand and capacity (D&C) review; • Respond to major service changes in the Health Board; • Set up planning for electronic patient care record system and 111 IT system; • Continue to work on major capital schemes e.g. Aberaeron and Pembroke Dock; • Complete Clinical Contact Centres and Non-Emergency Patients Transport Service D&C reviews; • Secure resources to replace over 100 vehicles in our fleet and refresh fleet plans for the future. • Build on work such as website and expand clinical advice.
Ambulance handovers and A&E/MIU waits	<ul style="list-style-type: none"> • Ambulance handover: <ul style="list-style-type: none"> ○ 1 hour handover delays have significantly reduced. However, ambulance handover time has increased due to the increased cleaning of vehicles between patients; ○ WGH: delays in Green Emergency Dept. (ED) due to increased walk to relocated department; • A&E/MIU waits: <ul style="list-style-type: none"> ○ GGH: 4 and 12 hour performance has significantly improved due to additional medical staff and senior clinicians at the front door. • Capacity limited by: <ul style="list-style-type: none"> ○ Maintaining Covid and non-Covid streams at front door and on the wards. Creation of a 3rd stream for elective surgery; ○ Time efficiencies - donning and doffing, Covid swabs results taking up to 3 days if they have to be sent to Cardiff; ○ Maintaining social distancing for staff and patients - reduced bed capacity by approx. 25%; ○ Staffing - absence through shielding and nurse vacancies (pre-COVID issue); • Non-COVID emergency demand returning to normal levels; • Anecdotal reports from clinical staff of very sick patients who have presented late – potentially due to fear of Covid. 	<ul style="list-style-type: none"> • Continue to maintain segregated red & green streams in EDs and hold regular reviews to reduce Covid designated areas; • GGH: Continue Senior A&E consultant and medical support to the front door (A&E and CDU). Consultant presence at x3 daily bed meeting to ensure all pathways have capacity and correct proportion of red and green beds. 24/7 COVID consultant on call to provide advice on all COVID related matters and patient assessment and transfer. • Prioritise hospital space for acute services and develop plans to move non-acute and administrative services off hospital sites; • WGH Streaming Unit to be relocated to develop further redirection service as community services become available again; • Consider options to change infrastructure of wards to minimise the number of beds lost due to social distancing; • Development of local COVID testing in GGH, BGH and WGH; • Address registered nursing recruitment; • Work with community to develop escalation plans that may include use of field hospitals.
Delayed transfers of care	<p>Positive Impact:</p> <ul style="list-style-type: none"> • Allowed our population to develop 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; • Service has retained robust response to the provision of care and support across all three counties. <p>Negative Impact:</p> <ul style="list-style-type: none"> • The extent of any impact caused by admission avoidance in relation to excess deaths is unknown; • Fragility of the independent care sector further compromised due to workforce retention; • Resilience of the care home sector compromised due to outbreaks (financial and workforce issues). Further impacted due to Public Health Wales guidance re. no admissions until 28 days after last positive test result; • Staff absences across community Discharge 2 Recover and Assess (D2RA) pathways; • Limited capacity for rapid processing of swab testing prior to discharge; • Lack of Elderly Mental Illness nursing bed availability causing DTOC for these vulnerable individuals with specialist needs. 	<ul style="list-style-type: none"> • Work collaboratively with Local Authority to further develop capacity within D2RA pathways, to ensure attainment of standards as outlined in the Welsh Government Discharge Requirements and Primary Care & Community Framework (PCCF); • To review and sustain 'Bridging Care' through embedding into D2RA pathway; • Increase Intermediate Care beds for people not yet able to return to embargoed Care and Residential Homes; • Implementation of hospital based swab testing and processing; • Strengthen intermediate care response in the community through embedding of standards outlined in the National Institute for Health and Care Excellence, National Audit of Intermediate Care, Covid-19 PCCF to support conveyance/admission avoidance where appropriate; • Integrate essential service provision between Primary Care and Community services in relation to Long Term/Chronic Conditions management; • Embed Telehealth solutions where possible and appropriate to support Intermediate, Palliative and Proactive Care pathway; • Better integrate of Palliative Care across our whole 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 frail older patients and those with Mental Health/Learning Disabilities needs.
Stroke	<ul style="list-style-type: none"> • The stroke units and teams have coped extremely well during this very difficult time. • PPH, BGH and WGH have maintained a steady high % of patients being admitted with 4 hours to the stroke units. GGH have struggled but have seen an improvement recently. Discharging back to the community has improved. • All 4 sites have hit the targets for patients to be reviewed by a stroke consultant within 24 hours. • Improvement has also been seen regarding the recommend minutes of speech and language therapy (SALT) each patient receives. SALT had been difficult to maintain prior to COVID. 	<ul style="list-style-type: none"> • All 4 sites have now returned to their own standalone units. WGH are piloting a new footprint. • All 4 sites have now started completing the full SSNAP data set. • SALT maintains to be an issue.

Area	Impacts to performance (both positive and negative) and new ways of working	Our reset plans
	<ul style="list-style-type: none"> Some sites have reported less stroke patients coming through the doors however WGH have seen the same amount of patients from last year's figures. Across all 4 sites the team have been doing virtual follow up clinics for both stroke and TIA patients. Some teams feel that patients have been discharged safely but may have poor outcomes due to lack of in-patient rehabilitation due to the COVID crisis. They have tried to follow up in the community. 	
Cancer	<p>COVID has had a negative impact on performance due to the following:</p> <ul style="list-style-type: none"> Suspension of any aerosol generated diagnostic tests and surgery in line with Royal College guidance has caused delays; Tertiary centre delays; Suspension of local surgery for those patients requiring HDU/ITU support post operatively and further restrictions in clinical criteria that apply e.g. patients whose BMI exceeds 35 and have existing comorbidities; 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 pandemic, as an alternative due to the current restrictions on the normal diagnostic pathways; Although urgent and USC imaging investigations are still being undertaken, they are reduced to being within the parameters offered by national clinical guidance for certain aerosol generating procedures; Bronchoscopies have been limited in line with national guidance. <p>The following outlines how the service has incorporated new ways of working:</p> <ul style="list-style-type: none"> As per the 6 levels of Systemic Anti-cancer Therapy (SACT), all levels are still currently being treated across the Health Board; Werndale Hospital has been commissioned to support cancer outpatient & surgical pathways during April & May 2020; Joint working progressed with regional multi-disciplinary teams for tertiary centre surgeons to provide outreach surgery in Gynaecology and Urology. 	<ul style="list-style-type: none"> Plans are being developed to reintroduce elective cancer care for those patients who do not meet the criteria for Werndale Hospital or require HDU/ITU support on the GGH site. This plan commenced on 30th April 2020 with one operating list per week reinstated on the GGH site; Bronchoscopy service to recommence on the PPH site week commencing 11th May 2020; The Health Board will reinstate endoscopy services for cancer patients within the next 3 weeks across our hospital sites. This will be reinstated via a phased approach starting on 18th May 2020 at PPH with other sites to follow pending completion of logistical changes to Red/Green zones.
Referral to treatment times	<p>COVID has had a negative impact on performance due to:</p> <ul style="list-style-type: none"> Services do not resemble previous service we are able to deliver and initial recovery of the 2019/20 position will be slowed by lack of capacity, infection control requirements and continued peaks of COVID; At the point of the COVID response the Health Board were positioned to maintain the RTT 36 week target and the efforts that were made to ensure delays were minimised across the planned care system for 2020; The magnitude of the task ahead. At present (May 2020) the Health Board has over 5,000 breaches, a figure not recorded since 2014/15. Reset plans will require additional time and resources, and will prove difficult without additional investment in resources, facilities and staff; Decreased capacity due to stringent infection control requirements; Appropriate supplies of PPE and enhanced hotel facilities requirements; The need to prevent patients having major surgery while they have coronavirus except for life, limb or sight-saving procedures, as their outcomes are likely to be poor; Significant public concern about attending acute hospitals; All Standard Operating Procedures for surgical services, operating theatres and critical care will need careful review and adjustment as necessary; The impact on tertiary treatments. 	<ul style="list-style-type: none"> Functional capacity of both bed and diagnostic space is required to assess the capability and test the system to restart planned care; Planned care had experienced significant bed capacity issues pre COVID across sites due to winter pressures and medical specialities requiring surgical bed space to cope with demand, this had developed a reliance on backfill, waiting list initiative lists, weekend working and also the private sector. The post COVID transitional footprint already looks and feels very different to this; To alleviate public concern, especially in hotspot areas and in the close aftermath of pandemic, there is potential merit in a 'clean hospital' approach of treating cohorts by site. All these factors need careful planning and may impact on timing of surgery and both anaesthetic and surgical staff deployment. The Health Board is working towards implementation of a centralised Critical care plan; Maximising surgical activity in the presence of the aforementioned processes will require streaming patient flows using patient shielding before admission and testing such that COVID-19-positive and COVID-19-negative pathways are created and used appropriately. All standard operating procedures for surgical services, operating theatres and critical care will need careful review and adjustment as necessary. Consideration of streamlining members of the surgical, anaesthetic and theatre teams such that those teams doing elective work are separate to those doing emergency and on call work.
Eye care	<p>The COVID-19 pandemic has come at a fast pace and has meant that the provision of Ophthalmology services have been swiftly reconfigured to meet essential urgent care where required however performance has been affected by:</p> <ul style="list-style-type: none"> All routine ophthalmic surgery and face to face outpatient activity being postponed; Due to the population demographics, the majority of patients require hospital transport which has affected attendance; Although aged macular degeneration (AMD) services continue, initially a number of patients were reluctant to attend; Ophthalmology relocated to Werndale to support the emergency service, however, Werndale is only licenced to see adults, therefore Paediatric arrangements continued at GGH. <p>New ways of working include:</p> <ul style="list-style-type: none"> An AMD consultant letter advising patients of the risk of non-attendance to their sight which has increased attendance; The telephone triage of Emergency Eye Casualty by a Senior Clinician which has reduced attendance at this clinic by 50% 	<p>Reset plans include:</p> <ul style="list-style-type: none"> A comprehensive Situation, Background, Assessment, Recommendation (SBAR) has been prepared which outlines the reset process. It includes detailed plans that cover the complexities each sub-specialty presents during the pandemic. It is in line with the Royal College of Ophthalmologist Covid-19 clinical guidance and outlines how the service will work towards a five phased plan based on patient safety and clinical guidelines; Prior to COVID-19 the service has been under pressure to meet its growing demand, therefore, additional redesign services post-COVID-19 will include: <ul style="list-style-type: none"> Reviewing all waiting lists; Developing AMD services by recruiting nurse injectors; Running dedicated General Anaesthetic whole list days and reviewing theatre timetables; Developing nurse led services and upskilling staff; Rolling out the glaucoma review services and various hubs established during COVID-19;

Area	Impacts to performance (both positive and negative) and new ways of working	Our reset plans
	<ul style="list-style-type: none"> with patients being managed via other routes, including Independent Prescribers in Optometric Practices; Increased collaborative working with Community Optometric practices due to COVID-19. 	<ul style="list-style-type: none"> Continue working with community optometrists; Delivering remote triage/use technology to minimise face to face appointments; Reviewing data to streamline mixed specialties; Validate follow up lists; Ongoing review of staffing levels due to shielding and COVID-19 symptoms.
Therapy waits	<ul style="list-style-type: none"> Covid has had a negative impact for Physiotherapy and Podiatry waiting times as that they are a physical hands on modality. Clinical activity has been limited to urgent/high risk patients as per the urgent vs non-urgent guidance; Podiatry waits have increased due to a move to reporting via Welsh Patient Administration System (WPAS) from manual processes for Carmarthen and Llanelli localities. Validation work scheduled to ensure any outstanding data entry on WPAS is completed. This should see the figures reduce. A re-submission may be requested next month. Other services have successfully managed to continue with significant elements of their activity remotely, using digital interface. Speech & Language referral figures have also dropped especially in relation to education referrals; All services have undertaken telephone consultations to ensure high risk and vulnerable service users are supported remotely; Telephone consultations are now being routinely used where appropriate in place of a face to face consultation; CMATs Physio service has gone live trialling Attend Anywhere digital platform for Consultations and expansion into Dietetics and Podiatry as part of CMATS pilot; Potential to explore group consultations via digital media to explore group therapy applications. 	<ul style="list-style-type: none"> All services developing service plans that outline how to resume prioritised clinical and therapeutic activity in a safe, efficient and sustainable way, taking account of staffing, environment and equipment needs against available resource; Services identifying new ways of working that are currently in place to continue to support reset planning, and ensuring Therapy Services continue to support scheduled and unscheduled care pathways; Exploration of digital solutions to address challenging areas e.g. where group therapy classes would be previously delivered, e.g. Pulmonary Rehab.
Delayed outpatients & Diagnostics	<ul style="list-style-type: none"> Performance has been affected negatively following the Welsh Government announcement to “contain” the “delay” phase of COVID 19 by suspending all non-urgent outpatient appointments and non-urgent surgical admissions but ensuring urgent appointments are prioritised. This was executed across Health Board and included the cancellation of all non-urgent outpatient, diagnostics and planned surgery with the exception of life threatening cancer surgery, urgent sight threatening Ophthalmology care and Endoscopy. Outpatients clinics have been suspended apart from urgent, fracture, multi-disciplinary team, do not cancel patients and unscheduled care clinics. All specialities have undergone rigorous clinical validation of clinic lists to prevent access to the acute sites which are considered at risk of COVID-19 spread. 	<ul style="list-style-type: none"> All outpatient face to face appointments are being clinically reviewed with a view to the majority of work becoming virtual in order to minimise face to face contact; All Endoscopy units will return to function on all sites with a clinically led validation programme supported by FIT testing. However capacity will be reduced for aerosol generating procedures; Volumes of backlog are currently being assessed to include Urology diagnostics.
Diagnostics (Radiology)	<ul style="list-style-type: none"> Radiology maintained the services for urgent and suspected cancer work; Some AGP have been changed to alternative imaging; All other 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; It's important to recognise that imaging capacity has significantly reduced due to infection control procedures required; Positives include the opportunity to evaluate referral pathways and ways of working to establish the new normal. 	<ul style="list-style-type: none"> Radiology continues to meet fortnightly to assess the ever changing landscape; Referrals are currently being reviewed and re prioritised in line with Royal College of Radiologist guidelines . Some low priority requests will be discussed with referrers to establish if they are still required; Reviews of scheduling taking into consideration the need for red and green capacity on each site will help identify the gaps in overall capacity; Continue to work with the Imaging Essentials Group across Wales to share ideas and understanding nationally and regionally on the bigger picture. This is being used to inform Welsh Government; Reviewing pathways in line with other clinical directorates to establish the priorities in which imaging modalities are required first.
Healthcare acquired infections	<ul style="list-style-type: none"> Negative outcomes from Covid included x3 staff shielding, impacting training provision. Reviewing areas to provide advice & supporting staff; Unreliable IT and Wi-Fi for homeworkers; Increased workload across acute, community and primary settings also Local Authority around care homes, schools, home visits, fire service; Additional and refresher staff PPE training required due to 11 changes in PPE guidance; Reconfiguration of wards, redistribution of staff; medical, nursing and allied; A positive impact has been that all staff across the HB have increased knowledge of PPE and spread of infection. 	<ul style="list-style-type: none"> Covid19 work: Care Home Testing, Track Trace and Protect, Operational guidance for reset - for Acute, Community, Primary Care and Local Authority; Recommence quarterly audits where possible; Ensure all staff take some annual leave in the next 6-8 weeks.
Complaints	<ul style="list-style-type: none"> Covid has had a negative impact due to services having less time to dedicate to handling their complaints. However, May has seen some improvement in the number of complaints responded to within 30 working days. To continue our Patient Support Services telephone line, our team has been enabled to take calls from home (via computer); Clients now offered audio/video meetings with senior staff members to discuss their concerns. 	<ul style="list-style-type: none"> The Team has quickly adapted to the changes and have successfully maintained the service during this challenging time. Many of the new innovations will continue to be offered as a way of providing prompt resolution to complaints.

Area	Impacts to performance (both positive and negative) and new ways of working	Our reset plans
Neurodevelopmental and psychological waits	<p>COVID has had a negative impact on ADHD performance due to no face-to-face clinics been undertaken since the end of March 2020.</p> <ul style="list-style-type: none"> The service has processed new referrals, by sending parents/guardians a position letter outlining that there are no face-to-face clinics and signposted to other agencies/resources for support (e.g. Team around the Family, ADHD foundation). Anyone with an urgent concern or emergency are advised to contact their GP. <p>COVID has had a negative impact on performance for psychological waits:</p> <ul style="list-style-type: none"> Delaying recruitment to vacant posts; Anxiety to engage in face to face assessments. New ways of working include increasing the number of telephone assessments undertaken and piloting Attend Anywhere as an alternative platform to deliver services. 	<ul style="list-style-type: none"> Neurodevelopment ADHD services are trialling virtual platforms to re-commence follow up and new appointments. Psychological services <ul style="list-style-type: none"> To actively recruit suitably skilled additional staff; Have established a rolling rota for staff to be in work and work from home; Have established a date to resume face to face activities; Will continue to see patients with a mixture of face to face/telephone assessments and therapy interventions. Identify suitable accommodation for the delivery of face to face interventions that comply with social distancing.
Childhood immunisations	<ul style="list-style-type: none"> 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 is temporarily suspended. 	<ul style="list-style-type: none"> Reset plans for childhood immunisation programme not required at present as the programme is continuing to be delivered. Enhanced uptake surveillance of childhood immunisations is being carried out by PHW during this COVID period, and any areas of poor uptake or concern can then be identified quickly and measures put in place e.g. extra clinics/support to address any issues. Planning is ongoing to re-instate school immunisation programmes where possible, with the school nursing teams working in collaboration with local authority partners to look at ways/venues to vaccinate children safely following social distancing and PPE guidance. There are no sessions planned as yet but work is ongoing to re-establish sessions as soon as practicably possible.
Smoking	<ul style="list-style-type: none"> All consultations are now provided via telephone; Smokers are no longer CO validated at 4 weeks post quit date due to the potential risk of COVID-19 transmission in exhaled air; Medical Humanities Research Centre (MHRC) approval was received to supply Nicotine Replacement Therapy via post just in case there was an issue with access to community pharmacies and supply. This has yet to be fully implemented; Following the transfer of Stop Smoking Wales staff from Public Health Wales to the HB, a new integrated smoking cessation services has been created to provide continuity of care across secondary care, primary care and community. 	<ul style="list-style-type: none"> Undertake an evaluation of telephone support; Currently looking at opportunities to provide group support via a digital platform such as Microsoft Teams and focus on condition specific groups that can provide additional peer support; Continue to implement the Wellbeing/Health Coach model; Undertake research to understand the impact of COVID-19 on smoking behaviour.
Workforce (includes sickness, core skills and PADR)	<ul style="list-style-type: none"> There has been a significant increase in Covid-related absence levels with an in-month sickness rate of 6.24% in April 2020 compared with 5.14% in April 2019. The core skills compliance rate has remained relatively stable across mandatory training modules with a 0.5% decline in overall compliance before the Covid outbreak in February 2020 but a 1.1% increase since April. The PADR compliance rate has fallen for non-clinical roles to under 70% for first time since October 2018. All clinical supervisions have been suspended until September 2020. 	<ul style="list-style-type: none"> County Workforce teams will start to reinstate their normal sickness absence reviews with managers and Attendance Management training if training rooms become available. Staff absence reviews with occupational health will be reinstated when capacity in the Occupational Health Service allows. Occupational Health continues to provides assessments for staff that fall within the vulnerable and extremely vulnerable categories as required. Preparation for the flu season and the flu vaccine roll out will commence over the next couple of months. Managers are being asked to support staff to continue mandatory training. Online mandatory fire safety training is now available on ESR. The Occupational Development (OD) team have sent out communications reiterating the need for continued performance conversations and yearly PADRs. The messages highlight how these conversations support staff wellbeing. The OD team are currently reviewing how they can deliver classroom learning virtually. The team are in the process of reviewing platforms such as Skype, Microsoft Teams and virtual classrooms to make an informed decision on which is best suited for this type of learning. The team have started reviewing the performance management session and breaking this down to meaningful 30-60 minute learning sessions. The roll out of these sessions should begin July/August 2020, depending on a suitable platform being identified.
Finance	<ul style="list-style-type: none"> Align the strategic response to current demand modelling indicators between Welsh Government, Gold Command and operational teams. 	<p>Work is currently on-going to:</p> <ul style="list-style-type: none"> Finalise the Quarter 2 Operational Plan, which is likely to impact the financial forecast. Gain clarity as to what current escalation measures can be safely and appropriately de-escalated/decommissioned and which ceased/deferred services/activities can be recommenced; Continue to work with Welsh Government to understand the level of additional revenue and capital funding available.



How did we do in May 2020?



55.8% of ambulances arrived to patients with life threatening conditions within the 8 minute target.



21 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). This is the lowest reported number since Jul'17 (37).



8,592 patients attended an A&E/MIU in May as a new attender. Of these patients, **86.7%** were seen and treated within 4 hours of arrival but **260** patients waited longer and **56** patients waited over 12 hours; There has been a 39% reduction in the number of new attendances compared to May '19 and 48% year to date.



In May there were 2,636 emergency admissions compared to 3,903 in May '19, to our hospitals of which 1,805 (69%) were admitted via A&E/MIU. On average medical emergency patients stayed in hospital for 10 days (May'19-May'20).

Risks

- Ambulance staff must put on (don) Personal Protective Equipment (PPE) for all calls, and higher specification PPE where procedures produce airborne particles or respiratory droplets. Some staff have to don the full Versoflow hood and battery pack due to failing the PPE fitting test;
- Ambulance handovers of patients >1 hour have reduced, however the time taken to become operational again has extended due the need to remove PPE and clean vehicles;
- Ambulance staff availability due to COVID19 related self-isolation and/or sickness and shielding;
- A deep dive is currently being undertaken following a further worsening of red performance and will be shared with the health board when complete
- Existing vacancies and staffing of the additional field hospitals with Registered Nurses (RN) and Health Care Support Worker (HCSW) for both the new Red (suspected COVID19 symptoms) and Green (no suspected COVID19 symptoms zones in the emergency departments (ED). Deployment of staff unaccustomed to ED could impact patient flow;
- Staff availability due to COVID19 related self-isolation and sickness; loss of regular agency/partnership nurses due to social distancing travel requirements; Junior doctors assigned to ED are being called back to their speciality rota's which will increase waiting times in ED;
- Residential and Care Homes requiring:
 - residents to have a negative COVID19 test before they are returned from hospital (ward or ED);
 - residents to have a negative COVID19 test before discharge home with reablement or a long term package of care;
 - residents to be returned to the home within 10 hours of being discharged from an ED;
- Off-site COVID19 testing, significantly delayed results (up to 72 hours) and cross border 'discharge to assess' challenges;
- Vacancies & sickness in Community Teams/Hospitals negatively impact the efficient transfer of some patients from acute sites. There are some delays in reablement and long term care package availability due to both COVID19 concerns and staff shortages;
- Daily differences in Red and Green zone capacity to treat patients and the number of patients needing the service. There might be more patients in Green zone than in Red;
- Establishment of Green ED has created a second access pathway for ambulances. There were some handover delays due to additional infection prevention processes undertaken by ambulance crews to protect staff and patients and increased patient flow through Green ED;
- Emerging increase in 'contact' patients who need a designated 'Amber' area since the Welsh Government implementation of 'Test, Track, Protect';
- In WGH the Ambulatory Emergency Care & Surgical Assessment Units have merged into a Green ED zone, so some patients have remained in the department for a longer period of time with the intention of a quick turnaround, rather than admitting to a ward area;
- The need to maintain social distancing for staff and patients has reduced bed capacity;
- Urgent cancer pathway has a backlog of patients requiring surgery.

What are we doing?

- Welsh Ambulance Service Trust (WAST) trained military personnel to undertake several roles, such as drive the ambulance and support the WAST clinicians; Deep cleaning of vehicles before becoming operational; Military personnel deployed with our Advanced Practitioners and rapid response vehicle to support the don and doffing PPE process. A number of Mid and West Wales Fire and Rescue staff trained to support WAST, awaiting occupational health clearance before they can be deployed;

- Detailed COVID19 plans on each site having Red and Green zones in the ED and defined inpatient wards;
- Patient streaming system implemented at the front door to screen for symptoms of potential COVID19;
- HCSW recruitment above normal levels to provide staff for acute and community hospitals;

Withybush

- Established a short stay medical inpatient unit during May '20 with the aim of improving patient flow out of the Green zone ED and discharging from this area within 48 hours. This has shown initial signs of success;
- WGH established a Blue team consisting of senior hospital medical staff and Advanced Practitioners, to work with the intermediate care team to set up care and support systems for patients to remain at home. The Blue medical team extended their scope to screen all referrals for hospital admissions including from GPs and WAST (with the exception of emergency priority calls) resulting in good levels of admission avoidance;
- A Consultant Geriatrician and a GP have commenced joint visits to care homes to review patients, ensuring care plans and Do Not Attempt Cardiopulmonary Resuscitation directives/Advanced Care Plans are in place;
- In hospital a Chronic Conditions Advanced Nurse Practitioner commenced during April and is now supporting the establishment of more focused reviews of patients with prolonged stays, turnaround from short stay unit and enhance links with community chronic conditions teams for those already in WGH;
- Further conversion of Red capacity to Green capacity planned for June 2020 to improve pathways out of the Emergency Department for surgical and trauma patients.
- Establishment of twice weekly Respiratory multi discipline team meeting between General Medical team, Physiotherapist and Specialist Nurse in WGH and Respiratory Team in PPH where appropriate case studies are discussed. Meetings to be recorded and used as a teaching tool to those working alternative shifts in WGH;
- Work continues in WGH and Pembrokeshire County colleagues to establish discharge pathways, e.g. discharge with voluntary sector support, discharge to assess, discharge to care home or intermediate care bed, discharge to community hospital, early supported discharge for patients post Stroke.

Glangwili

- Established a Consultant led COVID19 hub to provide follow up of COVID19 patients;
- Clinical leads meet weekly to ensure flow of emergency medicine and surgical pathways;
- Fortnightly joint Consultant, Nursing and Management meeting to review all acute pathways and forward planning of reintroducing and expanding patient services;
- Reviewing a portable cabin to replace the tent for ED, to ensure all patients who are potentially COVID19 positive are assessed outside of the Green ED department;
- Ring fenced beds for Urgent Cancer patients requiring surgery;


Prince Philip


- Reducing COVID19 designated areas in PPH as far as is possible whilst maintain separation of COVID and Non-COVID patients;
- Prioritise PPH space for acute services and develop plans to move non-acute and administrative services off hospital sites;
- Consider options to change infrastructure of wards to minimise the number of beds lost due to social distancing;
- Development of local COVID testing in GGH, BGH, WGH but not PPH;
- Plans to address registered nursing recruitment;
- Work with Community to develop escalation plans that may include use of Field Hospitals;


Bronglais

- Dedicated COVID19 team of medics and nurses continues to be operational, however dual rotas have been disbanded for the present due to low numbers. However the potential to reverse this decision remains;
- Management team and Scheduled Care directorate have agreed a plan for elective work – commencing with Cancer procedures and clinically urgent cases to recommence on site from the end of June; Endoscopy will recommence at BGH from quarter 2;
- Developing the 'return to new normal' plan for BGH which encompasses much of the learning we have gained from rapid change due to COVID19;
- Recently appointed Frailty Consultant is working actively with his team to support Primary Care with Frailty and specific initial focus will be on the 2 largest local care homes;
- Recently appointed advanced therapy practitioner is establishing a therapy led rehab pathway and programme of care for step down from ITU ventilation. This was initially part of the COVID19 plan, however will become operationalised as a site service due to the available expertise and personnel.

How did we do in April 2020?

 During April 2020, **65.9%** (58/88) 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 13.3% decline compared to the previous month. This reflects an approximate 50% reduction in the volume of patients treated during the month as a consequence of COVID19.

 **95.83%** (92/96) of patients who were not on an 'urgent suspected cancer' pathway commenced treatment within 31 days of the date the requirement for treatment was agreed with them.

 We are working towards implementation of the new single cancer pathway (SCP) to monitor progress of all newly referred cancer patients from the point of suspicion until treatment starts. The new pathway increases the number of patients who will be monitored during the diagnostic phase. In April, **74%** of patients covered by the SCP were treated within 62 days of the point of suspicion. This represents a 5% decline compared to the previous month.

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 (SBUHB) continue to significantly compromise our performance across a number of cancer pathways;
- Local diagnostic service capacity pressures within our Radiology service continue to present a risk to recovery;

- The new Single Cancer pathway significantly increases the number of patients monitored during the diagnostic phase, placing added pressure on diagnostic capacity;
- During the latter part of March, tertiary surgery was suspended due to COVID-19;
- Locally, surgery for those patients requiring intensive care/high dependency (ITU/HDU) support and all aerosol generated diagnostic investigations were suspended due to COVID-19 as per national guidance.

What are we doing?

- We are continuing to escalate our concerns regarding tertiary centre capacity and associated delays;
- The Health Board (HB) has secured recurrent investment from Welsh Government (£340k per annum) to invest in key diagnostic service capacity (Radiology, Endoscopy, Pathology, Dermatology) and tracking teams;
- Due to all tertiary Gynaecology surgery in SBUHB being suspended, the HB has arranged for the Consultant Gynaecology Oncological Surgeon at SBUHB to provide outreach surgery to help address delays for surgery;
- We are logging all patients who are not having investigations/diagnostics/surgery whether due to patient choice or cancelled by hospital on clinical grounds due to COVID-19;
- All urgent suspect cancer and imaging investigations continue as usual;
- The HB has commissioned Werndale Hospital to support cancer outpatient & surgical pathways during April & May 2020;
- Plans are being progressed in accordance with the WG Operating Framework to further increase the volume of cancer diagnostic and surgical cases undertaken at local acute sites.

How did we do in May 2020

 In May 2020 **44.6%** of patients (5,028/11,261) were waiting in or within 25% of their target date which represents a 7.9% decline compared to April 2020 at 52.5% (6,114/11,660). 98.3% of patients have been allocated a high risk factor (HRF) status leaving 268 (1.7%) patients waiting for an allocated HRF status.

Although the percentage performance has declined there are a number of R1 patients who have had immediate appointments and have not been included in the performance calculations. There is a validation exercise being undertaken to rectify this and ensure those patients in the over 50% category have undergone clinical review and are correctly prioritised. Since January there has been a reduction of 876 R1 patients and a 2,635 drop in patients overall on the Ophthalmology waiting list.

Risks

- New Eye Care 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;
- The COVID-19 pandemic has affected the following eye care services:
 - Outpatient appointments have been lost with approximately 166 new and 392 follow up appointments not taking place;
 - Approximately 190 surgical procedures have not occurred;
 - From 16th to the 31st March the overall waiting list has grown by 315 patients for stage 1 and 34 patients for stage 4;
 - The overall waiting list growth is lower than expected due to a reduction in referrals for both routine and emergency surgery.


What are we doing?


During the COVID-19 pandemic the Eye care service has:

- Maintained treatments and reviews for imminently sight threatening or life threatening conditions;
 - A drop in compliance is partly due to the COVID pandemic which has led to some patients choosing not to attend hospital appointments:
 - New 246 (25% for March as opposed to yearly average 14%);
 - Follow up 549 (27% as opposed to yearly average of 15%);
 - Total 795 (26% as opposed to yearly average of 15%).
 - 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 phone or email at all times of the day and a consultant is on site at Glangwili General Hospital from Monday to Friday;
- All Clinicians are reviewing clinics and contacting patients in advance as far as possible;
- 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 no symptoms of COVID-19. Some patients do not want to attend due to risks, therefore there is a virtual Clinical review happening weekly. This will change when and if the Royal College of Ophthalmology guidelines change.



How did we do?

 The '6 in 1' vaccine is given as a single injection to protect babies against 6 serious childhood diseases: diphtheria, hepatitis B, Haemophilus influenzae type b (Hib), polio, tetanus and whooping cough. The '6 in 1' vaccine is given at 8, 12 and 16 weeks old. Between January and March 2020, **95.5%** of children had received 3 doses of the '6 in 1' vaccine by their first birthday, consistent with uptake in the previous quarter (96.3%).

 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 January and March 2020, **90.0%** of children received 2 doses of the MMR vaccine by their 5th birthday, compared to 91.7% in the previous quarter.

Risks


- 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.

What are we doing?

- 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.



How did we do in May 2020?

 The Health Board's in month financial position at the end of May is **£8.4m deficit** against a deficit plan of £2.1m. This is after incurring additional costs of £9.8m directly attributable to COVID-19. Of this, £2.5m is due to the non-delivery of savings having diverted our operational focus to managing the COVID-19 pandemic. In May, we delivered £0.2m of savings schemes against our plans of £0.3m due to the operational responses required to COVID-19.

Risks

- We have a Financial Plan with a year-end of £25.0m deficit. A full year financial forecast was completed in May in line with the Welsh Government (WG) Quarter 1 Operational Plan; this will be refined once the Quarter 2 Operational Plan is finalised. Welsh Government have indicated that whilst certain specific additional costs incurred in response to the COVID-19 pandemic will be funded by WG, there is no certainty of funding beyond these specific areas. This means that there is a significant risk that the Health Board's financial position may be adversely affected.

What are we doing?

- 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-19 pandemic. These clarify the continuation of existing financial control principles and the importance of existing governance processes and frameworks, and state the significance of decision making in response to, and the accurate recording of the financial impact of COVID-19;
- An alignment of strategic response to current demand modelling indicators between WG, HDUHB Gold Command and operational teams is on-going;
- Feedback/clarity from Welsh Government is being sought as to the levels of additional revenue and capital funding available.