Hywel Dda University Health Board

Coronavirus (COVID-19) NHS Wales Operating Framework for Quarter 3 & 4 (2020/21)

October 2020

Introduction

Overview

This paper sets out the Hywel Dda University Health Board (UHB) quarter 3 and 4 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:

- Local prevention and response plans, including Test, Trace and Protect
- Essential Services
- Preparing Urgent and Emergency Care Services for Winter
- Working with Partners
- Organisations Capacity Plans
- Organisational Workforce Plans
- Finance Plans
- Research and development
- EU Transition
- Stakeholder Management, Communication and Engagement
- Framework Minimum Dataset

Our quarter 3 and 4 response builds upon on our quarter 2 submission (July 2020)

Our Planning Scenarios and Assumptions

SEIR-VD model assumptions

- Models at county level, and flow into acute hospital of field hospital
    - We track against our admissions, and use the above assumptions to estimate COVID-19 spread in the community
- 1.2 – 2.7% of all infections are admitted
    - We currently use 2.7%
    - This may overestimate admissions in lower age groups, where admission rate could be much lower
- ~66% of infections are symptomatic
    - We apply specific attack rates to our demographics
- SITREP: COVID-19 confirmed and suspected included
    - Captures “true demand”, i.e. patients treated as COVID-19 patients but later test negative
    - May overestimate admissions and cases in community as the suspected demand does not correlate directly to COVID-19 actuals
- LIMS: COVID-19 test confirmed, and admitted to hospital
    - Better method for estimating transmission in the community
    - Does not factor in COVID-19-like patients

- May underestimate the true service demands

Core planning models

- S9: SITREP COVID-19 confirmed and suspected
  - Rt=1.1 continuous until 31st March 2021
  - S13: LIMS positive and admission confirmed
  - Rt=1.3 (Sep) Rt=1.1 (Oct) Rt=1.5 (Nov) Rt=0.9 (Dec+)
  - S14: SITREP COVID-19 confirmed and suspected
  - Rt=1.3 (Sep) Rt=1.1 (Oct) Rt=1.5 (Nov) Rt=0.9 (Dec+)

M19 model assumptions

- 5 years of historical data
  - ED attendances,
  - Emergency admissions
  - Emergency discharges
- Patient groups
  - Medical
  - Surgical
  - Maternity/Neonatal
  - ICU
  - Ward Care
- Assumption examples
  - Length of stay / bed days distributions by site and patient group
  - Mortality, time spent at pathway stages,

Current Performance

Our performance data for the end of Month 6 (September 2020) can be found in our Integrated Performance Assurance Report (IPAR):

COVID-19			
Confirmed COVID cases as at 30th September 2020	Suspected & confirmed COVID patients admitted 1st-30th September	Confirmed COVID patients discharged 1st-30th September	Confirmed COVID patients who died in one of our hospitals in September
1,623	**157**	**107**	**0**

Non-COVID

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

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

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

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

- In August 28.3% of adults waited less than 26 weeks for a psychological therapy, declining by around 5% from the previous month;
- Between April and June, 90.3% of children had 2 MMR doses by age 5;
- Staff appraisals are below target with a 1.2% deterioration from the previous month;
- 84.2% of staff have completed their mandatory training (target 85%);
- Performance for Consultants and SAS Doctors with a current Job Plan fell to 36% in September. Due to the impact of COVID-19, this is significantly below the target of 90%;
- We have a financial plan with a year-end projected deficit of £25.0m. The current financial position at the end of September is £12.5m deficit against a deficit plan of £12.5m.

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

The full IPAR submission can be found at: https://hduhb.nhs.wales/about-us/performance-targets/our-performance-areas/monitoring-our-performance/

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Local Prevention Response Plans including Test, Trace and Protect

Hywel Dda Regional Prevention & Response Plan

- Strong multi-agency partnership approach to Prevention and Response Planning resulting in first iteration of the Hywel Dda Prevention and Response Partnership Local Coronavirus (COVID-19) Prevention and Response Plan (2020/21) being developed and submitted to Welsh Government in August, 2020. Presented to Public Board at its September meeting, recognising that this is a living, working document which will be adapted as lessons are learnt and built into practice moving forwards. This includes escalation and response plans to cases, clusters, incidents and outbreaks.
- Being aware of the way we have prepared, and responded to COVID-19 allows us to reflect, debrief and learn, which in turn leads to adjustment and long term resilience. A number of service area reflections have informed the development of a Strategic Discover Report. This report was presented to the Health Board on 30th July, 2020 and collated initial intelligence gleaned from a number of sources, and service reviews, to inform our collective priorities and ambition.
- "Learning and Review" is contained within Section 6 of this plan and details some of the internal, local, regional and national level debriefs, look backs and exercises that seek to test and challenge our plans and aid rapid learning. Learning from table top exercises has also informed the development of specific COVID-19 mass vaccination structures and plans, as well as wider COVID-19 response arrangements.
- Oversight through the Prevention & Response Regional Oversight Group, chaired by The Director of Public Health. Weekly meetings focus on delivery of agile, flexible and adaptable TTP services, including workforce planning and review of our Prevention and Response plans and of all 'protect' services delivered through Local Authorities and vaccination programmes for influenza and COVID-19 vaccine.

Test

- Since submission of the Quarter 2 plans Welsh Government have issued a number of strategic documents relating to SARS-CoV-2 testing. These include the, the Welsh Government Testing Strategy, COVID-19 in Wales (15th July 2020), a letter received from the Chief Nursing Officer (CNO) and Deputy Chief Medical Officer (CMO) on 29th September 2020 included the essential requirement for routine SARS-CoV-2 testing in unplanned emergency and urgent admissions to Welsh hospitals and, more recently, a letter from the CMO & Deputy Director General regarding Testing System Performance which included specific instructions on Care Home Testing. These publications serve to illustrate that in order to mount an appropriate response to this Pandemic, to promote safety and meet the needs of our population the Health Board and its partners must continually learn from experience, adapt and respond to changing circumstances.
- This requirement is reflected within our Testing COVID-19 Delivery plan (which also forms part of the regional Prevention and Response Plan) with the objectives of identifying COVID-19 cases to support contact tracing and thereby the spread of disease, diagnosing COVID-19 to help with treatment and care, contributing to Population health surveillance so that we can understand the spread of the disease and Business continuity, enabling people to return to work or education safely.
- Test capacity over recent months has been a challenge within the Health Board and across Wales and the UK. This is now improving as Welsh Government and Public Health Wales (PHW) negotiate increased capacity for central & local PHW laboratories and with the introduction of local Hot Labs in Prince Philip Hospital. The Health Board and its partners continue to work collaboratively on testing prioritisation aligned to our strategic drivers and is utilising epi-surveillance data on a daily basis to

target testing capacity to where it is most needed e.g. decision to increase to weekly testing in care homes is predicated on nationally agreed threshold/triggers and collaborative discussion with partners based on local incidence/prevalence.

- The UHB opened the first Coronavirus Testing Unit (CTU) in Wales on 28th February, 2020 and has since established a further four testing facilities strategically located across our footprint. These facilities were established to provide easy and rapid access to SARS-CoV-2 testing for key/critical workers. Over the summer months these facilities have also extended their service provision to provide testing for pre-operative patients in line with the NICE publication 'COVID-19 rapid guideline: arranging planned care in hospitals and diagnostic services', pre Specialist Advanced Cancer Treatment (Pre SACT) and COVID antibody testing (Antibody testing Opened 15th June 7 days a week up till the 5th October).
- In some of our CTUs we were able to offer testing facilities for symptomatic members of the public while we established further DHSC testing sites to reduce the travel distances for our residents. The requirement for mass testing of care home residents and staff, at the request of the Regional Response Cell in response to positive cases as part of the TTP process, is coordinated by the Health Board Command Centre.
- This Command Centre was established in March 2020 in response to the COVID pandemic, in order to provide a single point of contact for all staff enquiries and to co-ordinate the consideration and dissemination of new COVID guidance. Specialty cells were established to respond to enquiries including Workforce, Infection Control and Prevention. Primary care, Occupational Health, Public Health and Testing.
- This function has and will continually adapt in light of experience and policy and will remain in place for at least the next 12 months, during which an improvement and transformation project will be undertaken to create a permanent UHB Health Hub to provide a single point of contact for all staff enquiries and a system for communicating with all patients waiting for services, in order to provide them with support, regular updates, advice on self-management and a contact in the event that their condition deteriorates. The Hub will also be designed to ensure immediate response and escalation in the event of a Health Board wide response being required.
- Our CTUs also host a community service for testing people living at home who are unable to travel to a testing centre and for whom a postal test is not appropriate. This service also ensures that individuals requiring a care home admission and residents moving from one care home to another have access to a test. All these measures help to provide assurance to the care home sector and protect the sector from avoidable viral transmission and have enabled us to deploy contact tracing to control the transmission of the disease as part of the Test Trace Protect (TTP) Programme which is fundamental to helping us find a way to live with the disease until a vaccine or treatment is available.
- In addition to the UHBs Managed CTUs, the Health Board also has a Department of Health & Social Care (DHSC) Population Sampling Centre (PSC) in Carmarthen which offers capacity for 570 Antigen tests per day. This facility provides a hybrid approach to testing with a Health Board offering for assisted swabbing for key workers. Over the last Quarter we have negotiated access to 3 Mobile Testing Units which are currently deployed to locations in each of our 3 Counties (Aberystwyth, Haverfordwest and Llanelli). These MTUs are able to provide the local population with symptomatic antigen testing booked via the UK portal and have supported implementation of control measures arising from Incident Management Teams (IMTs). Since the 30th September in collaboration with colleagues in our neighbouring Health Board we were able to relocate a Local Testing Site (LTS) 'walk through unit' from Betsi Cadwaladar UHB. This partnership working has been instrumental in managing the incident linked to Aberystwyth University. This facility together with a bespoke Standard Operating Procedure (SOP) aligned to the UHBs CTU has supported easy and rapid access to testing in Aberystwyth. Going forward we have negotiated and secured a permanent (6 months) LTS 'walk through facility' for Aberystwyth which will be operational from the 22nd October.
- We continue to provide testing within our hospital settings for patients attending with, or developing COVID-19 symptoms, and for patients prior to hospital discharge to a care home. Although local laboratory testing capacity has increased significantly over the last quarter an assessment of current laboratory constraints demonstrates it is highly unlikely that turnaround times (TAT) for testing of all admissions will be achieved in 4 hours, a proportion will take up to 24 hours. Further

detailed assessment is underway to facilitate compliance with the requirement to test all admissions to hospital, however, it is worth noting that an analysis of the number of RT-PCR tests processed in our Health Board laboratories from emergency departments and clinical decision units over the past three months would suggest that clinicians were already testing a significant proportion of asymptomatic attendances in addition to those who are symptomatic.

- Work continues with our Operational Clinical Teams to ensure that we our end to end systems remain appropriate and do not adversely affect patient flow. Going forward the establishment of a 'Hot Lab' at Prince Phillip Hospital will have a positive impact on the TAT. We are also actively tracking developments in relation to point of care testing (POCT) antigen machines, which are currently being trialled for use. It is anticipated that these will be released to NHS Wales at the end of October 2020 or early November 2020 and will be incorporated into our Testing Delivery Plan. These can provide a test result in 10 minutes and would potentially be useful tool within emergency departments and admission units.
- We recognise that the developments over the last Quarter have been built upon the latest evidence, submitted by the Technical Advisory Group and the work of Scientific Advisory Group for Emergencies and its subgroups. We appreciate that the data and evidence is still evolving, where questions remain about the virus and our individual immune response. As such, the Testing Delivery Plan for Hywel Dda will be iterative and continue to evolve as evidence emerges. Testing is not a panacea - it has to have a purpose and be used appropriately, so that it does not introduce harm, such as through the generation of false positive or negative results. Going forward our plans will continue to reflect national, regional and local priorities, to ensure testing capacity is maximised to support changing testing requirements as we move through the autumn and winter 2020/21. This will include the need to continue be agile and flexible, to respond to any changing circumstances, such as the emergence of flu, as we move towards the winter period.

Trace

- The Hywel Dda Contact Tracing Teams and the Regional Response Cell hold Daily Huddle discussions. These are key and have cemented the strong multi-agency partnership and provides a forum to share issues, concerns and solutions, including sharing between the three levels of TTP work (National, Regional and Local), e.g. management of school bubbles and school transport in light of a positive case, care home cases, hospital wards and the emergence of community clusters.
- The Incident Management Team (IMT) process, adapted to respond to WG escalation processes, is working very well locally, in all three Hywel Dda counties, with excellent engagement and partnership working to address the response to increases in transmission in a collaborative and coordinated way. This has given all partners a good understanding of the epidemiology and how we determine and target interventions to focus on emerging risk factors and impact on transmission within each area, cluster or incident. There has been significant learning over the last six weeks which is shared weekly through the Prevention & Response Regional Oversight Group (ROG) to continually enhance our response to new clusters, incidents and outbreaks. The value of both forward and backward tracing intelligence for each of our IMTs has been significant – this learning and the ongoing capacity requirements being fed into ongoing (and weekly) workforce planning discussions at the ROG meetings.
- Clear working arrangements on management of incidents in Care Homes. Frequency of staff testing reviewed now via the IMTs which will trigger a whole system review panel, however regionally we have strong cross agency working on the management of testing, and tracing within homes for staff and residents. Clear pathways on management of asymptomatic staff, symptomatic residents have been developed getting both COVID and respiratory panel tests which has highlighted rhinovirus "outbreak" in one home, and IPC compliance discussions and visits. This learning has aided the multiagency response to incidents within homes.
- This in turn has aided response to cases and clusters across our acute and community in-patient settings. Through strong contact tracing, testing response and multiagency focus through either IMTs or Outbreak Control Teams (OCTs) depending on escalation/declaration, we have been able to develop rapid and robust Management Plans with clear roles and responsibilities for action.

- Good communications planning, through the weekly regional Communications community meetings has ensured consistent messaging across the partner agencies and planning of communications releases, sharing of resources (e.g. videos of healthcare staff, etc), and ensure the focus of campaigns are not diluted. This has provided a good response from the public have we have seen high compliance with isolation requests based on these consistent and clear messaging from all partners.

Protect

- Our Regional Prevention & Response plan for Hywel Dda details plans for prevention and mitigation across a number of key areas including the work undertaken by our local authority and third sector partners to protect the most vulnerable in our communities.
- Effective communications continue to be critical for the prevention agenda and the ongoing compliance of our communities with advice an guidance that will impact on the transmission of the virus (social distancing, hand hygiene, self-solation, face coverings etc.). Our regional Communications strategy developed for the Prevention & Response Plan is under constant review being adapted on the back of learning from incident management and policy change through the (multi-agency) Communications Community collaboration.
- Key for Winter Protection Planning and the future long-term management of COVID-19 is the delivery of our (Board approved) Seasonal Influenza Plan for 2020/21 and our COVID-19 Mass Vaccination Plans when the vaccine(s) become available.

Vaccinations

Key priorities for next 6 months:

- Plan for delivery of COVID19 vaccine in the UHB to those groups identified as priority groups by the JCVI – to include older adults resident in a care home and care home workers, all those 80 years of age and over and health and social care staff initially, followed by other priority cohorts as prioritised by the JCVI
- https://www.gov.uk/government/publications/priority-groups-for-coronavirus-covid-19-vaccination-advice-from-the-jcvi-25-september-2020/jcvi-updated-interim-advice-on-priority-groups-for-covid-19-vaccination
- Delivery of enhanced flu vaccination campaign alongside COVID19 vaccine planning and delivery. Welsh Health Circular (2020) 013, The National Influenza Programme 2020-21 (2) English/Welsh [Welsh Government, August 2020]
- Maintenance of routine childhood immunisation programme - 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 the statement below: http://gov.wales/written-statement-update-immunisation-programmes-march-2020
- The schools immunisation programme was restarted on 29th June 2020 as schools reopened.
- 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.
- We are in the process of appointing 8 new Community Nurse Immunisers on fixed term contracts until 31st march 2023 to support enhance flu programmes, COVID19 mass vaccination and improving uptake of all immunisations in the routine immunisation schedule for children and adults.

Our Influenza Vaccination Plan 2020/21 was endorsed by our Public Board in September 2020 and can be found at: https://hduhb.nhs.wales/about-us/your-health-board/board-meetings-2020/board-agenda-and-papers-24th-september-2020/24-september-2020-documents/item-4-8-hdduhb-seasonal-influenza-plan-2020-21/

Essential Services

Overview

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

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

Out of Hours services

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

❷ Essential services that are being maintained in line with guidance

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

Life-saving or life-impacting paediatric services
Paediatric intensive care and transport
Paediatric neonatal emergency surgery

Acute services
Urgent eye care
Urgent surgery
Urgent cancer treatments

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

Urgent cardiac surgery (at Bristol)
Paediatric services for urgent illness
Immunisations and vaccinations
Infant screening (blood spot, new born, hearing, 6 week physical exam)
Community paediatric services for children

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

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

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

Palliative care 24/7 provision in the community and specialist in-patient palliative care unit

Blood and transfusion services

Safeguarding services

Neurological conditions
Rehabilitation

Termination of pregnancy

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

Renal care-dialysis

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

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

Diagnostics

❸ Intermediate services that are being delivered

Maternity services; Management of Frailty Syndrome; Management of Catheter Care in the community; Remote monitoring via Telehealth in virtual ward

❹ Normal services that are continuing

Emergency ambulance services

The information below provides further detail on essential services

Primary Care Contractor Services

The section below summarises some key updates against actions in support of Primary Care reset. The document at the end of this section provides the detail against all areas of Primary Care re-set including detailed UHB actions; data collection; risks to current systems; reporting arrangements; and key dates.

Management of the General Medical Services Contract

- Contract reset in place from 1 October 2020.
- Practices in local lockdown areas being supported to work safely and effectively
- All GP Practices are using technology to support video consultations with patients;
- eConsult (funded through the Pacesetter programme in 2019/10) is in place in 37 (77%) of Practices. Approximately 8,000 patients are visiting the eConsult platform per month, resulting in the submission of 5,600 electronic consultations. Usage and satisfaction data is shared with the Local Medical Council (LMC), Practices and Clusters to inform future working models;
- Review of all Local Enhanced Services to consider minor variations to enable them to be delivered during the reset phase, taking account of the use of technology and applying social distancing rules;
- Revised Care Home DES issued to practices with 98% uptake
- Cluster flu plans in place;
- Managed Practices to operate with “open doors” from 1 October 2020 unless in a local lockdown area;
- Improvement Grant money distributed on a capitation basis to those practices that requested additional financial support to upgrade premises
- Discussions ongoing with the LMC regarding the potential to develop a LES for COVID-19 vaccination programme.

Community Pharmacies continue to be available to dispense and supply repeat and acute prescriptions

- 90 Pharmacies open either at pre-COVID-19 times or within one hour
- 9 Pharmacies continue to take two hours out during the working day
- Community Pharmacies in local lockdown areas being supported to work safely and effectively
- Majority of Community Pharmacies open “normal hours” with the flexibility to close for an hour during the day;
- Increased availability of Palliative Care drugs;
- Provision of Emergency Supply of Medication, Emergency Contraception and Common Ailments Service still in place, with a move towards more telephone consultations;
- NHS flu provision in place in 79 Community Pharmacies although supply issues being identified.

Delivery of NHS dental services

- Oscillating between high and low amber for areas in Local Lockdown; however note the extension of the Amber phase as issued by the Chief Dental Officer
- Continuing to provide Aerosol Generated Procedures through Urgent Dental Centre sites

- Fit testing rolled out and supply of FFP3 management system in place to ensure sustainable provision over the winter period.
- NHS dental services including specialist service provision working within the amber phase;
- Discussions around the paediatric dental pathway and the development of the future model are ongoing, however pre-surgery testing is in place.

All Optometric Practices to open; general ophthalmic services provided

- Support practices in adhering to and meeting National Wales Shared Services Partnership self-certification process for opening
- One practice not yet opened
- Optometric pathways established during the red phase remain in place and are being developed into a business case to shift the model from secondary care to primary care provision on a sustainable basis.

Community Services

The School Nursing Service

All essential elements of the service are being maintained:

- all safeguarding and LAC work is being undertaken virtually
- Nasal flu vaccination programme is being carried out in all Primary Schools, although this is taking longer due to the change method of delivery in classroom bubbles and staff using PPE
- Health promotion in schools is being delivered virtually
- Tier 1 emotional wellbeing support is being delivered virtually or over the telephone, however Secondary School 'drop-ins' have not recommenced as staff are only allowed in schools when vaccinating

Over the next 6 months it is anticipated that the service will remain the same as above, with all school aged immunisation programmes continuing as scheduled, however this will be dependent on the potential use of the immunising staff in the COVID-19 mass vaccination plan.

Childhood Vaccinations

Routine childhood vaccination programmes remain high priority and are continuing in line with social distancing and use of appropriate PPE.

- 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:
- This advice has been shared with all those providing the childhood immunisation programme in the 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.

Health Visiting Service.

- Full Healthy Child Wales Programme (HCWP) resumed from October.
- Areas of reduced staffing identified will provide a reduced service in line with priorities and staffing capacity, following a risk assessment
- Home visiting recommenced
- Clean Clinic areas identified and available
- Telephone central lines continue in each county
- Attend anywhere implemented for virtual contacts in areas where IT resources are available
- Reduced access to IT resources continue, this is improving.

Mental Health and Learning Disabilities

As with the primary care section above, this section provides an overview of our response with regards to Mental Health and Learning disabilities. This is supported by a further embedded file which notes that all treatments are currently being delivered

Older Adults Community Services & Dementia Wellbeing

- Memory Assessment Services are in recovery aided by Attend Anywhere and an enhanced design for Virtual MDT Diagnostic Formulation Meetings across three counties which should enhance and assure business continuity.
- Older Adult CMHTs continue to experience high levels of complexity & acuity and are looking to enhance care coordination capacity to counter this and any further increase in demand.
- Dementia Wellbeing Community Team are linking to the 'Commissioning Intent Options Appraisal' (in collaboration with the Long Term Care Team) to support skilled level training (Good work: a dementia learning and development framework for Wales) for evidenced based best practice dementia care for Care/Nursing Homes as an enabler to increase cost effective capacity for dementia care placements particularly in nursing home provision.
- Admiral Nurse Service is in recruitment with a view to commence operation in Quarter 4 to specifically to support carers of people living with dementia where there are significant support needs as a key 'wrap-around' feature within the dementia wellbeing pathway for West Wales

Older Adult MH Inpatient

- Older Adult Mental Health Inpatient services are presently at capacity having experienced an increase in demand. We are working in close collaboration with our colleagues in the long-term care team and local authority to help facilitate discharge to the appropriate setting.

Psychological Therapy

- Telephone assessments continue in respect of all referrals for a Psychological Therapy.
- Psychological interventions are being offered via a blended approach of Attend Anywhere and face to face for high risk cases with social distance guidance implemented.
- Work is progressing on developing group work for DBT via MS Teams and if safe face to face with social distance guidance implemented.

- Veterans NHS Wales service continues to offer telephone assessments once Triaged and psychological intervention via Attend Anywhere as part of the UHB Pilot.
- Psychology services delivered via telephone assessment and Attend Anywhere.

SCAMHS

- Single Point of Contact in situ.
- Seven day service available for referrals and crisis assessments.
- All referrals telephone assessment following which allocated for interventions.
- Face to face assessments continue with all PPE safeguards.
- Attend Anywhere being implemented to complement face to face.

Eating Disorder Services

- Face to face assessments and interventions have continued during COVID-19 due to this being a high risk group.

Perinatal Mental Health Service

- Face to face assessments have continued during COVID-19 due to high risk group.
- Consultation and liaison with Maternity services has continued.
- Attend Anywhere digital platform available for follow up and /or clinical interventions.
- Medication management in place via Consultant and Pharmacist.

Digital

- Use of digital platforms, including Attend Anywhere, being prioritised for progressive roll-out within the Directorate. Virtual and telephone clinics being held.
- Review undertaken to identify where additional software and hardware is needed in order to support productivity and patient safety.

Commissioning

- MHLD Commissioning will continue to prioritise urgent reviews using virtual options where possible. On site care home visits will only be undertaken following individual risk assessment taking into account current guidance and safety precautions.

Substance Misuse

- CDAT attend regular APB operational planning meetings to ensure that substance misuse treatment across the full range of services provided by the partnership are co-ordinated and responsive to the issues raised by the COVID pandemic.

Adult Mental Health

- Adult mental health community teams are continuing with their core business. During this time, the CRHT teams are now co-located with the CMHT's, to move towards the development of the community Mental Health Centres, in line with the Transformation plan.

- The centralised 136 suite remains, but the alternative place on safety provision has increased in Ceredigion to six days a week, with a plan for this to be a full seven days provision within the next month. Developments are currently underway for a further alternative place of safely to be in place on Pembrokeshire, which will be operational within the next month.
- The Out of Hours coordinators, commenced in April, which has been effective in the management of inpatient admissions, patient care and staff support, outside the core working hours.
- The pilot of the new Emergency Liaison service is underway in Carmarthenshire, and is continuing to develop as a service.

Support to Voluntary Sector Mental Health Service Provision

The areas that we are going to strengthen through our Third Sector colleagues (WWAMH) are:

- Independent Mental Health Advocacy
- Community Connection/Befriending
- Citizens Advice Services
- On Line Digital Resources for Children and Young People

Therapy & Rehabilitation Services

Therapies

In line with the all Wales and Health Board response to the COVID-19 situation, direct therapy service provision has been limited to urgent or essential services e.g. tissue viability/wound care, Rehabilitation & obviating functional decline, patients not appropriate or responsive to virtual or digital support.

Key therapy actions and resources associated with Quarter 3 and Quarter 4 plans, including “Winter Planning”, are set out with the individual Acute, Community and Locality plans. The plans have been developed in association with Acute and Community teams to maintain current system capacity associated with the above interventions, and to support surge and winter preparedness. These also include operational plans to resume primary care and education roles as part of whole system approach and to provide support to address the 4 areas of harm.

Virtual and remote service provision has been successfully implemented within therapy services with positive impact on access and referral to treatment times, and is being utilised alongside additional information and communication technology and deployment of digital platforms at scale as part of phase II deployments.

Key risks associated with the delivery and maintenance of therapy services are associated with:

- Reduction in clinical availability for therapy services provision due to estates and facilities being repurposed as part of acute COVID response;
- Reduction in clinical staff workforce due to shielding, and non-patient contact risk assessments for vulnerable/high risk staff;
- Reduced clinical efficiency due to physical distancing, and infection, prevention and control requirements to operate safely; These measures effectively increase the time required for each patient episode with a subsequent detrimental effect on efficiency with current activity
- Increased demand to accommodate student placements whilst maintaining IP&C and physical distancing

- Ability to resume suspended group therapeutic work within social distancing requirements.

In moving forward we will be:

- Service capacity and efficiency provision impacted by the need for physical distancing compliance, Infection Prevention and Control practice, including physical decontamination between patients and clinical estate availability to address F2F clinical treatment requirements. Where appropriate, services are restarting pathways although capacity is reduced;
- Virtual and remote service provision being successfully implemented within therapy services with positive impact on RTT. Requires additional information and communication technology and deployment of digital platforms at scale as part of phase II deployments;
- Audiology
    - COVID pre-appointment information is now sent with all Audiology appointment letters;
    - Postal hearing aid repair service embedded at all locations;
    - Urgent and routine adult patients are now being seen but there are still only limited appointments available;
    - Urgent and routine paediatric appointments continue to be arranged;
    - Support for ENT clinics at Glangwili, Prince Philip and Withybush;
    - Where clinically suitable, new patients are assessed and fitted with a hearing aid on the same day;
    - Tinnitus waiting lists have been significantly reduced due to staff up-skilling to conduct telephone consultations.

Rehabilitation Services

Internationally COVID-19 pandemic has already led to a marked increase in the burden of disease and disability and will continue to do so. Rehabilitation and recovery forms a critical component of the care pathway by improving functional independence, psychological wellbeing, societal reintegration, and managing the impacts of long-term disability and chronic disease. In addition to improving patients' outcomes and experience evidence has shown rehabilitation to be both effective and cost-effective, reducing the burden on acute/community services and long term care needs.

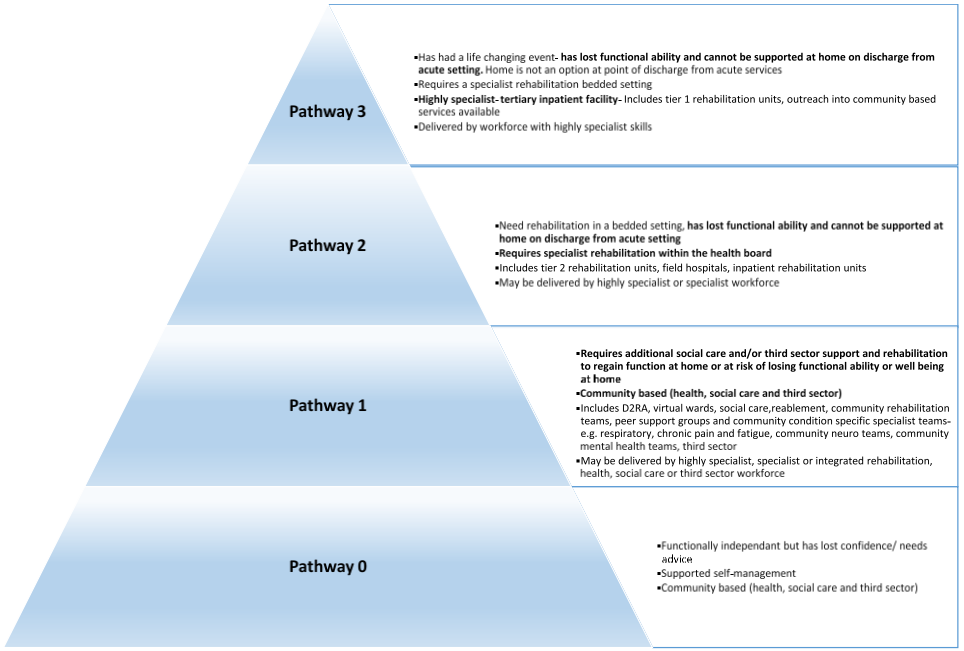
National guidance recommends that all patients with significant psychological, cognitive, functional or physical difficulties following hospitalisation for severe COVID-19, should be provided access to a structured, multidisciplinary rehabilitation package. Given the diversity of presentation and rehabilitation needs, different patients require different types of services than those currently provided within the system. Moreover, the same patient will require different services at different stages in their recovery. Due to the lower incidence of COVID 19 presentations within Hywel Dda the focus of expanding rehabilitation capacity has been directed at lower level population based approaches. These have been designed to address the needs of individuals either directly affected by COVID 19, and also individuals indirectly affected by lack of direct service access or deferred interventions.

All structured rehabilitation and recovery pathways for patients with multiple rehabilitation needs from different professional groups have been mapped and in order therefore to meet the needs of individuals affected by COVID-19, alongside those of the wider population, a more diverse person-centred approach to rehabilitation and recovery pathways has been taken. The UHB established a quality and service improvement project involving key MDT stakeholders to:

- Map and review current rehabilitation/ recovery services available across Hywel Dda that could potentially be adapted to meet the needs of COVID-19 survivors (including current capacity and predicted demand, gaps in service provision)

- Developed easy accessible advice and resources for patients/relatives/carers to aid COVID-19 recovery
- Development of web based symptom management resource to address lower level needs with signposting

Ongoing work over Quarter 3 and Quarter 4 to develop seamless pathways for COVID-19 patients alongside, and incorporated within, wider rehabilitation and recovery service provision



Cancer

The UHB's current assessment in respect of the 8 actions outlined in the NHS Wales Health Collaborative guidance / framework document for Cancer Services in Wales during COVID-19 is included as a supporting document at the end of this section. This section summarises the key elements of our intended cancer pathway response during Quarter 3/4.

Outpatient Appointments

At the beginning of March 2020, Hywel Dda saw a 49% reduction of USC referrals when compared with the same time period the previous year. As of the end of August 2020 the number of referrals have now increased to almost normal limits compared to this time last year.

Diagnostics

All imaging requests are triaged and USC and urgent imaging requests continue to be undertaken, within the parameters offered by national clinical guidance for certain aerosol generating procedures. For those cancer patients where treatment is ongoing, staging investigations will continue to be undertaken. CT Colonography investigations have resumed for failed colonoscopies and those cases that are discussed with the Consultant Radiologists.

Bronchoscopies have been limited in line with national guidance - this service is currently available on the Prince Philip and Glangwili Hospital sites.

As per the Wales Bowel Cancer Initiative, the use of FIT10 screening in the management of urgent suspected cancer patients on the colorectal pathway during the COVID-19 pandemic has been implemented. As of 7th October 2020, 842 test kits have been sent out to patients with an 87% up take. This has significantly cut back on the number of patients requiring Endoscopy or any further investigations, which are currently at 20% & and 11%.

The UHB has reinstated endoscopy services for cancer patients across all 4 hospital sites. Capacity is currently at 39% for Gastro endoscopies and 46% overall capacity which reflects the National Endoscopy Programme for Wales guidance that all Endoscopy units across Wales should be running at between 40 – 50% capacity.
Imaging appointment times are staggered to ensure that patients can maintain social distancing.

Chemotherapy

OPA Oncology clinics are being held via telephone consultation and virtually where needed supported by the Oncology CNS team. Pre SACT antigen swabbing is being carried out for **all SACT patients** in Hywel Dda who are attending the units for treatment. This is carried out at the Community Testing Units at each county, and in the SACT Units for those patients who fall through the lines of reasonable community provision, or reasonable referral to DN's etc. As of mid-September, the majority of pre SACT bloods have been carried out at the Community Testing Units at each county, at the same time that the Pre SACT antigen swabbing is carried out. Patients with central lines are continuing to receive central line care and pre SACT bloods tests in their own homes, under the care of the District nursing teams, along with their Pre SACT antigen swabbing.

All 6 levels of SACT is being administered on all 4 hospital sites. To mitigate the loss of chair capacity due to social distancing, the Chemotherapy Units have extended their hours of operation per day to ensure that patients receive their treatment in a timely manner. SACT activity has now returned to pre COVID levels.
Treatment is administered as per the National Institute for Health and Care Excellence (NICE) COVID-19 RAPID guidance for the delivery of SACT.

Surgery

Higher acuity elective cancer surgery continues to be delivered at Prince Philip Hospital for Colorectal, Urology and Gynaecology and Breast pathways. Head and Neck surgery continues at Glangwili Hospital. Lower acuity surgery for other pathways is delivered at Withybush & Bronglais Hospitals, supplemented by capacity in the independent sector at Werndale Hospital. Upper Gastrointestinal (UGI) acute UGI cancer treatments are delivered via the emergency service.

Local surgical backlogs which developed during the early phases of the pandemic have been resolved and patients are currently being listed for surgery within 28 days of a decision to treat.

Support for Cancer Patients

At the start of the pandemic, a telephone helpline for concerned cancer patients was introduced, staffed by the Oncology CNS Team to provide advice and support.. A patient information leaflet for cancer patients including helpline numbers was developed and widely circulated.

	Summary Q1 - January - March 2020	Summary Q2 - April - 30th June 2020	Summary Quarter 3 - July - September 2020	Total Q1 - Quarter 3 2020
	No.	No.	No.	No.
Total Number of contacts	161	1144	1271	2603
Service User				-
Person who has cancer	41	285	368	697
Person who had cancer	10	37	36	84
Carer	8	110	114	232
Health Care professional	47	401	383	843
Social care professional	7	44	75	126
Family	23	119	105	250
Friend	3	10	11	26
General Public	6	14	20	40
Other	16	124	159	305

This services will continue during Quarter 3/4.

The helpline has been supplemented by a supporting communications strategy including several social media video releases providing advice/ information and any relevant links for patients. These included contributions from cancer patients currently undergoing treatment who shared their experiences during the pandemic. These activities have also been supported by our Macmillan GP Leads to encourage patients to attend their GP practice if they have any worrying symptoms etc.

Rapid Diagnostic Clinics
A project group has been set up which consists of Primary Care, diagnostic services, senior Cancer Management and secondary care representation including the Lead Cancer Clinician, Service Delivery Manager for Cancer Services & Oncology and the Deputy Medical Directors. The Deputy Programme Lead for Macmillan Primary Care Cancer Framework, Macmillan GP Cancer Lead for Aneurin Bevan University Health Board Is also a member of the group. The group is led by the Director of Secondary Care.

Plans are currently being developed to establish a 'vague symptom' clinic in Hywel Dda. Radiology availability and location for the clinics are currently being explored, taking into account learning of the Swansea Bay UHB Rapid Diagnostic Clinic to facilitate service set up and delivery, along with the ACE programme's evaluation metrics.

The next phase of the project during Quarter 3 is to develop standard operating procedures, develop a pathway, baseline requirements and referral criteria and identify a clear governance structure with a responsible project manager.

Maintaining Cardiovascular Services

Community based monitoring and diagnostic options are available, including increasing equipment for community diagnostic hubs and patient loans and the potential for drive-in facilities where appropriate.

- Community venue currently being utilised in Llanelli to provide Cardio-physiology ambulatory monitoring diagnostics, taking this activity away from Prince Philip Hospital;
- Cardio-physiology ambulatory monitoring diagnostic pick-up/drop-off service at Withybush General Hospital to reduce in-hospital footfall/diagnostic activity;
- Robust Cardio-physiology 'green pathway' maintained at Glangwili General Hospital and Bronglais General Hospital, together with option for 'drive-through' or postal service;
- Scoping work on-going Health Board-wide to identify opportunities for extending availability of community-based cardiology diagnostics.

Extended hours (8am -8pm) and weekend access to address the capacity issues.

- Extension to 7 day/week working of Cardio-physiology service at Glangwili General Hospital;
- Extended Cardio-physiology service hours at all 4 acute hospital sites (8am-6pm) Monday to Friday;
- ECHO in-source on weekends to address capacity issues/backlog.

Regional solutions/cross boundary access to address any disproportional increases in activity in one area compared to that of an adjoining Health Board including the potential to provide access to primary care diagnostic hubs.

- Monthly reviews of Regional/cross boundary pathways by Service Delivery Manager;
- Scoping work on-going to explore the options for out-sourcing of Cardiac CT and Cardiac MRI to address backlog issues.

Lessons learned from the first wave of COVID-19 have reinforced the need to maintain essential services for cardiac patients to avoid an increased mortality due to subsequent delays in accessing services. It is therefore important to consider the staffing needs for such services and where possible avoid redeployment of cardiac staff to support COVID-19 activity.

- Development of improved referral/triage screening by Cardiologists and Cardio-physiologists;
- Electronic referrals to Cardiology currently in development to facilitate enhance 2 way communication between Primary Care and Cardiologists as a part of improved referral screening/triage;
- Pilot of dedicated GP advice line/hub to support enhanced GP capacity/ability to manage patients in Primary Care and avoid referral;
- Use of virtual clinics to avoid hospital clinic attendance and increase capacity/efficiency across all Cardiology Clinics (Consultant, HF, Community Cardiology, Cardiac Rehab);
- Prioritisation of 'green clinics' for patients that require a face to face consultation across all Cardiology Clinics (Consultant, HF, Community Cardiology, Cardiac Rehab);
- Emphasis on maintaining and enhancing safe Cardio-physiology pathways so that services are maintained throughout the second wave;
- Introduction of Cardio-physiology phone triage of patients on long-term follow-up/monitoring;
- Focus work on targeting and reducing waiting list for Cardiology follow-up;
- Cardiology Patient Helpline established at start of COVID and maintained to support patient queries.

Review job planning for clinical staff to allow flexibility for referral screening as a planned activity.

- Consultant Cardiologist Job planning on-going Health Board-wide with a specific emphasis on need to provide ring-fenced capacity/sessions for referral screening/triage and advice to Primary Care;

Actively report and manage patients in line with the cardiac component waits pilot.

- Health Board Cardiology service engaged with discussions/plans for cardiac components waits pilot via Heart Conditions Implementation Group and Cardiac Network; this will include the identification of formal commitments to multi-disciplinary meetings to provide medical support for nurse-led and physiology-led community services (including Heart Failure, Cardiac Rehabilitation/post-revascularisation, Valve surveillance, arrhythmia services).

Other Acute Services

Dermatology

Digital platforms will feature within the service to help reduce footfall within the OPD. This includes using Consultant Connect, not only for referrals from Primary Care into the service, but also to support in-patient referrals from across the Health Board. Attend Anywhere will be used to review general dermatology patients (new and follow ups), specifically sitting with the Clinical Nurse Specialists. PKB for biologic patients who can take ownership and responsibility for their pathway, in conjunction with necessary face to face appointments in line with BAD guidance. Telephone consultations will continue where necessary.

Continue see and treat sessions from Prince Philip for USC and urgent patients. Follow ups will continue to be a mixture of face to face and virtual.

YMS (insourcing team) have started to review and assess Dermatology patients over weekends from Prince Philip. This is likely to continue to ensure the number of patients waiting is reduced as per Welsh Government guidelines. With only USC and urgent patients being offered appointments.

The service is continuing to work within WG guidelines and BAD guidelines.

Ophthalmology

As part of the COVID recovery plan, moving into phase 3 the Ophthalmology service will continue with the following service provision:
Current Services:

- AMD treatments - Currently running from Amman Valley Hospital, Withybush General Hospital, Crymych Health Centre, AICC (Aberaeron Integrated Health Centre) and will be relocated to North Road Eye Clinic to a newly established clean room.
- Rapid Access Eye clinic (RACE - Eye Casualty) – Run from Werndale Hospital 9-5pm and Glangwili OPD out of hours.
- Telephone triage assessments for RACE

Outpatient Service

- Urgent/Emergency clinics continued to be run for sub specialty patients at high risk of rapid, significant harm and sight loss. Clinics are currently being run across all Health Board sites, Glangwili, Prince Philip, North road, Aberaeron Integrated Care Centre, Withybush. Clinics are being reinstated in Tywin in the next month.
- Clinical review of all referrals to risk stratify by Clinicians. Information regarding clinical prioritisation and change of clinical target date.
- Telephone follow up assessment clinics.

Current Theatre services

- Urgent Medical Retina, Vitreo- retinal, urgent plastic and cataract cases are being undertaken currently in Glangwili and Werndale hospital theatres.
- Pre assessment clinics for urgent cases.

Proposed Outpatient Service changes:

- Clinical review of New referrals
- The impending implementation of the National Eye Care EPR system (Electronic Patient Record) – to assist in patient data sharing with Primary care Optometrists and joint working
- Possible solution of digital platforms for virtual clinics:- Attend Anywhere.
- To work regionally with SB to devise a suitable model for Glaucoma.
- To continue to link with the community to progress the implementation of community clinics.
- During Q.3 we are looking to repatriate Emergency Eye Casualty back to Glangwili from Werndale.
- Further risk stratification of referrals.
- Regional discussions taking place to establish how Cataract surgery could be managed differently.

Endoscopy		
Quarter 3: Activity has increased to 39% for gastroenterology and 46% overall activity in line with the National average of 40-50% post COVID activity.		
Gastroenterology position: • P1 position-All P1 patients are dated within 2 weeks • P2 position-104 patients to be dated (reducing with increased activity). • P3 position-276 patients to be dated (currently no P3 patients are being treated until P2 patients are dated). • P4 position-94 patients to be dated (currently no P4 patients are being treated until P3 patients have been dated). • Surveillance outstanding: 1061 (being revalidated in line with NEP guidelines).	• **Cystoscopy position:** • P1 position-30 patients to be dated. • P2 position-313 patients to be dated. • P3 position-109 patients to be dated. • Surveillance outstanding: 536 patients	• **Fit:** • FIT test continues in line with National Endoscopy programme guidelines • 842 kits sent out • 87% results back • 44% discharged • 20% endoscopy (comparative to national average) • Therefore 80% reduction in patients sent for endoscopy who follow FIT pathway.
Quarter 4 Plan		
• Continue to increase capacity across site for gastroenterology and cystoscopy. • Date all P2 patients and begin dating P3 patients. • Continue to revalidate surveillance in line with National Endoscopy programme. • Continue with FIT test pathway. • Business case being drawn up with Value Based Health Care team for introduction of capsule endoscopy service which will reduce impact on the endoscopy waiting list by, 120 colonoscopies per year • 120 gastroscopies per year • 120 small bowel MRI procedures per year	•	•

Pain Management

Quarter 3: **Stage 1**	October Current EOY position-882 • All urgent patients (30) are being dated • Werndale clinic currently running and Mon evening Prince Philip clinic has been reinstated • Withybush routine w/list currently being validated. • Glangwili yet to start. • Pain involved in Phase 2 roll out of Attend Anywhere. Training in progress	November • All routine patients validated for suitability for virtual review • Werndale clinic to cease • F2F/virtual clinics to commence in Tenby Cottage Hospital by both Consultant & CNS • Full roll out of Attend Anywhere	December • Continue with virtual appointments • Introduce the 'Opt-in' letters for all referrals along with patient information leaflet
Stage 4	October Current EOY position-196 • Urgent-35 • Routine 161 • Continue to send validation/COVID letter to all patients on list. • Reinstate a day list in Withybush for urgent patients fortnightly. • Secure an ad hoc list in Carms for palliative patients awaiting treatment	November • Re-validate routine patients awaiting treatment against NICE and eligibility.	December • If there has been no second spike, potentially reinstate a weekly theatre session in Carmarthenshire
Quarter 4 Plan **Stage 1**	• Plan to review all routine new patients via Attend Anywhere • Update referral criteria and disseminate • Continue with Opt in letters for all new referrals • Continue to validate follow ups via telephone clinics		
Stage 4	• Secure a regular theatre session in Withybush/Carmarthenshire Set up a virtual clinic for patients who require a re-review due to the length of time they have waited. Re-assess, optimise medication, look at alternative therapies and if necessary set up a treatment plan.		

Service suspended/Change	Quarter 3 & Quarter 4 position
All face to face outpatient appointments for: Community & General Paediatrics	• Telephone Clinics, digital platforms for consultations in use and increasing. . Implementation of the Operational guide for the safe return of healthcare environments to routine arrangements. • To consider accumulative demand from suspended services and develop a new way of working for competing priorities including but not exclusively, Neurodisability assessments, cardiology, immunizations. Triaging of referrals will continue and will identify those referrals who will require essential services. Requirement for the provision of medications and supplies for ongoing management of chronic conditions will be monitored. • Diabetes: Drive-thru to be able to obtain blood sampling for HbA1c to enabling timely and appropriate adjustments to treatment regime.
Community Nursing – all meetings via virtual resource, caseloads temporarily collapsed, all essential home visits risk assessed	• End of Life Palliative Care provided at home; 24/7 Consultant Specialist Palliative Care advice line, current community workforce to support as able. • Prioritise delivery of Continuing Care packages and nursing support for those CYP requiring invasive nursing intervention. • Individual support introduction back into education where appropriate.
Bronglais General Hospital, Angharad Ward. Amber Zone	• Decommission of two separate zones due to low demand and acuity, with the provision of a separate child health area for assessment and reviews/ urgent clinic appointment.
Withybush General Hospital: Relocation of Puffin assessment unit to accommodate adult Emergency green zone. Within Child Health OPD department there is provision for Mon-Fri response for Pembrokeshire patients GP triage referral - General Paediatric consultants. This supports General Paediatric patients to attend for urgent clinic appointments for chronic conditions, acute episodes e.g. jaundice, child protection, bloods. All acute referrals via Glangwili.	• Acute Paediatrics will continue to be diverted to Glangwili Hospital to the Acute Hub. • Continuation of streaming in Child Health department.
Glangwili – Cilgerran Ward Paediatric Ambulatory care, inpatient and Paediatric High Dependency Care Provision of paediatric	• From 02/10/2020 Cilgerran and PACU will become and amber zone. • All referrals for acute secondary care paediatrics go to Glangwili paediatric team. • All urgent GP referral for children of Pembrokeshire go to the Glangwili on call team.

	• Any acute paediatric illness should go to Glangwili emergency Department in the first instance. • Assessment for review of paediatric Emergency temporary service, its purpose and sustainability to support Emergency services. • Urgent surgical specialities care including Urgent Radiology.
Glangwili, Children's Centre for essential assessments including but not exclusively; oncology, immunisations (BCG), ECHO and paediatric urgent assessments / investigations/ interventions.	• To maintain urgent OPD
Maternity services Essential services maintained in acute maternity services • Dedicated Red and Green COVID 19 areas identified. • Community midwifery 'Bookings' maintained via telephone appointments. • Antenatal clinics facilitated in line with NICE Guidelines • Community antenatal care streamlined in line with RCOG guidelines • Satellite Consultant Antenatal Clinics centralised to provide 'One Stop Shop' provision of care. • Face to Face community midwifery postnatal visits reduced to days 1 and 5 with telephone triage on any additional days if and when required. • Homebirth and Midwifery Led Care births maintained and demonstrated an increase in women commencing	• Essential services maintained with dedicated Red, Green areas, however there will be a reduction of bed numbers in the red zone to allow Antenatal Clinic (ANC) to return to Cadi Suite from the temporary relocation to Cardio Pulmonary Unit. • Face to Face community midwifery postnatal visits returning to days 1,5,10 to improve continuity of care. • Virtual parent education platform shared with all women during antenatal period • Introduced Progesterone only Pill prior to postnatal discharge from postnatal ward to ensure accessibility for the next 6 months. • Vaginal Birth after Caesarean Section virtual clinics reintroduced to provide women with choice for delivery. • Reintroduce the All Wales PROMPT training initiative • Reintroduced virtual CTG training sessions • Organised virtual CTG Masterclass to maintain staff member's interpretation skill of reviewing CTG tracings during antenatal and intrapartum period. • Monthly assessment regarding any local lockdown processes that will influence restricted visiting.

Normal Labour Care Pathway. Overall 50% increase in home births • Restricted Visiting Framework used.	
Special Care Baby Unit Glangwili Designated COVID area for • babies of mothers suspected or confirmed COVID • Babies requiring AGP Restricted visiting to parents only, one at a time. <u>Neonatal outreach</u> service reduced to essential visits only e.g. babies in oxygen and babies with complex condition. All essential home visits risk assessed. Telephone consultation by digital platforms for non-essential visits including bereaved families. Triage new referrals All scheduled developmental assessment clinics cancelled	• antenatal COVID testing of mothers in premature labour and mothers booked for elective section in order to safely care for AGP babies in non COVID area of unit (mother must also be asymptomatic and COVID negative) • Implementation of digital platforms along with telephone clinics will develop a new way of working. • Following tertiary centre recommendation and guidance a new developmental assessment tool to be implemented called 'PARCA-R'. Training for practitioners commenced 28/05/2020.

Gynaecological Services

Service suspended/Change	Quarter 3 & Quarter 4 position
• All routine gynaecology outpatients suspended.	• Validation of all new referrals completed. Ongoing clinical validation of all follow ups. • Identification and implementation of virtual clinics on attend anywhere for follow ups and fertility patients. • Implementation of the Operational guide for the safe return of healthcare environments to routine arrangements.
• Early Pregnancy Assessment Unit reduced provision of ultrasound assessment • Clinics suspended in Withybush	• Centralised telephone assessment and support of all cases. • Ultrasound provision for urgent cases in Withybush, Glangwili and Bronglais with identified red and green areas.
• Pregnancy Advisory Service maintained. • In patient abortion service suspended in Withybush.	• Provision of virtual telephone clinics and home abortion in line with RCOG guidelines. • Reduction in need for ultrasound confirmation of gestation. • In patient abortion provision in Glangwili and Bronglais.
• Routine gynaecology surgery suspended. • Low risk USC and urgent surgery provided in Werndale Hospital. • High risk USC and urgent surgery suspended.	• Drive to reduce USC and urgent backlog • Werndale Hospital surgical list ending November 2020 • Recommenced in Prince Philip ward 7

Sexual Health and Reproductive Services

Reproductive health services are included within the WHO list of 'essential services' which should be maintained during CV-19.

The following proposal will be subject to changes in line with any policies and guidelines issued from central and local government, The Health Board, The Faculty of Sexual and Reproductive Healthcare (FSRH) and The British Association of Sexually Transmitted Infections and HIV (BASHH) and The Royal College of Obstetrics and Gynaecology (RCOG).

In the event of further loss of accommodation and deployment of staff we would revert back to the quarter one SOP.

file:///H:/Profile/Downloads/fsrh-restoration-of-srh-services-during-COVID-19-at-a-glance-june-2020%20(1).pdf

https://members.bashh.org/Documents/COVID-19/Principles%20for%20Recovery%20of%20Sexual%20Health%20Draft%2008.06.2020%20-%20for%20website%20upload.pdf

Patients requesting routine testing for Sexually Transmitted Infections (STIs) who are asymptomatic are directed to Friskywales.org to access on line testing. Remote consultations for **all** patients seeking advice using current FSRH/BASHH/RCOG guidance on management of STIs and extended use of Long Acting Reversible Contraception (LARCs). Remote consultations will be supported by the digital platforms, Patient Knows Best (PKB) and Attend Anywhere.

Face to Face appointed lists will continue for those where a remote consultation is not appropriate. These appointments will be booked by the clinical staff following a telephone consultation. Face to Face appointment will also be offered for:

- Patients <16 year olds
- Other vulnerable groups such as victims of domestic violence and learning disabilities.
- Patient with some physical disabilities such as visual and hearing impairment.

Posting Medication

- We will continue where possible to post medication via Royal Mail recorded delivery.

The purpose of this plan is to:

- Reduce the number of direct contacts to sexual health, by identifying patients who can be safely managed without a face-to-face consultation
- Reduce duration of face to face consultations.
- Reduce additional pressures on Primary Care, A&E, Community Pharmacies and acute services.

Booked Appointments

- Appointment line staff will allocate the majority of callers to an appointed list for a video or telephone consultation.
- Lists will run every afternoon (except Tuesdays)
- There will be 2-3 lists with 7 appointments on each.
- All appointments will be allocated within a week of the request. If no appointments are available the patient can be advised to contact their GP or call back the following week.

Emergency Triage List

- Some patients will still need to be put on to the triage list for a telephone consultation that day. The triage list will run every morning and will be capped at 25.
- The phone lines will remain open in the afternoons and a doctor or registered nurse will be allocated to support the telephone staff.
- Patients can also be advised to access their GP
- All patients will have a full sexual history taken by a registered nurse or doctor.
- Patients who are offered an appointment will have all appropriate documentation completed prior to the appointment.

Patients allocated to the morning triage list

- Emergency contraception
- Genital Ulceration e.g. herpes,
- Acute pain/ symptoms e.g. testicular/pelvic pain, urethral discharge, dysuria
- Patients who have received a text message to contact the clinic regarding test results
- Coils with missing threads.
- Post Exposure Prophylaxis for HIV
- All under 16s.

- Sexual Assault and SARC referrals
- Safeguarding concerns.

The following will be offered an afternoon appointed telephone consultation.

- Contraception Choices discussion/Contraception problems
- Long standing problems (> 1/12, lumps, bumps, pains, discharge)
- Long Acting Reversible Contraception (LARC) requests/pre-LARC counselling
- New and Repeat pills / Depo Provera
- Pre-exposure Prophylaxis for HIV PrEP (new and follow)

Radiology

Since the start of the pandemic the numbers of patients being examined within diagnostic imaging has increased and has been in line with other clinical services. This has all been based on mitigating the risk of delayed diagnosis. The increase in access has been equitable for both primary and secondary care. The table below outline the current position with Hywel Dda

Modality	Current situation
First line imaging / plain film	Departments are open for all requests in all P categories. However, GP patients no longer have open access on some sites due to small radiology waiting areas and the need to observe social distancing. The use of community sites are increasing dependent on staffing levels to redirect referrals.
CT	Appointments maintained for USC, some cancer follow up patients and urgents along with inpatients. Referrals in P1-3 categories have increased and this is affecting the ability to deliver within required time frames. There is limited scope to undertake patients in categories p4/p5 The introduction of the additional CT scanner in GGH will help alleviate some of the capacity issues and make some steps to reduce the backlog. This is staffing dependent. Staff currently working additional hours to reduce waits
MRI	Appointments maintained for USC and urgents along with inpatients Appointments have now been opened to patients in p3-p5 Staff working additional hours to reduce waits
Fluoroscopy	Appointments maintained for USC and urgents along with inpatients Difficulties as a result of infection control measures reducing capacity However a new fluoroscopy room has been commissioned in GGH which improves capacity issues
USC	Appointments maintained for USC and urgents along with inpatients.. Staff working additional hours to reduce backlog Obstetric guidelines from Welsh Government allowed the presence of partners in some scanning appointments, to maintain social distancing capacity in other areas has been impacted
Nuclear Medicine	Imaging mostly confined to USC pathway. Some routine scans now being undertaken
Mammography	Symptomatic breast clinics (new patients). This is mainly USC patients.

	Breast MRI: For staging and breast CA patients, still on.

Whilst activity has increased since the start of the pandemic the levels still fall below the levels in the same month last year. It's important to note that current capacity is completely utilised and staff are undertaking additional overtime sessions. This is only sustainable if infection rates in the staff members remains low. Additional resource is being investigated via private suppliers however, radiographers to staff the additional capacity remains problematic.

The introduction of the additional CT capacity in Glangwili that became operational mid October, will assist with undertaking the more routine patients within the locality, that have been waiting longest. However, the amount of additional capacity is dependent on

- securing locum/ bank staff,
- the regional solution agreed with Swansea Bay
- the unpredictable downtime on the static scanners.

If all secured, there is potential for activity to be closer to 4000 per month

Pharmacy service at the Acute Sites

- Pharmacy departments have maintained extended opening hours as part of the reset programme to support patient's services.
- Monitor T20 Critical Care medication as outlined in Quarter 1 & Quarter 2 return. The stock of critical care medicines is used to inform the Medicines Management section of the functional capacity report on a weekly basis.
- Local guidance developed to support the principles of Medicines Mutual Aid across Wales, with full sight across Wales on stock levels of critical medicines.
- Just in Time Emergency Medication Pack (JEMP) scheme remains in place and is ready to be escalated if activity demands. This will also support the increased availability of palliative care medicines through community pharmacies.
- Planning for COVID mass vaccination – integral to the development of local plans (ordering, receipt, storage and distribution).
- Pharmacy services prioritisation plan to ensure essential services are maintained.
- Service integration with pharmacy primary care team to support the Field Hospitals.

Risks to Delivery

As articulated in our month 6 Integrated Performance Assurance report, these are the key risks to the delivery of services

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

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

Eye care

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

Follow-up appointments

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

Unscheduled Care

Ambulance Service

- Ambulance staff must don PPE for all calls, and higher specification PPE where procedures produce airborne particles or respiratory droplets;
- Military support withdrawn and vehicles needing deep clean have go to Tredegar;
- The time taken for ambulances to become operational post patient handover extended due the need to remove PPE and vehicle cleaning;
- Increasing staff numbers reporting COVID like symptoms and therefore self-isolation. Increased abstractions following the opening of schools, with children being sent home with COVID like symptoms.

Unscheduled Care

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

Delayed Transfers of CAre

Non-mental health

- Retaining staff in the domiciliary care sector;
- Any new COVID outbreaks in the care home sector;
- Public Health Wales guidance for no admissions from care homes until 28 days after the last positive test result and limited admissions during recovery period once the 28 days is lifted;
- Residential and care homes requiring:
  - residents to have a recent negative COVID test before they are returned from hospital (ward or ED);

- residents to be returned to the home within 6 hours of being discharged from an ED;

- Staff absence (shielding, vulnerable, child care) across the community has improved with schools reopening. However, if there is a cluster in a school this could have a further impact as staff will need to provide urgent childcare;
- Staff returning into the workplace remains challenging as guidance is not clear in relation to staff who are providing face to face care;
- Length of time it takes to receive swab results compromises patient discharge and flow;
- Acuity of patients has increased with complex discharge requirements;
- Medically optimised patients remaining in acute and community hospital beds, with access to long term packages of care re-emerging as a significant constraint to discharge;
- Lack of Elderly Mental Illness nursing beds causing delays for these vulnerable individuals with specialist needs;
- Changes to isolation period for COVID - from 30th July, people who have tested positive for coronavirus will have to self-isolate for 10 days instead of 7 days. The 10 day period starts from the day symptoms start, or if asymptomatic from the day a test is taken. Quarantine regulations could also impact on staffing levels;
- Localised lock downs will impact on patient flow across county border areas.

Mental health

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

Stroke

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

Cancer

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

Diagnostics
• For all areas capacity pressures, equipment failure and COVID precautions are impacting the service's ability to meet the 8 week diagnostic target.
Therapies
• Reduction in clinical estate availability for therapy services provision due to estates being repurposed as part of acute COVID response; • Reduction in clinical staff workforce due to shielding, and non-patient contact risk assessments for vulnerable/high risk staff; • Reduced clinical efficiency due to physical distancing, infection, prevention and control requirements to operate safely; **Audiology** • The cessation of routine Audiology clinical activity (assessment and subsequent hearing aid fittings) continues to impact on the service's ability to meet Referral to Treat (RTT) diagnostic targets; • Limited access to suitable digital platforms to support patients; • Reduction in clinical capacity due to supporting Ear, Nose and Throat (ENT) and availability of additional locations to provide services from.
Mental Health
Neurodevelopmental assessments • ASD: growing demand verses resources and difficulties in recruitment; • ADHD: historical referral backlog and vacancies within the team. **Psychological therapies** • Increased demand from primary and secondary care; • High waiting lists for both individual and group therapy;
Vaccination
• 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

Preparing Urgent and Emergency Care Services for Winter

Building on foundations laid in recent years, we have taken a genuinely cross-sector approach to the preparation of the West Wales Winter Plan for 2021-22. A multi-agency steering group comprising representatives from the UHB, Carmarthenshire, Ceredigion and Pembrokeshire County Councils and the third sector and covering all population groups, has overseen the process. Chaired by the Head of Partnership for the West Wales Regional Partnership Board, this group will remain in place to monitor the delivery of our plan and adjust activity as necessary where evidence suggests this would be beneficial.

Initial, integrated proposals for community-based activity were developed by managers from the UHB, county councils and third sector. Proposals for acute activity, some for delivery across the Hywel Dda footprint and others focused on specific locations, were developed in parallel. All these proposals were grouped under our health and care pathways (proactive care, intermediate care, long term and complex care and hospital care). They were then subject to a rigorous, iterative review process, taking into account:

- Fit with the strategic goals in the national Winter Protection Plan and the Welsh Government's Four Harms
- Likely impact
- Deliverability (considering issues such as staff recruitment and lead-in time for new projects)
- Specificity to winter
- Financial robustness, affordability and value for money
- Extent of alignment with existing work programmes

As a result of this process, proposals have been prioritised and a number removed from the plan. Some of those removed at this stage will be picked up in core business where practicable, whilst others have been retained as pipeline projects for possible commencement if further resources become available (see below).

Further consideration was given as to whether proposals initially centred on local areas should be upscaled to cover the whole region. Where it makes sense to deliver initiatives on a sub-regional footprint (for example, because of different levels of existing provision), we will monitor local impact and review the feasibility of extending the approach to other areas.

Our Winter Plan sits alongside a number of other plans developed within the region, including the Care Homes Action Plan and integrated plans for vaccination of frontline staff against both Flu and COVID-19. The Plan is currently resourced through the following funding streams:

- Discharge to Recover and Assess pathway funding announced on 5 October 2020
- Funding allocated to the UHB to support delivery of this Quarter 3/4 Operating Framework
- Proposal submitted to Welsh Government to develop and implement 'testing field' for Urgent Primary Care / Flow Hub that will support enhancement of our primary care and community unscheduled care pathway and align with national Phone First expectations. Similarly, a proposal is also planned for submission regarding our Same Day Emergency Care / Ambulatory Emergency Care pathways.

111 – ED/MIU Outcomes

HDuHB Local Hub
provided by Delta

GP Navigator for Self- presenters

Bronglais Hospital
ED / MIU

Glangwili Hospital
ED / MIU

Withybush Hospital
ED / MIU

Prince Philip
Hospital MIU

Cardigan ICC MIU

Urgent Primary
Care

SDEC / AEC

There is a current shortfall in funding to support all identified schemes, however prioritisation is needed, assessing the regional funding and workforce constraints, to manage this. We are in discussion with Welsh Government regarding the possible allocation of further funding. In the event of this becoming available, we will look to move pipeline proposals into the main plan and commence their delivery, on a priority basis. We will also look at the possibility of using funding from the Welsh Government's Transformation Fund, if available and where winter proposals augment our existing Healthier West Wales programmes.

A summary 'plan on a page' is also provided below, listing key initiatives under each of the Strategic Goals. At the time of submission, the Winter Plan is subject to sign-off by the Regional Partnership Board on 29 October 2020. A final, agreed version will be submitted to Welsh Government after this date.

Plan on a Page

1. Coordination for at Risk Groups	2. Signposting	3. Preventing admission or attendance

• Self-Management
  ○ Bio-psycho-social MDT for aftercare of COVID-19 acute/ITU patients.
  ○ Proactive psychological and behaviour change intervention with high risk COPD patients
  ○ Increasing capacity for supporting mental health needs in high risk vulnerable groups with chronic disease
• Investment in flu vaccination programme to support care sector
	• Pilot of Phone First project
	  ○ Updating of Directory of service (DoS) for community pathways
	  ○ DoS to include acute hospital alternative pathways e.g. Hot Clinics etc
		• Adult Mental Health Community support
		  ○ Provide community support to reduce risk of admission
		  ○ Support step down from residential care to increase care home bed availability
		  ○ Provision of a Mental Health out of hours sanctuary service with a community hospitality bed in Ceredigion
		• Investment in additional therapy support to improve turnaround at the front door
		• Reintroduction of SDEC/AEC
		• Developing the home care work force to address capacity issues in Pembrokshire

4. Rapid Response in a Crisis	**5. Great Hospital Care**	**6. Home First Approach**

• Additional investment in Mental Health crisis support
  ○ Support for people in crisis to remain at home
  ○ Target specific people in the community to ensure that they do not hit their crisis point over winter
  ○ Provide inreach support to care homes to avoid placement break down
• Pilot & expansion of soft 136/alternative place of safety
• Additional investment in Acute Response Team (ART) crisis support
• Reconfiguring respite care provision
	• Additional investment in therapy, support and medical cover to provide 24/7 services and facilitate flow
	• Block purchase of independent secure mental health beds to provide step down and maintain COVID red areas.
	• Additional investment for staffing in Emergency Departments/Minor Injury units on key dates to manage demand
	• Extended respiratory specialist nurse cover 7 days per week
	• Opening of additional winter acute bed capacity
	• Extension of British Red Cross service in the Emergency Department
		• Community Independence Service
		  ○ Provide short term bridging support
		  ○ Right sizing service for new packages of care
		• Securing temporary housing accommodation to support pateints leaving hospital waiting for accommodation
		• Additional investment in equipment, servicing & decontamination to promote discharge
		• Additional investment in Community Palliative Care services
		• Additional investment in Community Therapy services including early supported discharge for Stroke patients
		• Investment in 2 x Shared care pathway assessment beds across mental health and long term care.
		• Repurposing of excess residential/nursing capacity to support needs of the population

Working with Partners

Care Homes

Care Home Support and Contingency

WG requires the Health Board to have contingency plans in place to respond directly to circumstances where the performance of a residential or nursing home is such that its viability and ability to continue to provide for its residents is compromised. Further, Quarter 3 and Quarter 4 of the NHS Operating Framework outlines the explicit expectation that the Health Board's overarching plans include actions that include the ability to 'purchase and operate' a failing nursing home where this asset is deemed an essential service to meet population need.

A regional group has been convened to oversee review of the existing West Wales Care Home Risk and Escalation Policy, to consider our regional care home market position and to oversee any legal arrangements that we require to put in place to mitigate care home failure. A national perspective is sought specifically in relation to the expectation to Health Board's and the 'purchase' of nursing homes.

Regional working with other Health Boards

Mid Wales Joint Committee

The key priority areas for joint working across Mid Wales have been reviewed and refreshed to reflect the current status of COVID-19 recovery plans for services across the region. For quarters 3 and 4 of 2020/21 the main areas of focus will be as follows:

- **Ophthalmology**

Completion of the recruitment process for the Joint Clinical Lead for Eye Care services / Consultant Ophthalmologist for Mid Wales which is currently in progress with the post, which has received significant interest, currently out to advertisement. The Mid Wales Eye Care Plan will be reviewed by the end of Quarter 3 to reflect the current status of services across Mid Wales with a view to ensuring the plan reflects the timescale for the reinstatement and strengthening of services across Mid Wales for the plan's three priority areas - glaucoma, cataract and macular degeneration. The three Mid Wales Health Boards will re-commence their work on exploring the available options for addressing the gaps in Optometry service provision across the South Meirionnydd area following the commencement of Betsi Cadwaladar UHB's Optometric Advisor.

- **Cancer**

The Mid Wales Cancer group is due to meet in early November 2020 in order to review the current status of services across Mid Wales and the development of a plan for a Mid Wales approach to chemotherapy services in the community and the upper GI pathway for Mid Wales.

- **Colorectal Surgical Pathway**

Following the commencement of the newly appointed consultant colorectal surgeon at the Bronglais General Hospital site in early 2021 it is planned that elective colorectal surgery will be re-introduced at Bronglais General Hospital soon thereafter. Further work will also be carried out on the development of an agreed service model for the colorectal surgical pathway for Bronglais General Hospital with outreach services across Mid Wales by the end of Quarter 4 2020/21.

- **Clinical networks**

Meetings of the Mid Wales Clinical Advisory Group have now resumed in order to ensure continuation of the establishment of clinical networks across Mid Wales and cross border. The role of Joint Committee Lead Clinical Executive Director, who also Chairs the Clinical Advisory Group and is the lead for clinical networks, is vacant due to

retirement and work is underway to identify an interim replacement. The consultant network workshops to support the North Powys Wellbeing Programme have been re-established with the first sessions arranged for early November 2020. Whilst these workshops were originally established to support the North Powys Wellbeing programme the long term vision is that these will evolve into clinical pathway groups for Mid Wales.

- **Telemedicine**

During the COVID-19 the introduction of the use of digital platforms had been successfully implemented at pace. A review is currently being undertaken of the digital platforms introduced for clinical pathways since the start of the COVID-19 in order to develop a clinically agreed plan for future digital developments to be implemented across Mid Wales.

- **Welsh Community Care Information System (WCCIS)**

Work is in progress on the full deployment of WCCIS in Ceredigion (Hywel Dda) by the end of Quarter 4 2020/21. Also a confirmed and agreed timescale for deployment in Gwynedd (BCUHB) is expected by the end of Quarter 4 2020/21. NWIS have agreed to develop a plan around the requirements to allow information sharing abilities for all Welsh organisations utilising WCCIS.

- **Respiratory**

The Powys Teaching Health Board led Breathe Well Programme group meetings resumed in September 2020 to check progress during the COVID-19 period against the previously agreed Breathe Well Model of Care in order to inform the next steps. In Quarter 3 and Quarter 4, the Breathe Well Programme will take forward these actions, including the development of a business case to seek Transformation Funding to fast track supporting respiratory diagnostics (spirometry and adult sleep apnoea) and piloting the successful MDT approach from North East Powys in Mid & North West Powys.

- **Clinical Strategy for Hospital Based Care and Treatment**

The implementation programme for the Bronglais General Hospital Clinical Strategy in November 2019 was delayed due to COVID-19 pandemic. The revised implementation plan for the Bronglais General Hospital Clinical Strategy is under development and following agreement the key delivery groups for the implementation of the strategy will be established in readiness for the commencement of full implementation in 2021/22.

- **Rural Health and Care Workforce**

Workforce teams have been focusing on planning for and responding to the workforce planning requirements for the COVID-19 pandemic since March 2020 which is on-going. For Quarter 3 and Quarter 4 a review will be undertaken of the work undertaken in 2019/20 in order to develop and agreed set of objectives for 2021/22 onwards. In addition to this continued support will be provided to the establishment of a nurse training centre in Aberystwyth which if successful in the HEIW bidding process will receive its first intake of students in September 2022

- **Integrated care hubs**

Work has resumed on the development of three of the Joint Committee's priority Integrated Health and Care projects, namely, Bro Ddyfi Integrated Health and Care project, North Powys Wellbeing programme and Aberystwyth Integrated Care Centre. The Full Business Case for the Bro Ddyfi Integrated Health and Care was submitted in early October 2020 with works due to commence on site in Quarter 4 2020/21. For the North Powys Wellbeing programme the focus has been largely on finalising the Programme Business Case planned for submission during Quarter 3. The Programme Business Case for the Aberystwyth Integrated Care Centre is currently under development and planned for completion by early 2021.

Swansea Bay

In Quarter 3/4 through the ARCH Partnership (which includes Swansea University) the focus for regional working between Swansea Bay and the UHB will continue as follows:

- **ARCH Innovation Forum** – was established in July 2020 and will provide guidance, advice, support, and signposting from a multi-disciplinary stakeholder group to innovation projects from across the region. The purpose of the forum is to accelerate innovation in health boards, academia and industry across the health and care sector to improve the health, wealth and wellbeing of South West Wales.
- **City Deal Campuses Programme** – A programme business case is being developed for resubmission during October. The programme has multiple projects underneath it, including developments on the Morriston hospital and Pentre-Awel sites.

Across other service areas and as part of the Essential Services Framework, the following will continue:

- **Eye Care –** Following a Regional Eye Care workshop the following areas were agreed as priorities, Glaucoma, Diabetic Retinopathy, and Cataract. Glaucoma is seen as the greatest priority initially with an immediate need to stabilise services and an agreement to joint consultant appointments with a clinical lead to support the service in Hywel Dda. There is also an agreement for joint implementation of Open Eyes. Further work will be carried out across all areas through Digitisation and Value Based Healthcare approach.
- **Dermatology –** Regional project group meetings have resumed following cessation through COVID and a review of priorities and implementation plan commence to establish current position. A Clinical Lead role for Hywel Dda needs to be identified following retirement to support. In addition, the recruitment of joint consultant posts between Health Boards, both dermatology and plastic surgery will be pursued. The sub project, funded by Wales Cancer Network Innovation bid, to utilise AI and mobile phone continues with expected pilot in Quarter 4.
- **Endoscopy –** Work in this area has been deferred pending the outcome of the work on being undertaken nationally to establish regional facilities and the wider focus on the provision of planned care.
- **Orthopaedics –** Plans are being put in place to potentially utilise Neath Port Talbot Hospital as an elective orthopaedic unit for the UHB but this will require capital investment and a business case has been developed in readiness for submission to Welsh Government. Discussion are also taking place with Cwm Taf Morgannwg UHB with a view providing orthopaedic surgeons from Princess of Wales Hospital further access. In addition, our plans for elective services at Prince Philip are underway and it was agreed that the leads from both Health Boards should make links across these areas of work to ensure best use of resources.
- **Pathology –** Following the submission of the SOC for a Regional Pathology Service, there will be a co-ordinated approach to the Infrastructure Investment Board (IIB) in October 2020. A focussed regional group, that will include Public Health Wales, will attend with shared key messages and priorities.
- **Diagnostics –** A regional approach to Diagnostic recovery will be undertaken with utilisation of the mobile CT Unit at based Glangwili Hospital.
- **Test, Track, Protect** – Discussions are being held to investigate if there can be a wider regional community response to reduce impact of second wave and reduce reliance on National systems and share lessons learned. Strong links with Local Authority's across South West Wales have been established and closer links with partners are planned.
- **Field Hospitals –** The situation with regards to the utilisation of field hospitals is constantly being reviewed with the potential for a regional field hospital and a regional workforce model. At the moment this would centre around the idea that any regional plan on this front would be 'super surge' option once capacity within one of the Health Boards has been maximised.

Organisational Capacity Plans

Functional Capacity

ICU

- Following review of FICM document recommendations on staffing and on full review of staff base, skill set and those staff who could be redeployed back into Critical care from external roles, it is assessed that 33 Level 3 beds could be supported with safe staffing levels and skill set. This is a revised assessment in view of the changing staff environment. Staff identified and available to work would support escalation to 33 Level 3 ventilated beds within 3 weeks. This is subject to all staff being released from core substantive roles, all elective surgery suspended, and must include the availability and presence of health care support workers.
- This assessment includes known agency staff who have agreed to keep working with us; and an assessment on the average number of hours committed to the Critical Care Bank by HB substantive staff. Additional agency staff would be sought to support a further increase in capacity; recognising that many Hospital locations east of the HB may be more attractive from a travelling perspective.

Critical Care Medicines

- Figures only provided at the Health Board level because stock can be moved rapidly between sites.
- Stock levels will depend on availability/supply- currently National shortage of 2 neuromuscular blockers and opioids.
- CURRENT stock levels would cover us for 38 ventilators for up to 4 days but CURRENT stock levels would reduce to 22 by 1+ week if not replenished. Replenishment turnaround times are currently 1-7 days.
- Stock level calculation is based on every ventilated patient requiring average daily dose as per Royal College of Anaesthetists Guidelines.
- There is a recognised buffer within this calculation to allow for re-establishment of urgent elective surgery.

Staffing

- Functional capacity forecasts for both COVID and Non-COVID in-patient wards are currently based on the Nurse staffing Levels/planned rosters for each of the in-patient wards which have been approved through the Director of Nursing, Quality and Patient Experience and represent the 'normal' levels that have been calculated in line with the requirements of the Nurse Staffing Levels (Wales) Act.
- The calculation of the nurse staffing level requirements for each ward has been based on the number of beds available following the reduction of bed numbers as a result of social distancing measures/mitigation measures having been put in place. There is still some work to be done to ensure that the bed numbers used to base the nurse staffing levels on are consistent with the bed numbers being stated as 'available beds (covid and non-covid). This assessment includes bank and agency staff who we know to be working for us in the next two weeks. Additional agency staff would be sought to support a further increase in capacity although availability of additional agency staff remains uncertain and untested at this time.
- For Bronglais: It would require an additional 21 WTE temporary registered nursing staff to be able to meet the planned rosters for all areas which have been agreed with the Director of Nursing in line with Nurse Staffing Levels (Wales) Act . This staffing deficit might be mitigated to some extent by the availability of an additional 5 WTE HCSW within the available staffing which, together with risk assessment on a shift by shift basis might allow the full bed complement to be available;
- For Glangwili to be able to open all 278 beds in GGH would require an additional 35 WTE temporary registered nursing staff to be available AND an additional 18 WTE temporary HCSW if 'normal' staffing levels (as agreed with Director of Nursing in June 2020) are to be met;

- For Prince Philip to fully staff all 150 beds there would be an additional temporary registered nurse staffing requirement of approx. 15 WTE to meet the agreed nurse staffing level for every wards/nursing service in PPH for every shift. There are however a surplus of 22 WTE HCSW available which might mitigate any registered nurse gaps, based on a risk assessment of the clinical situation at the time. It should be noted that the site has experienced a small but noticeable rising level of COVID related absence amongst staff in the last 7 days;
- For Withybush it would require an additional 20 WTE (approx.) temporary registered nursing staff (to be obtained via Bank, agency or overtime/additional hours) to be able to meet the planned rosters which have been agreed with the Director of Nursing in line with Nurse Staffing Levels (Wales) Act . In addition, there would be a requirement for an additional temporary 13 WTE HCSW to meet the planned rosters as agreed.
- The TOTAL additional temporary registered staff above the known available staff that would be required across the HB to staff the bed numbers listed in this capacity forecast on all four sites would be 91 WTE. It is possible that this demand could be met through a mix of further agency and bank staff and Overtime/additional hours worked but there is a risk in this forecast situation. The TOTAL additional HCSW required to across the HB is 4 WTE and this is almost certainly available via the Nurse Bank - although the geographical distribution of the HCSW available may mean that additional staff on some sites are required whilst there may be surplus on other sites.

CPAP machines and consumables

- We currently have 703 CPAP units available within the Health Board. With 1,300+ available filters, these could support 173 CPAP machines for up to 8 days without further replenishment of the filters. This should be compared with the total number of CPAP machines currently in use which to date has not exceeded single figures.
- Taking into account required staffing ratios to support patients on CPAP and the occupancy thresholds for COVID and non-COVID pathways reflected within the Operating Framework, we estimate that we would be able to support approximately 70 patients on CPAP within a total operating base of 720 beds. If we were to approach this level of CPAP demand, we would look to further expand our CPAP capability by increasing capacity across our acute, community and FH bed stock (as appropriate) and/or explore opportunities for risk-assessed reductions in demand for non-COVID pathways.

Other beds (non-ICU, excluding. paediatrics)

- The Health Boards quarter 2 response identified a potential reduction of 192 beds due to the need to implement the social distancing bed spacing guidance. Work has been undertaken on each site to install perspex screening which has reduced the impact to 59 beds. Further capital works are planned in GGH on Towy Ward which may reduce this impact by a further 20 beds from January 2021.

Field hospitals

- Carmarthen Leisure Centre is currently mothballed but potentially available at around 4 weeks notice, Llanelli Leisure Centre and Parc y Scarlets stadium are now decommissioned. The remaining 5 sites are in hibernation.
- This will give potential capacity of up to 468 beds if surge capacity required (Carmarthenshire Leisure Centre giving the option of up to a further 70 beds). Stand-up time is variable across the field hospital sites remaining in our possession. Samuel Selwyn Centre is 4 weeks to operationalise and Bluestone 6 weeks – it is intended both of these will be ready to open by mid November with 30 beds in each and work has commenced to implement this. Plascrug is available at 2 to 3 weeks notice. Stand-up time at the Barn is subject to some remedial actions being taken to the site following a CHC inspection. Cardigan Leisure Centre is presently in the hands of the testing and tracing team to support testing and the mass vaccination plan with no plans to use the site for bed capacity.

Mortuary/body storage

- The current included figures relate to acute site mortuary spaces which are sufficient to meet existing demand.
- Should the demand exceed our acute site mortuary storage, local funeral directors will open surge capacity for body storage
- The temporary body storage facilities developed by the Local Authorities are currently being decommissioned but will remain able to be reactivated with a 2-3 week lead in time should demand require them.
- The facilities on the Nant-y-Ci site will be able to be activated within a couple of days and can provide space for 220.

Oxygen

- Oxygen supply levels have been assessed as sufficient to support the forecast level of combined ventilator, CPAP and general demand.

Forecast demand Modelling Cell:

- The revised EDAPT SEIR-VD forecasting model approved by Gold Command w/c 22nd June 2020 has been used to produce the forecast demand figures. The model simulates COVID (using EDAPT SEIR-VD model) and emergency demand (using EDAPT M19 model) to provide expected daily bed occupancy range.
- Excludes paediatric patients.
- COVID bed demand is forecast using EDAPT SEIR-VD model Scenario 13 Swansea University Model (LIMS confirmed) Rt = 1.3 (Sept), Rt = 1.1 (Oct), Rt= 1.5 (Nov), Rt = 0.9 (Dec)
- IPPV/CPAP is based on initial Hywel Dda estimated flow ratios of 10% and 18% respectively. This would equate to 11 ventilated patients and 20 CPAP patients at peak.
- Modelling cell are currently investigating flow ratios of IPPV and CPAP using existing data to test the 10% and 18% assumptions.
- All forecasts are based on the Upper Control Limit of simulated results, as approved by Andrew Carruthers on 12/10/2020. This reflects the most recent intelligence on actual numbers and provides allowance for covid related admissions as well as confirmed cases.
- ICU entry is based on IPPV requirements, not true ICU needs.

Field Hospitals

Overview

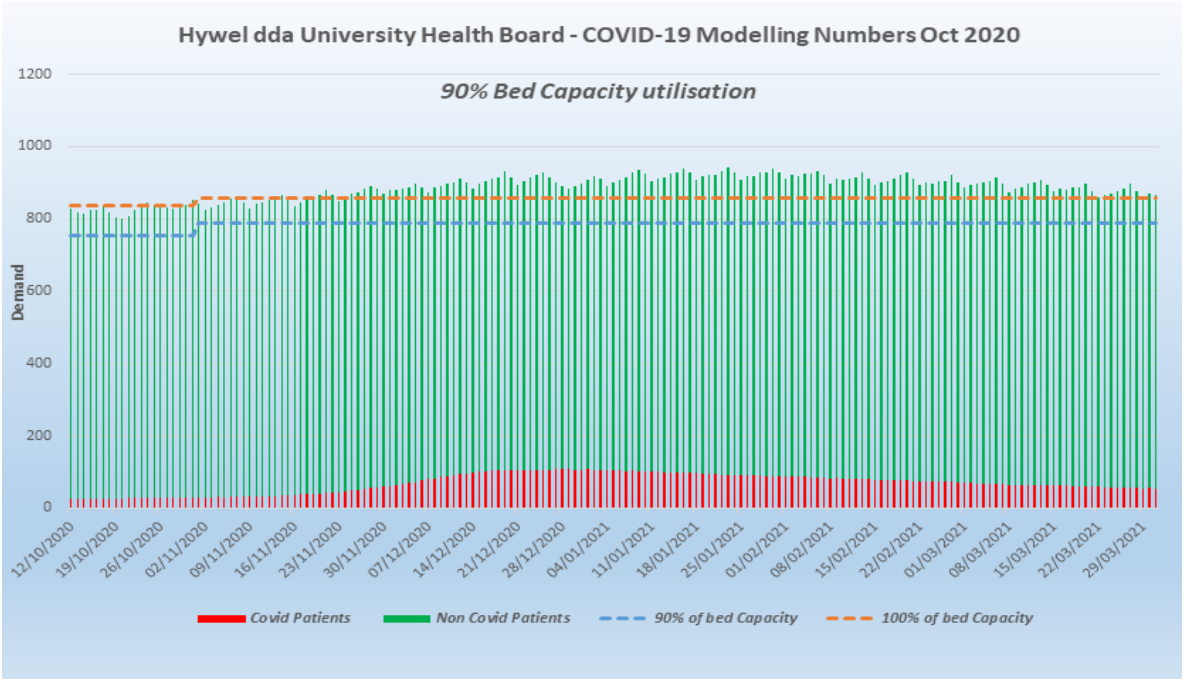
- UHB has continued to track COVID and Non-COVID demand as well as review its modelling scenarios to take into account new thinking at a national Wales and UK level
- WG confirmed a month ago that it was adopting a new model devised by Swansea University as its new reasonable worst case scenario for Wales;
- At the same time, it was made clear that Health Boards still need to develop a contingency plan to meet the worst case scenario articulated in the Director General's letter of the 24th June (for Hywel Dda - 613 COVID cases in hospital at peak);
- The Modelling cell have run the Swansea University model for Hywel Dda to give us a view of what is more likely a realistic view on activity over the rest of this year. This indicates at peak the Health Board may require 153 field hospital beds, with a covid peak of 107 cases;
- A key constraint is workforce but a deployment plan has been developed that describes how the health board will move, flex, and prioritise its workforce to support the additional capacity requirements. This is the means by which the health board would scale up for the potential 501 beds required at peak.
- There is an assumption also that Quarter 3&4 elective plan will need to be maintained throughout;

- In line with the above, the Quarter 2 plan identified that we would be maintaining a minimum of 501 beds in Field Hospitals on the Selwyn Samuel, PYS Barn, Bluestone, Plas Crug and Carmarthen Leisure Centre Sites. The beds will be used for the step down of non-covid patients prior to discharge.
- Additional capacity has also been developed at South Pembrokeshire and Tregaron Community hospitals;
- To date the health board has managed the increased non covid demand by exceeding the suggested 90% occupancy threshold. This was felt to be fine operationally whilst incidence was low during the summer, but plans are being put in place to reduce this now local incidence has increased, and one area (Llanelli) is subject to a local lockdown.
- Therefore the need to use field hospital capacity will be as much part of managing the indirect consequence of covid within our winter plan as it will covid demand itself. The health board are planning to open up to 30 beds in Bluestone and 30 beds in Selwyn Samuel from mid November as part of the plan to reduce bed occupancy to the 85% - 92% range.

Surge Capacity

	October	November	December	January	February	March
Acute 100% bed base	837	856	856	856	856	856
Acute 90% bed base	753	789	789	789	789	789
Forecast Demand Non COVID	822	837	825	850	848	849
Forecast Demand COVID	29	55	107	92	84	66
Total Demand	851	892	933	942	933	915
Surge capacity at 90%*	98	103	143	153	143	125

*based on highest capacity in a month



Planned Care Capacity

Work continues to explore opportunities to increase the volume of planned surgery across our four acute sites, in addition to supplementary capacity commissioned via the independent sector at Werndale Hospital.

Our Planned Care teams has worked closely with each hospital triumvirate team to identify practical solutions to the complexities and challenges associated with delivering protected 'green' pathways for planned surgical patients in hospital facilities which continue to provide for both COVID and non-COVID pathways. All patients listed for surgery follow strict pre-operative pathways including self-isolation and testing prior to admission.

We have undertaken a detailed assessment of the maximum capacity we can provide across our four sites whilst maintaining the current pattern of emergency medical and surgical flows (including our COVID response) across the Health Board area. In the absence of significant available dedicated 'green' surgical capacity, the volume of non-urgent surgery which can be undertaken across the current footprint of our four acute hospital sites remains limited, compared with total available capacity prior to the pandemic. Our focus for Quarter 3 & 4 will therefore continue to be placed on the delivery of surgical pathways in accordance with the Essential Services framework, with Category 1 & 2 (cancer and urgent) patients receiving priority.

These issues are explored in detail in the supporting paper included

The overall volume of surgery which can be delivered at each hospital site is influenced by the main factors:

- **Theatre capacity** – taking account of available staffing resources, the volume of staff currently shielding due to the risks of COVID-19 and the impact on throughput of additional IP&C procedures required to maintain safety of patients and staff
- **Critical care facilities** – predominantly the ability to achieve protected 'green' post-operative critical care pathways to ensure patients undergoing planned surgery are separated from those following 'amber' and 'red' pathways.
- **Beds** – the availability of protected 'green' ward capacity, staffed independently of other areas

The profile of planned surgical pathways to be undertaken at each hospital during Quarter 3&4 is summarised below:

Hospital	Specialties
Prince Philip	Colorectal, Urology, Gynaecology, Breast & Orthopaedic Surgery (from November 2020)
Bronglais	Emergency / Trauma / Obstetric Surgery, General Surgery, Gynaecology & Orthopaedics
Withybush	Emergency / Trauma Surgery, General Surgery, Gynaecology & Orthopaedics
Glangwili	Emergency / Trauma / Obstetric Surgery, ENT / Head & Neck, Ophthalmology and specific Urology cases
Werndale	Breast, Urology, Gynaecology, Dermatology, Orthopaedics & Ophthalmology

Prince Philip Hospital
In the absence of emergency surgical pathways at the hospital, Prince Philip Hospital offers the greatest flexibility to support planned surgery with two main theatres currently operating with a third theatre available from October 2020. As the hospital is also able to provide a dedicated post-operative critical care facility for planned surgical patients, it currently supports health board wide pathways for colorectal and Urology cancer surgery as well as gynaecology and some breast surgery. Due to the pressure on facilities at the hospital, a significant volume of breast surgery has been temporarily relocated to Werndale Hospital.

Plans have been confirmed to recommence urgent orthopaedic surgery at Prince Philip Hospital from November 2020 with the complexities of ensuring adherence to IP&C pathways for this patent group assessed in collaboration with the clinical team and supported by the Board. It should be noted that within the physical capacity constraints we currently have available at each of our four acute sites, our plans for urgent orthopaedic surgery do not meet all of the criteria advised by the British Orthopaedic Association (BOA) and Royal College of Surgeons (RCS) for 'Gold' or Silver' standard elective pathways. Our plans for urgent orthopaedic care reflect the 'Bronze Standard' criteria (and the influencing factors are described in more detail in the supporting document).

Bronglais Hospital

With one theatre dedicated for emergency surgery, urgent and cancer surgery is supported by one planned surgical theatre currently with the availability of up to 14 beds on Rhiannon Ward. As the hospital is unable to secure a dedicated 'green' post-operative critical care pathway, separate from the main critical care facility, surgical cases are limited to less complex procedures for orthopaedics, gynaecology and general surgery.

Withybush Hospital

To date, urgent surgical volumes at Withybush have been limited due to the absence of a 'green' post-operative critical care pathway and the limited availability of theatre staffing. During this period, surgical activity has been restricted to emergency surgery and less complex planned procedures in general surgery, and gynaecology. In recent weeks, a separate day theatre has commenced operating.

Plans to establish a post-operative critical care pathway in the Ward 4 area (to enable a greater range of surgical cases to be undertaken at the hospital) remain under consideration and will be primarily dependent on critical care and theatre staffing availability.

Glangwili Hospital

In the absence of dedicated 'green' critical care pathway (as the hospital is currently the designated 'red' COVID ITU for the Health Board) and pressures on available bed capacity following the closure of Towy Ward (pending urgent refurbishment), Glangwili continues to support emergency & obstetric surgery in addition to more specialist ENT / Head & Neck and urgent ophthalmology surgery. The planning focus at Glangwili centres on the provision dedicated bed capacity to support these pathways and the broader emergency medical demand at the hospital. With the advent of revised Major Trauma Network arrangements from September 2020 and recent increases in demand for orthopaedic trauma, additional trauma theatre capacity is being provided at the hospital.

Werndale Hospital

To supplement the surgical capacity at our four acute sites, facilities at Werndale Hospital are being utilised to support less complex urgent and cancer surgery across a range of specialties.

Limits to staffing resource both in theatre, and post operatively, was a challenge before COVID. The additional factors of providing separate staffing teams for red and green areas, is an added challenge and has shaped the model of provision suggested on each site. Taking all of the above factors into account, available capacity to support planned care pathways within the current footprint of our four acute sites (plus Werndale Hospital) during Quarter 3 & 4 will not match that available before March 2020 The plans described represent the maximum capacity available to us within the current configuration.

Whilst the current constraints described above remain, plans for the recovery of planned care volumes to match those delivered prior to the pandemic will be dependent on alternative models of care and the provision of dedicated 'green' capacity to a level that significantly exceeds that available within our four sites currently. These alternatives are not considered to be achievable within the short term (during Quarter 3/4) in view of the associated significant operational and engagement implications.

Outpatients

Our plans for delivery of outpatient care during Quarter 3 & 4 are described in detail in the supporting Outpatient Improvement Plan (see document at the end of the section). This plan has been approved by the Planned Care Programme and is supported by investment via the WG Outpatient Transformation Fund. Following the initial suspension of planned care pathways in March 2020 and the consequent reduction in outpatient activity, we have steadily recovered new and follow-up patient care volumes to

approximately 66% of pre-COVID levels whilst referral demand is currently 80% of levels received prior to March 2020. In supporting this recovery, we have focused our efforts on the development of alternative approaches to face to face clinic based appointments to the extent that 20% of our current volumes are delivered via virtual / digital platforms.

In order to maintain outpatient care during a potential second wave and to ensure our patients continue to receive the best care possible during these difficult times, our priorities during Quarter 3 & 4 are centred on the following work streams::

- **Managing core**

Our ambition is to maintain our current trajectory of increasing capacity during the months ahead. In a worst case scenario of a significant increase in COVID related hospitalisation rates we would effect a phased reduction in outpatient clinic based appointments, with the exception of MDT/USC/Fracture/'do no cancel' and Urgent new /Urgent follow ups . These clinics would be compressed as to demand on a weekly basis allowing our clinicians to be released into the wider support needed for the hospital site

- **Virtual / Digital Services**

Digital innovation has been a key part in the delivery of outpatient services during COVID. Working on the assumption clinicians are undertaking '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 continue to rollout digital services, including virtual clinics, SOS and clinical validation.

- **Consultant Connect** - immediate phone advice to teams of NHS consultants. The service is accessible through an app and it will provide a single point of access to specialist advice
- **Attend Anywhere** – video consultation process which will provide a virtual video consultation for patient and clinician.
- **Microsoft Teams / Booking App** – already established within the health board and being rolled out.
- **Patient Knows Best -** A patient portal to share and exchange health information, which empowers patients to manage their health.

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. The health Board continues to roll out digital services which will enable remote diagnosis, therefore reducing unnecessary hospital attendance, in particular for shielding and vulnerable individuals.

- **Work plan for Follow up Patients**

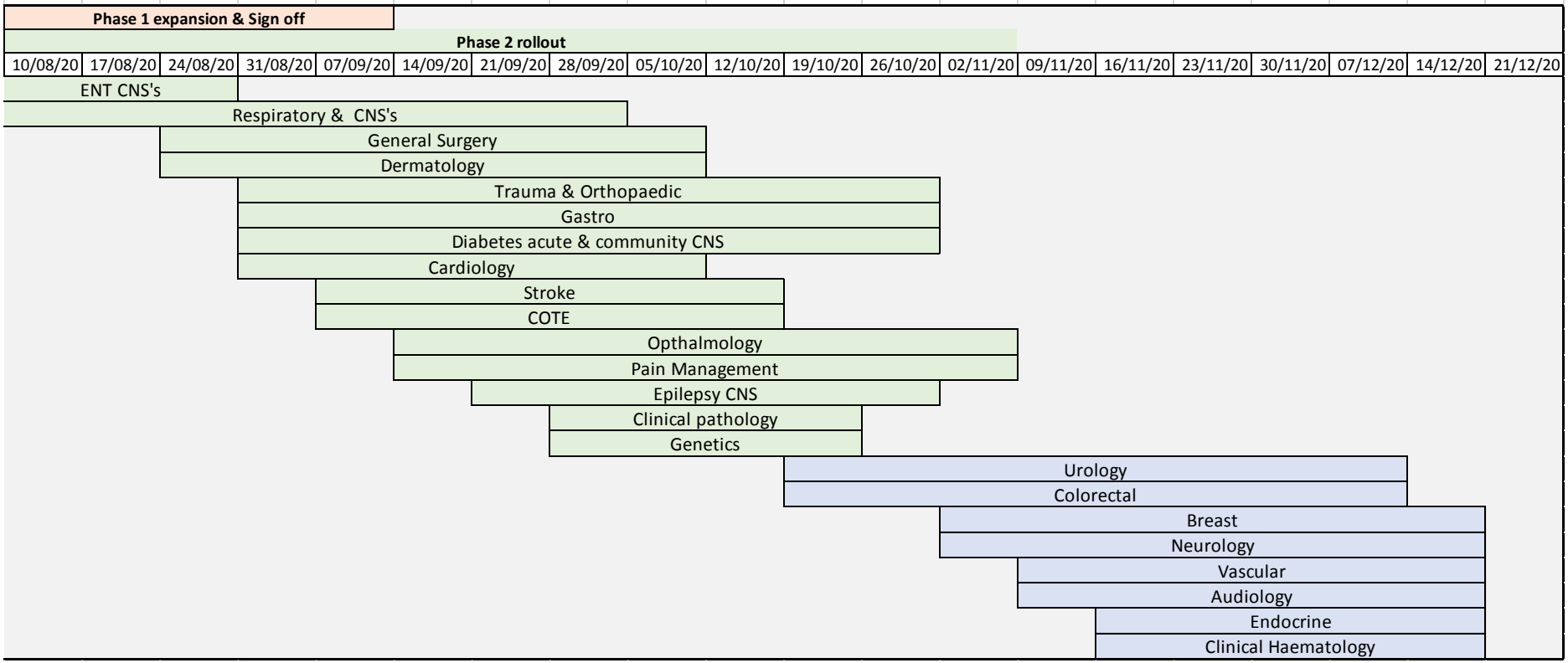
Continue to work with Service Teams to ensure continued validation of the follow up lists, as per the follow up plan (see attachment).

a. Admin validation
b. Clinical validation
c. Discharge if able
d. SOS if able (see attachment)

2. Wide rollout of Consultant Connect regarding sharing information advice.
3. Wider rollout of Attend Anywhere and Microsoft Teams (please see gantt chart below for schedule of rollout).

**In the early stages of the pandemic we saw a temporary reduction in the number of follow ups. However, within the last month we have seen an increase in the 100% + cohort. Our validators and medical teams are now focusing on these patients to ensure their care is not compromised.

HDUHB Attend Anywhere rollout



Organisational Workforce Plans

Workforce considerations remain a key component of the Quarter 3/4 response and in particular the Workforce Planning implications. The Workforce Bronze Command group has continued to meet on a weekly basis and links directly to the Silver Command. Regular interface also continues with the other Bronze Command groups and also through the Bronze Chairs group in order to ensure appropriate linkage and consistency of approach.

- Regular dialogue continues with the respective Chairs of the Staff organisations represented on a twice weekly basis. In addition, monthly meetings are held with the broader Partnership Forums and also quarterly with the Local negotiating Committee re Medical staff. FAQ's are regularly updated and mechanisms are in pace to address staff concerns and deal with queries as they arise.
- All staff are encouraged to take appropriate rest and holidays – various communications have been issued to staff in order to remind staff as appropriate and discussions have taken place at all Partnership Forums emphasising the importance of staff being able to take appropriate rest, breaks and leave.
- In order to on-board and train HCSW's recruited specifically for the COVID-19 demand, a shortened clinical skills induction was developed and has been delivered. In order to maintain standards of the All Wales Induction Programme arrangements are now in hand to enable all COVID-19 recruited staff to complete all remaining components and achieve the full programme.
- The provision of appropriate Training venues has presented a particular challenge for the Health Board, especially with the impending Field Hospital openings. Constant monitoring is needed to ensure flexible plans allow for all contingencies, especially as the venues in Aberystwyth University and Pembrokeshire College are no longer available. Greater use of virtual training is being arranged by creating a greater blended learning approach to clinical skills training.
- The Staff Psychological Wellbeing service continues to deliver existing services addressing team wellbeing, supporting managers and staff and providing one to one psychological support. Investment is being made in our in house counselling provision with an expansion of the team from October onwards as well as the continuation of our Employee Assistance Programme delivered through Care First. We are contributing to the evidence base for wellbeing at work through participation in appropriate research studies in collaboration with neighbouring universities. Arrangements are in hand to continue to develop a responsive framework for building organisational and individual resilience including:
    - A peer support and psychoeducational model for preventing and managing stress and psychological trauma
    - A programme for Psychological Flexibility (ACT in the Workplace) for individuals, teams and input into leadership development
    - Nature based Wellbeing Programme for staff who are at risk of burnout or on sick leave due to stress
    - Regular Listening Spaces for staff from various sites and professions to come together to share experiences and gain peer support
- Workforce indicators of sickness absence, PADR completion rates, Turnover and Core Training compliance continue to be monitored. Regular communications are issued to reinforce the importance of accurate and timely recording of sickness absence to help predict future workforce supply.
- Good progress continues to be made in terms of close collaboration with representatives of the BAME workforce in order to consider how we ensure those at increased risk are properly assessed. Alternative solutions have been enabled such as staff contributing towards the Test, Trace and Protect initiative. Staff returning from shielding have been supported to return to their substantive posts or if that isn't possible they have been deployed to other areas or to work remotely where that is possible. The Workforce team have developed guidance for managers to assist them with conversations with their staff who are returning from shielding.

Workforce Planning - Based on the capacity and demand modelling undertaken for COVID, Non-COVID and Planned Care requirements by our Operational Service teams, the Health Board is seeking to maximise workforce availability to meet surge requirements. However, there are some potential limiting factors i.e. the 2-meter rule on social

distancing, the need to maintain staffing levels within the Nurse Staffing Act (NSA) and also the availability of additional RNs to be able to safely staff surge areas. Please be aware that the Health Board was carrying a significant workforce deficit prior to assessing surge facilities, which has exacerbated our workforce position.

In addition, as this will need to be a sustained effort we are alert to the need to build ongoing capacity and capability within teams and resilience to cope with unforeseen circumstances. To understand the scale of the challenge, we have assessed our workforce demand and workforce availability based on the Essential Services Framework at an organisational and county level aligned to our surge facilities. We have taken account of the deficit presented by the loss of students, fixed term mass recruitments which may have included local students returning to University, and those furloughed, alongside a number of other facets including those risk assessed, and those on temporary registers, and will continue to do so.

To add, this work takes account of a current staffing model for Test, Trace and Protect, however we are alert to the fact that further modelling needs to be undertaken as testing requirements change. This will be a key piece of work in Quarter 3. Immunisation and vaccine delivery workforce modelling will be key in Quarter 3 to define and prepare the workforce needed to deliver the COVID 19 vaccination programme from December onwards.

In assessment of our workforce demand we have identified a significant deficit which is articulated in the workforce plan included as an additional document. A summary of our available workforce and projected workforce demand shows a workforce deficit across most staff groups, however, the most significant is within our registered nurses and healthcare support roles, a total of 680.46 WTE and 860 WTE respectively. For this scenario, based on reasonable assumptions (as noted), and after undertaking all mitigating factors within our influence to take i.e. agency, additional hours, overtime, recruitment to bank- we estimate at this time a residual deficit across each of key staffing group:

- Registered nurses c250 WTE
- Healthcare Assistants c108 WTE
- Facilities c 130 cWTE
- Therapy (including Health Psychology) c40 WTE
- Pharmacy c72 WTE
- Medical c11 WTE (for surge facilities specifically)

We are aware of the risks within our assumptions to reduce such significant deficits, and the unpredictability of our current environment to be able to predict activity, therefore we are exploring further options to increase agility within the workforce. The development of a “designation” and “rotational” model for General, Community and Field Hospital (specific to each staff group) for deployment to maintain resilience and skills development to be able to flex the workforce at times of escalation. To this end, we are looking at a phased approach to deployment of the workforce:

- within service deployment to key roles or to manage risks (individual or organisational)
- those trained for deployment during the initial surge to critical areas
- deployment of senior corporate team practitioners/registrants to operational areas alongside supernumerary leadership registrants redirected to hands on patient care
- closure of services at times of crisis, and deployment of teams to services at risk of failure

Alongside this work, “workforce stretch” will be considered i.e. the ability of registrants with additional support through alternative workforce models to support a greater number of patients utilising ratios as a crude measure to initially model implications. Work is taking place to assess the Quarter 3 & 4 plans within an escalation framework, to

designate priority services and workforce to deploy based on an escalating position; this analysis may identify significant difficulties during a second COVID wave to maintain the delivery of essential services or the ability to realise all surge facility beds. Additional activity is being developed to create greater resilience in the Social Care workforce through a joint workforce initiative with the three Local Authorities and the Health Board to support patient flow, and develop support at an escalated COVID position for domiciliary care, and care homes per se.

Further work will be needed to consider the opportunities for a collaborative approach depending on need with local, bordering Health Boards i.e. Powys and Swansea Bay in relation to flexible and contingent models of workforce. Due to geographical locations and the prevalence of COVID we currently believe this to be limited. The additional mitigating actions outlined in Quarter 2 are in progress and are accounted for in the work above (or have been assessed as not feasible given timescales, specifically the creation of 50-100 Band 4 roles in totality). Consideration of developing a "volunteer" or reservist model with other agencies with skilled clinical staff is in development - specifically, a pilot with Army Reservists to create a collaboration to upskill and deploy into areas of need for short periods. These actions seek to address and mitigate against the risks identified earlier i.e. a possible and significant shortfall in our Registrant and Non-Registrant workforce to some extent.

Other significant activities are in progress to maintain and develop workforce supply internally and externally i.e. managers have been encouraged to ensure vacancies in the budgeted establishment are stabilised by continuing with recruitment in the normal way via TRAC. We are recruiting up to establishment for HCSW and Facilities posts in order to provide stability in these areas. Managers are also leading on opportunities to increase the hours of part time staff and options for overtime hours when necessary.

A robust campaign has been initiated for Registered Nurse recruitment including extensive social media advertising, radio, newspaper and Nursing Times advert. Registered Nurses WTE as at 1.10.20 is significantly higher compared to the corresponding position in 2019. We have retained a number of employees who were offered fixed term contracts in March 2020 (234 extended and 93 converted to Bank). A significant proportion were keen to continue working for the Health Board if there was an opportunity to do so. Fixed–term contracts have therefore been extended until 31.3.21 to stabilise workforce supply for HCSW and Facilities staff during Quarters 3 and 4. In addition, a recruitment process is underway to recruit additional staff as HCSW's and Facilities posts on a bank only basis in order to provide further flexible supply should it be needed.

We have also been growing our Registered Nurse and HCSW Bank. Registered Nurses on the Bank as at 1.10.20 (307) compared to (246) as at 1.10.19 (increase of 61). HCSW on the Bank as at 1.10.20 (940) compared to (668) as at 1.10.19 (increase of 272). Agency usage is under continuous review to quantify the likelihood of additional availability during Quarters 3 and 4.

There has been no indication from workforce data that EU transition is having any impact on the organisation. It is still too early to assess effects of leaving the EU with a deadline of June 2021 for settled status applications in place. The organisation will monitor and assess any issues when and if they arise over the coming months.

The Workforce Planning Task & Finish Group has oversight of the workforce plans and forms part of a monthly risk assessment.

Finance Plans (including Capital)

Financial Forecast FY21 Summary

Following confirmation of additional funding from WG, the UHB is forecasting to deliver the planned deficit of £25m. However, the UHB is managing a number of risks in respect of Winter Planning, reinstating elective services and any unprecedented further impact of the pandemic; the UHB is planning to utilise funding streams already available to mitigate these risks, however those funding streams shared with Local Authority partners represent a level of risk. These risks are also potentially mitigated by any shortfall in workforce supply compared to plans.

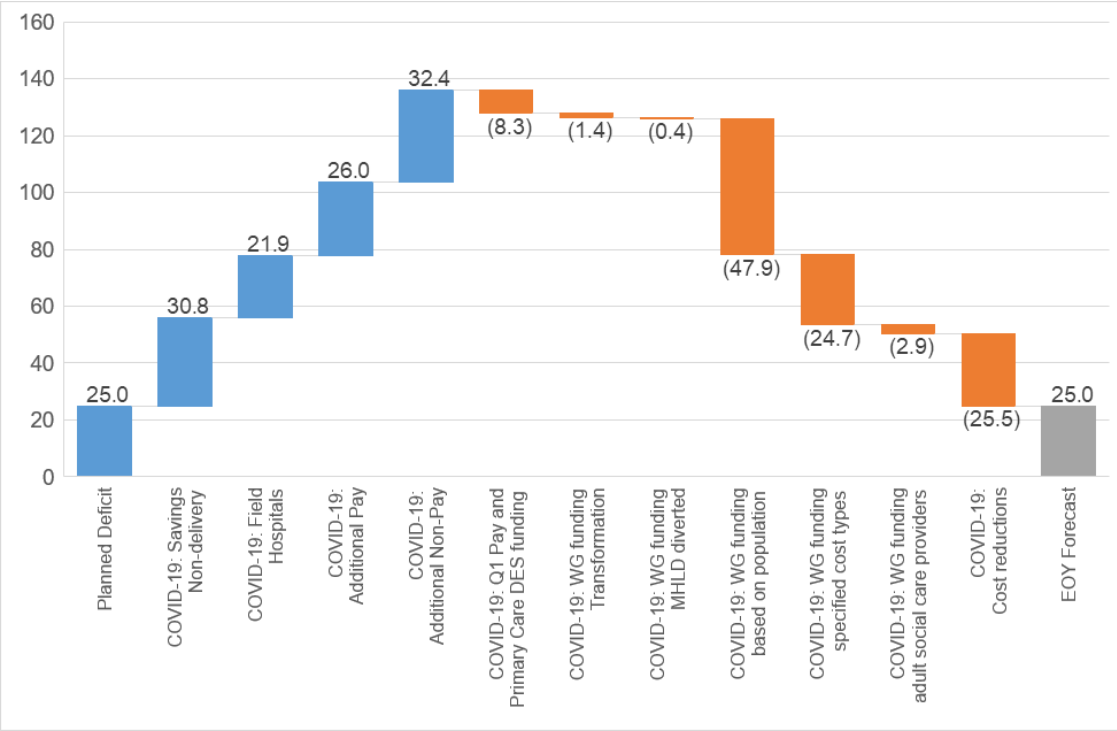
The UHB's financial forecast for Quarter 3 and 4 are in line with the Month 6 monthly monitoring return submitted to Welsh Government (WG), and has been discussed by the Board prior to this submission, including the detailed financial assumptions, forecast, risks, and opportunities.

A Financial Reporting Principles paper was developed to outline the UHB's approach to the internal and external reporting of the costs incurred in response to the COVID-19 pandemic, and continues to provide a consistent framework.

Guidance has been received from WG outlining the external expectations of the organisation's ability to record and report the costs incurred in the local response to COVID-19 pandemic. 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.

Key areas for consideration from a financial governance perspective are: Value for money; Decisions are rational and justifiable; Integrity; and Fraud. The UHB's Accountability statements in relation to the Budget for 2020/21 were replaced with a Delegations and Finance Delivery letter, issued in May 2020. 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. Performance is monitored monthly through System Engagement meetings for the highest risk Directorates.

The key components of the end of year forecast are:



- Non-delivery of savings (against a requirement of £34.2m) due to operational focus being diverted to COVID-19;
- Additional costs incurred as a direct result of the response to COVID-19;
- Confirmation of further WG funding towards impact of COVID-19 of £47.9m plus 'specific' COVID-19 funding to match costs incurred for PPE, TTP, Flu vaccinations, Field Hospital set-up and decommissioning costs, and consequential losses;
- WG funding to mitigate the impact of COVID-19 re Quarter 1 Pay, Primary Care Directed Enhanced Service, Transformation, MHLD, Adult Social Care Providers.
- Cost reductions across most services due to reduced activity resulting from COVID-19.

Key assumptions

The forecast has been modelled for a 'realistic' scenario based on demand to date and local intelligence, and assumes:

- Continued impact of current 2 metre social distancing guidelines in ward areas, whereby existing acute capacity would not significantly reduce following mitigating actions such as screens;
- Existing fixed term staff cohort extended to March 2021;

- The cost of delivering a COVID-19 vaccination programme is not included in the financial forecast. Current modelling anticipates a minimum of 100,000 patients; currently there is no confirmed WG funding;
- Werndale contract is directly funded by WG in Q4 based on Independent Sector Provider 'specific funding' guidance;
- Cost reductions due to reduced activity continue, to some extent, for remainder of financial year;
- Additional capacity required in response to Winter Pressures will largely be fulfilled by Field Hospitals;
- Field Hospital requirement of 82 beds at a potential peak is included in the financial forecast, notwithstanding the operational capacity is greater (see Field Hospitals section above for further details):
    - Fulfils capacity lost in existing sites following implementation of current 2 metre social distancing guidance;
    - Active sites: Bluestone and Selwyn Samuel;
    - Number of sites assume no requirement: Parc Y Scarlets Barn, Cardigan Leisure Centre, Plas Crug, Carmarthenshire Leisure Centre (with readiness plans in place if needed);
    - Number of sites decommissioned: Parc Y Scarlets Stadium, Llanelli Leisure Centre, Penweddig School;
    - Field Hospital staffing modelled on substantive costs basis – no premium for Agency workers is included. Where fixed term employees are available, assumed that these will firstly fulfil the requirements in the Field Hospitals;
    - All de-commissioning costs assumed to fall into the current financial year, regardless of exit date.

As a consequence of the increasing trend in COVID-19 activity, and current relatively modest Field Hospital financial assumptions, there is a risk that a 'second wave' would significantly affect the above assumptions.

Risks to the Financial Forecast

- At the time of submission, the Winter Plan is subject to sign-off by the Regional Partnership Board on 29 October 2020. A final, agreed version will be submitted to Welsh Government after this date;
- Increased elective activity if capacity allows – no significant increase is included in forecast to address RTT;
- EU Exit costs, in the event of a 'no deal' EU exit, may lead to premium costs for medical and clinical supplies, staffing issues due to new immigration laws and instability in the care provider sector;
- In line with a number of other Health Boards in Wales, it is expected that the UHB would opt to cover any benefit-in-kind liability arising from the provision of accommodation to staff resulting from measures to address the COVID-19 pandemic which would otherwise be a liability to individual staff members;
- GMS and Dental contractual 'true-up' as WG guidance allows GPs to claim the higher of actual claims or payments in the same period last financial year, and Dental under-performance may impact on contractor sustainability if withheld;
- As a result of the Home Office directive of utilising the Penally army base as a site for the placement of asylum seekers, the Health Board is anticipating a range of health costs associated with this.

Opportunities

- Remaining centrally held Reserves may not be fully utilised for planned investments; reviews continue with appropriate stakeholders;
- Further cost reductions may occur as a result of reduced activity should less services than planned be re-instated;

- Development of solutions in conjunction with Local Authority and Third Sector partners to repurpose resources;
- Any shortfall in workforce supply compared to plans may provide a financial benefit;
- Any pending or future National or Local lockdowns, as the previous lockdown demonstrated reduced patient activity levels that have now started to recover;
- Additional WG funding may be available to mitigate the risk of Winter Plan costs above.

Capital

The current Capital Resource Limit (CRL) for 2020/21 has been issued with the following allocations:

Expenditure	£m
All Wales Capital Programme	9.555
Discretionary Programme	7.271
Slippage due to COVID- 19 from 2019/20	1.090
COVID-19 – Digital Devices	0.935
COVID-19 - Equipment	7.722
Total	**26.573**

No additional capital funding has currently been assumed for 2020/21 for COVID-19 issues or other developments.

Expenditure	Costs Committed 2020/21 £m	Funding Released to Date £m	Current Funding Gap £m
Acute Sites	5.846	3.603	2.243
Field Hospitals	3.846	3.719	0.127
Informatics	1.296	0.981	0.315
Women and Children Phase II (Glangwili)	0.024	0.024	0.000
Equipment purchased through Shared Services	0.235	0.139	0.096
Total	**11.247**	**8.466**	**2.781**

Orders have been placed to the value of £11.247m on items and schemes to enable the Health Board to respond to the COVID-19 pandemic. It is anticipated that WG will provide funding for these items.

In addition to the cost committed to date, there are schemes to the value of **£11.971m** which the UHB would ideally wish to progress to deal with COVID-19 and social distancing issues if it were not for funding constraints. The top 6 items on this list are as follows

DETAIL ON TOP 6 SCHEMES					
Rank	**Scheme Name**	**Grouping**	**Scheme Urgency**	**Scheme benefits**	**Impact of not proceeding**
1	ICU Options at Glangwili £54,000	Isolation Social Distancing Service Resilience	Urgent	• Requirement to increase the number of side rooms in Critical Care to improve isolation options where Aerosol Generating Procedures (AGPs) would place other patients and staff at risk of spread of infection	• Would not address the risks of AGPs in spaces where other patients and staff are exposed. • Would not address staff concerns on the current limited ability to protect their patients or peers on the Unit.
2	ENT Equipment at Glangwili £190,824	Restart Essential Services	Urgent	• Additional equipment is required to safely assess ENT patients across the Health Board; ensure ENT and H&N cancer patients are seen & diagnosed promptly and within target; and to re-achieve the efficiency and throughput of ENT clinics. • Majority of ENT patients require face-to-face consultations with a wide range of highly specialised diagnostic investigations; only a very small proportion of ENT & H&N cancer patients can be managed virtually. • Current equipment is not adequate to meet service provision in light of COVID 19 restrictions. The purchase of additional equipment that complies with UK & Nice Guidelines for AGP would ensure patient safety and create additional capacity.	• Impaired service provision and increased waiting times for patients as a result of reduced clinical capacity. • COVID 19 clinic restrictions around Aerosol Generating Procedures (AGP) and ENT UK Guidelines have significantly reduced clinical capacity. A typical clinic would usually see 20 patients but can now only facilitate 8 patients. • There is potential for misdiagnosis & missed cancers; increase in incidents, complaints and claims.
2	ENT/Audiology Facilities at OPD, Glangwili £92,131	Social Distancing Restart Essential Services Service Resilience	Urgent	Improvement work (redesign and reallocation of clinic rooms) is required in outpatients to facilitate: 1) The direct to Audiology referral pathway: and 2) Increase clinical capacity for ENT clinics The Direct to Audiology pathway will contribute to the achievement of a sustainable ENT service and evidence that there would be an active reduction in demand on the ENT waiting list by approximately 25% through the implementation.	• Increased waiting times for patients due to reduced clinical capacity. Impaired service provision with a potential for increase in incidents, complaints and claims.

				Current clinic space is not adequate to meet ENT service provision needs in light of COVID 19 restrictions. Aerosol Generating procedures (AGP) and PPE have resulted in a significant reduction in clinical capacity - the turnaround and cleaning time between patients is 1 hours and 20 minutes. A typical clinic would usually see 20 patients but can now only facilitate 8 patients. The loss of the treatment room on Merlin has also reduced capacity, resulting in emergency patients having to be accommodated in outpatient setting. Creating additional space in outpatients that comply with UK & Nice Guidelines for AGP would ensure patient safety, re-achieve efficiency and throughput of clinics and avoid unacceptable waiting times.	
3	Glangwili A&E Examination Rooms £54,525	Isolation	Urgent	• Glangwili Emergency Department currently has 4 open trolley areas (Majors 3 – 6) with disposable curtains. The remaining rooms are equipped with ¾ doors or sliding screens to enable access for beds and trolleys. This proposal is to add doors to Majors 3-6 to make them cubicles for infection control reasons. • Doors would enable safe containment of any infectious symptom to other patients and staff working within ED.	• Patients with infectious symptoms unable to be safely isolated in Majors 3, 4, 5 and 6 in line with infection prevention and control. • This is further compounded by the COVID assessment not being fit for purpose during the autumn and winter months so additional A&E cubicles will need to be assigned for this process leaving insufficient A&E assessment areas for majors patients
4	ICU Options at Bronglais / Glangwili / Withybush £198,000	Isolation Social Distancing Service Resilience	Urgent	• Requirement to increase the number of side rooms in Critical Care to improve isolation options where Aerosol Generating Procedures (AGPs) would place other patients and staff at risk of spread of infection	• Would not address the risks of AGPs in spaces where other patients and staff are exposed. • Would not address staff concerns on the current limited ability to protect their patients or peers on the Unit.
4	Shower facilities x 4 sites - Withybush £94,429 each	Bed capacity Service Resilience Social Distancing	Urgent	• Clinical space is at a premium so the use of this for changing & shower facilities is not sustainable going forward. Withybush has no staff changing facilities in clinical areas outside of departments such as the	• Loss of clinical space to shower / changing facilities. This totals 12 single rooms across the site. The site has been scoped for alternative facilities but no suitable space is available.

				Intensive Care Unit, Day Surgery Unit, Theatres and Endoscopy. • The provision of an external shower & changing facility will result in 12 clinical rooms being returned to their primary patient accommodation function across the hospital site. This will not only increase overall bed capacity but also single room isolation facilities. These are of prime importance particularly during a pandemic and going into the winter period where flu & Norovirus become more prevalent. • Providing this facility will contribute to enhanced staff wellbeing by recognising the importance of reducing infection prevention risk created through a lack of shower/changing facilities on site and increasing stress through a more pressured working environment and fear of spreading Coronavirus.	• It is not considered appropriate infection prevention practice for staff to come to, or leave, work in their uniforms. Not providing appropriate changing & shower facilities will mean that staff will have no allocated space to change into work clothes / uniform following arrival. • This will also increase staff anxiety around the increased likelihood of transporting Coronavirus out of the hospital and into their homes.
6	JDR En-suite Facilities at Block 10, Glangwili - £78,000	Isolation Service Resilience		• Safety of our staff and to avoid large-scale disruption if anyone had a suspected or actual COVID infection.	

Whilst the UHB has welcomed the additional capital resources received to date for the management of the COVID-19 response there is a clear identified need for further additional resource should it become available. Additional resources would enable the HB to address the following

- progress the additional priority COVID-19 schemes
- limit the diversion of the discretionary allocation to progress COVID-19 schemes and schemes normally funded from All Wales Capital Programme
- prioritise the discretionary programme to deal with the backlog of equipment, statutory and infrastructure and digital items
- with WG approval to progress capital schemes in development in-year, such as Transforming Mental Health and Aseptic Services and issues of Fire Regulation compliance.

Research and Development

The COVID 19 pandemic has had a significant impact on the amount of clinical research that is being undertaken in the Health Board. In March/April a large number of our existing studies were either closed or suspended as the focus turned to Urgent Public Health (UPH) COVID 19 studies. The current position is that the UHB is taking part in seven UPH COVID 19 studies, and sponsoring three further COVID 19 studies. Two of these UHB sponsored studies are recruiting, and one is in set-up. Over 300 people from across the UHB have taken part in some form of COVID 19 research study to date and the focus is on keeping the COVID studies open to monitor and react to any future cases as the incidence of COVID infections increases again.

The Research and Development department has also been in discussion with Health and Care Research Wales (HCRW) regarding the potential for vaccine trials to take place in the Health Board. In conjunction with relevant senior staff, three field hospitals were identified as being potential venues. At the end of September however, HCRW stated that it is now unlikely that the UHB will be used as a primary site for vaccine trials as these are being focussed on the large population centres in both South and North Wales. It may be that the UHB will be asked to perform a supporting role for a vaccine trial in Swansea Bay UHB, and we have indicated our willingness to do this. In July, two members of staff from the clinical research teams in the UHB were lent to Aneurin Bevan UHB to assist in the first vaccine trial.

As the incidence of COVID 19 started to fall R&D put a restart framework in place to re-open non-COVID activity alongside the UPH studies. The Delivery team meet weekly with the higher management of R&D and the Medical directorate to discuss the re-opening of research activity. Studies are assessed against set criteria that consider the level of infection risk associated with the study, and then match this with the capability and capacity on the relevant site, which includes pharmacy, pathology, radiology and other supporting services. This process is proving challenging due to reduced access to hospital facilities and previously research active departments being under pressure to reduce clinical backlog. The re-start process was shared at the Quality Safety and Experience Assurance Committee in August. To date 20 of the suspended studies have been restarted and 12 new studies have been started.

EU Transition

- Work is taking place to review previous organisational preparations and plans relating to EU Exit, and to make adjustments where necessary in order to ensure that arrangements are fit for purpose for the forthcoming period;
- EU Transition preparations and arrangements are being appropriately considered/reported at relevant senior fora within the organisations;
- Organisations engage in national arrangements/structures where appropriate, and factor relevant developments into their local planning arrangements;
- Organisations are considering and applying learning from COVID-19 response as part of their EU Transition preparations; and
- Organisations will have arrangements in place to support their staff throughout the period of transition, particularly those most directly affected by EU Transition.

The Hywel Dda Brexit Steering Group was reconvened on 12th August, 2020. The group, chaired by the Director of Finance, provides a senior level, multi-professional forum, utilising a risk management approach, for planning, preparing and responding to the consequences of EU Transition within the Health Board. The group is currently focusing on the review of existing arrangements, risk assessments and contingencies with an extra focus on any additional impact and learning from COVID-19. The Brexit Steering Group reports directly to the Executive Team. The UHB participates in:

- Brexit SRO Group (national planning)
- Wales Brexit Communications Group (national planning)
- WG Health & Social Care Civil Contingencies Group (national planning)
- Dyfed Powys LRF Brexit Group (regional planning)
- Dyfed Powys LRF Risk Group (regional planning)

Additionally, our Procurement Team links in to national planning via NWSSP arrangements. Professional leads participate in planning for EU transition via their professional leads fora and all work steams feed back into the UHB Brexit Steering Group.

Supporting staff remains a key priority for Hywel Dda. A dedicated intranet page for all things “Brexit” has been maintained and signposts to key information sources: http://howis.wales.nhs.uk/sitesplus/862/page/74794 including how to access help to apply for settled status. The ESR data gap has been targeted and the Health Board now has a 98% nationality compliance on ESR which has aided us in understanding our workforce and our key risk staffing groups. This in turn has assisted in developing, and maintaining a workforce action plan which details risk areas and actions in key workforce related areas.

An organisational issue reporting mechanism has been developed which enables staff to report and escalate areas of concern which will be addressed by the Brexit Steering Group. This process, hosted on sharepoint also provides an internal portal for sit reps and other key documentation. The risk register entry for EU transition has been updated and presented to the Quality, Safety and Experience Assurance Committee (QSEAC) during October 2020.

We currently await further information on the requirements for providing situation reports as Operation Yellowhammer has now been replaced with D-20.

Stakeholder Management, Communication and Engagement

Organisations must have effective mechanisms in place to engage with stakeholders, including service users and carers, staff, the Community Health Council, partners and the wider public. Consideration will also be needed on how the information and plans for a challenging winter, in the context of COVID-19, are communicated with the public including those personally affected and awaiting treatment. To help allay these concerns and respond to enquiries, it will be necessary to have a robust communication and engagement plan in place.

- The health board has frameworks and established mechanisms in place for communicating and engaging with staff, partners (including the Community Health Council and elected public representatives), and people who use our services or live and work in our communities and these have all been utilised during the pandemic and responses, insight and feedback have informed our action going forward
  Case example – We have taken insight and engagement from the CHC and politicians on confusion in regards to difficulties accessing the UK testing portal. This resulted in a direct enhancement to our approach (i.e. an alternative local booking mechanism in our health protection zone of Llanelli) and improved local clarification of how to access testing through a testing and tracing question and answer resource We are using stakeholder communications, messaging to our Siarad Iechyd / Talking Health members and general communications to raise awareness of this resource.
- A high level health board communications strategy on COVID-19 is currently being refreshed and broadened to include engagement and to reflect not just how we communicate in regards to COVID-19 itself, but the wider environment and impacts on services, people and access as we live alongside the pandemic. This includes how we plan for the challenges that winter brings and how we support our patients and community to stay as well as possible and how we are re-establish services
  Case example – Work has already started to communicate with patients' waiting longer for treatment. This was based on engagement and insight from patients contacting the Patient Support Team who wanted updates on when they could expect their treatment or appointments. The scheduled care team have used letters and SMS messaging to check people's status on waiting list. The communications team has worked with scheduled care, the local public health team, the therapies team and patient support services to develop a weekly published status report on how we are re-establishing services. We are also due to launch keeping well advice to support and guide patients to look after their own health and well-being whilst they await treatment – this is expected early in Quarter 3. In the next two quarters we will work with the nursing directorate and wider organisation on a project to continually communicate directly with patients on our waiting lists.
- The strategy is underpinned by several bespoke communication and engagement plans such as Winter & Flu Vaccinations
  Case example – It is imperative that we protect our staff, patients and community against seasonal flu, for the benefit of their health, but also the wider capability of the NHS this winter. We have a robust communications plan for seasonal flu this year which includes both traditional newspaper advertising and social media advertising and a new internal approach using champions, as well as supporting for our primary care partners on delivery. We are seeing some early success – in September 2019 community pharmacy delivered 1,652 vaccinations and it was a record breaking year for us, this year they have done 16,300!
- All this work is also supported by a regional communications plan (Hywel Dda COVID-19 Regional COVID-19 Response and Recovery Plan) which has been embraced by partners from the health board and local authorities, and also by other organisations locally including Dyfed Powys Police and further education providers
  Case example – Communication leads meet weekly to share insight and planning to give strength and amplification to our regional messaging. This also reduces duplication or audience dilution – for example Carmarthenshire Council communications team developed some excellent resources that were used by schools and directly sent out to parents via digital applications. These have now been utilised at a regional level with all partners using the same and with all logos appearing

(attached asset as example) In Quarter 3 and Quarter 4 we will continue to prioritise our joint approach to incidents but also to proactively manage risks based on intelligence and known risks such as challenges of social distancing during celebrations such as Halloween and Christmas

Framework Minimum Data Set

General information

- Not all data has been available for all data fields
- Public Health Wales are providing All-Wales figures for screening
- The Welsh Ambulance Services NHS Trust provided the ambulance figures

Vaccination tab

- **Data source:** The uptake figures stated are those reported to Public Health Wales Influenza Vaccination Online Reporting system (IVOR). Due to the methods and inclusion criteria used by IVOR, the reported figures each year are lower than the actual number of vaccinations given. For example UHB staff without direct patient contact, healthcare students, agency and bank staff, carers, first responders and social care staff who do not additionally fall into one of the categories listed above will not be included in the total. However the IVOR figures are the standard used for reporting purposes across Wales and allow comparison between health board areas.
- **Pregnant women**: Although routine surveillance data are collected automatically from General Practice on vaccinations given to pregnant women, difficulties in robust ascertainment of the denominator in this group result in underestimation of uptake. Therefore, an annual survey is conducted in January to provide additional estimates of coverage of pertussis and influenza vaccine in pregnant women. The sample size for Hywel Dda in January 2020 was 45.
- **School aged children**: The spreadsheet asks for data on children aged 4-8 years, and this has been provided. However the school-based vaccination programme has expanded over recent years and all primary school aged children (aged 4-11 years) are now eligible. The sum of all vaccinations given in the 2019-20 season includes vaccinations given to children aged 4-11 years.
- **Data for 2020-21:** Vaccination is well underway in all campaigns and initial uptake data for the current season are expected imminently. Uptake this season is difficult to predict and is unlikely to follow the pattern of previous seasons, due to increased demand and amended clinic schedules as a result of COVID-19. However it is widely expected that uptake will increase significantly. Australia and New Zealand, where flu season coincided with the first peak of COVID-19 infections, experienced a 40% increase in flu vaccination uptake. As a local indication, across Wales, uptake in community pharmacy in September 2020 increased ten-fold over September 2019 (16,300 vaccinations given in Welsh community pharmacies this September compared to 1,652 in September 2019). However it is not yet clear if this increase will be repeated in the coming months or if it represents an earlier than usual start to the vaccination season.
- **Data for childhood immunisation programme** taken from the last quarterly COVER report: Vaccine Uptake in Children in Wales April to June 2020 COVER 135: Wales August 2020