Performance update for Hywel Dda Univerity Health Board

as at 30th April 2020

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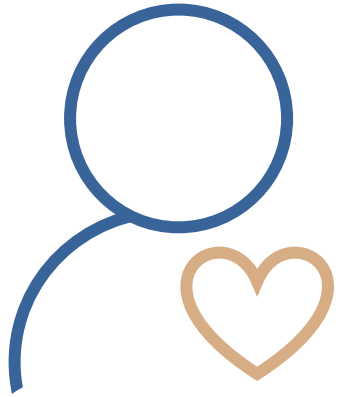


Executive summary

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

COVID-19

Confirmed COVID cases as at 30th April 2020	Suspected & confirmed COVID patients admitted 4th-30th April*	Confirmed COVID patients discharged 4th-30th April*	Confirmed COVID patients who died in one of our hospitals in April
759	406	245	37

* daily national situation reporting (sitrep) for COVID started on 4th April 2020

Non-COVID

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

- **Where have improvements been made?**
  - The percentage of urgent suspected cancer patients who commenced treatment within 62 days of referral improved by 5.4%;
  - Performance in respect of the Single Cancer Pathway improved by 6% from the previous month;
  - 37 ambulance handovers were reported as taking longer than 1 hour during April 2020;
  - 86.5% of patients were seen within 4 hours in A&E/MIU (target 95%) and 47 patients spent longer than 12 hours (target 0);
  - Between October and December, 96.3% of babies had the recommended 3 doses of the '6 in 1' vaccine by their 1st birthday.
- **Where is improvement needed?**
  - The 65% target was not met for ambulances arriving within 8 minutes to calls for patients with life threatening conditions (56.7%);
  - Between July and September, 91.7% of children had 2 MMR doses by age 5;
  - The percentage of non-urgent suspected cancer patients who commenced treatment within 31 days of referral has declined by 1.6%;
  - 57.1% of high risk Ophthalmology patients waited no more than 25% over their clinical target date, a decline of 6.3% compared to February.
  - We have a financial plan with a year-end of £25.0m deficit. The current financial position at the end of April is £6.3m deficit against a deficit plan of £2.0m.
- **Impact of COVID-19**
  - Staff absence has increased; on the 30th April '20 sickness was 5.39% with 1.5% absent due to COVID and 2.57% self-isolating;
  - Some staff have been deployed from their substantive posts to assist with COVID-19 planning (e.g. recruitment and establishing field hospitals);
  - Most elective procedures and outpatient appointments have been cancelled to create capacity for staff training and COVID-19 patient admissions;
  - Staff are taking additional time for the putting on and taking off (donning and doffing) of personal protection equipment;
  - To avoid inpatient admission where appropriate, the temporary physical redesign of acute hospital facilities to accommodate separate COVID & Non-COVID pathways has led to some patients receiving extended clinical assessments within ED departments beyond the 4 hour threshold;
  - Where possible, staff have shifted to working from home which has required additional IT infrastructure and resources;
  - Fewer therapy appointments have occurred due to the increased risk of face to face contact and reduced staffing;
  - Non-urgent diagnostic investigations have been deferred with urgent & cancer related diagnostic investigations receiving priority;
  - Mental Health and Learning Disability patients have had reduced leave (i.e. attending social activities or shopping) to limit their risk of exposure.

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

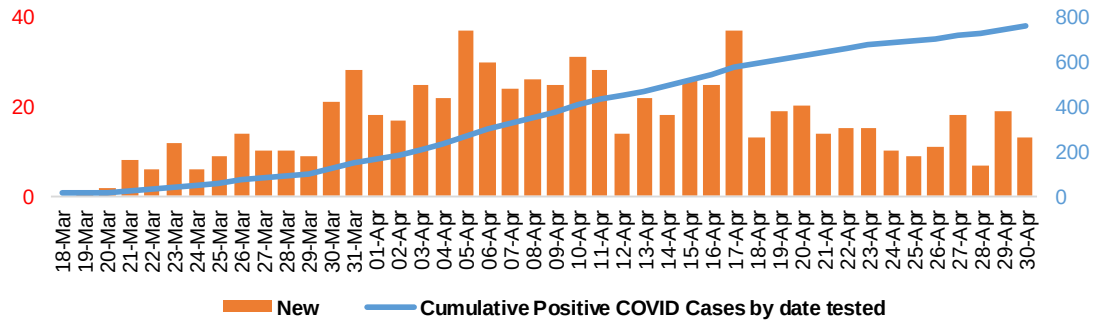
COVID-19

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

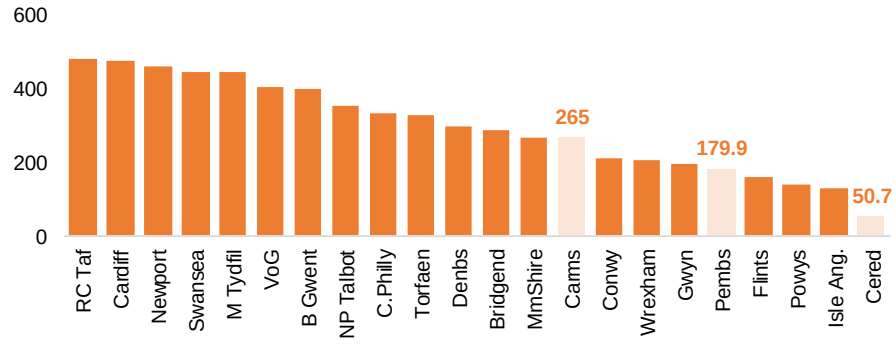
Confirmed cases

As at 30th April 2020, there were 759 confirmed cases of COVID-19 for Hywel Dda residents, an increase of 608 cases from 31st March 2020. The highest number of new positive cases tested was on 5th and 17th April with 37 new cases reported for both days. Population rates for confirmed cases are seen to be lower in Hywel Dda than in many other local authority areas. On 30th April 2020, Ceredigion had the lowest local authority rate in Wales (50.7 per 100,000 population). It is important to note that the local authority rates may be skewed due to testing variation in each area and therefore should be used as a proxy.

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



Confirmed cases per 100,000 resident population



Supporting our staff

We have established a COVID command centre which is open from 7am to 9pm every day. Staff are able to contact the command centre by email or phone with all COVID related queries e.g. staff testing, personal protective equipment (PPE), wellbeing support. In April the command centre had on average 99 calls per day from staff (2,971 in April overall). In addition, our Staff Psychological Wellbeing Service has changed the way they work to offer one to one support services to staff.

Personal Protective Equipment (PPE)

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

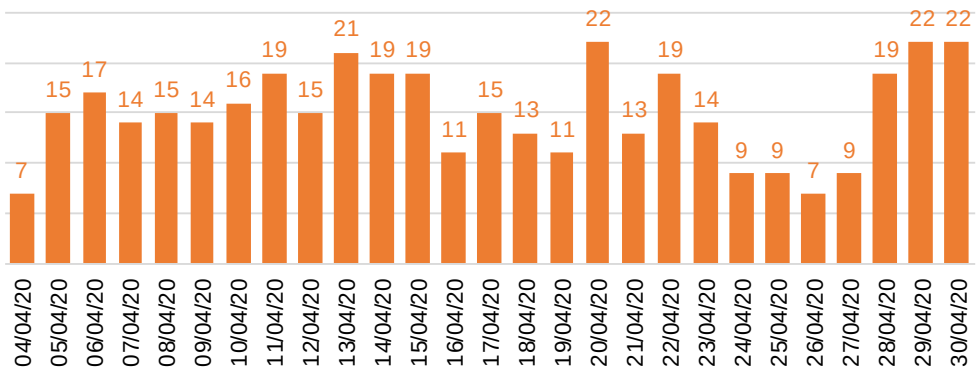
Admissions

Between the 4th and 30th April there were 406 COVID (confirmed and suspected*) admissions to our acute hospital sites; 21 in Bronglais General Hospital (BGH), 206 in Glangwili General Hospital (GGH), 73 in Prince Philip Hospital (PPH) and 106 in Withybush General Hospital (WGH). This is an average of 15 COVID admissions a day across the Health Board and approximately 25% of all admissions. Non-COVID admissions averaged 60 per day over the same period.

We have worked hard over the last 4-6 weeks to create 9 field hospitals across Hywel Dda. These new sites will offer important flexibility in the coming weeks and months for us to care for additional patients if the demand for acute hospital capacity exceeds threshold levels.

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

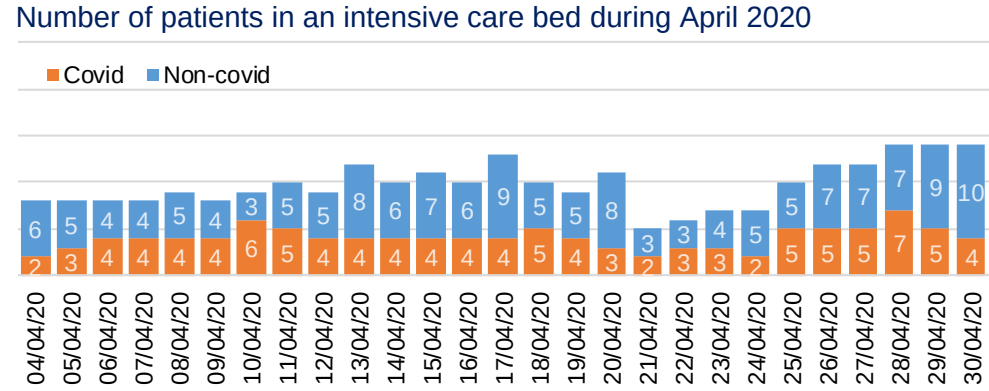
Hywel Dda daily COVID* admissions during April 2020



Intensive care

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

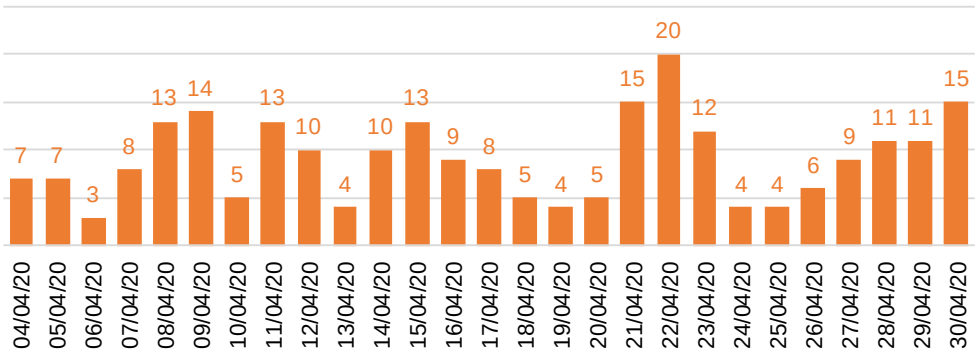
Number of patients in an intensive care bed during April 2020



Discharges and deaths

Between 4th and 30th April, 245 COVID patients were discharged from hospital alive. Sadly, 37 patients died in our hospitals during April after being admitted and subsequently having a confirmed diagnosis of COVID-19.

Number of COVID patients discharged during April 2020



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

Non-COVID overview

This section includes summary information on some of the key areas that we prioritised to make improvements in 2019/20 and we are continuing in 2020/21. Due to the COVID 19 pandemic, we are providing data updates for all available indicators. However, to reduce the burden of our key operational staff, we have only included narrative for those areas Welsh Government have flagged as priority areas where measure reporting should continue. The reporting time period and frequency differs by indicator. See the performance overview matrix for details.

		Target	12m previous	Previous period	Latest data	Notes **
Unscheduled care	Ambulance red calls	65%	67.9%	56.9%	56.7%	Carm 57.1%, Cere 41.7%, Pembs 62.1%. Additional military staff drafted in to support WAST. Sickness is not impacting upon emergency ambulance conveyance.
	Ambulance handovers over 1 hour	0	417	288	37	Ambulance arrivals decreased and although notification to handover has significantly reduced, handover to clear has significantly been extended due to the need to remove PPE and clean vehicles.
	A&E/MIU 4 hour waits	95%	81.3%	77.9%	86.5%	There has been a 56% reduction in the number of new attendances since April '19. GGH had the highest 4 hour performance in April '20 (90.7%) and we met trajectory for both 4 and 12 hours performance. In order to maximise opportunities to avoid inpatient admission where appropriate, some patients received extended clinical assessments within Emergency Department beyond the 4 hour threshold.
	A&E/MIU 12 hour waits	0	924	540	47	
	Non-mental health DTOC	12m↓	46	46	43	Due to COVID-19, DTOC census patient number monitoring has been suspended until Sep'20. Latest data is based on unverified numbers from the National DTOC database as at 13th May '20.
	Mental health delayed transfers of care (DTOC)	12m↓	7	13	8	
Stroke and cancer	Admission to stroke unit <4 hours	59.8%	67.8%	n/a	n/a	Due to COVID-19 the requirement to submit data to SSNAP (Sentinel Stroke National Audit Programme) was suspended on 20th March. Whilst all 4 acute sites are collecting data locally, there is a backlog in inputting data from March and April '20 and there have been practical difficulties in maintaining a complete dataset in PPH and GGH with the recovery of data taking a minimum of one month depending on Covid-related pressures. WGH and BGH are reporting the same volume of stroke admissions as April '19 with a decline in PPH. GGH figures to follow.
	Assessed by stroke consultant <24 hours	84.2%	100%	n/a	n/a	
	Stroke patients - speech and language therapy	12m↑	38.3%	n/a	n/a	
	Urgent suspected cancer	95%	84.2%	73.8%	79.2%	Reported performance relates to March 2020 and part reflects improvements secured during prior to the WG suspension of routine diagnostic and surgical activity. Further improvement was limited by the suspension of tertiary cancer surgery pathways during the end March / early April period.
	Non urgent suspected cancer	98%	95.8%	98.0%	96.4%	
	Single cancer pathway	12m↑	79.4%	73%	79%	
Planned care and therapies	Hospital initiated cancellations	5%↓	158	113	1,072	During March '20, in response to the pandemic, an additional 959 operations were cancelled within 24 hours compared to February '20.
	Delayed follow-up appointments 5 specialties	12m↓	18,199	15,478	15,694	The number of delayed follow-up appointments has increased due to non-emergency outpatient appointments being postponed.
	Ophthalmology patients seen by target date	95%	n/a	63.4%	57.1%	Despite a 6.3% deterioration in performance, which is primarily due to patient cancellations, high risk treatment is continuing and there is a reduction in patients compared to last month (501 fewer high risk patients awaiting treatment). 370 (2%) patients are to be allocated a risk factor.
	Diagnostic waiting times	0	56	336	3,860	The cancellation of routine appointments has significantly increased the number of patients waiting beyond 8 weeks for Radiology & Cardiology diagnostic tests. Both services have confirmed that clinically led validation arrangements are in place to prioritise urgent referrals.
	RTT – patients waiting 36 weeks+	0	213	722	2,202	In line with the WG instruction to Health Boards, non-urgent pathways have been suspended due to the COVID pandemic. As a result the number of patients waiting over 36 weeks for treatment increased by 1,480 between March and April '20 and is 1,989 higher than April '19.
	RTT – patients waiting <=26 weeks	95%	89.4%	83.6%	78.7%	
	Therapy waiting times	0	41	212	880	Increases seen for Physiotherapy & Podiatry due to them being 'hands on' therapies, clinical activity has been limited to urgent/high risk patients.
Quality and safety	C.difficile	<=25	19	10	10	Cumulative reduction rate reporting has been stood down until July '20. As an interim measure we are reporting the numbers of infections.
	E.coli	<=67	23	16	27	
	S.aureus	<=20	13	19	10	
	Serious incidents	90%	25%	42.0%	17%	For the month of April 2020 there were 12 SI's due for closure and 2 were closed in date. There were also 3 never events reported.
	Concerns and complaints	75%	81%	68.9%	61.0%	Covid-19 activities have reduced time available for our services to resolve investigations. 73% compliance achieved overall for 2019/20.
MH +	Children/young people neurodevelopment waits	80%	35.8%	26.5%	22.9%	Assessments have continued successfully by telephone. The service is expected to have an increased waiting list going forward as the number of therapeutic intervention face to face appointments has been reduced.
	Adult psychological therapy waits	80%	n/a	49.3%	50.2%	
Population Health	'6 in 1' vaccine	95%	94.10%	94.5%	96.3%	The risk of COVID-19 has raised concerns among parents / guardians, who may delay bringing infants and children for routine childhood immunisations, leading to a decrease in uptake of all childhood immunisations, including the 6 in1 and MMR.
	MMR vaccine	95%	91.0%	91.0%	91.7%	
	Attempted to quit smoking	5%	2.5%	1.8%	2.6%	COVID-19 presents a risk to smokers accessing cessation support services and to be CO validated as quit.
	Smoking cessation - CO validated as quit	40%	45.6%	47.1%	48.4%	
Workforce & finance	Sickness absence (R12m)	12m↓	4.86%	5.08%	5.19%	Covid-related pressures have impacted on workforce performance: • Occupational Health capacity has been severely limited. • Medical appraisals have been suspended until September 2020. • Core skills compliance is expected to rise when level 1 fire training (63.6%) reverts to the e-learning module but Covid priorities have delayed the implementation of this change.
	Performance appraisals (PADR)	85%	79.0%	67.4%	68.6%	
	Core skills mandatory training	85%	80.1%	82.9%	81.6%	
	Consultants/SAS doctors - current job plan	90%	75%	78%	78%	Compliance is static due to Covid-19 activities. Work to be undertaken with service managers to determine how to address going forward.
	Finance - deficit	£25m	£2.92m deficit	£34.94m defcit	£6.29m deficit	Board's financial position at the end of April is £6.3m deficit against a deficit plan of no more than £2.0m. Additional costs have been incurred in response to the COVID19 pandemic.

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

Unscheduled care

Executive Lead: Director of Operations

Senior Responsible Officer(s): General Managers

How did we do in April 2020?

56.7% of ambulances arrived to patients with life threatening conditions within the 8 minute target.

37 ambulances waited more than 1 hour at our hospitals to handover their patient to an Accident and Emergency (A&E) department/Minor Injury Unit (MIU). This is the lowest reported number since Jul'17 (37).

6,045 patients attended an A&E/MIU in April as a new attender. Of these patients, **86.5%** were seen and treated within 4 hours of arrival but **202** patients waited longer and **47** patients waited over 12 hours; There has been a 56% reduction in the number of new attendances compared to April '19.

In April there were 1,923 emergency admissions compared to 3,942 in April '19, to our hospitals of which 1,344 (70%) were admitted via A&E/MIU. On average medical emergency patients stayed in hospital for 11 days (Apr'19-Apr'20).

Risks

- Ambulance staff must put on (don) Personal Protective Equipment (PPE) for all calls, and higher specification PPE where procedures produce airborne particles or respiratory droplets. Some staff have to don the full Versoflow hood and battery pack due to failing the PPE fitting test;
- Ambulance handovers of patients > 1 hour have reduced, however the time taken to become operational again has extended due the need to remove PPE and clean vehicles;
- Ambulance staff availability due to COVID19 related self-isolation and/or sickness and shielding;
- Existing vacancies and staffing of the additional field hospitals with Registered Nurses (RN) and Health Care Support Worker (HCSW) for both the new Red (suspected COVID19 symptoms) and Green (no suspected COVID19 symptoms zones in the emergency departments (ED). Deployment of staff unaccustomed to ED could impact patient flow;
- Staff availability due to COVID19 related self-isolation and sickness; loss of regular agency/partnership nurses due to social distancing travel requirements; In BGH staff are risk assessed to determine if they can work in Red ED or elsewhere accordingly;
- Residential and care homes requiring:
  - residents to have a negative COVID19 test before they are returned from hospital (ward or ED);
  - residents to be returned to the home within 4 hours of being discharged from an ED;
- Off-site COVID testing, delayed results and cross border 'discharge to assess' challenges;
- Vacancies in community hospitals negatively impact the efficient transfer of some patients from acute sites. There are some delays in reablement and long term care package availability due to both COVDI19 concerns and staff shortages;
- Daily differences in Red and Green zone capacity to treat patients and the number of patients needing the service. There might be more patients in Green zone than in Red;
- Establishment of Green ED has created a second access pathway for ambulances. There were some handover delays due to additional infection prevention processes undertaken by ambulance crews to protect staff and patients;
- The Ambulatory Emergency Care & Surgical Assessment Units have merged into a Green ED zone, so some patients have remained in the department for a longer period of time with the intention of a quick turnaround, rather than admitting to a ward area.

What are we doing?

- Welsh Ambulance Service Trust (WAST) trained military personnel to undertake several roles, such as drive the ambulance and support the WAST clinicians; Deep cleaning of vehicles before becoming operational; Military personnel deployed with our Advanced Practitioners and rapid response vehicle to support the putting on and taking off (don and doffing) PPE process. A number of Mid and West Wales Fire and Rescue staff trained to support WAST, awaiting occupational health clearance before they can be deployed;
- Detailed COVID19 plans on each site having Red and Green zones in the ED and defined inpatient wards;
- Patient streaming system implemented at the front door to screen for symptoms of potential COVID19;
- WGH to establish a short stay medical inpatient unit from 4th May '20 with the aim of improving patient flow out of the Green zone ED and discharging from this area within 48 hours;
- HCSW recruitment above normal levels to provide staff for acute and community hospitals;
- WGH established a Blue team consisting of senior hospital medical staff and an Advanced Practitioners (AP), to work with the intermediate care team to set up care and support systems for patients to remain at home. The Blue medical team extended their scope to screen all referrals for hospital admissions including from GPs and WAST (with the exception of emergency priority calls) resulting in good levels of admission avoidance;
- BGH has a dedicated COVID19 team of medics and nurses and the benefit of an experienced member of staff with previous experience from the Middle East Respiratory Syndrome (MERS) outbreak;
- From 4th May a Consultant Geriatrician in WGH and a GP will commence joint visits to care homes to review patients, ensuring care plans and Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) directives/Advanced Care Plans are in place;
- In hospital a Chronic Conditions Advanced Nurse Practitioner (ANP) commenced in April and after induction will support reviews of patients with prolonged stays, turnaround from short stay unit and enhance links with community chronic conditions teams for those already in WGH.

Cancer

Executive Lead: Director of Operations

Senior Responsible Officer(s): Assistant Director

How did we do in March 2020?

During March 2020, **79.2%** (84/106) of cancer patients who were referred by their GP as urgent with suspected cancer, commenced treatment within 62 days of their referral. This represents a 5.4% improvement over the previous month.

96.4% (133/138) of patients who were not on an 'urgent suspected cancer' pathway commenced treatment within 31 days of the date the requirement for treatment was agreed with them.

We are working towards implementation of the new single cancer pathway (SCP) to monitor progress of all newly referred cancer patients from the point of suspician until treatment starts. The new pathway increases the number of patients who will be monitored during the diagnostic phase. In March, **79%** of patients covered by the SCP were treated within 62 days of the point of suspicion, a 6% improvement on the previous month.

Risks

- Complex pathway delays – the nature and complexity of tumours for some patients do not support rapid diagnosis and treatment due to the need for multiple investigations and multi-disciplinary team reviews;
- Tertiary (specialist) centre capacity pressures at Swansea Bay University Health Board (SBUHB) continue to significantly compromise our performance across a number of cancer pathways;
- Local diagnostic service capacity pressures within our Radiology service continue to present a risk to recovery;
- The new pathway significantly increases the number of patients who will be monitored during the diagnostic phase of their pathways, placing added pressure on capacity within our diagnostic services;
- During the latter part of March, tertiary surgery was suspended due to COVID-19;
- Locally, surgery for those patients requiring ITU/HDU support and all aerosol generated diagnostic investigations were suspended due to COVID-19 as per national guidance.

What are we doing?

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

Eye care

Executive Lead: Director of Operations

Senior Responsible Officer(s): Assistant Director

How did we do in March 2020

In March 2020 **57%** of patients (7,514/13,170) were waiting in or within 25% of their target date which represents a 6% decline in performance. 98% of patients have been allocated a high risk factor (HRF) status leaving 370 (2%) patients waiting for an allocated HRF status.

Risks

- New Eye Care patients can wait longer due to a shortage of consultant ophthalmologists. Capacity being used to cover the Emergency Eye Care service can also impact on waiting times;
- The COVID pandemic has affected the following eye care services:
  - Outpatient appointments have been lost with approximately 166 new and 392 follow up appointments not taking place;
  - Approximately 190 surgical procedures have not occurred;
  - From 16th to the 31st March the overall waiting list has grown by 315 patients for stage 1 and 34 patients for stage 4;
  - The overall waiting list growth is lower than expected due to a reduction in referrals for both routine and emergency surgery.

What are we doing?

During the COVID pandemic the Eye care service has:

- Maintained treatments and reviews for imminently sight threatening or life threatening conditions;
  - A drop in compliance is partly due to the COVID pandemic which has led to some patients choosing not to attend hospital appointments:
    - New 246 (25% for March as opposed to yearly average 14%)
    - Follow up 549 (27% as opposed to yearly average of 15%)
    - Total 795 (26% as opposed to yearly average of 15%);
  - Although compliance had dropped, clinicians have been triaging patients waiting beyond 25% of their target date. This has led to an overall reduction in the number of patients on the R1 waiting list. This has ensured the correct clinical prioritisation of high risk patients is being undertaken and high risk patients are offered appointments first.
- Postponed any patients on longer than an 8 week follow up. These patients have been put onto a COVID crisis holding category which is being reviewed by clinicians going forward;
- Patients due back at 8 weeks or less are having their notes reviewed by a doctor to determine the appropriate action;
- Senior input is available via phone or email at all times of the day and a consultant is on site at Glangwili General Hospital from Monday to Friday;
- All Clinicians are reviewing clinics and contacting patients in advance as far as possible;
- The clinical team continue to see all ages of patients in the intravitreal injection therapy service including wet aged macular degeneration, retinal vein occlusion and diabetic macular oedema. This only applies if the patient is well and no symptoms of COVID-19. Some patients do not want to attend due to risks, therefore there is a virtual Clinical review happening weekly. This will change when and if the Royal College of Ophthalmology guidelines change.

Childhood immunisations

Executive Lead: Director of Public Health

Senior Responsible Officer(s): Immunisation leads

How did we do?

The '6 in 1' vaccine is given as a single injection to protect babies against 6 serious childhood diseases: diphtheria, hepatitis B, Haemophilus influenzae type b (Hib), polio, tetanus and whooping cough. The '6 in 1' vaccine is given at 8, 12 and 16 weeks old. Between October and December 2019, **96.3%** of children had received 3 doses of the '6 in 1' vaccine by their first birthday, consistent with uptake in the previous quarter (95.1%).

The MMR vaccine is also given as a single injection and protects against mumps, measles and rubella (German measles). It is given within a month of a baby's first birthday then again when the child is around 3 years 4 months. In Hywel Dda, between October and December 2019, **91.7%** of children received 2 doses of the MMR vaccine by their 5th birthday, compared to 91.0% in the previous quarter.

Risks

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

What are we doing?

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

Finance

Executive Lead: Director of Finance

Senior Responsible Officer(s): Assistant Director

How did we do in April 2020?

The Health Board's financial position at the end of April is **£6.3m deficit** against a deficit plan of £2.0m. This is after incurring additional costs of £4.6m directly attributable to COVID19, and the impact of unidentified savings required of £2.0m due to diverting our operational focus to the response to the COVID-19 pandemic. In April, we delivered £0.2m of savings schemes against our plans of £0.8m due to the operational responses required to COVID-19.

Risks

- We have a Financial Plan with a year-end of £25.0m deficit. A full year financial forecast will be completed in May in line with the Welsh Government Quarter 1 Operational Plan. Welsh Government have indicated that whilst certain specific additional costs incurred in response to the COVID19 pandemic will be funded by Welsh Government, there is no certainty of funding beyond these specific areas. This means that there is a significant risk that the Health Board's financial position may be adversely affected.

What are we doing?

- Internal budget holder accountability statements in relation to the 2020/21 budget were replaced with a Delegations and Finance Delivery letter, in light of the COVID-19 pandemic. These clarify the continuation of existing financial control principles and the importance of existing governance processes and frameworks, and state the significance of decision making in response to, and the accurate recording of the financial impact of COVID-19;
- An alignment of strategic response to current demand modelling indicators between Welsh Government, HDUHB Gold Command and operational teams is on-going;
- Feedback/clarity from Welsh Government is being sought as to the levels of additional revenue and capital funding available.