Bundle Quality, Safety & Experience Assurance Committee 9 June 2020

3.1 COVID 19 Response Update

Presenter: Andrew Carruthers

Item 3.1 COVID-19 Response 9th June 2020

Appendix 1 - Response to WG COVID-19 Operating Framework Q1

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

PWYLLGOR ANSAWDD, DIOGELWCH A SICRHAU PROFIOD
QUALITY, SAFETY AND EXPERIENCE ASSURANCE COMMITTEE

DYDDIAD Y CYFARFOD: DATE OF MEETING:	09 June 2020
TEITL YR ADRODDIAD: TITLE OF REPORT:	COVID-19 Response Update
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Andrew Carruthers, Executive Director of Operations
SWYDDOG ADRODD: REPORTING OFFICER:	Andrew Carruthers, Executive Director of Operations

Pwrpas yr Adroddiad (dewiswch fel yn addas)
Purpose of the Report (select as appropriate)

Ar Gyfer Trafodaeth/For Discussion

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

The purpose of this report is to provide the Quality, Safety and Experience Assurance Committee (QSEAC) with an Operational overview of the University's Health Board COVID-19 response update.

Cefndir / Background

The Minister for Health and Social Services issued a statement to the NHS on 13th March 2020. The statement required Health Boards to suspend a range of services, and take a number of actions. By implementing the guidance, as a Health Board, it enabled us to prepare, both in terms of service redesign, and also plan for staff training, to ensure we could meet the imminent and significant surge in COVID-19 demand that we believed we were facing.
The guidance included:

1. Suspending non-urgent outpatient appointments and ensure urgent appointments are prioritised.
2. Suspending non-urgent surgical admissions and procedures (whilst ensuring access for emergency and urgent surgery).
3. Prioritise use of Non-Emergency Patient Transport Services (NEPT) to focus on hospital discharge and ambulance emergency response.
4. Expedite discharge of vulnerable patients from acute and community hospitals.
5. Relax targets and monitoring arrangements across the health and care system.
6. Minimise regulation requirements for health and care settings.
7. Fast track placements to care homes by suspending the current protocol, which gives the right to a choice of home.
8. Permission to cancel internal and professional events, including study leave, to free up staff for preparations.
9. Relaxation of contract and monitoring arrangements for GPs and primary care practitioners.
10. Suspend NHS emergency service and health volunteer support to mass gatherings and events

Welsh Government issued further guidance document to NHS in Wales called 'Maintaining Essential Health Services during the COVID-19 Pandemic'. This can broadly be defined as services that are lifesaving or life impacting i.e. where harm would be significant and irreversible, without a timely intervention. Irreversible for purposes of palliative and end of life care will include anything that will not realistically improve within the remaining life span.

In moving to support essential services across the University Health Board, the following series of key initiatives and decisions were taken.

Primary Care Services

- General Medical Services
  - Providing enhanced care services over bank holiday periods
  - Continuation of the immunisation schemes
- Community Pharmacy Services
  - Dispensing services, working with palliative care teams in relation to supply of palliative care drugs & working with Local Authority colleagues to provide Monitored Dosage System (MDS) to support discharge of patients who need care packages and conversion from MDS to original pack for domiciliary care staff
- Dental Services & Optometry
  - Provision of red and green pathways for access to community services in line with current infection control and prevention requirements
- Optometry
  - Provision of red and green pathways for access to community services to avoid requirement to attend secondary care services

Community Services

- Providing services that maintain people's health and well-being of those with a known long-term condition – avoid admission;
- Urgent new health issues which require time sensitive nursing and / or Allied Health Professionals intervention;
- Palliative care services;
- Care home support & prioritisation;
- Integrated community rehabilitation, reablement and recovery;
- Integrated community teams / virtual ward;
- Rehabilitation pathways;
- Safeguarding – all ages.

Acute Secondary Care

- Urgent surgery continuing on a risk based approach with alternative treatment approaches being considered where deemed clinically appropriate;
- Urgent cancer treatments continuing with a regional aid approach in place ;
- Lifesaving medical & paediatric services continuing on a risk based approach;
- Maternity & Neonatal services;
- Urgent eye care.

On 6th May 2020, Welsh Government (WG) issued a third set of guidance. WG announced Wales was moving out of a period of COVID-19 critical planning and response, and into a longer period where the health and care system must remain both prepared for any future peaks and effectively providing essential services and other high quality care and treatment for the people of Wales.

Therefore, in order to maintain momentum and to ensure the system continues to focus its attention on the provision of a wider range of services, the NHS Wales COVID-19 operating framework for quarter 1 (2020/21) was issued. The document highlighted four types of harm that could emanate from COVID-19 that Health Board's must remain focused on and guard against.

These are:

- Harm from COVID-19 itself;
- Harm from an overwhelmed NHS and social care system;
- Harm from a reduction in non COVID-19 activity;
- Harm from a wider societal actions / lockdown.

The Operational Framework outlines not only the need to deliver essential health services for our population, but where possible recommence more routine care. The Framework states the NHS needs to do this progressively and with caution, through short planning cycles that will maintain the flexibility and agility that has been witnessed over recent months.

Asesiad / Assessment

The Committee requested to receive an update specifically on the following subject matters in order that it can be assured robust plans and services are in place, or actively being progressed.

1. Field hospitals;
2. Which Non-COVID-19 activities have now increased;
3. Issues regarding discharging of patients to the care home sector;
4. Patient experience and update on Family Liaison Roles;
5. Update on Orthodontic and Ophthalmology Activity during COVID-19.

However, in order to provide a holistic Operational overview, the Health Board's Quarter 1 response report to the NHS Wales COVID-19 operating framework is attached as Appendix 1. The document details include:

- A specific focus on Essential Services, any risks and regional solutions;
- A summary of new ways of working and plans for evaluation;
- Clear roles and activity plans for independent sector facilities and field hospitals;
- Progressive implementation of routine activity;
- A reflection of local discussions with partners about social care resilience;
- Workforce plans including use of additional temporary workforce;
- Financial implications;
- Risks to delivery.

1. Field hospitals

There are currently 9 Field Hospitals across 7 sites offering 921-bed capacity across the three counties, all of which are entering the final build stages in terms of estates and equipment. However, following the new modelling assumptions and deductions from these figures, it is highly unlikely that the Health Board will see the peak model numbers, initially published by Public Health Wales (PHW), and are now following PHW version 2.4 40%, which suggests flatter peaks for COVID-19 demand over an extended period. WG have advised that Health Boards should plan against the assumptions in PHW version 2.4 40%. There are a number of assumptions in that model that may over-inflate the anticipated model for Hywel Dda as a region, and therefore a modelling cell within the Health Board continues to review our actual

demand data in an attempt to develop a model that more accurately forecasts what might be expected locally based on the live experience both locally and nationally.

As the organisation remains at critical incident level 4 and as the revised modelling indicates there may be a significant demand and capacity challenge as winter commences, the Health Board has continued to work on the premise that all 9 sites may be required and thus should be ready for operationalisation as and when required, at 7 days' notice. This approach also supports the pre-existing organisational strategy to maintain acute sites at approximately 80% occupancy rate, which has subsequently been confirmed as an expectation within the Annual Operating Framework and allows the additional capacity to be considered within a winter planning context.

As part of reviewing the ongoing potential implications of COVID-19 through 2020/21, the Health Board is scoping all alternative uses for the Field Hospitals in order to support the wider acute, community and social care system. This work has informed a phasing/hibernation plan, which is based on the current preparedness, risks per site and community/winter pressure assumptions.

2. Which Non-COVID 19 activities have now increased

The Health Board continues to maintain its list of Essential Services. The following actions are being progressed, to ensure patients continue to receive the best care possible, during both the current and post COVID-19 position.

Acute Services – Schedule of Services

Outpatients - Non-Urgent clinics cancelled until 26th June 2020

- Outpatient and treatment services for Urgent Suspected Cancer (USC) and other urgent patients for General Surgery, Colorectal, Breast, Urology, Gynaecology and Ophthalmology have all been relocated to a local private hospital.
- As COVID-19 management of services are unlikely to resume their previous format, the Health Board is actively establishing the use of digital technology to reduce the requirement for 'face to face' non-urgent consultations for all specialties. Digital services can include virtual clinics, See on Symptoms (SOS), telephone and video clinics and clinical validation. These services are a key element within WG National outpatient's strategy and have the potential to transform the management of outpatients in the Health Board. Virtual telephone clinics have been established in most services, with more being added daily.

Urgent & Emergency Surgery

- Plans for increased trauma surgical volumes will be assessed according to COVID-19 demand patterns and availability of facilities at Glangwili General Hospital (GGH), Withybush General Hospital (WGH) and Bronglais General Hospital (BGH).
- Urgent Cancer Treatments - endoscopy cancer diagnostic procedures to recommence during June 2020 via a phased approach pending completion of logistical changes to Red/Green zones at individual sites.
- As per the Wales Bowel Cancer Initiative, the use of FIT10 in the management of urgent suspected cancer patients on colorectal pathway during COVID-19 pandemic is being explored as an alternative due to the current severe restrictions on the normal diagnostic pathways. FIT10 screening will commence within 2 weeks of agreement.
- Surgery - Priority Level 3 (surgery which can be delayed up to 12 weeks without a predictive negative outcome) colorectal resection & nephrectomy procedures scheduled to recommence from 2nd June 2020.

- Life-Saving Medical Services (including Critical Care) - Arrangements for critical care service provision are being reviewed in parallel with plans for the expansion of urgent and cancer surgery at each acute site.
- Imaging - Plans for expansion of imaging services for routine referrals are being assessed for inclusion in the Health Board's Q2 proposals for service provision in line with the WG operating Framework.
- Cardiology - A managed increase of investigations for other urgent patients referred is planned for June 2020. Details are currently being reviewed and assessed via the Acute Bronze Group.

Community Services

- In summary, those services which were deemed non-essential as part of immediate COVID-19 contingency, will continue to be suspended. For all services provided, alternative means of provision has been considered e.g. clinics rather than home visits, use of technology or patient led care with oversight of nursing team;
- Essential provision which will be prioritised includes proactive care of chronic conditions, intermediate care, palliative care and further early years services.

Mental Health and Learning Disabilities (MH&LD) Services

- Commissioned service reviews remain suspended. Phone reviews however, are continuing, but these are less detailed.
- Group interventions, as part of Local Primary Mental Health Services are not able to be delivered
- Learning Disabilities Intensive Support Team were previously suspended from normal duties although, partially recommencing
- Memory Assessment Services remain suspended. Urgent work is processed via Single Point of entry Triage. A recovery plan which references new ways of working safely, is being progressed, albeit, a formal resumption date has not been set.
- Acute Hospital Dementia Wellbeing Service is available upon demand. Currently the Acute Hospital Base Wards are not available, due to COVID-19 and internal reconfiguration.
- Integrated Psychological Therapy telephone services continued as normal. However, implementing the Therapy care element of care is challenged, due to the lack of a digital platform on which to launch. Progress is being made, with the service now running a pilot called, "Attend Anywhere".

3. Issues regarding Discharging of patients to the Care Home Sector

A Regional 'Risk and Escalation Management Policy' has been developed and agreed by the West Wales Care Partnership (WWCP). This provides our overarching joint approach to supporting care home resilience in relation to COVID-19. It outlines how we will monitor risk and implement escalation processes to mitigate impact on the care home residents and the care home itself. Welsh Government have acknowledged this collaborative work by the Health Board and its Local Authority partners as exemplar.

WG recently published their 'COVID-19 Discharge Requirements' [1] and the Update to Guidance in respect of Step-up and Step-down Care Arrangements during the COVID-19 period.[2] This update specifically relates to the discharge arrangements for inpatients who are

[1] Welsh Government (April 2020) *COVID-19 Hospital Discharge Service Requirements (Wales)*

[2] WG (2020) Update to Guidance in respect of Step-up & Step-down Care Arrangements

being discharged to care and nursing homes and the testing requirements associated with those discharges. The policy outlines the WWCP Region's response to this guidance and provides the Region with an overarching framework of principles and standards that each County System should implement.

The WWCP Discharge Requirements policy document is also developed in response to WG request for the Health Board's plan against Quarter 1 of NHS Operating Framework for COVID-19[3].

The Discharge Requirements set out hospital discharge requirements that the Health Board, the three local authorities (Carmarthenshire, Ceredigion and Pembrokeshire), the third sector and other independent parties MUST adhere to and implement during the 'COVID-19 Emergency Period.

The foundation of these requirements are those developed as part of the 'Every Day Counts; Home First 'ethos and the associated Discharge to Recover and Assess (D2RA) pathways. The WG discharge requirements now provide the opportunity and platform to develop a regional standard for discharge coupled with local delivery

The Health Board Gold Command have tasked the Bronze Community Group to provide a response to the WG discharge requirements and as such;

'To develop a plan which would promote the efficient and safe patient transfer from hospital for patients (COVID-19 and Non COVID-19) requiring care home admission or step down care in bedded facility.'

A Task and Finish Group has been established, recognising however that this would involve a wide range of stakeholders from across the 3 Local Authorities' and the 4 acute hospital sites, Task and Finish Group members engaged with wider stakeholders; representation includes senior decision makers from the Health Board acute and community directorates and Local Authority partners.

The WWCP document outlines the current position on pathways 3 and 4 i.e. how each County whole system has designed its plans according to its own infrastructure and Field Hospitals, and how this is to be used at time of extreme pressure. This describes the proposed methods to monitor the latter; i.e. through Daily Operational Command in each County (as per Care Home Risk and Escalation Management policy), heat map showing escalation levels across the whole system and risk assessment prior to transfer outlined in appendix three to ensure safety of transfer, etc.

Infection Control & Prevention Services provide a weekly summary to all 3 counties of the current COVID-19 status of residents within care homes. Anecdotally, there have been issues raised around care home residents who have attended Emergency Departments (ED) and are then being discharged, as the updated guidance only relates to testing for inpatients and does not offer guidance for ED attenders. In response to this, Local Authority partners provided an advice note to Care Home Managers and Service Providers for residents attending ED or Outpatient Appointments and returning home the same day.

[3] Welsh Government (May 2020) *NHS Wales COVID-19 operating framework for quarter 1 (2020/21).*

4. Patient experience and update on Family Liaison Roles

The Committee received a full update on patient experience during COVID-19 at its previous meeting. However, by way of a reminder, the main issue regarding patient experience relates to communication between patients and relatives.

In response to this, a family liaison role has been developed to work as part of the ward team for two shifts per day, 7 days a week, to focus on communication and patient experience. Following training, the teams, which will be commencing in the next fortnight, will then be liaising with the Patient, Advisory and Liaison Service (PALS) teams.

A working group has been established to review patient experience in the field hospitals. The Health Board will be establishing a Patient Reported Experience Measures (PREM) for the field hospital and measuring experience before, during and after discharge. There will also be a dedicated family liaison role on the field hospital sites for the morning and afternoon shift, which will focus on communication and patient experience.

The Community Health Council (CHC) are seeking to further understand patient experience during the pandemic by conducting a survey on accessing services remotely, and/or those that were stood down. Similarly, the Health Board is also considering undertaking this approach.

5. Update on Orthodontic and Ophthalmology Activity during COVID-19.

Orthodontic Activity during COVID-19
Under COVID-19 (red alert for dental services), Orthodontic Practices can only provide an urgent/emergency service. The Practices providing services for our residents have been providing a full advice service for patients if they have any issues. However, we have not been able to remove patients from the waiting list to commence treatment.

Orthodontic Activity (Data collection 13th April to 17th May 2020)

- The Orthodontic Practice based in Carmarthen received 214 telephone calls, provided 151 patients with advice and seen 3 patients face to face.
- Patients currently in their treatment phase have received communication from us, outlining what to do, if they have problems with their braces.
- Our second provider of Orthodontic Services is based in the Swansea Bay University Health Board (SBUHB) area. Activity undertaken on the Health Board's behalf, is not available, data flowed directly into SBUHB.

Ophthalmology Activity during COVID-19
Due the current COVID-19 situation, the Health Board are mindful that there is a clear and urgent need to plan for Ophthalmology activity over the coming weeks and months. In addition, it needs to be in line with guidance developed by the Royal College of Ophthalmology.

The Committee can take assurance that recommendations made by both independent reviews, namely, CHC - NHS Eye Care Services in Wales (5) and the Delivery Unit - Eye Care Measures (8), are regularly reviewed, and updated in line with COVID-19 guidance from Royal College of Ophthalmologists.

The risk of patients acquiring COVID-19 infection during an ophthalmology appointment should be weighed against their risk of coming to harm through failure to treat serious eye disease. The Royal College of Ophthalmologists (RCOphth) recommended the following be

implemented at NHS clinics, private practice, and independent treatment centres with immediate effect:

All routine ophthalmic surgery should be postponed:

- All face-to-face outpatient activity should be postponed unless patients are at high risk of rapid, significant harm if their appointment is delayed
- Ophthalmology Accident and Emergency services should stay open with consultant level support for both triage and seeing patients
- Routine diabetic retinopathy screening should be postponed, with provision made for high risk situations e.g. pregnancy

Prior to planning for the current pandemic, the Health Board operated 1 Ophthalmology service working over 4 Counties.

As part of the planning for COVID-19, the service reviewed the way in which it delivered Ophthalmology across the Health Board. The following articulates the Health Board's response.

Hospital Eye Service

- Maintain treatments/review for imminently sight threatening or life threatening conditions
- Postponement of any cases on longer than 8-week follow up (put onto COVID-19 CRISIS holding category to be reviewed by clinicians going forward).
- Doctors determining appropriate action by looking at medical notes, for those coming back at 8 week interval or less;
- A clinician is reviewing clinics and contacting patients in advance, as far as possible.

Age Related Macular Degeneration (AMD) Service

- Clinical Team continue to see all (well and no symptoms of COVID-19) patients in the Intravitreal Therapy (IVT) service including wet) AMD, retinal vein occlusion (RVO) and diabetic macular oedema (DMO).
- Virtual clinic review undertaken for COVID-19 concerned patients.

Paediatric Provision

- Continue to screen the premature babies for retinopathy of prematurity (ROP).
- Delay paediatric uveitis screening, however monitor active cases.
- Specific guidance issue for when Immunosuppressed children need to be seen
- Virtual clinical review of children with glaucoma, retinoblastoma and optic pathway tumours and seen as appropriate.
- Notes review for patients with amblyopia, watery eyes, blepharitis etc and seen after the emergency is over.
- Swansea Bay support us with:
    - Ocular trauma in children out of hours at Morriston Hospital.
    - Paediatric cataracts under 8 weeks of age at Morriston Hospital
- Continue to manage inpatient emergencies as normal for orbital cellulitis and abusive head trauma.

Primary Care Optometric Support

- Optometrists with medical retina qualification to offer support to IVT clinics, including but not limited to assessment and treatment of sight threatening AMD.
- 4 optometric practices/day across HDdUHB to offer acute eye care support, ensuing that only those eye conditions which require surgery or laser treatment are referred on to the hospital eye service.

In summary, the Health Board has implemented the recommendations from the Royal College of Ophthalmology, including individualised approach to glaucoma care, with acceptance of delay for those at lowest risk, an offer of telephone review for those at medium risk with concerns, and the opportunity for a remote or face to face consultation for those at highest risk. Actions put into place are as follows:

- Emergency Ophthalmology services (Eye Casualty & Urgent Follow Up Clinics) have been temporarily relocated to BMI Werndale;
- On Call rota continued to be maintained from the Outpatients Department at GGH;
- Continued to deliver Emergency, Urgent Follow Up and AMD services by utilisation of Community and Private premises;
- Worked in conjunction with Community Optometric practices and the Community Optometric Advisor to provide a Multi-disciplinary approach to Ophthalmology.

A further iteration of the Coronavirus (COVID-19): NHS Wales Operating Framework, outlining a Quarter 2 response, will be prepared for future review, and consideration.

Argymhelliad / Recommendation

The Committee is asked to consider the UHB's attached response document, to the Coronavirus (COVID-19): NHS Wales Operating Framework, and review the assurance provided within.

Amcanion: (rhaid cwblhau) **Objectives: (must be completed)**	
Committee ToR Reference: Cyfeirnod Cylch Gorchwyl y Pwyllgor:	4.5 Provide assurance that the organisation, at all levels, has the right governance arrangements and strategy in place to ensure that the care planned or provided across the breadth of the organisation's functions, is based on sound evidence, clinically effective and meeting agreed standards.
Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	Risks are identified at service level and monitored through service risk registers and escalated to corporate risk register through governance
Safon(au) Gofal ac Iechyd: Health and Care Standard(s):	All Health & Care Standards Apply
Nodau Gwella Ansawdd: Quality Improvement Goal(s):	All Quality Improvement Goals Apply
Amcanion Strategol y BIP: UHB Strategic Objectives:	All Strategic Objectives are applicable

Amcanion Llesiant BIP: UHB Well-being Objectives: Hyperlink to HDdUHB Well-being Objectives Annual Report 2018-2019	9. All HDdUHB Well-being Objectives apply

Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	Included within the report
Rhestr Termau: Glossary of Terms:	Included within the report
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Pwyllgor Ansawdd, Diogelwch a Sicrhau Profiod: Parties / Committees consulted prior to Quality, Safety and Experience Assurance Committee:	Hywel Dda University Health Board Gold Command Hywel Dda University Health Board Silver Tactical Hywel Dda University Health Board Bronze Group Chairs

Effaith: (rhaid cwblhau) Impact: (must be completed)	
Ariannol / Gwerth am Arian: Financial / Service:	Any financial impacts and considerations are identified in the report
Ansawdd / Gofal Claf: Quality / Patient Care:	Any issues are identified in the report
Gweithlu: Workforce:	Any issues are identified in the report
Risg: Risk:	Consideration and focus on risk is inherent within the report. Sound system of internal control helps to ensure any risks are identified, assessed and managed.
Cyfreithiol: Legal:	Any issues are identified in the report
Enw Da: Reputational:	Any issues are identified in the report
Gyfrinachedd: Privacy:	Not applicable
Cydraddoldeb: Equality:	Not applicable

Hywel Dda University Health Board

Coronavirus (COVID-19) NHS Wales Operating Framework for Quarter 1 (2020/21)

May 2020 Version 7

Introduction

Introduction

This paper sets out the Hywel Dda University Health Board (UHB) quarter 1 response with respect to COVID-19. We have sought to respond to the Welsh Government (WG) NHS Wales COVID 19 Operating Framework under the following headings:

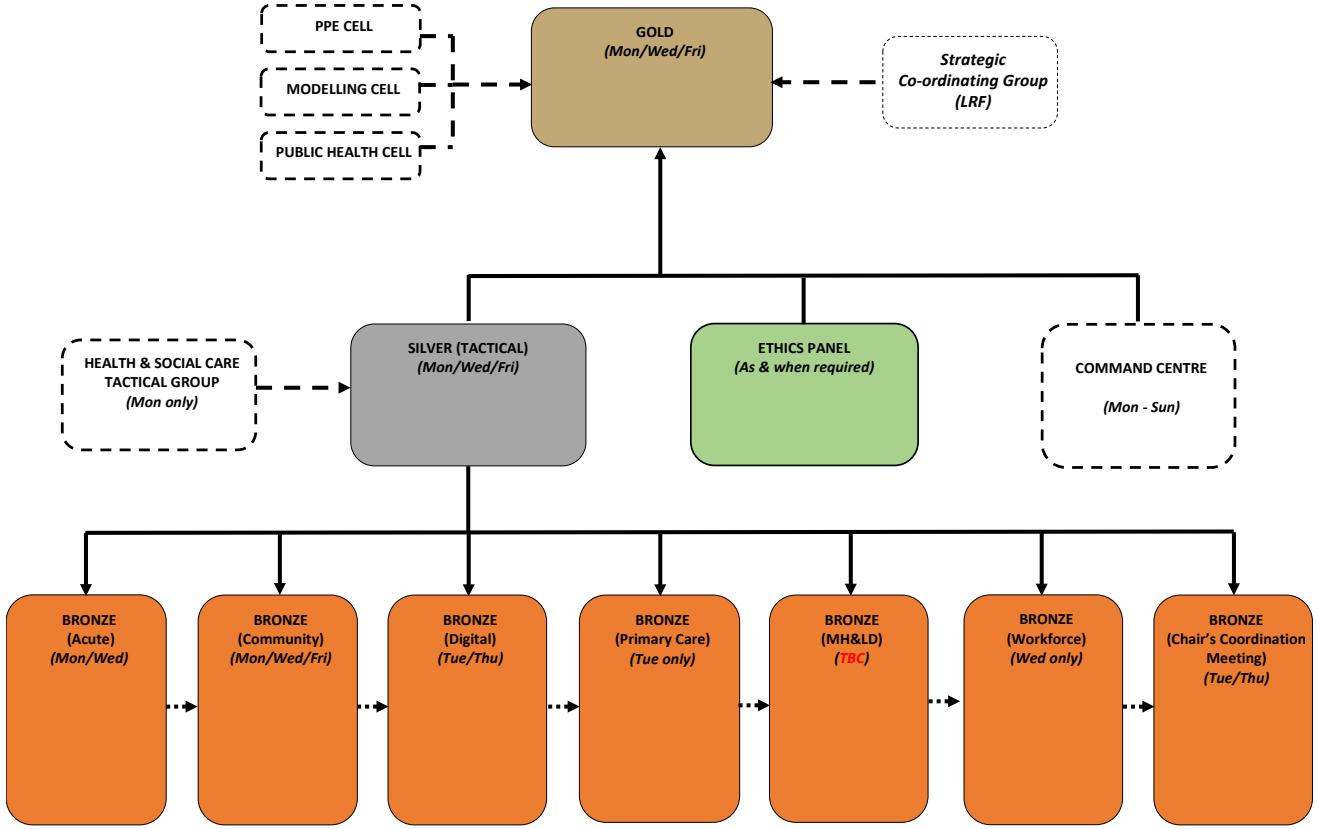
- A specific focus on Essential Services, any risks and regional solutions
- A summary of new ways of working and plans for evaluation
- Clear roles and activity plans for independent sector facilities and field hospitals
- Progressive implementation of routine activity
- A reflection of local discussions with partners about social care resilience
- Workforce plans including use of additional temporary workforce.
- Financial implications
- Risks to delivery

However, it should be noted that the consequence of the seismic shift that the COVID-19 pandemic has had on planning, deployment and implementation of systems, structures and services across the University Health Board has been both significant and dynamic and cannot be underestimated. It has potentially changed and advanced the way we approach our future planning, meaning that many changes previously identified for the longer-term have had to already be implemented or are due to be so over the next few months – digital enablement being a prime example of this, along with the emphasis on delivering services to Teulu Jones – the family we use to illustrate changes through our health care strategy – 'A Healthier Mid and West Wales'. This means our future planning and assumptions need to be significantly re-thought, along with their timelines, as we move into a transformational period. Despite the challenges and fundamental changes we are currently encountering, there may be unexpected opportunities presented to re-set, accelerate and expedite where appropriate to transform our services through our three transformation programmes – Transforming Our Communities; Transforming our Hospitals; and Transforming Mental Health (and Learning Disabilities) which are all within the Board approved strategy.

Command and Control

In order to deal with the unprecedented crisis in facing COVID-19, the UHB has put in place a Command and Control Structure in order to deal with the key strategic (Gold); Tactical (Silver); and Operational (Bronze) issues and decisions. The structure in place, is diagramtically shown below, followed by a brief explanation of the remit of these key groups.

COMMAND AND CONTROL STRUCTURE



Command and Control Structure Roles

- **Strategic/Gold (What)**
  - The purpose of the Strategic/Gold Group is to take overall responsibility for managing and resolving an event or situation. Establishing a framework of policy within which tactical managers will work by determining and reviewing a clear strategic aim and objectives.
  - The Strategic/Gold Group has overall control of the resources of the Health Board and should ensure sufficient resources are made available to achieve the strategic objectives set, also considering the longer term resourcing implications and any specialist skills that may be required.
  - This level of management also formulates media handling and public communications strategies, in consultation with any partner organisations involved. The Strategic/Gold Group will also ensure the Health Board's image and reputation is safeguarded.

  - The Strategic/Gold Group will then delegate actions to the Tactical/Silver Group for them to implement a Tactical Plan to achieve the Strategic aims. All Strategic actions should be documented to provide a clear audit trail.
- **Out of Hours/Urgent Decisions required**
  - Out of hours the Executive Director/Director on call has the authority to make the decision on behalf of Gold, however advice should be sought from the relevant affected Executive Directors before this decision is made and communicated. There will also be times when urgent decisions will be required to be made in between gold meetings and in these cases Chair's actions can be utilised. The Chair/Vice Chair/Reserve Chair with support of the Board Secretary will enable this decision to be made, reported & recorded at the next Gold meeting.
- **Tactical/Silver (How)**
  - Responsible for developing and implementing a Tactical plan to achieve the Strategic direction set by the Strategic/Gold Group and will be required to work within the framework of policy outlined at the Strategic level. This is essential to ensure a consistent and co-ordinated response within an ethical framework.
  - They provide the pivotal link between Strategic/Gold and Operational/Bronze levels. Tactical/Silver should oversee, but not be directly involved in, providing any operational response at the Operational/Bronze level.
- **Operational/Bronze (Do it)**
  - This level responds to events at the operational level as they unfold. The term Bronze refers to Operational teams who will manage the physical response to achieve the tactical plan defined by Silver.
  - Controlling the management of resources within their given area of responsibility. There may be several Bronze groups based on either a functional or geographic area of responsibility.
- **Clinical Ethics Panel**
  - The purpose of the Clinical Ethics Panel (CEP) is to provide ethics input into Health Board policy and guidelines, support health professionals with ethical issues arising within patient care and facilitate ethics education for health professionals and other Health Board staff.
  - The CEP will not provide legal advice, advise on research ethics or advise on specific issues of resource allocation.
  - The aim of the advice provided by the CEP is to be consultative rather than prescriptive. Where advice is required before the next scheduled meeting of the CEP, a sub panel can be convened by the Chair or Vice Chair to represent the CEP. This sub panel must report to the full CEP at the next scheduled meeting.

In order to deliver our services, and to monitor the situation within our University Health Board boundaries of Carmarthenshire, Ceredigion and Pembrokeshire, as well as working with partners including Social Care, we have undertaken a number of key tasks which are summarised below, under the establishment and direction of the Hywel Dda Modelling Cell; A Functional Capacity Model; and a COVID-19 dashboard to monitor and report the situation to our Gold Command.

Establishment and Direction of Hywel Dda Modelling Cell

Subsequent to Imperial College modelling and the UK Government actions to suppress the potential impact, locally we redirected some of our team to form a Modelling Cell. Reporting to Gold Command via our Executive Director of Operations, their role was to take the initial and subsequent national modelling and adapt for Hywel Dda University Health Board. Work on this has been directed towards five key priorities:

- Understanding and then localising the academic models
- Repurposing local simulation and activity planning models
- Using early COVID admissions to test the applicability of the models
- Aligning the forecasts of potential need with our capacity to respond
- Developing the models beyond their initial acute and admissions focus

Understanding and then localising the academic models

Firstly understanding and adapting the Transmission Model for our own population. For example whilst an initial percentage cut of the Welsh model allowed us to begin considering potential impacts and timings, this understanding then allowed us to replicate with our own age stratified population and consequently increased the hospitalisation prediction by around 10%. In localising were able to:

- Build county level models
- Incorporate the various mitigation and suppression models from Public Health Wales
- Incorporate expected external population flows from neighbouring Health Boards and holiday / second home populations, which added around 12%.
- Utilise local data on admissions flow to move from population based to hospital site based modelling.
- Support field hospital and mortuary planning at county levels.

Repurposing local simulation and activity planning models

Our informatics team had previously developed and implemented simulation models of admissions flow to support local planning. Adapting these to then utilise emerging data for our COVID-19 admissions as well as non-COVID admissions, where across the country admission patterns significantly changed as the pandemic reached the UK. This allows scenario modelling of changes to non-COVID flow and planned care for example, in predicting likely admission patterns and timings.

Using early COVID admissions to test the applicability of the models

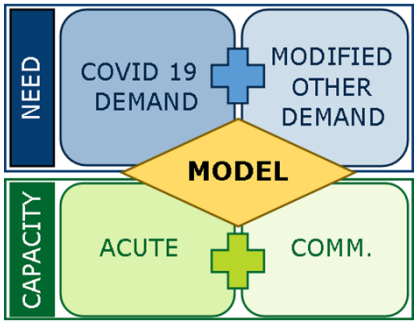
As agreed across Wales we began with the Reasonable Worst Case model and mitigated to a 34% impact for initial planning. Then taking data from real cases to test and adapt the assumptions, for example:

- actual data from our own confirmed cases that have been discharged to test model length of stay assumptions
- sharing data and learning from other Health Boards on proportions of ventilated patients
- clinical input to challenge and modify the model assumptions of patient management from the early experience of outbreaks in other parts of the world, adjusting to how we would manage such cases

- different rates of spread across our communities

Aligning the forecasts of potential need with our capacity to respond

To complement our capacity planning work, the diagram illustrates how we developed the modelled predictions of need, both for COVID-19 and our other patients. Then combining this with an adaptable capacity model of beds across acute and community sites. A frequently updated dashboard sitting at the centre to predict and manage our weekly bed capacity, as it changes over time and by county.



By this point sufficient data and understanding had emerged to test ourselves against more recent PHW models. In keeping with advice and our own experiences, moving the reasonable worst case prediction to Public Health Wales (PHW) v2.4 model at 40% compliance, alongside likely trajectories based upon the simulation projections of our own data.

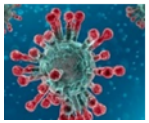
Developing the models beyond their initial acute and admissions focus

The academic modelling, whilst estimating those infected and symptomatic as a result of the COVID-19 pandemic, then understandably focused upon the most acute needs of those hospitalised as a result. However there will likely be health impacts throughout our communities, particularly as evidence emerges from others as well as locally of those discharged showing increased debilitation and deconditioning as a result of COVID infection.

Locally we are now flexibly building upon these models to estimate the additional health related needs this pandemic will ask of Hywel Dda, Local Authorities and our other partners, for two distinct cohorts:

- possible needs of the much larger cohort of those symptomatic but remaining in our communities
- Patients post hospitalisation returning to a community setting. Here updating and adapting a previous right-sizing exercise, undertaken with the Delivery Unit, that considered patient requirements following hospital discharge.

In a similar vein alongside this demand modelling then also supporting capacity modelling and potential pressure points, alongside non-COVID service demands and also considering the potential for step up of care from care homes for example.



Covid-19

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

Functional Capacity Model

Hywel Dda University Health Board

	Functional Capacity					Actual	Forecast Demand							Surplus/(deficit)				
	Today	+1 wk	+2 wks	+3 wks	+4 wks	Today	+1 wk	+2 wks	+3 wks	+4 wks	+5 wks	+6 wks	+7 wks	Today	+1 wk	+2 wks	+3 wks	+4 wks
	13/05/2020	20/05/2020	27/05/2020	03/06/2020	10/06/2020	13/05/2020	20/05/2020	27/05/2020	03/06/2020	10/06/2020	17/06/2020	24/06/2020	01/07/2020	13/05/2020	20/05/2020	27/05/2020	03/06/2020	10/06/2020
ICU (covid and non-covid)																		
Ventilated beds	47	47	47	47	47													
Consumable bundles	35	35	35	35	35													
Staffing (beds)	24	25	28	31	32													
Beds supported by critical care medicines	43	20	*See Readme*															
Other constraint (specify) - Q&S	*See single site comments*																	
ICU functional capacity	**24**	**20**	**28**	**31**	**32**	**12**	**31**	**32**	**32**	**30**	**27**	**25**	**23**	**12**	**-11**	**-4**	**-1**	**2**
CPAP																		
Staffing (beds)	292	292	292	292	292													
CPAP machines	703	703	703	703	703													
Consumable bundles	112	*See Readme*																
CPAP functional capacity	**112**					**1**	**53**	**55**	**54**	**52**	**47**	**42**	**38**	**111**	*See Readme*			
Other beds (non-ICU, excl. paeds)																		
1. Covid *Available beds*	260	321	321	321	321													
Staffing (beds)	292	296	296	296	296													
Covid bed / CPAP functional capacity	**217**	**278**	**278**	**278**	**278**	**63**	**203**	**209**	**207**	**197**	**180**	**159**	**143**	**154**	**75**	**69**	**71**	**81**
2. Non-covid *Available beds*	570	645	645	645	645													
Staffing (beds)	340	340	340	340	340													
Non-covid bed functional capacity	**340**	**340**	**340**	**340**	**340**	**428**	**376**	**409**	**437**	**447**	**460**	**467**	**471**	**-88**	**-36**	**-69**	**-97**	**-107**
Other beds (excl. ICU) functional capacity	**557**	**618**	**618**	**618**	**618**	**491**	**579**	**618**	**643**	**643**	**640**	**626**	**614**	**66**	**39**	**0**	**-25**	**-25**
Field hospitals																		
Available beds	-	500	600	700	750													
Functional beds	-	100	150	200	250													
Staffing (beds)	*To be confirmed*																	
Field hospital functional capacity																		
Total functional capacity (beds) - acute sites	**581**	**638**	**646**	**649**	**650**	**503**	**610**	**650**	**675**	**673**	**667**	**651**	**637**	**78**	**28**	**-4**	**-26**	**-23**
Mortuary space	**113**	**113**	**113**	**113**	**113**													

Number of beds in existing hospitals from the above	877				
Available hospital beds (excl. paeds)	**949**				
Existing hospital beds surplus/(deficit)	72				
Piped oxygen supply required for ventilators & CPAP (l/m)	1360	*tbc*	*tbc*	*tbc*	*tbc*
Piped oxygen available (litres per minute)	**7688**	**7688**	**7688**	**7688**	**7688**
Available oxygen to supply other acute beds (l/m)	6328	*tbc*	*tbc*	*tbc*	*tbc*

Please note the below in relation to staffing of covid/CPAP and non-covid beds. Further details can be found on the Readme and individual site sheets

To achieve the 292 CPAP beds and 340 non covid beds across the HB there is RN deficit of 2.26 WTE and a HCSW deficit of 13.72 WTE

Bank, agency and deployed staff: see individual site comments

Dashboard

The UHB has created a dashboard reported to Gold Command on a daily basis and includes:

- Testing – daily tests; daily positive tests; cumulative positive tests
- Number of cases
- Staff sickness rates
- Availability of Personal Protective Equipment (PPE)
- Admissions (by acute site)
- Bed occupancy rates (by acute site)
- Bed occupancy rates – invasive ventilated beds (by acute site)
- Discharges (by acute site)
- Hospital deaths (by acute site)
- Mortuary capacity (by acute site)

The data is drawn from a number of internal and external sources including Public Health Wales, and allows easy access to monitoring and reporting information and trends. This is shared with Local Authority partners to ensure clear understanding of the situation which can change on a daily basis.

Personal Protective Equipment (PPE)

Critical to supporting our approach to managing the crisis is the appropriate provision of PPE. In response to the Covid-19 crisis, a PPE Cell was established to provide clarity on the appropriate use of PPE across the different user groups, in-line with guidance received, and to model and report current and forecasted demand and supply. With an initial period expected where PPE supply across the UK would be limited, a controlled supply chain and stock monitoring process to allow deficiencies to be highlighted and escalated in a timely manner was deployed. Our internal logistics have been remodelled significantly to reduce the number of requestors and delivery points, to allow for an increased service to operate with robust controls. Regional acute hub stores have been implemented, and provide clear daily reporting on stock levels and quantities issued. Ongoing review and escalation processes are in place, as are combined local and national procurement sourcing activities and infection prevention and control guidance adherence discussions.

CONTENTS

Essential Services, any risks and regional solutions

This section provides an overview of the University Health Boards approach to the list of essential services set out in the Welsh Governments' document 'Maintaining Essential Health Services during the COVID-19 Pandemic – summary of services deemed essential'

Primary Care

In moving to support essential services across the University Health Board, a series of key initiatives and decisions are noted below

General Medical Services

- Bank Holiday Designated Enhanced Services commissioned for the Easter Bank Holidays with 18 of Practices participating (2 for half day only); this has been converted into a Local Enhanced Service for the May Bank Holidays with the additional request for data collection included to assess its value both in terms of patient contact and wider system benefit;
- Local and national discussions are ongoing around screening for particularly vulnerable groups and we are awaiting national guidance;
- Local and national discussions are ongoing around the potential to turn back on Long Term Condition management safely and to protect vulnerable groups;
- Issues with 6 week checks for babies have been identified and addressed in line with national consideration of including with 8 week immunisation schedules to limit the number of contacts;
- Use of the British Medical Association / Royal College of General Practitioners guidance on Essential services to inform discussions with GP colleagues;

Community Pharmacy

- Supported to have flexible opening to deal with increasing workload;
- Increased availability of Palliative Care drugs;
- Capacity to provide Monitored Dosage System (MDS) obtained from all pharmacies to support discharge of patients who need care packages from Local Authorities. On-going work to support transition from MDS to original pack for Local Authority domiciliary care staff;
- Provision of Emergency Supply of Medication, Emergency Contraception and Common Ailments Service still in place, with a move towards more telephone consultations;

Dental

- Green sites identified within the Community Dental Service (CDS);
- Red site developed to bring in patients who require urgent/emergency treatment that are Aerosol Generating Procedures (AGPs);
- Appropriate FFP3 and fit testing undertaken within the CDS;
- Minor Oral Surgery service relocated to deliver services within UHB premises with FFP3 (protective masks) provided to ensure continuation of services;

Optometry

- Green sites established and working, suspension of routine care; urgent and emergency cases only;

- Red site identified and due to come online during May 2020;
- Domiciliary service established;
- All Wales Low Vision Service telephone advice line agreed and in place;
- Four acute eye care hubs established treating and managing acute eye care problems which previously would be referred into secondary care

The table below shows current compliance for each of the essential services

Community Pharmacy	Framework Principles - Compliance Level	Comments
COVID 19 pharmacy weekly bulletin 23/03/20 and 30/03/20- additional advice embedded in bulletin- HOWIS Support for community pharmacies issued 18/03/20- WG website Community Pharmacy Contractors COVID-19 Toolkit issued 15/04/20 - Primary Care One website	Amber	• On the 21st March, an announcement by the Minister for Health & Social Services set out some flexibility around the times that pharmacies could be open to the public. • The Health Board is currently seeking information from Pharmacies about what flexible working arrangements are still in place and if there are plans to return to normal working patterns in the next two weeks (as at 1st May 2020). • The current services are continuing; **Essential services:** • Dispensing services, • Disposal of unwanted medicine **Enhanced services:** • Emergency medication service • Emergency contraception and • Advice and treatment for common ailments. • Services have been amended to allow pharmacies to maintain social distancing principles, telephone consultations, and patients being able to nominate another person to collect on their behalf. • Appropriate supplies of Personal Protective Equipment (PPE) has been provided to pharmacies who are still required to provide services within closer distances. • The number of pharmacies offering palliative care medication has been increased, for ease of access the Pharmacies offering this service have been asked to provide an alternative phone line for health care professionals.

GMS	Framework Principles - Compliance Level	Comments
Dental Red Alert principle guidance issued 23/3/20	Compliant	• The UHB is fully compliant with the guidance provided by WG. Dental Practices in Hywel Dda are providing services in accordance with the guidance. • Tier 2 Minor Oral Surgery services are commissioned through an independent provider. The independent provider is delivering services in accordance with the red alert guidance within the UHB green centres, utilising UHB enhanced PPE. • The UHB has established three green emergency/urgent dental centres in UHB Community Dental Services premises and services are provided by Community Dental Service staff. The UHB has established one health centre and services are also provided by Community Dental Services. • Where outpatient treatments (OPT) are not available on our community sites, two General Dental Practitioner (GDP) Practices have provided access to OPT services for the emergency/urgent dental centres, in order to ensure patients do not have to go to Hospital sites to have these images taken.
Dental care during the COVID-19 pandemic	Amber	• UHB implemented systems with Faculty of Dental Surgery and the emergency/urgent dental centres to ensure timely triage of emergency referrals. Guidance has been issued to NHS and private General Dental Practices.
Dental 24/7 Model Work Stream	Compliant	• WG issued this guidance in the 22 April, which is a compilation of all guidance issued to date and this was distributed to all private and NHS GDP practices in Hywel Dda for information.
Optometry correspondence and guidance issued 17/03/20-	Compliant	• Practices identified to remain open for acute and essential services on a Cluster basis utilising standard PPE issued by the UHB. • The UHB has identified a domiciliary provider to provide services in accordance to the guidance also utilising standard PPE issued by the UHB. • The Optometry team has established a dedicated support line for the signposting of patients to appropriate eye care services.
Ophthalmology guidance issued 07/04/20		• The UHB has established a joint working relationship across Ophthalmology and Optometry. • Optometrists with or working towards the Medical Retina qualification are providing sessions in the UHB Intravitreal injection (IVT) clinics, under the supervision of a Consultant Ophthalmologist.

Urgent Eye Care	Amber	• Practices have been identified across the UHB as green acute eye care hubs. All Eye Care hubs provide acute eye care mid-week and provide acute eye care on weekends and bank holidays on a rota basis. Practices were identified based on Optometrists in Practices with or working towards the Independent Prescribing qualification. • The UHB has identified premises and Optometrists for the provision of a red acute eye care hub, utilising UHB provided enhanced PPE. Intended to be in place by 11/05/20.
GMS Acute Work	Compliant Compliant Compliant Compliant	• Triage & E-consult -Practices have moved to a triage model where all requests for advice or assessment are dealt with by remote consultation • Remote Consultation -Where a face to face encounter is necessary practices are using Attend Anywhere video consultation as the preferred option • Surgery Consultations-Practices have established red / green zones; have the ability to safely cohort patients • Home Visits-When clinically appropriate, carried out by a member of the Primary Care team
GMS - Disease Specific Areas	Amber	• Urgent Suspected Cancer - Practices continue to see patients and refer - Work ongoing with Macmillan Cancer Leads to streamline the pathways for COVID-19 as part of our response to seeing a 50% reduction in referrals • Mental Health- General concern re increased need and need for new model of care
Long Term Conditions	Amber	• Heart Failure/Diabetes/Chronic Kidney Disease/Coronary Heart Disease/Hypothyroidism/Stroke/Transient Ischaemic Attack- Good practice guidance on remote consultation being developed - one stop appointment for bloods encouraged & telephone review
Palliative Care/AF	Compliant	Continuing
Enhanced Services	• Amber • Amber • Compliant • Compliant • Compliant • Amber • Compliant • Compliant • Amber • Amber • Amber • Amber	• Cervical Smears - suspended • Learning Disabilities - Suspended but essential acute care continuing • Childhood 6 weeks Medical - Continuing • Childhood Immunisation Scheme -Continuing • Gender Identity Suspend administrative component - care should continue as clinically needed. • Influenza & Pneumococcal Immunisations Scheme - Suspended • Services for Violent Patients - Continuing • Treatment Room - Continuing at a reduced level • Minor Surgery - Routine suspended - essential continuing • Asylum Seekers & Refugees - Normal healthcare Continues • Type 2 Diabetes Mellitus Care Scheme for Adults -Suspended but being reintroduced • Care Home Acute work and DES. - Suspended but focus on ACP and daily contact with care homes

	• Amber	• Extended Surgery Opening - Suspended
	• Compliant	• Pertussis Immunisation for Pregnant and Postnatal Women - Continuing
	• Amber	• Homeless- Suspend - normal provision of healthcare in the interim - Normal healthcare Continues
	• Compliant	• Oral Anticoagulation with Warfarin - Continuing
	• Amber	• NOAC monitoring- Continuing but DES needs amending to allow remote working
	• Compliant	• DMARD Monitoring - Continuing
	• Amber	• Contraceptive Services -Continuing but needs some work to facilitate remote working and
	• Continuing	• Substance Misuse - Continuing
	• Amber	• DVLA Medicals -Suspended
	• Continuing	• Fostering Medicals - Continuing

Primary Care Supporting Documentation

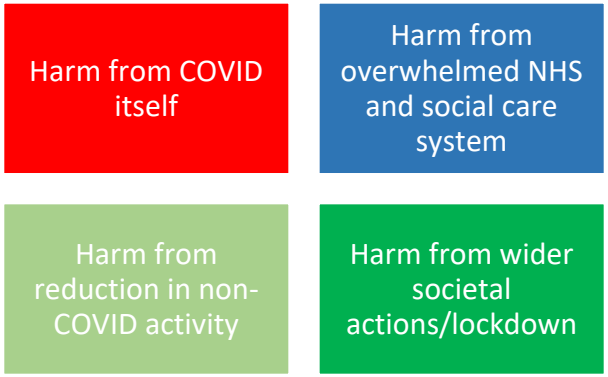
To support our Primary Care submission and to provide further detail, the following supporting document is provided

Primary Care Re-set

Primary Care .pdf

Community and County Based Plans

- Our approach includes an integrated system between primary and community care, although for the purposes of this response we have separated these out to allow alignment to the essential services framework.
- The NHS Wales Operating Framework for Quarter 1 outlines the need to maintain essential services, retains flexibility and adaptability to changes in community transmission rates of COVID-19 but also reflects the need to consider 4 types of harm and address them all in a balanced way.



- A Healthier Mid and West Wales (our strategic health and care strategy) outlined Hywel Dda's commitment to innovating and transforming our services to deliver on the collective commitments outlined in 'A Healthier Wales'. We presented this wellbeing offer to our population across five key areas of provision within our health and care system on the basis that these areas collectively contributed to improving health outcomes for our population. It is suggested that our 'Healthier Mid and West Wales' planning framework also provides the basis on which to present our reviewed and considered System plans as a response to the COVID-19 NHS Wales Operating Framework and a reduction in harm.


4. Help long term
Reducing harm from an overwhelmed H&SC system
3. Help when you need it
Reducing harm from an overwhelmed health and social care system
2. Help to help yourself
Reducing harm from the reduction of non-covid activity
1. Help for strong communities
Reducing harm from the wider societal impact of the pandemic and its contingencies
Help in hospital
Reducing harm from COVID the disease - ensuring critical care & bed capacity

Population Offer	Operating Framework Theme	Bronze Group Response
Help for Strong Communities	• New Ways of Working	• Enhanced community resilience and support through new community organisations and hub within Local Authorities. • CONNECT model of Technology Enabled Care (TEC) proactive support, communication and rapid response deployment
Help to Help Yourself	• Essential Services / Managing COVID-19 • Progressive Re introduction of suspended Services	• COVID hubs review and triage of all new referrals against criteria. • Stratification of community and specialist nursing caseloads to support targeted and prioritised service delivery • Supporting self-management of care needs • Maintaining separate COVID and Non-COVID community clinics and teams. • Proactive MDTs to be supported virtually – virtual wards.
Help When You Need It	• New Ways of Working • Essential Services	• Fast track the transformation changes delivering intermediate care and rapid response • Integrated community teams and co-ordinations through COVID Hubs • Discharge to recover & assess pathways • Community based rehabilitation • Intermediate care response via single point of access in each County – deployment of rapid response to avoid admission. • Remote Oxymetry Monitoring post Discharge of COVID-19 patients; supporting early discharge home and admission prevention • Community hospital and care home beds supporting assessment and rehabilitation outside of acute hospital settings.
Help Long Term / Palliative	• Essential Services • Social Care Resilience	• Hospice at Home with Clinical Nurse Specialist availability 24/7 and access to Consultant Specialist Palliative Care and Geriatricians • Care Home Risk and Escalation Management Policy development and implementation to support Care Home Resilience • Regional Discharge Requirements policy • Step up and Step down plans utilising field hospitals; mitigates over stretched NHS and Social Care system
Good Hospital Care	• Essential Services • New Innovative ways of working • NHS and Social Care Resilience • Management of COVID-19	• Agreed plan for surge capacity utilising field hospitals • Whole System Daily Monitoring of Risk Escalation across Acute and community health and social care system at County and Regional level

- In addition to the five Population Offers we also have digital, workforce, finance and infrastructure enablers :

Enablers	Operating Framework Themes	Bronze Group Response
Workforce	• Recruitment • Wellbeing	• Secured additional workforce. • Robust and diverse psychological and wellbeing support programme for staff.
Digital	• Enhanced communication and technology enabled care provision	• e-consultation, vision anywhere • Agile working hardware and software • Enhanced productivity and pace of decision making through virtual meeting space • Mathematical modelling to support planning • Technology Enabled Care solutions and Digital Monitoring Platform (Delta Wellbeing)
Infrastructure	• New ways of working • NHS and Social Care Pressure mitigation	• Revised admission criteria to existing community hospitals • Repurposed closed wards / care homes to create additional capacity • Increased residential care bed availability
Finance	• New Ways of working	• Additional Transformation Fund Allocation • Regional agreement to redirect ICF and Transformation to pump prime developments

Domain	Key Criteria
New Ways of Working	• Compliance with social distancing • Essential travel guidance • Reducing congestion in primary & acute settings • Embedding & making sustainable change – formal evaluation • Delivery of A Healthier Wales
Managing COVID-19	• Separate the COVID and non COVID patient flows as far as possible • Triage & streaming processes • Continued acute pathway for COVID-19 • Rehabilitation pathways
Essential Services	• Providing services that maintain people's health and well-being of those with a known long-term condition – avoid admission • Urgent new health issues which require time sensitive nursing and / or Allied Health Professionals intervention • Palliative care services • Care home support & prioritisation

	• Integrated community rehabilitation, reablement and recovery • Integrated community teams / virtual ward • Rehabilitation pathways • Safeguarding – all ages
Routine Services	• Re-introduction of services where there is capacity
Surge Capacity	• Physical space • Workforce • Ready for activation within 7 days
Workforce Wellbeing	• Support those staff who have been under significant pressure in responding to COVID 19 to date – front line workers, support staff and management teams
Social Care Interface	• continue to work with partners to ensure an effective interface with social care

Community and County Supporting Documentation

To support our Community and Counties submission and to provide further detail, a series of supporting document are provided

Ceredigion Ceredigion.pdf	Carmarthenshire Carms Plan for ammend_.pptx	Re-instating Services Resulting from COVID-19 Re-instating services in the Community.pdf	Revised Community Nurse Specification Community Nursing.pdf
Pembrokeshire Pembrokeshire Covid-19 Plan v13.pp	3 Counties Community Response Three Counties Response.pdf	Wellbeing and resilience plan TBC	Health Visiting Recovery Plan Health Visiting.pdf

Acute

The following two tables provide a review of the essential services and are compliance against them and our approach to individual services

Essential Service	Compliance with principles outlined in Framework	Comments
Urgent Surgery	Compliant	• All patients are being risk-assessed in accordance with the 5 categories and alternative (interim) treatment approaches are being considered where deemed clinically appropriate
Urgent Cancer Treatments	Compliant	• Services currently delivered in accordance with WG guidance. • Detailed Cancer Service contingency plan published. • Regional aid arrangements in place with tertiary centre surgeons providing outreach surgery. • Endoscopic diagnostic services have been restricted in accordance with national guidance for individual procedures / pathways
Life-Saving Medical Services	Compliant	• All patients are being risk-assessed to balance risks of cross – infections and deferred treatment. • Individual endoscopic diagnostic procedures available for life-savings scenarios where alternative diagnostic approaches are not available / clinically appropriate
Life-Saving / Life-Impacting Paediatric Services	Compliant	• Urgent illness, screening, Immunisations & Vaccinations and high clinical priority community paediatric services are continuing. • Specialist services provided at tertiary centres.
Maternity Services	Compliant	• Antenatal, Intrapartum, post-natal & risk-assessed community midwifery care continuing.
Neonatal Services	Compliant	• Level 1 Neonatal care continues to be available. • Glangwili Neonatal Unit separated into RED & GREEN pathways. • Neonatal transport services available as per normal.
Urgent Eye Care	Compliant	• Urgent eye care pathways continue. • Local Independent sector hospital commissioned to support urgent eye care pathway • Regional clinical concerns raised regarding some aspects of WG guidance
Termination of Pregnancy	Compliant	• Service provided in accordance with WG guidance
Other Infectious Conditions	Compliant	• Services available for urgent / emergency sexual health assessments / treatments
Renal-Care Dialysis	Compliant	• Service provided by external providers

RESPONSE TO COVID-19: SHARING EXAMPLES OF GOOD PRACTICE	
SCOPE	
Please outline what actions you have put in place to deliver outpatient services during the current COVID-19 outbreak, e.g. telephone clinics, video clinics, etc.	• In order to support the outpatient requirements, set out above by WG and to ensure our patients continue to receive the best care possible during these difficult times, the following actions have taken place: • All non-urgent outpatient clinics up to and including 26th June 2020 are being cancelled. These have been compressed as to demand on a weekly basis allowing our clinicians to be released into the wider support needed for the hospital sites. • Services including General Surgery, Colorectal, Breast, Urology, Gynaecology and Ophthalmology have been relocated to a local private hospital, providing outpatient and treatment services for their Unscheduled Care (USC) and Urgent patients. • Working on the assumption clinicians are undertaking outpatient 'face to face' consultations for the most urgent cases only, and to endorse new ways of working as set out by WG, the health board are exploring new digital services, including virtual clinics, SOS and clinical validation. These services are a key element within The WG National outpatient's strategy and have the potential to transform the way we manage outpatients in the UHB in the future, as well as supporting patients during the current pandemic.
In what specialisms/functions are you currently using these approaches? Please give examples.	• Virtual telephone clinics have been established in most services, with more being added daily. • Active testing in progress around the use of various methods in order to identify the pros and cons of different systems. • Examples of how specialties are delivering outpatients during the current COVID outbreak are as follows: **Respiratory** • teams using the cloud based platform Patient Knows Best (PKB) to communicate, remotely monitor and share information with patients. • Currently live with Intestinal Lung Disease patients and due to go live with 3 other teams over the next few weeks (including Home Oxygen Service, Severe Asthma & COPD patients. https://vimeo.com/325843544 **Pain Management** • Associate Specialist & Clinical Nurse Specialist Team conducting twice weekly virtual clinics for all follow up patients. • Clinical Psychologist triaging all pain referrals into UHB and prioritising between medical pain pathway and PMP. • Referrals being prioritised on a regular basis and any urgent referrals into UHB are directed to local Consultant in Pain Management for advice and guidance. • A remote MDT is possible if needed. • A basic PMP team consisting of Psychologist, Nurse & Physiotherapy still continue to offer support and advice via telephone to chronic pain patients. **Cardiology** • Using a telephone platform with the backup of Welsh Clinical Portal (WCP), Patient Administration System (PAS), GP record, Electronic results, Horizon cardiology and the Moriston shared portal.

- Having access to a potential follow up call with a cardiac specialist nurse for some patients is very reassuring and has really helped especially if the patient forgets important information during the first consultation.
- Access to a phone number to call the nurse if need is extremely helpful and has been gratefully received.

Ophthalmology

- Ophthalmology Services have been relocated to Werndale Hospital, to continue to run the Emergency eye care services.
- Virtual review and triage of all emergency cases.
- Orthoptist telephone consultations are also being undertaken.

Paediatrics

- Recent telephone clinics have been successful. There have been some positive responses to a recent communication sent to our clinicians. There appears to be some willingness to explore ways of working remotely and ways of communicating safely with patients, with a view to reducing waiting times.

Rheumatology

- Review clinics are being undertaken over the phone and sending letters stating that this was a telephone clinic. If clinicians identify any red flags, then the patient is offered an appointment in the flare clinic.
- Documenting telephone consultation on cellma (description of symptoms etc. discussions around treatment options) as unable to physically assess the patient.
- Using virtual patient information regarding drug administration where possible e.g. patient information leaflets, videos for administration of injectable biologics.
- We are still offering urgent new / EIA patients face to face appointments (aiming for HCQ/SSA) but we have found that the DNA rate is still high on patients ideally we would still want to see. Phoning patients before their appointments to see they can be assessed and managed over the phone or if they require face to face consultation.

Orthopaedics

- Follow up validation taking place.
- Patients have been communicated with via telephone and letter.
- Some Clinicians keen to trial virtual models.

Urology

- All outpatient PSA clinics moved to virtual telephone clinics. Patients PSA are being monitored so no build-up of waiting list and rebooked into clinics 3/6 months' time or if there is a problem referred to the consultant.
- ISC/ISC Clinic - Triaged virtually by telephone first by the CNS Nurse.
- USC are triaged, contacted by the consultants and the patients that need to have a face to face appointment these are being offered at the Werndale.

Breast

- USC patients are triaged, contacted by the consultants and the patients that need to have a face to face appointment The same process is being rolled out to Urgent patients from 27th April 2020.
- Routine patients are being triaged and when a face to face appointment is required they are remaining on the WL @ HD.

Colorectal

- All Colorectal referrals are being prioritised by the Consultants at Glangwili and where possible patients are being sent STT (Straight to Test).
- For patients that need to have a face to face appointment these are being offered at the Werndale.
- Patients are being seen by virtual and telephone clinics. The optimal pathway for assessing, triaging and investigating colorectal referrals is rapidly evolving. A meeting is planned for 28th April to agree on pathways, including the use of FIT.
- Stoma patients - patients are contacted initially by telephone and their needs assessed. All new patients are sent a Stoma Care Self Help Guide (Endorsed by the ASCN UK). Patient are encouraged to send in pictures of their problematic stomas via email. These are assessed and advice given. This may result in many contacts with the patient. If the problems cannot be resolved, then the patient is offered an Outpatient Department (OPD) appointment for a stoma review following protocol in place.

Vascular

- Weekly hot clinic running in one hospital every Wednesday morning for urgent new and follow up patients from across the UHB
- The consultant team have reviewed all of the planned outpatient clinics and have written to all patients and GP's.
- Telephone consultations have been undertaken where appropriate.

Dermatology

- USC clinics condensed with MOP sessions to create 'see and treat' sessions, therefore reducing number of times patient has to visit OPD.
- Telephone validation is taking place for all clinic appointments that have been cancelled.
- Virtual telephone follow ups are in place for acne and biologic clinics. This situation has made it clear that acne patients could be managed more virtually and the cost of a BETA HCG blood test for a female patient is much more cost effective than having to see a patient face to face in clinic. This would also free up clinic appointments for the systemic and biologic patients to reduce the backlog. The nursing team has been essential in ensuring patients receive advice and medication and are monitored appropriately, therefore avoiding any breaks in their treatment. There is a possibility of more being done virtually e.g. when patients condition flares, if we are able to get photographs and treat rather than them being added at short notice to very overbooked lists. This would make the clinic situation less pressurised.

Gastroenterology and Neurology

- Clinics ongoing as normal but converted to telephone consultations.
- Ad hoc emergency clinics in place for urgent cases and physical appointments where possible.

If known/available, what impact has this had on waiting lists?	Too early to validate
Does the UHB intend to roll out to other specialisms as part of your COVID-19 response? Please give examples.	• Whilst we continue to work to Welsh Government guidance in regards to many the outpatient services, we recognise that post COVID management, services are unlikely to resume their previous format. • Expectation is to establish the use of digital technology to reduce the requirement for 'face to face' consultations. • We will also be looking at if possible, to use digital technology for new referrals, e.g. Dermatology skin conditions. However, we note than most patients will require a physical examination.
IMPLEMENTATION	
Please provide a summary outlining how these approaches were implemented, e.g. systems, processes, development of standard operating procedures, engagement with key stakeholders, etc.	• Discussions with clinical leads on the suitability and process for telephone / virtual clinics. • Review of data • Linked with Cancer services • Scheduled Care Team to establish if their Clinicians have access to Microsoft teams on their PC/ Laptops / phones etc. • Virtual review using Microsoft Teams being undertaken by respiratory clinician • Post Pilot, select specialities to continue trial of Microsoft Teams and Attend Anywhere for virtual clinics. • Consideration via Digital Bronze of other virtual platforms e.g. Doctor Doctor
LESSONS LEARNED	
Can you give a brief summary/list of the challenges/barriers to implementation?	**Patient Barriers** • Some patients find it difficult to absorb the information given over the telephone. • Patients with hearing problems. • Patients are reluctant to answer calls with no caller ID even if they are expecting the clinic to phone them. **Clinical Barriers** • Some clinicians frustrated with NHS IT systems, and feel it is not reliable enough for virtual clinics. • Information governance and integration support with NHS Wales Informatics Service (NWIS). Often if clinicians hear there is no integration with Welsh Patient Administration System (WPAS) this can switch off their engagement. • Lack of access to digital dictation which some clinicians suggest would make it so much quicker to get the letters into the WCP in real time.
Please outline how you overcame some of the major challenges and	**Patient Barriers** • Following initial concerns with non-face to face contact, patients are now feeling reassured. • Patients with hearing problems

barriers to implementation?	• Conducting the calls via switchboard (they can reveal our hospital's phone number). **Clinical Barriers** • Reassure the clinicians that IT infrastructure going forward will support the clinical needs. • Pilot with specific services and encourage peer to peer communication before roll out to all services.
What approaches worked well and will be taken forward in rolling this approach out to other services?	• In some services, we have experienced a shift to positive clinical engagement to virtual management of patients, with the realisation that COVID-19 will influence how we manage patient pathways in the future. • Promotion of positive clinical experience of virtual platforms to deliver outpatient services, has and will continue to encourage other clinicians to undertake virtual activity.
What has been the response/feedback from patients regarding this approach?	Following initial concerns with non-face to face contact, patients are now understanding of situation and are being reassured of support available during these times.
MOVING FORWARD	
What resources would have been useful in rolling out this approach but were not available?	Digital dictation for remote access

Acute Care Supporting Documentation

To support our Acute Care submission and to provide further detail, the following supporting documents are provided

Maintaining Cancer Treatment	Essential Services Assessment	Planned Care Service
Cancer.pdf	Acute Services.pdf	Planned Care Services.pdf

Mental Health and Learning Disabilities

- The supporting document "Maintaining Life Saving and Life Impacting Essential Services during the COVID 19" pulls out actions from the guidance provided by Welsh Government, put against related Mental Health and Learning Disabilities activity along with any further action that would be required.

- The document pulls out what would be required under the sections - 3.8, 3.10. 3.11, 3.12 and linked to national guidance for areas needing reporting on. These areas are:
    - **3.08 Urgent supply of medications and supplies including those required for the ongoing management of chronic diseases, including mental health conditions** Co-ordination of medicine delivery during the COVID-19 pandemic
    - **3.10 Mental Health Services** Maintaining Life Saving and Life Impacting Essential Services during the COVID 19 Pandemic
    - **3.11 Learning Disabilities Services** Coronavirus (COVID-19): support for the Disability Equality Forum
    - **3.12 Substance Misuse Services** Coronavirus (COVID-19): guidance for substance misuse and homelessness services (version 1)

Mental Health Services	Framework Principles - Compliance Level	Comments
Medicine delivery	Yes	• All in-patient Mental Health wards (medicines will be delivered via hospital porters/ couriers/pharmacy staff) • All OPD prescriptions. If the patient cannot attend the Mental Health pharmacy to collect the medication, then pharmacy will look at other options e.g. Care Coordinators to pick up from pharmacy/ porter to deliver to Community Mental Health Teams (CMHT)/ post medication out via 1st class recorded delivery post. • Clozapine clinics. Pharmacist to attend all clinics and have medication ready to give to patient once the blood test result has been obtained via the POCCHI system. Those CMHT's WITHOUT Clozapine clinics, pharmacy to ensure all patients have their bloods taken and send medication out via 1st class recorded delivery post, or collected from pharmacy by patient/CMHT staff. We are also taking into account the ZTAS guidelines that have been sent out re extended validity of blood samples and off license usage for patients having bloods every 8-12 weeks. • All CMHT work re medication management and medication delivery to continue. • A Remote Prescribing Standard Operating Procedure has been developed for Mental Health and Learning Disabilities (MHLD) inpatient wards. This can be used in emergency cases where a prescriber may not be available due to sickness etc. The remote prescribing system utilises an online platform and all prescribers and MHLD ward representatives have had training to use it.
Maintaining Life Saving & Life Impacting Services	Yes	• **MHLD -** Emergency Single Point of Contact (SPoC) being developed for Adult Mental Health, Learning Disabilities, Older Adult Mental Health. Children and Adolescent Mental Health Services already has established SPoC service.

		• ECT is continuing to operate following Government, Health Board and Directorate recommendations regarding COVID. Responsible Clinicians are reviewing the need for ECT on a case-by-case basis taking into account the risk to patients and services in light of COVID -19. A contingency plan for ECT has been developed on this basis. • NHS Liaison COVID 19 service in development. A senior nurse manager has been recruited to lead the service that will aim to provide a single cross age/speciality liaison team with a single point of referral. The team will support DGHs, field hospitals and is scoping out the need to liaise with residential placements for bespoke packages of care for MHLD service users. • **Adult Mental Health -**Co-location of Crisis Resolution Teams (CRTs) and Community Mental Health Teams (CMHTs) in Haverfordwest, Carmarthen and Llanelli. Rotas have been altered to ensure these CMHTs are now 7 days a week on a 9am-5pm basis, CRT remain 24/7. Gorwelion in Aberystwyth has merged teams and provided 7-day week cover prior to COVID -19 developments. • Centralised 136 suite operational in Bryngofal inpatient ward, Carmarthenshire. A soft 136 suite/alternative place of safety has been developed and is operational in Gorwelion, Aberystwyth. Additionally, another soft 136/alternative place of safety is currently in development for Pembrokeshire. • Clinical Coordinator posts expedited and started on 30th of March. Provides band 7 nursing care and clinical coordination out of hours, seven days per week. • **Older Adult Mental Health -** Collapse of Memory Assessment Service into Older Adult CMHT to provide 7 day a week service, all referrals (both services) come to a single point of entry and are triaged/risk assessed for urgency and safety within the contingency plans. The Acute Dementia Wellbeing team are also working alongside the Older Adult CMHTs across Hywel Dda in readiness to support service users in DGHs or Field Hospital environments where required. Work is underway on 'recovery plans' to resume services cautiously within the 'new normal' situation. • The Dementia Wellbeing team have developed guidance (socially Isolating Individuals Living with Dementia) for care staff to support them looking after people living with dementia during the COVID -19 lockdown period for use in Care Home, Field and Acute Hospitals. The psychologist for this team has also been co-opted to work alongside Long Term Care Team to support staff resilience in the Care Homes. • **Children and Adolescent Mental Health Services (CAMHS) -** The Early Intervention Psychosis (EIP) service has been reconfigured to provide a 7-day service and is working alongside the S-CAMHS Crisis Team. • The Crisis and Assessment Team has been identified as a critical service and has been strengthened. • **ADHD services (18+)** – A review and rationalise the waiting list has occurred due to pressures from staff sickness. Currently the service is working on a recovery plan to re-establish clinical contact.

		• ASD – Continued to operate, adapted using online phone calls to do assessments – inpatient units, technology.
Report against continued mental health in-patient services at varying levels of acuity	Yes	• **Adult Mental Health -** Proposed Central Assessment Unit (CAU) and 136 suite being implemented at Bryngofal inpatient ward. As part of this change, an alternative place of safety has been developed for Ceredigion and is currently in development for Pembrokeshire. • The pathway for referral into inpatient services has been reviewed to ensure that people can still gain access to services when necessary. • A conveyance scheme to support service users to and from inpatient settings has been developed and is now operational. It is anticipated the scheme will support inpatient flow and add capacity to workforce. • The MHLD commissioning team have expanded discharge liaison activities to coordinate patient transfers and support patient flow from inpatient settings. The team are currently taking a lead role in identifying placements and facilitating transfer. The team link with providers, care coordinators and LA budget holders to accelerate discharge in order to support service user flow and ward capacity.
Report against Community MH services that maintain a patient's condition stability (to prevent deterioration, e.g. administration of Depot injections)	Yes	• **MHLD –** Senior Directorate staff are testing the 'Attend Anywhere' digital platform functionality for its ability to provide avenues for service user interventions. Initial indications are of a clear and intuitive system without the need for the patient to download software. It could be used in a number of ways including MHA assessments where a patient's solicitor will be able to join an MDT meeting remotely on a secure line without attending a ward, where appropriate. Further testing and investigation is ongoing. • **Adult Mental Health** - Secondary services are maintaining a duty system, clozapine and depot clinics. • All 3rd sector commissioned services have adapted service provision to offer telephone/online services on a 3-county basis where possible. A list of 3rd sector services has been developed and distributed for staff and service users detailing services offered and is updated regularly. • The Llanelli Twilight service (a jointly run 3rd sector and Health Board MH managed community drop-in service, operating out of hours Thursday-Sunday) to be phased back to operation in May. • Virtual touch points meetings arranged with third sector to support ongoing delivery of adapted services. • **Primary Care** - Local Primary Mental Health Support (LPMHSS) telephone screening maintained and some interventions are also being delivered by phone. Otherwise, patients will be contacted again or invited to contact the service in there months if an intervention is still required. • The LPMHSS are signposting service users to most appropriate digital e-libraries. Stress control courses are also being offered via online platforms.

		• LPMHSS are trailing a fast-track system for those that have been discharged from LPMHSS to self-refer back into service if needed rather than via GP referral. • **OAMH** - Development of new algorithm for triage of new referral into OAMH services. • **CAMHS** -The service has carried out a review of its provision and identified the core elements that it is able to deliver. Low risk service users will be discharged from the service This will be done predominantly through virtual means, but the ability to provide face-to-face support will be retained where needed. For those discharged, they will be provided with information containing sources of support, websites and apps which can support them, their families and carers, along with information of how to contact the service should they be unable to maintain their mental health in the community. • The S-CAMHS Primary Mental Health Assessments and Interventions are coordinated from the SCAMHS SPOC. All young people who have a Care and Treatment Plan continue to be monitored and receive prescribed care as per Care Plan - has been identified as a critical service, to be maintained. • SCAMHS Inpatients - An urgent review of current caseload has taken place to identify those at highest risk to ensure that resources are in place to maintain virtual support to prevent decline in mental health. All new referrals are continuing to be collected through the services' Single Point of Contact. This service is being operated with a core group of staff, with urgent referrals being allocated and telephone assessments/interventions undertaken and other referrals being placed on a waiting list
Learning Disabilities	Framework Principles - Compliance Level	Comments
Sharing hate crime reporting	Yes	UHB are part of the Pegasus Scheme, in collaboration with Dyfed Powys Police and Carmarthenshire Community Safety Partnership, to enable those with an illness or disability to contact the police in non-urgent situations to report hate crime, or receive police assistance.
Link with national volunteering	Yes	UHB have issued easy read letters to service users, along with contact details of who to contact in the event that they or their carers become ill and they need additional support.
Sharing of Public Health Wales information with vulnerable people	Yes	Easy read information is being disseminated to people with learning disabilities about Coronavirus (COVID-19).
Residential provision for those with a social worker	Yes	Arrangements are in place to maintain commissioned services for vulnerable children and young people.

Special schools continuing to meet learning needs	Yes	Arrangements are in place to maintain services at specialist schools and colleges for vulnerable children and young people. Further work is being done to finalise arrangements for summer holiday period.
Provision for Social workers and vulnerable children contacts	Yes	CTLD service is providing virtual support for its service users. The intensity of virtual support is increased for higher risk individuals, with face-to-face capacity for those who require it pending risk assessment.
Substance Misuse	**Framework Principles - Compliance Level**	**Comments**
Area Planning Board (APB) leads to establish relevant structures and contacts in each area.	No	Link in with board to ensure consistent service planning and responses across the following services; • Day services for both substance misuse services and people who are homeless • Community treatment services for substance misuse • People with co-occurring conditions • Community services for people who are homeless • Hostels and temporary accommodation, including night shelters and houses of multiple occupation for these client groups • Housing First projects • Substance misuse outreach services, including mobile services • Homelessness outreach services, including mobile units and soup runs • Residential rehabilitation services • Community drug and alcohol services
Prioritise services and staff to supporting the most vulnerable.	Yes	Desktop triage of cases have taken place in CDAT to prioritise service response.
Telephone/ video calling	Yes	Service has virtual assessment arrangements in place.
Continuity of specialist substance misuse pharmacological interventions	Yes	Service has arranged for continued prescribing and pharmacy dispensing across the three counties, including development of contingency prescribers.

Sustainable and clinically appropriate alternatives to existing OST supervised consumption services etc.	Partial	Where supervised consumption is not possible, the cases are being managed on an individual risk basis. Existing Buvidal injections are being maintained.
Management of n restrictions or closures of any service providing pharmacological interventions via supervised consumption. Contingency plans to be in place	Partial	Work with leads to meet required guidance where appropriate.
Service delivery should continue to be in line with local and national clinical guidance. (injecting equipment to meet needs and 100% coverage	Partial	CDAT to liaise with DDAS regarding Needle Syringe provision and availability for service users. Labs are not currently processing DBST. CDAT to liaise with lab services and continue to offer DBST to service users following the pandemic. Concern that there may be shortages of needles and syringes, leading to an increase in BBV, which cannot be tested while services are unavailable.
Home delivery of injecting paraphernalia (including sharps disposal bins).	No	Look at distributing sharp disposal bins with prenoxad kits.
Drug poisoning prevention advice	Yes	CDAT staff routinely provide advice to clients on social distancing and risks associated with sharing of supplies. Letters are routinely given to clients when starting or changing prescriptions. CDAT continues to provide Prenoxad kits to service users and concerned others. DRDs will be reviewed via the NEO database and Team Leaders will review cases known to the service.
Collection of NSP paraphernalia items	No	Look at arrangements in place for nominated individuals collecting prescriptions on behalf of those who are isolated in self/ household quarantine.

Care of Vulnerable Populations	Framework Principles - Compliance Level	Comments
Looked After Children	Compliant	The S-CAMHS service has developed a robust pathway for Children looked after/ edge of care whereby we are able to offer consultation to Social Workers/ Social Care Practitioners to discuss any potential referrals and to offer advice/ support. S-CAMHS has also recruited 3 x full time Social Worker Practitioners who work as part of the multidisciplinary teams in each locality providing a dedicated link to each LA Children Service. Alongside this, the S-CAMHS operates a Single point of contact for all urgent referrals.
Perinatal Mental Health Services	Compliant	Perinatal Mental Health services continue to be delivered and is continuing to receive referrals from all key agencies. The team is working collaboratively with colleagues from Maternity Services and prioritising high-risk referrals where urgent assessments continue to be undertaken following the Guidance for safe practice.
Veterans Mental Health Service (VMHS)	Compliant	Referrals to the service continue to be received and screened as usual, as have opt-in processes to the service. All accepted referrals who opt-in are offered telephone triage, undertaken in line with the pathway and usual procedures. VNHSW continues to work and supervise key partner Change Step who offer additional support for veterans accessing VNHSW. VNHSW have made contact with all clients across the caseload, providing them with ongoing contact with the service, or have provided them with relevant signposting advice.

Mental Health and Learning Disabilities Supporting Documentation

To support our MH and LD submission and to provide further detail, the following supporting document is provided

Mental Health and Learning Disabilities

Mental Health and LD.pdf

New ways of working and plans for evaluation

Primary Care

GMS

- 46 out of the 48 GP Practices have Attend Anywhere "live" and in use; one Practice has declined to participate in using the programme;
- E-Consult (funded through the Pacesetter programme in 2019/20) is in place in 36 (75%) of Practices, with an additional 5 due to come online shortly. Usage data has recently been made available and will be analysed and shared with Practices and Clusters to inform future working models

Community

Remote Oxymetry Monitoring (virtual ward)

- High risk COVID patients being cared for in the community and those patients discharged from hospital receive a pulse oximeter to measure blood oxygen level
- A 'virtual ward' clerk coordinates the referrals and virtual ward doctors' rota providing 24/7 monitoring
- 'Ward' Doctors are retired and / or shielding Doctors who are unable to provide face to face clinical care
- Doctors contact the patients on a regular basis
- Patient takes their own Oximetry reading
- If oxygen saturation drops below 92% persistently the patient will require admission / readmission to the acute hospital
- There are clear pathways for the patient to be readmitted to hospital if they deteriorate both in and out of hours; these are not solely reliant on WAST
- Delta Wellbeing (Digital Monitoring Platform) is responsible for the coordination / distribution of the monitors.

Acute Care

To support a rapid and effective response to COVID 19, our acute hospital teams have significantly reconfigured the way in which care, clinical pathways and staffing resources have been organised across each of our hospital sites. Common themes include:

- ED streaming systems to support patient & staff safety including front door triage units
- New systems to support clinical communication between GPs, WAST and specialist staff, designed to signpost patients to the most appropriate care pathways and support admission avoidance where appropriate
- Separation of existing Emergency Departments and hospital facilities to support COVID (Red), Non COVID (Green) and Suspected (AMBER) streams;
- Use of digital technology to support patient & family communication given the cessation of visiting;
- Use of digital technology to support virtual board rounds & MDT discussions whilst supporting social distancing measures;
- Establishment of staff well-being areas and support sessions;

- Redirection of pathways to support opening of CPAP designated & COVID wards
- Acute medical staff outreach support to care homes to undertake joint review visits with GPs to ensure ACPs are in place;
- Establishment of PPE hubs on each site to coordinate and support timely distribution of equipment to clinical areas
- Structured daily clinical handover & briefing sessions between staff in RED & GREEN zones with a focus on new admissions, discharge planning, PPE, equipment, oxygen usage, staff resources and clinical education based on experience of managing COVID patients
- Introduction of GP led virtual wards
- Clinical management of patients led by Specialist Respiratory team, reflecting on international clinical experience with an early focus on alternatives to invasive ventilation, thereby minimising demand for critical care admissions
- Early enrolment of patients onto national therapeutic research trials to support future clinical learning re appropriate clinical management of COVID
- Introduction of staff breakout, rest and changing facilities in RED & GREEN zones to support IP&C management
- Delivery of enhanced skills training for registered nurses and HCSW staff e.g. venepuncture & cannulation, CPAP delivery and management
- Use of Clinical Nurse Specialists to support the delivery of dedicated training for CPAP Clinical Nurse Specialist working with the COVID teams to support development and enhancement of skills and confidence.
- Full rota changes for medical staff to enable 24hr senior cover in Red & Green streams;
- Redeployment of staff from non-acute areas to support staff shortfalls and enable services to continue.

Outpatients

- The Health Board will be pursuing all options to implement virtual review and looking at methods to reduce both acute site visits and a firm reduction in face 2 face consultations going forward.
- The Digital Bronze Group will provide the oversight for all products
- This Group will also offer an evaluation framework for the various virtual clinic solutions on offer including Attend Anywhere, Microsoft Team and others as we pilot them over the weeks / months ahead.
- Operational implementation of these solutions within Secondary Care will be steered via the Planned Care Work stream of our Acute Bronze meeting.

Digital

Testing, Implementation and Evaluation of:

- Microsoft Teams
- Attend Anywhere
- Dr Doctor
- Patient Knows Best
- Consultant Connect

Service changes

To support our New Ways of Working submission and to provide further detail, the following supporting document is provided

Service Changes

Service Changes - Covid 19 ACTIONS V1

Independent sector facilities and field hospitals

Use of Independent Sector Facilities

- On 23rd March 2020, the Welsh Government announced the suspension of a number of NHS services, this included undertaking any routine surgical operating procedures. A national press release was issued detailing the agreement reached between the NHS and independent sector to help tackle the coronavirus and provide additional capacity to deliver USC treatment and other urgent operations to NHS patients. The press release made clear this work will be reimbursed at cost, meaning no profit will be made and this point was stressed in discussion with NHS Wales.
- The Welsh Government plan endorsed immediate sign off for suspending both routine Out Patient Clinics and Theatre Operating sessions, this supported a plan to move the USC Out Patient Clinics and Surgical Operating to a COVID free hub, which is the Werndale (BMI) Hospital in Carmarthen. The key principles noted are to keep people safe and to keep patients out of acute clinical settings if there is no urgent need to attend.
- On 30 March 2020, national guidance recommended that consideration should be given to consolidating USC Patients for Outpatients and Surgical Intervention into a COVID-free hub, with centralised triage to prioritise patients based on clinical need. The Health Board on the 19th March 2020 had already started exploring options with Werndale and their proposal plan was used by Welsh Health Specialised Services Committee as a baseline for a national model
- Service Delivery Managers from Hywel Dda and Managers/Staff at Werndale met on several occasions via Skype to discuss the proposal and agree the specialities, sessions, patient's templates, governance and processes.
- Hywel Dda Informatics team have been involved in the process for capturing the data on WPAS and supporting the installation of WCP on Computers at the Werndale.
- Clinicians have been included in all patient selection, the management team along with the support of the Waiting List teams and Health Records book the patients, all this information is recorded on WPAS. The staff at the Werndale transfer this information on to their own internal systems. A tracker from informing us of the patient's outcome is completed on a daily basis and returned to the management team. For Colorectal Clinics the Consultants from Glangwili General Hospital are supporting all the clinics, they are prioritising UHB wide referrals.
- Pre assessment is undertaken at the Werndale for patients undergoing surgical intervention.
- Outpatients and theatre sessions are supported by the Consultants, SAS Doctors and CNS.
- Where necessary theatre nursing scrub staff are allocated to sessions, equipment has also been transported to support some operating lists. Faxitron for Breast Surgery, Portable Laser for Urology surgery.
- Diagnostics can be undertaken at the Werndale for ultrasound or CT every 3 weeks, for the other weeks patients will have these investigations at their local site, a process has been put in place that the requesting Consultant completes a request form and brings it back to the site and the medical secretary will send to the relevant department.
- A weekly meeting is in place for the Service Delivery Manager and the Werndale Manager to discuss what has gone well and areas for improvement.

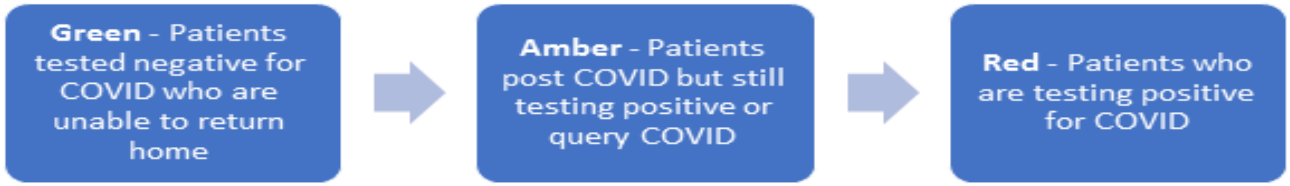
- The UHB has been able to secure protected capacity and implement the plan from the 14th April 2020 to support for the following Specialities, there is scope for this to be expanded if necessary:-
    - **Breast** - Operating Sessions only – Outpatients UHB wide patients continue at Peony Suite Prince Philip Hospital, which is an isolated unit.
    - **Colorectal** – Outpatients clinic only - Colorectal USC surgical cases are being managed via the emergency pathway and NCEPOD operating lists. The patients are assessed on an individual basis by the Consultants and provided with the appropriate treatment/surgery. There is a facility at all 3 sites Bronglais, Glangwili and Withybush Hospital. These practices are in line with directive from the Gastroenterology Society.
    - **Gynaenacological** - Out Patient Clinic and Operating Sessions
    - **Head & Neck (ENT)** – Operating Sessions only – Outpatients UHB wide patients are seen via the emergency clinic at Glangwili Hospital
    - **Urology -** Out Patient Clinic and Operating Sessions

- In parallel to the consideration the UHB is giving during this quarter to the re-introduction of in particular cancer services onto our acute sites (further detail to be found in the next section), we are also considering how the capacity released with our independent sector partners could be utilised for accommodating other urgent and/or routine procedures from quarter 2 onwards.

Field Hospitals

- The COVID Management team have continued to work on the premise that all 9 sites (7 field hospitals) may be required and thus should be ready for operationalisation as and when required. This approach supports the organisational strategy to maintain acute sites at approx. 80% occupancy rate. Working closely with all relevant teams, the Triumvirate have scoped alternative uses for the Field Hospitals in order to support the wider acute and community system and this work has informed a phasing plan.

- It is proposed that patients are cohorted in the following categories for Field Hospitals: -



Location	Beds
Carmarthenshire	
Carmarthen Leisure Centre	93
Selwyn Samuel Centre (Llanelli)	143
Llanelli Leisure Centre	121
Parc-Y-Scarlets, Barn (Llanelli)	259
Parc-Y-Scarlets Stadium (Llanelli)	82
Pembrokeshire	
Bluestone (Narberth)	128
Ceredigion	
Cardigan Leisure Centre	48
Aberystwyth Leisure Centre	52
Aberystwyth School	51

- To further test the above, a proposal to run one site as a pilot site has been tested by the Triumvirate with Acute and Community teams and it has been proposed that Carmarthen Leisure Centre becomes operational to Non-COVID patients from Glangwili General Hospital w/c 1st June 2020. This will afford us the opportunity to pilot the patient pathway, standard operating procedures (SOPs), operational processes and workforce with up to 28 medically fit patients. We would also look to involve our Patient Experience team to measure patient reported experience measures (PREMs).
- The Field Hospital at Aberystwyth Leisure Centre could become operational in June 2020
- All other Field Hospitals could potentially be hibernated until Q3 (with the potential impact of winter pressures) or if a spike in COVID cases is noted. The decision on the opening of a Field Hospital will be based on discussion at our daily escalation meetings and a lead in time of approximately one week before it becomes operational will be required.
- Our Community Hospitals would be utilised as step down facilities for Non-COVID cases.

Admission Criteria/trigger for trial site

- The trial site will open to medically fit, non COVID patients. Negative swabs prior to admission
- After the pilot period, FHs are only to be used when there is no functional capacity in the Acute Hospital or where there is a need to support an escalating Community situation.
- A system based risk assessment would be undertaken daily with a co-ordination call @ 4pm to consider the risk and pressure in the system across the Counties. This call will cover Community Nursing, Domiciliary Care, Residential & Nursing care, Virtual Ward, Acute Hospitals & Field Hospitals.
- Patients will be risk assessed on a case by case basis before admission and a template will be developed to facilitate this.
- Patients admitted to the FH would need to be risk assessed and transferred with a clear care pathway in place. ALOS should be no longer than 14 days.

- Exemptions will include:-
    - <18 yrs of age,
    - Patients on End of Life pathway
    - Increased mental health input requirement for example some dementia patients as the environment could exacerbate symptoms/delirium
    - Some post-operative patients pending surgery type and length of time since surgery.

Operating manual (OM)
All sites will have a tailored OM that will include:-

- Site leadership triumvirate and contacts including on call arrangements
- Clinical SOPS
- Catering, Laundry and Transport arrangements
- Security expectations and escalations
- Governance
- Estates management and processes
- Site Mortuary arrangements
- Site training needs
- Family/ Patient communication/visiting
- Staff well being
- Infection control
- Incident reporting
- Risk assessments

Progressive implementation of routine activity

This section outlines the benefits of addressing the considerations of resuming planned care with particular focus on surgery

- Before the return of planned surgical activity, efforts should be made to evacuate or relocate temporary ICUs that occupy key physical locations within the surgical patient pathway. Many hospitals have used operating theatres, Post-Anaesthesia Care Units (PACUs or Recovery Rooms) and surgical ICUs to accommodate Level 2 and 3 patients, but normal surgical activity should not resume if these remain as temporary ICUs for logistic and infection control reasons. Where such stepping down of temporary ICUs is not possible, it must be acknowledged that this is not 'business as normal', and any planning for elective surgery should be undertaken in this context. Further expansion in critical care facilities may be required in the coming months if coronavirus infection rates increase again or demand from other seasonal illness increases. Critical care bed expansion plans should ideally avoid a return to surgical pathway locations if a return to decreased planned activity is to be avoided.
- Other locations that may be considered for managing planned surgery or the care of patients with COVID-19 may be considered: these include treatment centres, independent hospitals, mobile facilities and the field hospitals. These provide space but will only facilitate resumption of planned surgery if they also can provide staff, stuff and systems that are separate from and do not compromise those in the main NHS hospitals.
- The Health Board commitment to the use of Werndale will continue until further notice.
- While there is considerable concern over the potentially severe impact of COVID-19 on patients who have undergone surgery, there is also a mounting expectation from clinicians, the NHS and the public to return to what is seen as a 'normal' service as soon as possible.
- We seek to ensure that planned activity matches a realistic assessment of the ability of NHS staff and resources to deliver this activity. We must not create a situation where in effect, our acute sites become the epicentre of any future local community transmission in the UHB area.
- It is essential that when the resumption of planned care at all stages of the pathway that it takes place, safely, efficiently and in a sustainable manner, taking into account the staffing, environment and equipment needed , but also the continuing impact of care of COVID-19 patients on postoperative critical care capacity.
- As a UHB we are aware of the need to ensure an appropriate supply of blood, and note the concerns raised by the Welsh Blood Service with respect to the re-introduction of certain services and their ability to meet demand.

Key Principles:

- During the reminder of Quarter 1, the focus will be on re-establishing those aspects of cancer & urgent diagnostic & surgical work currently paused (within the framework offered by WG & the Wales Cancer Network)
- Routine diagnostic and surgical work will not recommence prior to Q2 and requires further significant consideration to ensure staff and patients are protected. This will include evaluation of all possible options, including the benefits of dedicating some of our facilities for COVID or Non COVID pathways
- All urgent / cancer diagnostic & surgical work will be supported by a clear pre-operative assessment pathway designed to protect staff and patients from the risks of COVID

- Critical care pathways will be considered in our plans, recognising the extent to which escalated capacity will be limited by equipment and staffing.

Endoscopy:

- Proposals to recommence by early June those aspects of urgent / cancer diagnostics currently paused (all in accordance with national guidance). The main challenges relate to Bronglais General Hospital as the Endoscopy Unit currently supports the Critical Care Escalation Plan.
- Our Endoscopy plan will be supported by a Standard Operating Procedure reflecting capacity volumes, PPE requirements, swabbing protocols & a validation protocol to ensure equity of access and appropriate prioritisation of patients

Surgery:

- We plan to recommence those aspects of urgent / cancer surgery currently paused on all four sites by early June, but routine surgery will not recommence prior to Q2
- All plans are flexible and adaptive with opportunities to upscale / downscale as COVID demands dictate

Bronglais General Hospital:

- Facilities in place to support the reintroduction of urgent / cancer surgery in those areas which have been paused

Prince Philip Hospital:

- First floor at Prince Philip Hospital has been re-designated as a Non COVID area and can accommodate urgent elective care for key specialties
- Proposal to designate Prince Philip Hospital ITU as post-op 'GREEN' HDU to support urgent surgery. The low volume of COVID / suspected COVID ITU admissions would be directed to Glangwili General Hospital unless/until COVID demand significantly increases

Withybush General Hospital:

- To enable urgent and cancer surgery to recommence, there is a requirement to relocate the ITU escalation area out of Theatre facilities
- Proposal to relocate the ITU to the current Ward 4 dependent on installation of additional Medical Air supplies and appropriate partitioning work to establish separate COVID & Non COVID critical care areas
- Critical care staffing is a significant rate limiting factor (major challenges in supporting both RED & GREEN ITU areas) – proposal (as per Prince Philip Hospital) is to redirect the very low level of COVID / Non COVID ITU admissions to Glangwili General Hospital unless / until COVID demand picks up ('no sense to have 4 RED ITUs across the UHB at present period of very low COVID critical care demand')

Glangwili General Hospital:

- Pathways & infrastructure already in place

Outpatients:

- Routine outpatient work can re-commence but only via digital platforms. The only face to face OP work available will be for the most urgent cases for which physical clinical assessments are required.

To support our progressive implementation of routine activity submission and to provide further detail, the following supporting discussion documents are provided for background information and to illustrate the developing thinking of our clinical teams:

To support our progressive implementation of routine activity submission and to provide further detail, the following supporting document is provided

Scoping Doc	Gantt Chart	Digital	Endoscopy USC All Sites
Digital.pdf	Gant Chart.xlsx	Digital Power Point.pptx	Endoscopy USCs All Sites.xlsx
Recovery Plan	**Endoscopy Recovery Plan**	**Endoscopy Options Appraisal**	
Health Visiting.pdf	Endoscopy Recovery Plan.pdf	Endoscopy Options Appraisal.pdf	

Cancer

- Cancer services have been disrupted as a result of COVID-19. The Director General Health and Social Services/NHS Wales Chief Executive for Wales has reinforced the view of the clinical community that urgent and emergency cancer treatment must continue, and has directed services to think how capacity could best be developed to meet the needs of cancer patients, including regional solutions and use of the independent and third sector facilities.
- In response the NHS Wales Health Collaborative has issued a framework/guidance on what the minimal level of service provision must be maintained during the three phases of the crisis. The framework also describes what must be clinically provided as a minimum during all of the phases and to ensure that patients have equitable access and minimal harm. There are 8 key actions that health boards are asked to consider and align to, with a particular focus on specific challenges and risks to our organisation. The framework suggests that health boards plan for recovery in three phases. Acute Phase: peak acute service demand due to COVID-19 (0-6/8weeks), during which we continue to deliver emergency and urgent cancer care. Recovery: develop a service model that minimises harm from the acute phase and deals with the backlog of cases using the most efficient, effective and evidence based approach. Reactivation phase: minimal service disruption due to COVID (24-indefinite weeks), recommencement of 'regular' cancer services, but adopting lessons learned and new models of care where appropriate from the acute and recovery phases.

Action 1: Organisations, services (e.g. diagnostics, chemotherapy, radiotherapy, surgery) and site specific teams must work together to develop transparent, consistent and equitable access to tests and treatment.

Diagnostics

- Referrals being assessed for appropriateness by radiologists

- USC and Urgent patients continue to access the service as normal
- Ongoing cancer patients with staging continue if the patient is continuing with treatment.
- Detailed information to be provided from referrers as to the patient's treatment plan.
- CTC changed to CT abdomen.
- Bronchoscopy are planned to recommence on the Prince Philip Hospital site week commencing 11th May 2020
- As bowel screening has been suspended there are currently 231 patients awaiting a colonoscopy, the health board are to introduce FIT testing as an alternative and are in the procurement phase of this plan.
- Appointment systems staggered for patients to maintain social distancing

Chemotherapy

- OPA Oncology clinics are being held via telephone consultation and virtually where needed from Prince Philip Hospital, supported by the Oncology CNS team.
- Phlebotomy services have been set up in 2 community centres in Carmarthenshire and Pembrokeshire for pre- treatment blood tests and central line care for cancer patients. These services are available Monday, Wednesday and Friday every week.
- Bronglais General Hospital service remains as normal service.
- Chemotherapy is currently administered on 3 hospital sites. Glangwili General Hospital, Bronglais General Hospital & Withybush General Hospital.
- Treatment is administered as per the NICE COVID 19 RAPID guidance for the delivery of SACT. This is being monitored very carefully.

Surgery

- As of 14th April 2020, USC OPD clinics and surgery have been carried out at Werndale Hospital with exception of H&N and GI).
- Lower Gastro-Intestinal Clinicians will undertake any life threatening surgery via the emergency pathway.
- Upper Gastro-Intestinal Acute and cancer problems are delivered through the emergency service.
- Head & Neck surgery continues at Glangwili General Hospital at present.
- Two sessions of operating capacity has been agreed on the Glangwili General Hospital site for those patients who do not meet the criteria for Werndale and may require ITU/HDU. Further capacity is being planned dependant on demand.
- Scoping exercise to assess suitability to open operating capacity at the Bronglais General Hospital and Withybush General Hospital site began week commencing 4th May 2020 and will conclude 11th May 2020.
- Joint working with regional MDT to operate on patients on a tertiary pathway who reside in Hywel Dda has occurred within Gynaecology and Urology and is being negotiated for other tumour sites
- Meetings are taking place regularly with the relevant Service Delivery Managers & Lead clinicians to ensure that this all patients are being monitored and tracked carefully.

Action 2: Cancer service teams must collaborate to understand the varying demand for diagnostic tests and treatments during the varying phases of the COVID-19 crisis. Similarly, estimates of capacity that can be provided to meet this demand should be shared and where appropriate include delivery models that share and maximise the efficiency of available capacity across organisational boundaries.

- Currently carrying out a Capacity and demand exercise working with the Radiology Manager to estimate the capacity required to meet this demand.

Action 3: Organisations must put in place support systems able to deal with concerns from cancer patients regarding social isolation, shielding and the likely benefits and harms of ongoing cancer care. Organisations should work with the third sector to give advice and support to such patients.

- A 9-5 helpline for concerned cancer patients has been set up in the Oncology unit at Withybush, supported by the Oncology CNS Team in terms of ensuring the advice given continues to be valid and up to date.
- The CaPS (Cancer Psychological Support Service) is being run from Ty Cymorth as a telephone service for psychological support for patients and staff for the foreseeable future. This service will combine with the bereavement counselling service for this period to provide support where needed.
- A Patient information leaflet for cancer patients has been developed and widely circulated with helpline numbers on.
- Tumour site CNSs / Key worker is currently contacting patients that currently have their cancer treatment delayed or altered, and those patients that self-isolating due to COVID, are contacting patients every 4 weeks, to check on their wellbeing and to ensure they have not developed any further symptoms or issues.

Action 4: During the acute phase it is accepted that there will be disruption to acute care. This also applies to teaching, training, research and improvement programmes:

- Urgent and emergency care must continue to minimise harm to patient outcomes as a result of cancer
- Specialised cancer services should focus on maintaining the integrity of cancer services and the delivery of cancer care, where necessary on a regional basis
- Urgent and emergency care continues as usual.

Action 5: Health Boards must work with the Cancer Network through their service specific and site-specific CSGs to determine:

a) the quantity of cases that are likely to come into the emergency and urgent category
b) how they plan to provide this capacity throughout the acute phase, including considering on a regional basis where appropriate

a) 5 LGI cases have been carried out across the UHB during the past 3 weeks. This is being monitored on a weekly basis by our cancer tracking process.
b) Currently, joint regional operating is being carried out for Gynaecology with some Urology planned imminently. Discussions are taking place with regards to further working regionally with Swansea Bay University Health Board (SBUHB) to carry out surgery locally in Glangwili for residents of Hywel Dda.

Action 6: Health Boards and Velindre must work with the Cancer Network through their service specific and site specific CSGs to determine:

a) the quantity of cases that are likely to come into the prioritised categories (including displaced activity)
b) agree evidence based reduction in activity during the acute phase
c) how they plan to provide this capacity throughout the acute phase, including considering on a regional basis and the use of the independent sector where appropriate

- OPA Oncology clinics are being held via telephone consultation and virtually where needed from Prince Philip Hospital, supported by the Oncology CNS team.
- Phlebotomy services have been set up in 2 community centres in Carmarthenshire and Pembrokeshire for pre- treatment blood tests and central line care for cancer patients. These services are available Monday, Wednesday and Friday every week. Bronglais General Hospital service remains as normal service.
- Chemotherapy is currently administered on 3 hospital sites. Glangwili General Hospital, Bronglais General Hospital & Withybush General Hospital. Treatment is administered as per the NICE COVID 19 RAPID guidance for the delivery of SACT.
- As of Monday 30th March all Carmarthenshire SACT has been provided at Glangwili General Hospital. This ensures we can provide 2 meters between the treatment chairs. Additionally, as staff become sick workforce capacity will be maximised. The units will be upskilling to provide a place for transfusion of blood products to cancer patients also, should this be necessary. As per the 6 levels of SACT, all levels are still currently being treated across the UHB.

Action 7: Health Boards and Velindre should work with the Cancer Network through their service specific and site specific CSGs to determine:
a) the quantity of cases that are likely to come into the categories prioritised
b) agree evidence based reduction in regimen and doses that maintain activity but reduce hospital attendance for elective and unscheduled care during the acute phase
c) how they plan to provide this capacity throughout the acute phase, including considering on a regional basis, and the use of the independent sector where appropriate.

- Radiation therapy is provided regionally by SBUHB
- All that can be and are currently within the planning system have been delayed on hormones for (min) 12 weeks and are in Mosaiq back to ‘pre CTSim’ appt stage. They will need a repeat CTSim in due course. Further patients have been diverted to Rutherford who were suitable also within the planning queue. This has had the biggest immediate impact on RT capacity. Delegated Approval Pathway (by RT technologists) back up and running.
- Radiotherapy altered fractionation being implemented immediately for: Breast and Prostate
- All other treatments are ongoing for both Rx and SACT unless patient choice. All linacs up and running.
- Mould Room
- Now a reduced service Weds / Thurs / Fri only 11am-3pm. No new electron end plates to be made.
- Physics
- Similarly have been cross-skilling themselves and further enabling off site working.
- This all means that we are aiming to reduce our treatment linacs down to 3 functioning, matched machines

Action 8: Health Boards and Velindre must work with the Cancer Network through their service specific and site specific CSGs to determine:

a) the quantity of cases that are likely to come into the prioritised categories
b) agree evidence based reduction in activity during the acute phase
c) how they plan to provide this capacity throughout the acute phase, considering on a regional basis, and use of the independent sector where appropriate

a) For UGI/LGI only emergency UGI cases are being done on the CEPOD lists. Cystoscopy for USC Hematuria. EBUS only following PET and only if accurate staging essential. Reintroducing Bronchoscopy with strict safety criteria.
b) Some diagnostics are being carried out in Werndale Hospital. Within the health board Urgent and USC investigations are still being carried out.
c) CTCs are being changed to CT abdomen. As of 14th April 2020, USC clinics have been carried out in Werndale Hospital (except H&N and GI). Diagnostic capacity includes digital X-ray, static MRI, mobile CT, ultrasound.

Oncology - Cancer Escalation Plan

HDUHB
Oncology-Cancer Ser\

Health Visiting

- The Recovery Plan has been driven by WG and the document 'A proposal to support the psychological and physical wellbeing of vulnerable people affected by the COVID 19 pandemic', the document recommends that the impact should be considered at population level and across the life course
- Because of the significant social impact of the COVID-19 response, children and their families are experiencing disruptions at multiple levels and could exacerbate adverse childhood experiences. The Health Visiting service will provide a service for the Early Years', and on 'Starting and developing well'. Focussing on some emerging trends that are:
    - Families Facing financial insecurity as a result of the crisis -Support to reduce child poverty –
    - Increased focus on safeguarding, ensuring children are safe, whether they are attending a childcare setting or staying home for those at risk of abuse or neglect and those with special needs. Those children requiring an enhanced or intensive service.
    - Support the mental wellbeing of all children through crisis – particularly in context of childcare and school closures and pressure on health services
    - Issues effecting social distancing with very young children, creating productive social and educational groups
    - Reduced uptake of immunisation and vaccinations and wider Healthy Child Wales Programme (HCWP)

Local discussions with partners about social care resilience

At a strategic level, the joint Integrated Executive Group that is convened between the UHB and its three Local Authority Partners has been utilised to ensure a clear level of communication at the very highest levels of the organisations. Key decisions at this level have driven the agenda with regards to our Field Hospitals, Personal and Protective Equipment provision, and discharge pathways. This works alongside the revised Regional Partnership Board (RPB) arrangements such that, in West Wales:

1. Temporary regional governance arrangements have been put in place from 23 March 2020 to ensure timely decision-making during the pandemic whilst retaining openness and transparency. These were ratified by the RPB on 11 May 2020 and include:
   - Weekly meetings of Health and Social Care Leaders. This comprises of the Chief Executives of the partner organisations, Chair of the Health Board and Leaders of each Council.
   - The formation of a Health and Social Care COVID -19 Planning Group (HSCCPG), which temporarily supersedes the Integrated Executive Group. Meeting on a weekly basis, this comprises all members of the UHB Executive Team, Directors of Social Services and the Chief Executive of Ceredigion Association of Voluntary Organisations for the third sector. Its purpose is to coordinate a joined-up approach to the crisis, facilitate a whole system approach and take decisions on deployment of new funding and redirection of existing resources to support the COVID -19 response.
   - Virtual meetings of the RPB to receive updates from partners and to ratify decisions taken by the HSCCPG).
2. Several schemes within the ICF Capital programme have been paused and funds totalling £8m diverted to meet design, build and restoration costs of the 9 field hospital sites (7 field hospitals) across the region; discussions are ongoing with Welsh Government regarding potential release of alternative capital funding to recompense for the diversion of existing resources and allow reinstatement of the paused programmes at a future date.
3. ICF revenue programmes for 2020-21 are being reviewed to optimise impact of existing programmes on the COVID -19 response and identify opportunities for diverting funding to specific COVID -19 related schemes where necessary.
4. Healthier West Wales (Transformation Fund) programmes are being reviewed and refocused as appropriate to support the COVID -19 response. Examples include:
   - Extending the proactive calls that are being made through Delta Wellbeing as part of Programme 1 (Technology-enabled Care/ Connect) to cover shielded groups and other vulnerable residents including those with dementia and those at risk of domestic abuse. These calls also provide an opportunity to promote the programme and encourage take-up beyond the pandemic.
   - Expanding the Connect2you ('Vincles') element of the Connect Programme to enable a greater number of isolated and vulnerable participants to link virtually with peer groups, family and friends.
   - Adjusting crisis response capacity funded through Programme 3 (Fast-tracked, Consistent Integration) to optimise alternative pathways of care and help keep people safe within their homes and enhancing the approach through technology to enable virtual consultations.
   - Diverting a portion of the set-up grants earmarked within Programme 7 (Connecting People, Kind Communities) for the development of local action hubs to fund local groups providing COVID -19 specific support and use of the 'Connect2' time-banking platform to help match volunteer offers with requests for support within the community.

5. Evaluation of the Healthier West Wales programme has currently been suspended, although local monitoring of delivery and outcomes will continue with a view to evidencing impact and highlighting the potential contribution of the new models to the post- COVID -19 recovery and new pathways of care/ clinical models that are likely to be in place following the pandemic.

At an operational level and as noted in the section on community and county plans under essential services, the approach taken in our three counties and across Hywel Dda, has been built upon delivery of services with key partners, to ensure support and maintenance of wider health and social care delivery. Examples include:

- Enhanced community resilience and support through new community organisations and hub within Local Authorities.
- CONNECT model of proactive support, communication and rapid response deployment
- Fast track the transformation changes delivering intermediate care and rapid response
- Integrated community teams and co-ordinations through COVID Hubs
- Discharge to recover & assess pathways
- Community based rehabilitation
- Intermediate care response via single point of access in each County – deployment of rapid response to avoid admission.
- Community hospital and care home beds supporting assessment and rehabilitation outside of acute hospital settings.

Two key pieces of work undertaken with Local Authority partners to support our communities have been the Nursing & Residential Care Homes Risk and Escalation Management Policy which has demonstrated significant impact in supporting resilience in this fragile setting which has been impacted by COVID-19 in a large proportion of our homes; and the COVID-19 West Wales Care Partnership Hospital Discharge Requirements. The latter draws on the Welsh Government Discharge Requirements and ensures implementation across the West Wales Region. The document currently focuses on discharge pathways from acute hospital for patients living in care settings or for those requiring placement following an inpatient period. Work is progressing on Discharge to Recover then Assess Pathways 1 and 2.

Nursing & Residential Care Homes Risk and Escalation Management Policy	COVID-19 Hospital Discharge Service Requirements
Care Homes.pdf	West Wales Care Partnership Hospital D

The University Health Boards Response to Providing Testing to Support Care Homes

Discharges from hospital to a care home
Processes are in place to enable all hospital patients for discharge to a care home setting to be tested for COVID-19. We are currently working through the processes for managing both positive and negative test results in this group of patients with identification of appropriate step-down facilities that cannot be discharged directly to the care home setting.

Admissions to and transfers between care homes
Individuals who are to be admitted to a care home from the community or transferred from one care home to another can be referred for testing via the Health Board Command Centre. We will need to agree a process for managing those with a positive result.

Testing for care home residents and staff
We are currently working through the operational processes to enable to following:

- Commence testing all symptomatic and asymptomatic care home residents and staff (apart from those who have already had a positive test) in homes where we know we currently have positive cases
- Commence testing all symptomatic and asymptomatic care home residents and staff (apart from those who have already had a positive test) within those homes where we receive new symptomatic referrals for testing of residents or staff and results come back positive
- Commence testing all symptomatic and asymptomatic care home residents and staff (apart from those who have already had a positive test) within the largest care homes (those with more than 50 beds) which are at greater risk of experiencing an outbreak because of their size.
- Repeat tests for all negative results on a weekly basis so we can track spread within the care home sector, until we reach a 14 day period of no new positive results

We will implement a phased and targeted approach to mass testing across the care home sector, prioritising those homes with current presence of COVID-19, receipt of new symptomatic referrals and those with more than 50 beds.

This approach will help the care homes identify residents and staff who test positive for COVID-19, appropriately zone positive patients, advise staff to self-isolate and reduce the risk of spread across the home and possible the wider care home sector where staff are employed in more than one setting.

Workforce plans including use of additional temporary workforce.

- **Support and Guidance**
  - From the onset of the pandemic there were a significant number of staff queries and concerns raised. Staff were understandably anxious and sought answers to numerous queries relating to a wide range of issues including overseas travel, symptoms, child care, underlying health conditions, deployment etc. In order to address this the UHB developed a series of Frequently Asked Questions ahead of those published at an All Wales level and also produced a series of guides and protocols to support managers and staff in terms of managing in the pandemic. In addition, members of the Workforce team have helped support the COVID Command Centre Enquiry Line with a physical presence in order to respond to staff queries. The UHB has invested in the provision of and access to technology in order to maximise the opportunity for staff to work remotely. Homeworking guidance has been disseminated and managers encouraged to permit homeworking wherever possible. New working arrangements have also been introduced in order to minimise staff presence in the workplace and to enable effective social distancing. There is clearly more still to do although good progress has been made and business continuity has undoubtedly significantly improved.
  - Risk assessment templates have been introduced and professional advice has been provided by a Consultant in Occupational Health Medicine. This has been particularly useful in relation to the 'at risk' categories and those with underlying health conditions. In addition, the Black and Minority Ethnic Groups (BAME) risk assessment has also recently been introduced and members of the Workforce team are actively working with Line Managers in order to undertake risk assessments for BAME members of staff. The UHB will continue to encourage Managers to undertake and review risk assessments of those staff members who may be at increased risk and will continue to make adjustments to the workplace, roles and working patterns in order to provide a safe method of working for our staff.
  - A Workforce Dashboard is also under development to present a range of metrics to help inform planning and decision making, including information on workforce demand and supply, starters and leavers, sickness absence, Learning and Development, Well-Being agenda activity etc.

- **Upscaling the Workforce**
  - A large scale recruitment campaign was initiated at the end of March 20 to recruit Health Care Support Workers and Facilities staff i.e. Porters, Catering Assistants, Domestic Assistant, Laundry and Semi-Skilled. NHS Jobs and Social Media were used as advertising platforms. The response rate was extremely positive and interviews were conducted intensively by telephone over a period of 5 days. Whilst the process was not aligned to our traditional recruitment pathway, measures were taken to manage and mitigate risks appropriately. Managers are being supported locally by members of the Workforce Team to manage any issues arising post start date. The extent of the recruitment exercise was unprecedented in terms of numbers recruited and on-boarded however it has positioned the Health Board well in terms of the support staff required to respond to the pandemic. In addition, new roles at bands 2, 3 and 4 are being developed and training planned in order to further supplement the wrap around support needed for the Registered nursing workforce. In total, almost 1200 individuals were offered contracts of employment (part time or full time) or bank. Only 56 candidates have withdrawn so far which represents a withdrawal rate of just under 5%. The campaign has therefore proved extremely successful. The numbers recruited will help facilitate the UHB being able to quickly respond to surges in demand if and when we

enter another peak in demand. The additional cohort of cleaning staff will also help to ensure wards and offices are cleaned to a high standard in order to prevent any potential future spread of infection. In terms of collaboration, the UHB has also worked in conjunction with Local Authority partners in order to assist in supporting Care Homes. The additional recruits has enabled the UHB to provide a level of support to our partners.

- In addition, 19 wte Medical Students and 167 wte Nursing Students have been on-boarded into paid employment. Discussions continue in relation to the placement of additional student cohorts i.e. Midwives, Pharmacists, Allied Health Professionals and other Medical students.

	Increase in Supply FTE				
	Carmarthenshire		Pembrokeshire	Ceredigion	Total FTE
Job Title	Llanelli area	Carmarthen area			
HCSW - Mass recruitment	69.81	82.27	120.00	43.34	315.42
HCSW - Student Nurses	111.00		33.80	22.00	166.80
HCSW - Medical Students	6.00	6.00	3.00	4.00	19.00
Porters	27.03	33.76	48.90	9.53	119.22
Laundry	0.80	12.96	0.00	5.20	18.96
Catering	7.91	17.27	33.79	14.37	73.34
Domestics	35.24	72.33	111.61	34.50	253.68
Semi-Skilled	5.00	10.80	7.03	3.60	26.43
Total	**262.79**	**235.39**	**358.13**	**136.54**	**992.85**

- Workforce leads are an integral part of the Command structure and are well positioned to influence service and operational plans accordingly. There are close links with all Bronze groups and also a specific Workforce Bronze which focusses on the provision of professional support and advice in the planning arrangements. Workforce leads have also worked closely with professional leads in order to ensure professional staffing ratios are safe and workable. Service provision and patient pathways are likely to continue to change and will need an agility of response in terms of the staffing required. Members of the Workforce team are therefore closely aligned to the Acute, Community, Primary Care and Field Hospital groups in order to ensure that all staffing implications are properly considered. The key emphasis will be on ensuring flexibility and adaptability of the workforce as we move towards a longer term planning phase which needs to respond to possible future peaks in demand.

- **Training**
  - There has been a significant focus on training the large numbers of new recruits both in terms of induction and skills to care training. In addition, over 80 current staff have also received skills to care training in order to enhance skill levels to assist with deployment to critical care areas if required. Much of the training is now provided on a completely virtual basis negating the need for classroom gatherings. Face to face training has

been unavoidable for those in clinical roles – new staff have completed a shortened bespoke clinical induction and manual handling programme, with training being carried out using college and university premises in order to assist with social distancing guidelines. Learning has been supplemented by email and telephone support to new recruits.

- Bespoke sessions have also been completed in medicines management, fundamentals of care, critical care, NIV/CPAP and IV and pump training in order to up skill our temporary workforce in addition to our existing workforce. The focus is now moving towards ensuring sustainability – work is now underway to design an interactive virtual induction programme which will re-introduce additional e-learning modules and provide additional training in areas including safeguarding, PPE and infection control. Planning is also underway to develop the workforce to maximise the skills needed to deliver effective patient care and to provide support to services in the use of digital learning software.

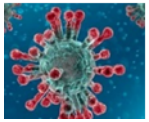
- **Staff Wellbeing support**
  - A Staff Psychological Wellbeing group was set up early in the campaign and was chaired by the Health Board Chair. This helped to demonstrate the emphasis placed by the Health Board on staff wellbeing and helped in terms of the prominence of the issue.
  - The group developed a Staff Psychological Wellbeing plan for COVID 19 which reflected the different phases that the crisis was likely to involve. A service tracker was also developed to capture experiences and key themes across the Health Board. A 24/7 Employee Assistance programme was initiated in order to build upon and supplement the in house service. In addition, staff resources from Clinical Psychology have been mobilised and deployed to support individuals and group interventions in areas such as Critical Care, A&E and COVID wards, Acute Mental Health and Learning Disability wards. A range of online material to support staff is also available on line. The key aim has been to ensure access to support as and when staff require it and to ensure they are encouraged to take periods of rest including leave.

- **Staff testing**
  - The UHB set about testing staff in accordance with the CMO Letter on 18th March.
  - Coronavirus Testing Units (CTU) were opened across the UHB during March & April recognising that our geography meant that one would not be sufficient. Units were commissioned in Cardigan followed by Carmarthen and then Aberystwyth. These were all walk in units where the individuals temperature & Oxygen saturation's were recorded and a throat swab taken. Subsequent to this the UHB opened a drive through CTU in Llanelli (10th April) and then in Withybush one week later. Mutual aid testing was then offered to all staff who worked for WAST and the LRF.
  - On the 30th April a Deloitte drive through testing unit on the Carmarthen Showground was opened (in place of the existing walk in CTU in Carmarthen). Since this time testing has been offered to other key workers. Any staff member (or household contact) presenting with symptoms is now eligible for testing. More recently the UHB has had the opportunity to work with the military and since the 7th May has enabled the extension of the testing protocol to the care home sector.
  - To date the UHB has tested almost 3000 staff members. The positivity rate climbed gradually from 10% in March to over 30% mid-April and is now gradually reducing, currently at 11%.

Financial Plans and Implications

- A Financial Reporting Principles paper has been developed to outline the UHBs approach to the internal and external reporting of the costs incurred in response to the COVID-19 pandemic.
- Guidance has been received from Welsh Government outlining the external expectations of the organisation's ability to record and report the costs incurred in the local response to COVID-19 pandemic both the gross and net (costs exceeding available funding).
- WG have provided a monitoring template, which is a monthly reporting requirement for 2020/21. The recording and reporting mechanisms that are implemented locally have been be designed to fulfil this requirement as well as any further internal requirements.
- The high level principles are expected to be relatively fixed, subject to material changes in guidance from WG. The methodology of delivering the reported output however, is expected to evolve and be refined, especially in the first quarter of the year. This is due to the pace at which the organisation has needed to respond to COVID-19 and the fluidity of plans as the situation progresses.
- The over-arching principles described in the guidance received from Welsh Government are:
  - There are clear and pragmatic financial arrangements in place which minimise disruption to the system;
  - Business continuity arrangements are effective;
  - Frameworks to support effective decision making are clear;
  - Core financial assumptions are clear and monitored, but with a light touch approach whilst maintaining clarity on minimum key measures.
- There is a need to have the ability to articulate both:
  - the gross costs incurred in response to COVID-19 (being the total cost of additional purchases/resources incurred extraordinarily, for example additional ventilators, plus the cost of diverting existing resources towards to the response to COVID-19, therefore not delivering a 'business as usual' activity); and
  - the net ("additionality") costs incurred in response to COVID-19 (being costs incurred in excess of the Health Board's available funding) offset by reductions in expenditure (such as reduced elective activity).
  - Procurement processes have been enacted to automate the coding of Non-Pay COVID-19 expenditure at source through the PO process.
  - The central collation of Workforce plans will be key in delivering robust and transparent financial reporting.
- The UHB, in common with all health and social care providers in Wales, faces unprecedented challenges during this time of response to the pandemic. The UHB has already made and is very likely to continue having to make decisions at pace to protect both staff and patients and, for reasons of expediency, has not always be in a position to follow the scheme of delegation as written. Where this has occurred, we will document the reason for this and ensure that decisions are regularised through the appropriate governance processes.
- Key areas for consideration from a financial governance perspective are: Value for money; Decisions are rational and justifiable; Integrity; Fraud

To support our Financial Implications submission and to provide further detail, the following supporting document is provided



Covid-19

Bwrdd Iechyd Prifysgol
Hywel Dda
University Health Board

Financial Forecasting Principles	Financial Forecast
COVID-19 Forecasting Principles	Q1 COVID-19 Financial Forecast.xlsx

Risks to delivery

- Unexpected surge capacity required
- Potential return of Field Hospital sites to original usage
- School and workplace access changes
- Tourism activity
- Policy roadmap
- Staffing / resources – new employees returning to substantive positions/sectors, return to University etc

Additionally, each of the groups in our command and control structure have individual risk registers

To support our Risks to Delivery submission and to provide further detail, the following supporting document is provided

Risk Register

PDF

Item 3.1
Responding to the (